

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Post operative assessment – Case C_ Respiratory Depression		
Original Scenario Developer(s)	L. Rodriguez; K. Bawel-Brinkley; C. O’Leary-Kelley; C. Miller		
Date - original scenario	02/09		
Validation:	03/09		
Pilot testing:	03/09		
Revisions:	04/10, C. O’Leary-Kelley, PhD, RN, CNE 12/14 H. Traxler, MSN, RN, CHSE; M. Punnoose, MSN, RN-BC, CHSE, M. Miller, MA, RN, CHSE 4/18 Melissa Punnoose, MSN, RN-BC, CHSE, CHSOS		
<u>Estimated Scenario Time:</u> 20 minutes <u>Debriefing time:</u> 40 minutes			
<u>Target group:</u> 4 th semester nursing students or new grad RNs <u>Core case:</u> Identification and management of respiratory depression in the post op patient.			
<u>Brief Summary of Case:</u> This case presents a female, 65-year-old retired college professor on the medical-surgical unit who is s/p total abdominal hysterectomy POD 1 for dysfunctional uterine bleeding. RN 1 and RN 2 (primary and backup nurses) receive report that the patient has been stable and received pain medication within the last hour for moderate to severe incisional pain. The patient has orders to ambulate. The patient’s family member is at the bedside. The RNs enter the room to assess the patient and prepare her for ambulation.			
<p>The patient will be difficult to arouse when the RNs enter the room to assess the patient and prepare for ambulation. The RN(s) should attempt to arouse patient and assess respiratory depression and intervene appropriately. One of the RNs to notify charge nurse or MD.</p>			
<u>QSEN Competencies</u> X Patient Centered Care X Patient Safety <input type="checkbox"/> Quality Improvement X Teamwork and Collaboration			

EVIDENCE BASE / REFERENCES (APA Format)
Hoch, C.R. (2017). Postoperative care. In Lewis, S., Bucher, L., McLean, M., and Harding, M.(Eds.), Medical-surgical nursing: Assessment and management of clinical problems (10 th ed.)(pp.330-348). St. Louis, Missouri: Elsevier.
Naloxone hydrochloride (2018). In Micromedex [Electronic version]. Greenwood Village, CO: Truven Health Analytics. Retrieved 4/2/2018 from http://www.micromedexsolutions.com
Jarzyna, D., Jungquist, C., Pasero, C., Willens, J., Nisbet, A., Oakes, L., Dempsey, S., Santangelo, D., and Polomano, R. (2011). American Society for Pain Management nursing guidelines for monitoring for opioid-induced sedation and respiratory depression. <i>Pain Management Nursing</i> , 12(3), 118-145.
Dolansky, M.A., and Moore, S.M. (2013). Quality and safety education for nurses (QSEN): The key is systems thinking. <i>Online Journal of Issues in Nursing</i> , 18(3), Manuscript 1.

CSA REV template (12/15/08; 5/09; 12/09; 4/11, 12/14, 4/18)

ALL DATA IN THIS SCENARIO IS FICTITIOUS

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes
1. Apply clinical decision making and nursing process skills in providing post operative nursing care.
2. Prioritize interventions based on accurate interpretation of assessment data.
3. Provide care to clients utilizing principles of safety.
Specific Learning Objectives
1. Identify findings from a psychosocial assessment that demonstrate risk of complications in a postop client
2. Demonstrate an accurate respiratory assessment
3. Identify and interpret significant findings that require immediate reporting and or intervention
4. Accurately prioritize interventions for the patient with an unexpected change in status.
5. Evaluate effectiveness of interventions by reassessing critical parameters
6. Effectively communicate patient change in status using SBAR
7. Effectively communicate with patient/family throughout care to keep informed & relieve anxiety
8. Safely administer medications
9. Apply safety and infection prevention measures.
Critical Learner Actions
1. Perform focused assessment
2. Recognize sedation and respiratory depression
3. Call for help/RRT early
4. Perform rescue breathing with BVM/apply O ₂
5. Administer IV Naloxone as ordered
6. Notify MD
7. Reassess/monitor patient
8. Communicate with family throughout care.

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies	
Knowledge	Skills/ Attitudes
<input type="checkbox"/> Post operative priorities for nursing care	<input type="checkbox"/> Rescue breathing and use of bag valve mask
<input type="checkbox"/> Post op assessment, interventions, and pathophysiology	<input type="checkbox"/> Comprehensive Post op assessment
<input type="checkbox"/> Therapeutic communication skills	<input type="checkbox"/> Oxygen administration
<input type="checkbox"/> Risk factors/treatment for respiratory depression	<input type="checkbox"/> IV medication administration
<input type="checkbox"/> Pharmacology of naloxone	<input type="checkbox"/> SBAR and closed loop communication
<input type="checkbox"/> AHA guidelines for rescue breathing	<input type="checkbox"/> Teamwork: importance of early call for help

SECTION III: SCENARIO SCRIPT

A. Case summary

This case presents a female, 65-year-old retired college professor on the medical-surgical unit who is POD 1 s/p total abdominal hysterectomy for dysfunctional uterine bleeding. RN1 and RN2 (or a primary nurse) receive report that the patient has been stable and received pain medication within the last hour for moderate to severe incisional pain. The patient has orders to ambulate. The patient’s family member is at the bedside. The RN(s) enter the room to assess the patient and prepare her for ambulation.

B. Key contextual details

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)	Standardized Participant (SP) or Learner (L)
Off-going RN	Gives report and leaves	SP
RN 1/Primary RN	Leads Action	L
RN 2/Back up RN	Takes direction from RN1	L
Family member	Concerned, not disruptive	SP
ChargeRN/ICU/RRT RN	Assist learners as needed	SP

D. Patient/Client Profile				
Last name:	Phillips		First name:	Anastasia
Gender:	Age: 65	Ht: 5'6"	Wt: 155	Code Status: Full code
Spiritual Practice: Atheist	Ethnicity: Caucasian		Primary Language spoken: English	
1. Past history				
Intermittent uterine bleeding x1 month. Biopsy performed 2 weeks ago. Showed uterine hyperplasia. Scheduled for elective total abdominal hysterectomy (TAH) for today. Currently 12 hour SP total abdominal hysterectomy				
Primary Medical Diagnosis	Post-menopausal uterine bleeding			

2. Review of Systems	
CNS	A&O x 4
Cardiovascular	RRR, HTN
Pulmonary	Clear to auscultation Bilaterally
Renal/Hepatic	
Gastrointestinal	
Endocrine	
Heme/Coag	
Musculoskeletal	Osteoarthritis in her hands
Integument	
Developmental Hx	
Psychiatric Hx	
Social Hx	No smoking. Denies ETOH
Alternative/ Complementary Medicine Hx	

Medication allergies:	NKA	Reaction:	
Food/other allergies:	NKA	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Lisinopril	10mg	PO	daily
	Ibuprofen	600mg	PO	Q6hrs prn pain

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.0	Cl: 102	HCO3: 22	BUN: 26	Cr: 0.9
Ca:	Mg:	Phos:	Glucose:90	HgA1C:	
Hgb: 10	Hct: 32	Plt: 200	WBC: 8	ABO Blood Type:	
PT	PTT	INR	Troponin:	BNP:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:		
CXR:	ECG:				

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	
<u>Alterations in appearance (moulage):</u> wig, ABD pad to abdomen with paper tape slight amount of sero-sanguineous drainage.			
x	ID band present, accurate	ID band present, inaccurate	ID band absent or not applicable
	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: 110/70	HR: 75	RR: 8	T:98.3	SpO ₂ : 92%	
CVP:	PAS:	PAD:	PCWP:	CO:	
AIRWAY:	ETCO ₂ :	FHR:			
Lungs: Sounds/mechanics	Left: clear	Right: clear			
Heart:	Sounds:		S ₁ S ₂		
	ECG rhythm:		NSR		
	Other:				
Bowel sounds:	hypoactive			Other:	

3. Initial Intravenous line set up						
	Saline lock #1	Site:			IV patent (Y/N)	
x	IV #1	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
x	Main	RA		LR	100/hour	
	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						
x	Foley catheter		Amount: 200	Appearance of urine: clear yellow		
	Epidural catheter			Infusion pump:		Pump settings:
						.
Environment, Equipment, Essential props						
1. Scenario setting: (example: patient room, home, ED, lobby)						
Med Surg Room						

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	Oral suction catheters	Chest tube kit
x	Defibrillator	x		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		IV fluid additives:	IV Piggy back	Blood product ABO Type: # of units:

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

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record		H & P	x	Lab Results
	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
x	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
1	Naloxone	0.4mg/ml (1ml vial)	IV					
	0.9% NS	To dilute Naloxone						

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario :

This is Anastasia Phillips, a 65-year-old female, who is POD 1 s/p total abdominal hysterectomy for dysfunctional uterine bleeding. No other medical history. Full code. NKA. A/O X4. The patient has been stable. Her dressing is CDI. She has been getting IV morphine for pain. She received 4mg an hour ago for 7/10 incisional pain. 30 minutes after administration her pain level was down to a 2/10, which is acceptable for her. Family member is at the bedside. Last set of VS: 110/70, 75, 8, 98.3, 92%. IV fluids are LR at 100ml/hr.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline</p> <p>Patient lying in bed, sleepy, difficult to arouse, snoring; Very sedated & will not awake unless stimulated. Only groans slightly, but does not open eyes or speak.</p> <p>HOB >30. Family member at bedside</p>	<p>Operator</p> <p>Display vital signs as learner completes task RR 7-8, snoring BP 110/70 SpO₂ 92% Temp 98.6 HR 70-80</p> <p>Triggers: Change in VS and unable to arouse</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. wash hands 2. Introduce RNs to pt and family 3. Begin focused head to toe assessment 4. Take VS 5. Recognize ↓ LOC & ↓RR 6. Stimulate/attempt to arouse patient 7. Assess and respond to changes in patient condition 8. Communicate with family member at bedside, eliciting help in stimulating patient 	<p>Debriefing Points:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patient safety (hand washing, patient identification) <input type="checkbox"/> Abnormal assessment data/trends indicating change in condition <input type="checkbox"/> Essential assessments in monitoring patients receiving opioids <input type="checkbox"/> Components of Post op assessment <input type="checkbox"/> Communication with family member about status without undue alarm

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2. Pt becomes more difficult to arouse</p> <p>Falls asleep and snores when not stimulated</p> <p>Family asking why patient isn't waking up. Says she does not usually snore.</p>	<p>Operator: Pt snoring RR 7 (count) BP 110/70 HR 70 SPO₂ 88% Temp: 98.6</p> <p>Triggers: -if O₂ applied, O₂ sat ↑90% -if no O₂, O₂ sat – 88%</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Check orders 2. Apply O₂ via NC 3. Sit patient up 4. Obtain back-up help of charge RN and give SBAR report 5. Call RRT 	<p>Debriefing Points:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Recognition of change in condition <input type="checkbox"/> Initiate request for help when appropriate to situation <input type="checkbox"/> Apply evidenced based interventions for respiratory depression <input type="checkbox"/> Safety check in room (ambu bag) <input type="checkbox"/> Recognize when to seek assistance
STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3. Unresponsive Intermittent loud snoring</p> <p>Family increasingly concerned, but not hysterical</p> <p>MD ORDERS during scenario</p> <ol style="list-style-type: none"> 1. Narcan 0.04mg IV now. May repeat Q2 minutes. Max dose of 0.4mg 2. Ventilate with BVM q 6 seconds 3. When breathing ≥ 12/min, apply O₂ @2L via NC 	<p>Operator: <u>Deterioration</u> RR 6 HR 68 BP 105/70 SPO₂ 86%</p> <p>Triggers: If learners ventilate with BVM O₂ sat ↑ to 95%. If learners stop ventilating, O₂ sat returns to 86%</p> <p>If naloxone (Narcan) given, patient will make a full recovery – see state 4</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Call MD using SBAR to communicate change in patient condition 2. Obtain a orders using RAV 3. If using EMR, verifies orders on EMR 4. Perform rescue breathing with BVM 5. Administer medications as ordered 6. Assess and evaluate effectiveness of interventions 7. Monitor patient response to medication 8. Communicate actions and explanation to family 	<p>Debriefing Points:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Need for rescue breathing when RR<8 <input type="checkbox"/> Reason why oxygen administration does not increase O₂ sat when ventilations are low <input type="checkbox"/> Expect pain to return after naloxone given <input type="checkbox"/> Awareness of pharmacology of Nalaxone; patient reassessment <input type="checkbox"/> Role of education and information to decrease anxiety of family <input type="checkbox"/> Dilute 0.4mg Narcan with 9ml NS for 0.04mg/ml.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>Patient groggy, but talking Asking what happened to her</p>	<p>Operator:</p> <p><u>Recovery</u> B/P 120/80 HR: 70-80 RR: 12 O₂ Sat: 96%</p> <p>Triggers:</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Explain what happened to patient without saying “she had too much medication” 2. Teach family member to notify RN when they notice changes in their family member 3. Give SBAR report to RRT RN on arrival on scene 	<p>Debriefing Points</p> <ul style="list-style-type: none"> ❑ Compare ½ life of Naloxone to Morphine. Short half-life of naloxone can lead to repeat episodes of respiratory depression ❑ Incorporate patient and family in treatment plan
<p>Scenario End Point: Recovery of patient or after RRT called and “ICU RN” arrives and gets SBAR report from primary RN</p>			
<p>Suggestions to <u>decrease</u> complexity: RR stays between 8-10. Patient responds to stimulation. No medication needed. Suggestions to <u>increase</u> complexity: respiratory depression leads to respiratory arrest.</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Anastasia Phillips DOB: 3/1/xx Age: 65 MR#: Q0007139		Diagnosis: Post-menopausal uterine bleeding
†No Known Allergies †Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Diet: clear liquid advance diet as tolerated per RN discretion
		Activity: Ambulate TID, OOB as tolerated
		Vitals Signs: vital signs q 2 hours x2, then q4 hours
		IV: LR at 100ml/hour
		SCDs
		O2 2-4 liters/min per NC to maintain SpO2 ≥ 92%
		DC foley catheter on POD 2
		IS hourly while awake
		Routine I&O
		Lovenox 40mg subcutaneous daily
		Ancef 1G IV q8 hours
		Protonix 40mg IV q24 hours
		Ibuprofen 600mg po q8 hours PRN pain
		Norco 5/325mg 1-2 tabs PO q4 hours PRN pain
		Morphine sulfate 2-4mg IV q4hours PRN pain
		Tylenol 650mg po q4 hours PRN T>101.5
		Zofran 4mg IV q6 hours PRN N/V
		Benadryl 12.5mg IV q4 hours PRN itching
		Naloxone 0.04mg IV q2 minutes PRN RR≤10
		Chloroseptic spray 2 sprays q3 hours PRN throat pain
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:			