SECTION I: SCENARIO OVERVIEW

Scenario Title:	Post-operative Assessment_Case A_↓LOC & resp (Fundamentals)
Original Scenario Developer(s):	Colleen O'Leary-Kelley RN, PhD, CNE
Date - original scenario	03-16-09
Validation:	3-09 K. Bawel-Brinkley, RN, PhD, CNE
Revision Dates:	08-12; 04-18
Pilot testing:	9-09 SJSU
QSEN revision:	08-12 C. O'Leary-Kelley RN, PhD, CNE 05-18 Colleen Nevins DNP, RN, CNE; Jaime Hannans PhD, RN, CNE

Estimated Scenario Time: 15 - 20 minutes Debriefing time: 30 - 40 minutes

Target group: Medical Surgical Nursing students, new grads
Core case: Post-operative management; clinical decision making in an evolving case scenario

QSEN Competencies:

- ❑ Patient Safety
- ❑ Teamwork and Collaboration
- ❑ Patient Centered Care

Brief Summary of Case: First part of a 3-part evolving scenario of a patient after abdominal surgery. The patient is 65-year-old female who is admitted to the medical-surgical telemetry unit from the PACU. The patient is status post total abdominal hysterectomy. The RN on the unit receives report from the PACU nurse who remains in the room for the first few minutes. The patient's family member is at the bedside. A second RN is also present as she/he is orienting to the unit as a new staff member. The purpose is to ensure that the learners recognize signs of airway compromise in a fresh post-operative patient. Learners must call for assistance and institute measures to stimulate the patient.

EVIDENCE BASE / REFERENCES

Hoch, C. R. (2011). Nursing Management: Postoperative Care. In S. L. Lewis, S. R. Dirksen, M. M. Heitkemper (Eds.), *Medical - surgical nursing: Assessment and management of clinical problems* (8th ed. pp. 366 – 382). St. Louis: Mosby.

Cronenwett, L., Sherwood, G., Barnsteiner, J. et al. (2007). Quality and safety education for nurses. *Nursing Outlook*, 55(3), 122-131. doi:10.1016/j.outlook.2007.02.006

Mamaril, M. E. (2006). Nursing considerations in the geriatric surgical patient: The perioperative continuum of care. *Nursing Clinics of North America, 41,* 313-328.

2018 National Patient Safety Goals (Hospital) retrieved from: https://www.jointcommission.org/hap_2017_npsgs/

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Provide nursing care that promotes safety and minimizes risk of error.
2. Apply clinical decision-making skills in interpreting and analyzing data in evolving situations.
3. Prioritize interventions to provide care that is safe and patient-centered.
4. Communicate effectively with members of the inter-professional team.
Specific Learning Objectives
1. Identify findings from a physical assessment that demonstrate risk of complications in a postoperative client.
2. Demonstrate accurate assessment of the client with a focus on the respiratory system.
3. Identify and interpret significant assessment findings requiring immediate reporting and/or intervention.
4. Accurately prioritize immediate interventions required for a client with an unexpected change in status.
5. Evaluate effectiveness of interventions by reassessing critical parameters.
6. Effectively communicate change in status to physician/charge RN/RT utilizing SBAR tool.
7. Effectively communicate with client/family throughout simulation to keep informed and relieve anxiety.
8. Apply safety and infection control measure appropriate to situation.
Critical Learner Actions
1. Wash hands, introduce self, identify client (with 2 identifiers) upon entering room.
2. Perform complete assessment and documentation.
3. Recognize decreased responsiveness and stimulate the patient.
4. Report findings to charge nurse/ MD using SBAR.
5. Apply oxygen per agency protocol.
6. Provide support to family member.

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies Required prior to participating in the scenario	
Knowledge	Skills/ Attitudes
❑ Postoperative complications in older adults	❑ Airway management and adjuncts
❑ Current National Patient Safety Goals	❑ Significance of abnormal assessment findings
❑ Airway protection	❑ Therapeutic communication in acute situations
❑ Structured Communication Tools (SBAR)	❑ Request for assistance in escalating situations
❑ Concepts of oxygenation	❑ Use of SBAR to give report
❑	❑ Application of oxygen therapy

SECTION III: SCENARIO SCRIPT

A. Case summary
This case presents a 65-year-old female retired college professor, who has just been admitted to the medical-surgical telemetry unit from the PACU. The patient is s/p total abdominal hysterectomy for dysfunctional uterine bleeding. The RN on the unit receives report from the PACU nurse who remains in the room for the first few minutes. The patient's family member is at the bedside. A second RN is also present as she/he is orienting to the unit as a new staff member.

B. Key contextual details
Learners receive report from the PACU nurse who reports that the patient was stable in the immediate post-operative period. The patient is lethargic but arousable at first. After the first few minutes, the patient becomes less responsive and makes loud snoring respirations indicating airway compromise. Learners must stimulate the patient vigorously, apply oxygen, and call for assistance.

C. Scenario Cast		
Patient/ Client	❑ High fidelity simulator	
	❑ Mid-level simulator	
	❑ Task trainer	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
RN 1	Assigned to care for patient	Learner
RN 2	Newly orienting to unit	Learner
Family member	Concerned re: pt. sleepiness	Scripted L or SP

D. Patient/Client Profile				
Last name:	Phillips		First name:	Anastasia
Gender: F	Age: 65	Ht: 66”	Wt: 150#	Code Status: Full
Spiritual Practice: Protestant		Ethnicity: White		Primary Language spoken: English

1. History of present illness

Anastasia Phillips is a 65-year-old retired college professor with a diagnosis of Dysfunctional uterine bleeding x 6 months. The patient has NKA. Medical history includes hypertension x 10 years and arthritis. She has no prior history of surgery. She is post-menopausal with last menses at age 52. Patient elected for a vaginal hysterectomy, possible total abdominal hysterectomy.

Primary Medical Diagnosis	Post-menopausal uterine bleeding

2. Review of Systems	
CNS	A & O x4
Cardiovascular	Regular rate and rhythm, no murmur; hx of hypertension; BP 130/90
Pulmonary	Lungs clear to auscultation
Renal/Hepatic	Labs normal
Gastrointestinal	Abdomen soft, round, distended
Endocrine	No noted history
Heme/Coag	Labs normal other than Hgb 10.0 and HCT 32.0
Musculoskeletal	Moves all extremities; arthritis in hands bilaterally
Integumentary	Intact, no lesions
Developmental Hx	Normal for age
Psychiatric Hx	No noted history
Social Hx	One glass red wine per day; no illicit drugs; married with grown children
Alternative/ Complementary Medicine Hx	none

Medication allergies:	NKDA	Reaction:	
Food/other allergies:		Reaction:	

3. Curre

Drug	Dose	Route	Frequency
Lisinopril	10 mg	PO	Daily in a.m.
Ibuprofen	200 mg	PO	Q6h prn for pain

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.0	Cl: 102	HCO3: 23	BUN: 26	Cr: 0.9
Ca:	Mg:	Phos:	Glucose: 96	HgA1C:	
Hgb: 10	Hct: 32	Plt: 200,000	WBC: 8,000	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: clear; no infiltrates		ECG: Normal Sinus Rhythm at 80 bpm; no ectopy			
CT:		MRI:			
Other:					

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

1. Initial physical appearance					
Gender: F		Attire: Patient Gown			
Alterations in appearance (moulage): Abdominal dressing to abdomen (clean and dry); sterile 4x4s available near bedside; wig; eyeglasses					
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:					
	No monitor display		Monitor on, no data displayed	X	Monitor on, standard display

BP: 112/70	HR: 80	RR: 14	T: 98.8	SpO2: 95%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC02:	FHR:		
Lungs:	Left: Clear		Right: Clear	
Heart:	Sounds:	S1, S2 – no ectopy or murmurs		
	ECG rhythm:	NSR		
	Other:			
Bowel sounds:	Absent immediate post-op		Other:	

3. Initial Intravenous line set up							
	Saline lock #1	Site:					IV patent (Y/N)
X	**IV #1**	Site:	RA	Fluid type: LR	Initial rate: 100 ml/hr		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		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					
x	Foley catheter	Amount: 200 ml		Appearance of urine: clear yellow	
	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 telemetry unit

2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)							
	Bedpan/ Urinal		Foley catheter kit		Straight cath. kit	x	Incentive spirometer
x	IV Infusion pump		Feeding pump		Pressure bag		Wall suction
	Nasogastric tube		ETT suction catheters	x	Oral suction catheters		Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit		Dressing Δ equipment
X	IV fluid Type: LR				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-rebreather 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		Lab Results
x	Progress Notes		Graphic record	x	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 or electronic health record constructed per institutional guidelines				Other Describe: EMR		

5. Medications (to be available in sim action room)								
#	**Medication**	**Dosage**	**Route**		#	**Medication**	**Dosage**	**Route**
	Morphine Sulfate	2 mg	IV					
	Norco	5/325	po					
	Acetaminophen	325 mg	po					

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario: This case presents a 65-year old female retired college professor, who is admitted to the medical-surgical telemetry unit from the PACU. The patient is s/p total abdominal hysterectomy for post-menopausal dysfunctional uterine bleeding. The surgeon was not able to do a vaginal approach. The RN on the medical-surgical unit receives report from the PACU nurse who remains in the room for the first few minutes. Report includes stable vital signs, responsive to voice, and a dressing clean dry and intact. Patient has a patent IV and foley catheter in place. The patient's family member is at the bedside. A second RN is also present as she/he is orienting to the unit as a new staff member.			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline Pt. lying in bed w/HOB elevated. Responds briefly to questions but is sleepy. Denies pain "2/10" if assessed in abdomen; too sleepy to offer any additional information	**Operator** BP 112/70 HR 80 RR 14 T 36.4 C (97.6 F) O2 sats 94% on2L/ NC EKG Normal Sinus Rhythm **Triggers:** complete actions within 5 minutes	**Learner Actions:** Wash hands / ID patient Introduce RNs to patient and family Begin focused post-operative assessment or directs other RN - Obtain vital signs - Assess pain (OLDCART) - Assess respiratory and cardiac status - Assess IV, foley and surgical site	**Debriefing Points:** NPSG's to prevent infection Potential issues in the 60+ age group surgical patient Pain assessment Nursing responsibilities in the immediate post-operative period

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
2. Patient becomes more difficult to arouse -Falls asleep and snores when not stimulated (family member is concerned; asks "Why is my mother/aunt so sleepy?")	**Operator:** B/P 120/80 HR 98 RR 10 T 36.7 C (98° F) O2 Sat 92% on 2 L/NC EKG: Normal Sinus Rhythm **Triggers:** Arouses/stimulates sedated patient - Go to state 3 (Rescue) Failure to stimulate - Go to state 4 (Failure to Rescue)	**Learner Actions:** Complete post-op assessment: Neuro, GI, Musculo-skeletal. Document vital signs Notice change in LOC and difficulty staying awake Attempt to arouse/stimulate patient vigorously - Raise HOB - Attempt to awaken patient and encourage deep breaths - Increase 02 if needed Notify Charge RN/MD using SBAR Provide calm explanation to family member, or delegate to other staff	**Debriefing Points:** Complications in fresh post-operative patients, e.g., over sedation related to drug absorption and metabolism Signs and risk associated with airway compromise Acceptable methods of stimulation in patient with decreased responsiveness Importance of professional closed-loop communication using SBAR Recognize family member's concern and the need for reassurance/information; use of therapeutic communication

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
3. (Rescue) Increased responsiveness; more conversant Describes pain at 2 – 3/10, located in abdomen area of surgery, intermittent, sharp at times but mostly pulling type feeling, non-radiating and less pain when still	**Operator:** B/P 120/80 HR 80 RR 18 T 36.9 C (98.4° F) O2 Sat 96% on 2+ L/NC **Triggers:** continued monitoring / stimulation	**Learner Actions:** Continue to assess patient LOC Reassess vital signs, pain level (OLDCART) Stimulate / arouse patient as needed to maintain patent airway and optimal respiratory status	**Debriefing Points:** RN role in assessing and maintaining airway patency Potential complications in post-operative patients and age-related risks associated with geriatric patients

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
4. (Failure to Rescue) Decreased responsiveness; loud snoring. Arouses briefly, mumbles, but returns to sleep if not vigorously stimulated	**Operator:** B/P 130/90 HR 100 RR 8 T 36.9 C (98.4° F) O2 Sat 90% on 2L/NC **Triggers:** Prompt intervention leading to recovery	**Learner Actions:** Notice acute change in LOC and decreased airway patency Attempt to arouse/stimulate patient vigorously - Raise HOB Attempt to awaken patient and encourage deep breaths- Increase 02 Call for help: Notify Charge RN/MD using SBAR	**Debriefing Points** Rationale for prompt action in recognizing airway compromise Identify potential complications: respiratory failure QSEN Competencies: Patient-Centered Care; Safety; Teamwork and Collaboration
Scenario End Point: SBAR to persons responding to call for help			
Suggestions to decrease complexity: other team members (Charge RN or MD) can enter room "making rounds" to provide cues. Suggestions to increase complexity: Add abnormal assessment findings, e.g., Hgb, HCT, BUN, Cr, ABGs; bleeding at incision with serosanguinous or bloody dressing; or add additional pre-existing conditions (heart failure, diabetes). Objectives should be determined by the level of learner.			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Phillips, Anastasia **DOB: 1/15/XX** **Age: 65** **MR#: PCS654321**	**Diagnosis: s/p total abdominal hysterectomy**

† No Known Allergies
† Allergies & Sensitivities Code Status: FULL CODE

Date	Time	**HEALTH CARE PROVIDER ORDERS AND SIGNATURE**
		Admit to Medical/Surgical Telemetry Unit
		Diet: sips of water, advance to clear liquids as tolerated
		Activity: Out of bed tonight; up as tolerated
		Post-op vital signs every 2 hours x2, then every 4 hours; Call MD if BP > 160/90, Temp ≥ 38.3 C (101 F)
		IV: LR at 100ml/hour
		Sequential Compression Device (SCDs)
		Indwelling foley catheter to gravity drainage; Call MD if urine output less than 30 ml/hour
		I & O per routine
		Titrate O_2 2-6 liters/min per NC to maintain SpO_2 . 92%
		Incentive Spirometer 10x every hour while awake
		Medications:
		Morphine Sulfate 2 mg IV push every 4 hrs prn severe pain (7 – 10)
		Hydrocodone/Acetaminophen (Norco) 5/325 2 tabs every 4 hrs prn moderate pain (4 – 6)
		Acetaminophen (Tylenol) 325 mg 2 tabs every 4 hours prn for mild pain (1 – 3) or fever > 38.2 C (100.8 F)
		Ancef 1 gm IVPB every 8 hrs x 3 doses
		CBC, Chem Panel in am
Signature		*Georgina Johnson MD*

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			
☐ 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. Was there any RELEVANT information missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?
5. The main objective of the simulation was to recognize airway compromise in an immediate post-op patient and appropriately intervene.
    a. With that in mind, can you identify aspects of your nursing care where you addressed the objectives?
    b. Are there any aspects of your care that you would handle differently if you could?
6. What risk factors did the patient have that pre-disposed her to airway compromise? Discuss considerations and potential issues with advanced aged surgical patients.
7. In what ways did you feel the need to check ACCURACY of the data you were given?
8. In what ways did prioritization affect your performance?
9. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?
10. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members?
11. Discuss actual experiences with diverse patient populations.
12. Discuss roles and responsibilities when addressing acute needs of patients or during a crisis.
13. Discuss how current nursing practice continues to evolve in light of new evidence.
14. Discuss how each of the QSEN competencies for patient-centered care, safety, and teamwork & collaboration impacted your care of the patient.
15. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?

Notes for future sessions: