

SECTION I: SCENARIO OVERVIEW

Scenario Title:		Sepsis_Meningitis_8-year-old_Case C – AACN Essentials	
Original Scenario Developer(s):		Michele Solakian, MSN, RN, CPNP; Colleen Nevins, DNP, RN, CNE; Jon Victor Altamira, BSN, RN	
Date - original scenario		06/11	
Validation:		10/18 mm	
Pilot testing:		06/17, 07/17	
Revisions:		08/24 L. Catron, DNP, M.A.ED, BSN, RN, CHSE	
<u>Estimated Scenario Time</u>		15-20 minutes	<u>Debriefing Time</u> 30-40 minutes
<u>Target group:</u> Pre-licensure nursing students in their Pediatric or critical care rotation			
<u>Core case:</u> 8-year old with sepsis secondary to meningitis with emergent admission via ER requiring care in the pediatric intensive care unit.			
<u>Brief Summary of Case:</u> 8-year-old female patient presented in the ER with 4-day history of high fever (39.4-40 °C) and rash for 24 hours. The rash started yesterday on the trunk, arms, and legs. The rash is rapidly coalescing and becoming dark purple in color, resembling purpura. Patient was treated at home with antipyretics (Motrin suspension 20mg/kg every 4 hours) and cooling measures which failed to reduce the fever. Patient is irritable and lethargic.			
Signs and symptoms are correlated with possible meningococcal meningitis. The primary diagnosis is sepsis, and signs and symptoms are consistent with septic shock. Initiation of treatment to treat the underlying infection and hypotensive distributive shock. Treatments include: rapid assessment of the patient, fever management, intravenous fluid resuscitation (bolus), antibiotic therapy, and establishing Isolation (“droplet”) precaution and vasopressor medications.			
<u>Other:</u> <i>This scenario is appropriate for undergraduate nursing students in their pediatric rotation or new graduates. Complexity can be adjusted to level and needs of the learner.</i>			

EVIDENCE BASE / REFERENCES (APA Format)
Center for Disease Control. (2020). CDC sequence for donning personal protective equipment (PPE). https://www.youtube.com/watch?v=1xy00pLT9M4
Cummings, B. M. (2024). Treatment of Sepsis and Septic Shock in Children. Medscape. https://emedicine.medscape.com/article/2072410-overview?form=fpf
Cruz, A. T., Lane, R. D., Balamuth, F., Aronson, P. L., Ashby, D. W., Neuman, M. I., Souganidis, E. S., Alpern, E. R., & Schlapbach, L. J. (2020). Updates on pediatric sepsis. Journal of American College of Emergency Physicians Open, 1(5), 981-993. https://doi.org/10.1002/emp2.12173
Hazinski, M. F. (2013). Nursing care of the critically ill child, 3rd Edition, St. Louis Missouri: Elsevier.
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Perry, S. E., Hockenberry, M. J. Cashion, K, Alden, K, R., Olshansky, E., & Lowdermilk, D. L. (2022). Maternal child nursing care (7th ed.). Mosby.
Pomerantz, W. J. (2024). <i>Children at risk for sepsis and septic shock in resource-abundant settings: Rapid recognition and initial resuscitation (first hour)</i> . UpToDate. https://www.uptodate.com/contents/children-with-early-and-life-threatening-sepsis-in-resource-

SECTION I: SCENARIO OVERVIEW

abundant-settings-rapid-recognition-and-initial-resuscitation-first-hour
Society of Critical Care Medicine. (2020). Surviving sepsis campaign pediatric patients. https://www.sccm.org/SurvivingSepsisCampaign/Guidelines/Pediatric-Patients
Society of Critical Care Medicine. (2020). Initial resuscitation algorithm for children. Society of Critical Care Medicine and the European Society of Intensive Care Medicine. https://www.sccm.org/sccm/media/ssc/Initial-Resuscitation-Algorithm-for-Children.pdf
Stanford Medicine. (2024). Meningococcal infections in children. Children's health. https://www.stanfordchildrens.org/en/topic/default?id=meningococcal-infections-in-children-90-P02529

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes

1. Recognize and identify the pediatric patient with signs and symptoms of septic shock.
2. Apply decision making skills for appropriate fluid resuscitation to pediatric patients exhibiting hypotensive, distributive shock based on physical assessment findings and the guidelines for pediatric sepsis.
3. Prioritize assessment and interventions to assure safe, effective outcomes of care.
4. Communicate using closed loop methods within the healthcare team.

Specific Learning Objectives

1. Participants will complete a comprehensive initial assessment and focused patient reassessment.
2. Participants will provide critical thinking with prioritization of care & clinical reasoning with patient interventions.
3. Participants will apply evidence based practice guidelines for the assessment and delivery of care for patients with sepsis.

Critical Learner Actions

1. WII: wash hands, introduce self, identify patient
2. Perform focused and comprehensive assessments: Vital Signs, and reassessment after providing treatment.
3. Recognize signs of shock based on evaluation of vital signs, decreased level of consciousness, poor peripheral perfusion and response to fluid resuscitation.
4. Assess parent's willingness to learn and initiate discussion about central line infection, and over dosage of home Motrin.
5. Communicate with healthcare team members including physician, charge nurse or pharmacist.
6. Administer medications safely, including antibiotics, rapid administration of fluid bolus, and antipyretic.
7. Recognize the difference between IV fluid resuscitation (bolus) and IV fluid maintenance.
8. Wear the appropriate personal protective equipment (PPE) for Droplet & Contact Precautions.
9. Re-assess and evaluate patient following interventions, recognizing core measures for sepsis.

AACN Essential Learner Activities Based on Learning Objectives & Actions

Domain	Sub competencies
1 Knowledge for Nursing Practice	1.2a; 1.2e; 1.3a; 1.3b
2 Person-Centered Care	2.1; 2.2; 2.3a-g; 2.4; 2.5a-e; 2.6c; 2.7a; 2.7b; 2.8b; 2.8c; 2.9e;
4 Scholarship for the Nursing Discipline	4.2c
5 Quality and Safety	5.1b; 5.1c; 5.2c; 5.2f
6 Interprofessional Partnerships	6.1b; 6.1e; 6.2c; 6.3b; 6.3c

State or Regional Core Tenet Learner Activities

QSEN Competencies

<input type="checkbox"/> Patient Centered Care	<input type="checkbox"/> Teamwork and Collaboration
<input type="checkbox"/> Patient Safety	<input type="checkbox"/> Informatics
<input type="checkbox"/> Evidence Based Practice	<input type="checkbox"/> Quality Improvement

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies	
Knowledge	Skills/ Attitudes
<input type="checkbox"/> Care of the child with sepsis or meningitis.	<input type="checkbox"/> Teamwork and Collaboration
<input type="checkbox"/> Developmental Level and Growth Ratio	<input type="checkbox"/> Safety
<input type="checkbox"/> Therapeutic Communication with parent of a critically ill child.	<input type="checkbox"/> Professionalism
<input type="checkbox"/> Nursing process	<input type="checkbox"/> IV Fluid and antibiotic administration
<input type="checkbox"/> Pathophysiology of meningitis and sepsis	<input type="checkbox"/> Administration of suppository medication with cooling measures
<input type="checkbox"/> Structured communication using SBAR	<input type="checkbox"/> Administration of vasopressor medication to support blood pressure.

SECTION III: SCENARIO SCRIPT

A. Case summary

History of Present Illness: 8-year old female with 3-day history of high fever 39.4-40 °C and rash for 24 hours. Parents brought their child today to the Emergency Room for evaluation. Parents report 3 day prior history of upper respiratory symptoms, diarrhea, vomiting and cough. The rapid onset of rash to the trunk, arms and legs started yesterday. The rash is rapidly coalescing and becoming dark purple in color, resembling purpura. Patient is irritable. Parents provided antipyretics (Motrin suspension 20 mg/kg every 4 hours) and cooling measures, which failed to reduce the fever.

PMH: Significant for prematurity, born at 32-week gestation, was intubated for 3 weeks and developed Necrotizing Enterocolitis at 2 weeks of age with 50% of jejunum small bowel resected. A Port-a-Cath is placed in left, upper chest to provide nightly TPN infusions. G-tube Mickey placed at 6 months of age, and used for supplemental feedings and medications.

B. Key contextual details

Child brought to the Emergency Room by parents after 3-day history of fever and rash. Signs and symptoms are correlated with sepsis and probable meningitis. Initial treatment is to prevent sepsis shock. Treatment to implement includes fever management, intravenous fluid resuscitation (bolus), intravenous fluid maintenance, antibiotic therapy, initiation of vasopressors to improve hypotension and follow “droplet” precautions demonstrating the use of PPE.

Immunizations: Not up-to-date: Influenza, Rotovirus, Prevnar, MMR. Received: Hepatitis B vaccine at birth, DTaP at 2 and 5 months

C. Scenario Cast

Patient/ Client	<input type="checkbox"/> High fidelity simulator	
	<input checked="" type="checkbox"/> Mid-level simulator (Mega-code Kid) with Sim Pad	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input type="checkbox"/> Standardized patient	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
Team Leader	Oversees and guides care; communicates with healthcare team	L
Primary Nurse	Performs Physical Assessment	L
Nurse Interventionist	Administers Medications	L
Recorder	Delivers SBAR Report	L
Charge Nurse/Physician	Support participants as needed	SP
Parent	At bedside	SP

D. Patient/Client Profile

Last name: Dott	First name: Katie Scarlett			
Gender: F	Age: 8	Ht: 48 in	Wt: 20 kg	Code Status: Full
Spiritual Practice: Catholic	Ethnicity: Caucasian			Primary Language spoken: English

1. Past history

Chief Complaint: High fever and rash

History of Present Illness: 8-year old female with 3-day history of high fever 39.4-40 °C and rash for 24 hours. Parents brought their child today to the Emergency Room for evaluation. Parents report 3day prior history of upper respiratory symptoms, diarrhea, vomiting and cough. The rapid onset of rash to the trunk, arms and legs started yesterday. The rash is rapidly coalescing and becoming dark purple in color, resembling purpura. Patient is irritable. Parents provided antipyretics (Motrin suspension 20 mg/kg every 4 hours) and cooling measures, which failed to reduce the fever.

PMH: Significant prematurity born at 32-week gestation, was intubated for 3 weeks and developed Necrotizing Enterocolitis at 2 weeks of age with 50% of Jejunum small bowel resected. A Port-a-Cath was placed 3 years ago to provide nightly TPN infusions. G-tube Mickey placed at 6 months of age. Used for supplemental feedings and medications.

Primary Medical Diagnosis Septic Shock with Meningitis; Short Bowel Syndrome; TPN Dependence with Gall Stones

2. Review of Systems

CNS	Irritable, lethargic, photophobia, nuchal rigidity; no noted seizures
Cardiovascular	Sinus Tachycardia, Port-a-Cath in left upper-chest; accessed with Huber needle
Pulmonary	Tachypnea, increased work of breathing, no chronic lung disease; oxygen sat 91%
Renal/Hepatic	No urinary tract infections, hepatomegaly or jaundice; gallstones
Gastrointestinal	No constipation, chronic diarrhea; poor appetite G-Tube Mic-Key
Endocrine	No diabetes, no hypothyroidism
Heme/Coag	Bruises easily; no epistaxis.
Musculoskeletal	Moves all extremities; decreased muscle bulk and tone
Integument	Dark purple petechial generalized rash, purpura to chest, trunk, arms, legs
Developmental Hx	Tanner Stage 1 Female, normal appearing genitalia.
Psychiatric Hx	None
Social Hx	Attends Second grade with IEP plan, mild learning delays; Participates in Girl Scouts
Alternative/ Complementary Medicine Hx	None

Medication allergies:	Penicillin	Reaction:	Rash
Food/other allergies:	None	Reaction:	
Diet:	Table foods, Pediasure 2 cans daily		

3. Current medications	Drug	Dose	Route	Frequency
	Vitamin B12 (Cyanocobalamin)	100 mcg	Sub-Q	Monthly
	Actigal	200 mg	G-Tube	BID
	Multivitamin	1 chewable	PO	Daily
	Total Parenteral Nutrition (TPN)	60 ml/hr for 15 hours	IV	Nightly
	Motrin	400 mg	GT	Every 4 Hours

4. Laboratory, Diagnostic Study Results: admit

Na: 147	K: 3.5	Cl: 100	HCO3: 24	BUN: 34	Cr: 2.1
Ca: 9	Mg: 1.9	Phos: 3.5	Glucose: 124 mg/dl	HgA1C: 5	
Hgb: 11.2	Hct: 32	Plt: 248	WBC: 24	ABO Blood Type: AB+	
PT: 13	PTT: 32	INR: 0.92	Troponin: <0.04	BNP: 170	
ABG-pH: 7.25	paO2: 80	paCO2: 37	HCO3/BE: 24	SaO2: 91	
VDRL:	GBS:	CRP: 102	ESR: 14	Lactate: >4	
CXR:	ECG:	Herpes:	HIV:		

E. Baseline Simulator/Standardized Patient State

(This may vary from the baseline data provided to learners)

1. Initial physical appearance

Gender: Female Attire: Wearing hospital gown and sports shorts

Alteration in appearance (moulage): Presence of port-a-cath on left upper chest, accessed with Huber needle. Attach pictures of skin petechiae seen on abdomen, and lower extremities. PIV in left hand with saline lock.

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	Monitor on, data displayed
BP: 80/60	HR: 140	RR: 30	T: 102.4 F (38.4 °C)	SpO ₂ : 95%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETCO ₂ :	FHR:		
Lungs: Sounds/mechanics	Left: Crackles	Right: Crackles		
Heart:	Sounds: Systolic Murmur grade 3/6			
	ECG rhythm: Sinus Tachycardia			
	Other: Friction Rub Left side at Erb's Point			
Bowel sounds:	Hypoactive, non-tender on palpation, mild distension			Other: G-Tube (Mic-Key 14 Fr.) Left mid-abdomen

3. Initial Intravenous line set up						
✓	Saline lock #1	Site:	LAC		✓	IV patent (Y/N) Yes
	IV #1	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
✓	Main	Left upper Chest		D 5 ½ NS	(60 ml/hr)	Yes
	Piggyback					
4. Initial Non-invasive monitors set up						
✓	NIBP	✓	ECG First lead:		ECG Second lead:	
✓	Pulse oximeter	✓	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: Alaris			Pump settings: 5 ml/hr
Environment, Equipment, Essential props						
1. Scenario setting (For example: patient room, home, ED, lobby)						
Scenario takes place in Emergency Department, then later transfers to the Pediatric Intensive Care Unit.						

2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)						
✓	Bedpan/ Urinal	✓	Foley catheter kit	Straight cath. kit	Incentive spirometer	
✓	IV Infusion pump		Feeding pump	Pressure bag	Wall suction	
	Nasogastric tube		ETT suction catheters	Oral suction catheters	Chest tube kit	
	Defibrillator		Code Cart	12-lead ECG	Chest tube equip	
	PCA infusion pump		Epidural infusion pump	Central line Insertion Kit	Dressing Δ equipment	
✓	IV fluid Type:	NS; D51/2 NS	IV fluid additives:	IV Piggy back	Blood product ABO Type: # of units:	

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

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

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route
1	Acetaminophen	10 mg/kg	PR		4	Ursodiol	10 mg/kg/dose	IV
2	Vancomycin	200 mg/100 ml	IVPB		5	Epinephrine Drip	0.05 mcg/kg/min	GT
3	Meropenem	800 mg/100 mL	IVPB		6	Ativan	1 mg	IV

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario:

8-year-old child in room with parent; septic work-up being initiated; received 60 ml/KG NS fluid bolus; IV antibiotics given (see B scenario) If continuing simulation following B, Group gives report to C group of students and receives Order sheet 4.

STATE / PATIENT STATUS		DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE	
Baseline	Operator	Learner Actions	Debriefing Points:
<p>STATE / PATIENT STATUS</p> <p>Assessment findings with HTT Signs/Symptoms:</p> <ul style="list-style-type: none"> Lethargic Headache (moaning) Pain 5/10 Nuchal Rigidity Photophobia Poor skin turgor Weak peripheral and central pulses (both 1+) Capillary refill > 4 seconds <p>If parent is not present patient says: "I want my Mommie."</p> <p>Neuro: lethargic, moaning, pain, not responsive to answering questions. Neck pain Lips: dry, cracked</p> <p>With neuro exam: Complains that "the lights hurt my eyes"</p>	<p>BP – 100/60 HR – 120 RR – 34, mod retractions, bilateral crackles TEMP: 38.1 °C PERL sluggish 3-4 mm SpO2: 92% if RA; 95% if on O₂ CPR - < 4 sec Bowel sounds – hypoactive UOP - 0</p> <p>Within 2 minutes, ↓ saturations to 90% ↑HR to over 140.</p> <p>Provide Lab results if participants call the lab.</p> <p>Triggers</p> <p>Complete antibiotic administration: (Vancomycin or Meropenem) administer them after proper safety ID check, IVPB and at the correct rate.</p>	<ol style="list-style-type: none"> WII: wash hands, introduce self, identify patient. Dress in appropriate PPE Conduct general survey including head-to-toe assessment and Central-Cath site/dressing check Note IV rate of 60 ml/hour. Complete antibiotic administration if not yet given. Titrate oxygen concentration and mode to maintain saturations over 95% Note generalized rash and assessment findings: decreased LOC, poor peripheral perfusion, no UOP. Report back to team Communicate with physician regarding findings after antibiotic administration. Vasopressor support needed after 60 ml/kg NS fluid boluses. Take telephone orders, verify and read-back. 	<ol style="list-style-type: none"> Rationale for proper hand washing and correct use of PPE Identify the patient ID with a second RN prior to medication administration Note allergy to Penicillin. Clinical reasoning/evidence for fluid bolus as the top priority including all of the assessment findings indicate septic shock. Pathophysiology to explain the hypotension that results from antibiotic administration in sepsis. Differentiation between antibiotic anaphylaxis and endotoxin release. Vasopressor support for low BP following adequate fluid bolus administration. Assessment of neurological status, CV, respiratory, poor perfusion, skin, GI and GU systems. Criteria for safely administering medications to non-verbal patients and taking verbal orders.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
Frame 2	Operator	Learner Actions:	Debriefing Points:
<p>Assessment findings with HTT Signs/Symptoms:</p> <ul style="list-style-type: none"> Lethargic Headache Nuchal Rigidity Photophobia Poor skin turgor Weak peripheral and central pulses (both 1+) Capillary refills > 4 seconds <div> <p>verbal order for:</p> <p><i>Epinephrine drip to start at 0.05 mcg/kg/min titrate up to 0.1 mcg/kg/min</i></p> </div>	<p>Patient moans, not answering questions.</p> <p>Reassessment of VS:</p> <p>If no antibiotics administered HR 135 BP 90/60 RR 28 T 38.7 °C</p> <p>2 If antibiotics given: HR – 160 BP – 70/50</p> <p>No urine output persist with hypotension and poor perfusion until additional fluid bolus is given</p> <p>Triggers:</p> <p>Antibiotic administration triggers hypotension to 80/60.</p> <p>HR increases to 145.</p>	<ol style="list-style-type: none"> 1. Perform focused Head-To-Toe assessments, followed by complete assessment. 2. Review signs of shock, hypotension with parent 3. Review or request lab results; including gram stain, lactate levels or differential from earlier CBC test. 4. Call provider to report persistent low BP; request vasopressor support. 5. Takes orders following safety protocol. 	<ol style="list-style-type: none"> 1. Proper assessment techniques such as auscultation of the chest or noting the skin rash on chest, upper thigh and feet. 2. Notify the provider of the assessment findings after complete assessment is obtained and after reassessment following fluid bolus. 3. Initiation of antibiotics within the first hour or as soon as possible. 4. Therapeutic communication skills to alleviate parental anxiety during rapidly evolving situations. 5. Vasopressor support needed after sufficient fluid bolus administration.

STATE / PATIENT STATUS		DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE	
Frame 3	Operator:	Learner Actions:	Debriefing Points:
<p>Reassessment of VS: If epinephrine drip not administered persist with hypotension and poor perfusion</p> <p>Assessment findings with HTT After epi drip started:</p> <ul style="list-style-type: none"> • Lethargic • Nuchal Rigidity • Photophobia • Poor skin turgor • Peripheral and Central pulses 2+ • Capillary refill >3 seconds • Bladder distension/wet diaper/urine output (200 ml) 	<p><i>If epinephrine drip started:</i> HR 135, BP 110/65, RR 28 T 38.5 °C</p> <p><i>End if Epinephrine drip not started after 10 minutes.</i></p> <p>Triggers:</p> <p>Urine output (200 ml) if epinephrine drip initiated.</p> <p>No urine output if no epinephrine drip started.</p> <p>BP and HR decrease 10 points.</p>	<ol style="list-style-type: none"> 1. Perform focused Head-To-Toe assessments, followed by complete assessment. 2. Update parent with the administration of fluid bolus 3. Titration of oxygen 4. Initiate epinephrine drip at 0.05 mcg/kg/min on IV pump 5. Review signs of shock and hypotension with parent. 	<ol style="list-style-type: none"> 1. Proper assessment techniques such as auscultation of the chest or noting the skin rash on chest, upper thigh and feet. 2. Notify the provider of assessment findings and after reassessment following fluid bolus. 3. Initiation of vasopressor support to improve cardiac output and blood pressure.
Scenario End Point: Antibiotics given with 60 ml/KG NS fluid bolus. Vasopressor drip started to stabilize patients BP.			
<p>Suggestions to <u>decrease</u> complexity:</p> <p>Suggestions to <u>increase</u> complexity:</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDER Sheet 4

Patient Name: Patient Name: Katie Scarlett Dotts DOB: 05/20/XX Age: 8-Year Old Weight 20 KG MR#:		Diagnosis: Sepsis Possible Meningitis/Septic Shock Short Bowel Syndrome
†Allergies & Sensitivities: PCN (Rash)		
Date	Time	Pediatric Intensive Care Unit
		Admit to PICU service Dr. Sweet.
		VS: Continuous Cardiac monitoring including saturations, hourly neuro checks,
		LP complete: send CSF for culture, gram stain, protein, glucose, RBC and WBC
		Maintenance IV: D51/2 NS @ 60 mls/hour
		Diet: NPO; strict I and O
		EMLA cream for all IV starts and lab draws.
		Acetaminophen 200 mg PO/PR every 4 hours for T 38.7 °C, notify MD if T> 38.9 °C
		Vancomycin (10/mg/kg/dose) 200 mg IV every 4 hours; Pharmacy to adjust
		Dose. Peak and trough levels with 3 rd dose.
		Meropenem 800 mg IVPB every 12 hours
		Ursodiol 200 mg GT Three times daily
		Notify MD of BP systolic< 70, HR >140, Saturations < 92 despite oxygen
		titration, RR> 30, urine output less than 1 ml/kg/hour.
Signature		Dr. Sweet

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



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:			