# Firelands Regional Medical Center

## School of Nursing

### Student Developed Simulation Scenarios

**Directions:** Students will be expected asked to develop a scenario on a chosen topic related to the Maternal Child Nursing content taught throughout the semester. Faculty will be implementing the student developed scenarios on the day of the scheduled simulation. Students will be expected to perform a scenario in the simulation center that was developed by one of their classmates on the day of the simulation. Students will sign up to be in a group of 4 to develop a simulation scenario on the assigned topics. Please only include skills in the scenario students have been taught in the curriculum already.

The scenario should be should be roughly 15 minutes in lengths. Students should use the attached storyboard and patient chart to develop their scenario and will need to submit the completed storyboard by **October 30, 2023 by start of class** via the Student Developed Scenarios dropbox. You are required to wear your student uniform the day of the simulation. A mid-semester checkpoint will be at week 7 (**October 9, 2023**) of the course. The first page of the document will be required to be turned in at the beginning of class so the faculty of your scenario can review the document.

Students will vote on the best Student Developed Scenario and the chosen team will receive a prize.

During the debriefing process students will be expected to provide constructive feedback to their fellow students. Please be kind and considerate. Remember this is constructive feedback and not criticism. All students are expected to actively participate in the group debriefing.

The activity requirements and grading rubric are below. To be satisfactory for this experience you will need to score at least 77%. For any student not attending the day of simulation, credit will not be granted for the simulation time and will follow the Student Accountability Flow Sheet. This experience is worth 4 hours of simulation. Remember any missed simulation time needs to be made up hour for hour.

|   | **Student Developed Simulation Scenario Rubric** | **Points** | **Total** |
|---|---|---|---|
| 1 | In your group, develop a simulation scenario related to the assigned topic. | 10 | |
| 2 | Develop 2 questions to ask in debriefing related to your developed scenario. Questions should be specific and not simply what did you do well and how could you improve. | 10 | |
| 3 | Develop 2 questions NCLEX style questions with rationale related to the content in your developed scenario. | 10 | |
| 4 | Be creative and highlight the essential information to know about the assigned topic on the storyboard. | 10 | |
| 5 | Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm throughout the group process. | 10 | |
| 6 | Mid-semester checkpoint with faculty on **October 9, 2023**. (Page 1 document to dropbox by 0800. Meet with assigned faculty after class.) | 10 | |
| 7 | Completed Storyboard submitted to the Student Develop Simulation Scenarios Dropbox on Edvance360 by **October 30, 2023 at start of class.** | 17 | |
| 8 | Actively participates throughout the entire process (Development/day of simulation). | 23 | |
|   | **Total** | 100 | |

| Student Developed Simulation Scenario Storyboard EXAMPLE | |
|---|---|
| **Identified Problem/Scenario Topic and Related Resources:**<br><br>Post-Operative Respiratory Depression<br><br>Textbook Chapter 13 | **Desired Overall Goal:**<br>1. Recognize Respiratory Depression<br><br>2. Correctly identify cause<br><br>3. Intervene appropriately<br><br>4. Effective ventilation returns |
| **Case Summary:**<br><br>68 year old female patient just transferred from PACU to medical-surgical unit in stable condition following a right total knee replacement. She begins to have decreased LOC, falling respiratory rate and depth, decreased O2 sats. | **Expected Interventions of Students:**<br>1. Receives bedside report<br><br>2. Begins post-operative assessment<br><br>3. Connects equipment<br><br>4. Notices decreased O2 sats, decreased RR & depth, decreased LOC<br>5. Changes nasal cannula to mask |
| **Supplies:**<br>1. **SimMan**<br>2. **Nasal canula**<br>3. **O2 mask**<br>4. **Morphine 5mg/1mL injection**<br>5. **Narcan 10mg/5mL injection (x2)**<br>6. **NS @ 125 IV**<br>7. **IV pump** | 6. Increases O2 liter flow & reassesses<br><br>7. Calls for help (Rapid Response Team)<br><br>8. SBAR communication<br><br>9. Administers Narcan & reassesses<br><br>10. Communicates effectively with family throughout |

**NCLEX Questions**

1.
   a.
   b.
   c.
   d.

   Answer:

2.
   a.
   b.
   c.
   d.
   Answer:

## Case Flow (15-20 Minute Simulation Time) EXAMPLE

**Initiation of Scenario:**

**Case Study:**

Patient in bed-hand off received.

Patient in stable condition with reported pain level 2/10 after general anesthesia

Patient received 3 doses of IV Morphine

| Vital Signs | T | 98.0 | HR | 88 | RR | 16 | BP | 140/82 | SPo2 | 98% on 2L | Pain | 2/10 | BS | NA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | WNL | | | | | | | | | | | | | |
| **Respiratory** | Clear lung sounds | | | | | | | | | | | | | |
| **Neuro** | WNL | | | | | | | | | | | | | |
| **Skin** | WNL | | | | | | | | | | | | | |
| **GI** | WNL | | | | | | | | | | | | | |
| **GU** | WNL | | | | | | | | | | | | | |
| **Other** | Right knee surgical site surgical site dressing D&I, | | | | | | | | | | | | | |

**First Frame:**

**Case Study:**

Nurse introduces self and begins assessment.

Patient is responsive at first.

Vital signs begin to change with decreased O2 sats, decreased RR & depth, decreased LOC

| Vital Signs | T | 98.0 | HR | 58 | RR | 10 | BP | 100/54 | SpO2 | 88% on 2L | Pain | | BS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | Heart rate regular and starts to become bradycardic | | | | | | | | | | | | | |
| **Respiratory** | Respirations slow, shallow, and regular, Lung sounds clear | | | | | | | | | | | | | |
| **Neuro** | Pt becomes unresponsive as assessment continues | | | | | | | | | | | | | |
| **Skin** | Pale, warm, and dry | | | | | | | | | | | | | |
| **GI** | WNL | | | | | | | | | | | | | |
| **GU** | WNL | | | | | | | | | | | | | |
| **Other** | NA | | | | | | | | | | | | | |

**Second Frame**

**Case Study:**

Change O2 from NC to mask

Reassess-no change

Primary nurse calls for help (RRT)

Gives SBAR to RRT

| Vital Signs | T | 98.0 | HR | 58 | RR | 10 | BP | 100/54 | SpO2 | 94% on 6L per mask | Pain | NA | BS | 80 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | Heart rate regular, bradycardic | | | | | | | | | | | | | |
| **Respiratory** | Respirations slow, shallow, and regular, Lung sounds clear | | | | | | | | | | | | | |
| **Neuro** | Pt unresponsive | | | | | | | | | | | | | |
| **Skin** | Pale, warm, and dry | | | | | | | | | | | | | |
| **GI** | WNL | | | | | | | | | | | | | |
| **GU** | WNL | | | | | | | | | | | | | |
| **Other** | NA | | | | | | | | | | | | | |

| **Third Frame** | | | | | | | | | | | | | | |

**Case Study:**
RRT responds with Narcan
Checks order
Identifies and assesses patient
Administers per order, titrating dose
Reassesses

| Vital Signs | T | 98.0 | HR | 76 | RR | 16 | BP | 122/62 | SpO2 | 98% on 6L per mask | Pain | NA | BS | 80 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | WNL | | | | | | | | | | | | | |
| **Respiratory** | Respirations regular rate and depth, Lung sounds clear | | | | | | | | | | | | | |
| **Neuro** | Pt becomes A/O x 3 as medication starts to work | | | | | | | | | | | | | |
| **Skin** | Pink, warm, and dry | | | | | | | | | | | | | |
| **GI** | WNL | | | | | | | | | | | | | |
| **GU** | WNL | | | | | | | | | | | | | |
| **Other** | NA | | | | | | | | | | | | | |

**Scenario End Point**

**Case Study:**
Patient responds to Narcan
Nurses communicate with patient and family

| Vital Signs | T | 98.0 | HR | 76 | RR | 16 | BP | 122/62 | | 98% on 6L per mask | Pain | 5/10 | BS | 80 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | WNL | | | | | | | | | | | | | |
| **Respiratory** | Respirations regular rate and depth, Lung sounds clear, | | | | | | | | | | | | | |
| **Neuro** | A/O x 3 | | | | | | | | | | | | | |
| **Skin** | Pink, warm, and dry | | | | | | | | | | | | | |
| **GI** | WNL | | | | | | | | | | | | | |
| **GU** | WNL | | | | | | | | | | | | | |
| **Other** | NA | | | | | | | | | | | | | |

**Debriefing Questions:**
1. **What did you notice regarding the patient's respiratory assessment?**

2. **What interventions did you perform related to concerns you noticed in the patient's assessment?**

| Student Developed Simulation Scenario Storyboard | |
| --- | --- |
| **Identified Problem/Scenario Topic and Related Resources:**<br><br>**Sickle Cell Disease in Pediatric Patient**<br><br>*Default - Stanford Medicine Children's health.* Stanford Medicine Children's Health - Lucile Packard Children's Hospital Stanford. (n.d.-a). https://www.stanfordchildrens.org/en/topic/default?id=sickle-cell-disease-in-children-90-P02327 | **Desired Overall Goal:**<br>1. **Recognize risk factors associated with Sickle Cell Disease**<br><br>2. **Recognize signs of pain crises r/t Sickle Cell Disease**<br><br>3. **Adequate hydration**<br><br>4. **Effective pain management** |
| **Case Summary:**<br><br>**9 year old female patient named Clotty C who was born and raised in Africa. She has a family history of Sickle Cell Disease. She is visiting Cedar Point with her family in late October. She began having acute pain in her hands, feet, and abdomen after riding the Magnum. She was transported from Cedar Point to FRMC via ambulance where she is still experiencing acute pain.** | **Expected Interventions of Students: (Minimum of 5 required.)**<br>1. **Receive bedside report from previous nurse**<br><br>2. **Begin vital sign and pain assessment**<br><br>3. **Recognizes abnormal pain in hands and feet**<br><br>4. **Administers Morphine IM per orders along with 5% Dextrose Solution IV**<br><br>5. **Notices decreased oxygen stats**<br>6. **Puts Nasal Canula on patient and reassesses oxygen saturation**<br><br>7. **Does pain reassessment**<br><br>8. **Educate patient on potential triggers for pain crisis**<br><br>9. **Educates on the importance of follow up care when returning home**<br><br>10. **Communicates clearly with family and interdisciplinary team** |
| **Supplies:**<br>1. **SimGirl**<br>2. **Morphine 5mg/1mL injection**<br>3. **5% Dextrose Solution @ 125 mL/hr**<br>4. **IV Pump**<br>5. **O2 Nasal Canula**<br>6. **Water** | |

**NCLEX Questions**

1. **Who is most at risk for developing Sickle Cell Disease?**
   a. **2 year old with African American descent that has a mother diagnosed with Sickle Cell Disease.**
   b. **54 year old Latino descent that has a  brother diagnosed with Leukemia.**
   c. **4 year old African American descent that is allergic to shellfish.**
   d. **21 year old Caucasian male who lives in Delaware.**

   Answer:
A: 2 year old with African American descent that has a mother diagnosed with Sickle Cell Disease.
   Rationale: Ethnicity and genetic factors increase risk for developing Sickle Cell Disease.

2. **Identify factors that contribute to increased risk of experiencing pain crisis in Sickle Cell Disease  (Select all that**

apply):
  a. Low Altitudes
  b. Cold weather
  c. Dehydration
  d. Excessive exercise
Answer:

B,C,D: Cold weather, dehydration, excessive exercise.
Rationale: Each increases risk for developing pain crisis.

**Case Flow (15-20 Minute Simulation Time)**

**Initiation of Scenario:**

**Case Study:**

| Vital Signs | T | | HR | | RR | | BP | | SpO2 | | Pain | | BS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | | | | | | | | | | | | | | |
| **Respiratory** | | | | | | | | | | | | | | |
| **Neuro** | | | | | | | | | | | | | | |
| **Skin** | | | | | | | | | | | | | | |
| **GI** | | | | | | | | | | | | | | |
| **GU** | | | | | | | | | | | | | | |
| **Other** | | | | | | | | | | | | | | |

**First Frame:**

**Case Study:**

| Vital Signs | T | | HR | | RR | | BP | | SpO2 | | Pain | | BS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | | | | | | | | | | | | | | |
| **Respiratory** | | | | | | | | | | | | | | |
| **Neuro** | | | | | | | | | | | | | | |
| **Skin** | | | | | | | | | | | | | | |
| **GI** | | | | | | | | | | | | | | |
| **GU** | | | | | | | | | | | | | | |
| **Other** | | | | | | | | | | | | | | |

**Second Frame**

**Case Study:**

| Vital Signs | T | | HR | | RR | | BP | | SpO2 | | Pain | | BS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | | | | | | | | | | | | | | |
| **Respiratory** | | | | | | | | | | | | | | |
| **Neuro** | | | | | | | | | | | | | | |
| **Skin** | | | | | | | | | | | | | | |

| | |
|---|---|
| **GI** | |
| **GU** | |
| **Other** | |

<br>

| **Third Frame** | |
|---|---|
| **Case Study:** | |

| Vital Signs | T | | HR | | RR | | BP | | SpO2 | | Pain | | BS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | | | | | | | | | | | | | | |
| **Respiratory** | | | | | | | | | | | | | | |
| **Neuro** | | | | | | | | | | | | | | |
| **Skin** | | | | | | | | | | | | | | |
| **GI** | | | | | | | | | | | | | | |
| **GU** | | | | | | | | | | | | | | |
| **Other** | | | | | | | | | | | | | | |

<br>

| **Scenario End Point** | |
|---|---|
| **Case Study:** | |

| Vital Signs | T | | HR | | RR | | BP | | SpO2 | | Pain | | BS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cardiac** | | | | | | | | | | | | | | |
| **Respiratory** | | | | | | | | | | | | | | |
| **Neuro** | | | | | | | | | | | | | | |
| **Skin** | | | | | | | | | | | | | | |
| **GI** | | | | | | | | | | | | | | |
| **GU** | | | | | | | | | | | | | | |
| **Other** | | | | | | | | | | | | | | |

**Debriefing Questions:**
1.

2.

**Patient Report:**

## Additional information, Medical History:

**Patient data:**

**DOB:**

**MR#:**

**Prior medical history:**

**Allergies:**

**Social history:**

# Firelands Regional Medical Center
## Sandusky, Ohio

## Physician's Orders

| | |
|---|---|
| NAME: _____ SIGNED | STATUS: |
| DATE ORD: XX/XX/XX _____ | ROOM: |
| ORD PHYS: _____ _____ | MR# |
| ATTENDING: _____ _____ | DOB: |
| AGE:___years old XX/XX/XX | DATE: |

| Date/Time | |
|---|---|
| XX/XX/XX | Admit to _____ |
| | Diagnosis: _____ |
| | VS every _____ |
| | Activity:_____ |
| | Diet:_____ |
| | I&O |
| | IV:_____ |
| | Medications:_____ |
| | Other:_____ |
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| | |
| | Dr. _____ |

| √ | Start | Medication | Dose | Next Sched ↓ | History | Assoc |
|---|---|---|---|---|---|---|
| | | | | | | |

| | Stop | | Route | Ack | Monograph | Asmnt |
|---|---|---|---|---|---|---|
| | Current Status | | Frequency | Adjustment | Co-sign | Ref Err |
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| | xx/xx/xxxx | | | | | |

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| | Label Comments | | | | | |
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| Administer | Admin Comments | Non-Admin Reasons | Acknowledge | Undo | Admin Schedule | View Order | +/- Admin Instructions | Additional Functions | Display Options |
|---|---|---|---|---|---|---|---|---|---|

# Firelands Regional Medical Center
## Sandusky, Ohio
## LABORATORY

NAME: _____ SIGNED                                    STATUS:

DATE ORD: XX/XX/XX _____                               ROOM:

ORD PHYS: _____ _____                            MR#

ATTENDING: _____ _____                             DOB:

AGE:___years old XX/XX/XX                                    DATE:

| HGB/HCT | XX/XX/XX Admission | Reference Range |
|---------|--------------------|-----------------|
| HGB     |                    |                 |
| HCT     |                    |                 |

| CMP | XX/XX/XX Admission | Reference Range |
|-----|--------------------|-----------------|
| Na | | |
| CL | | |
| K | | |
| BUN | | |
| Creatinine | | |
| Blood Glucose | | |
| Blood pH | | |

| URINALYSIS | XX/XX/XX Admission | Reference Range |
|------------|--------------------|-----------------|
| pH | | |
| Specific Gravity | | |
| Glucose | | |
| Protein | | |
| Blood | | |
| Ketones | | |
| Nitrite | | |
| Leukocyte esterase | | |
| Clarity | | |
| Color | | |

# Firelands Regional Medical Center

## Sandusky, Ohio

## IMAGING DEPARTMENT-

| | |
|---|---|
| NAME: _____ | STATUS:  SIGNED |
| DATE ORD: XX/XX/XX | ROOM:  _____ |
| ORD PHYS: _____ | MR# _____ |
| ATTENDING: _____ | DOB: _____ |
| AGE:___years old | DATE: XX/XX/XX |

**CLINICAL DATA/Reason for Test:**

**X-ray:**

**IMPRESSION:**