Simulation Prebriefing

Questions to answer in the prebriefing are based on Tanner's Clinical Judgment Model:

Directions: Provide in-depth, thorough answers to each of the following questions. Answers should be added directly into this document. Details from the patient's chart can be located on Edvance360 in the Simulation Resources folder labeled Scenario # 1 or Scenario # 2. The prebriefing questions related to noticing and interpreting should be typed and submitted via Dropbox labeled with the simulation name (Prebrief Scenario # 1, Prebrief Scenario # 2) by **0800** the day of your simulation. The prebriefing assignment can be found in the Simulation Resources on Edvance360.

Report:

Review the patient's information in the chart provided on Edvance360 in the Simulation Resources. Utilize the handoff report sheet while reviewing the chart. Fill in the appropriate information from the chart in the corresponding sections of the handoff report sheet. This will be checked for completion immediately prior to starting each simulation scenario.

Formulate additional questions for the off-going nurse to clarify unclear information or missing details. These questions can be written on the back of your handoff report sheet.

Noticing:

What is one thing you notice from the patient's history or report that will guide your initial nursing care (maybe it is specific labs, their diagnosis, or past medical history, etc.)? Explain.

One thing I noticed is that the medications ordered by the provider are different routes. This will guide my care as I am the medication nurse and it is essential to follow each medication order exactly how the provider ordered them. Also, these medications are PRN for nausea/vomiting and pain, so it will be important to collaborate and communicate with the assessment nurse on the status of the patient in case those medications need to be administered. I also noticed in the chart that the patient is NPO, this will also guide my care because this includes oral medications so those will need to be avoided.

What expectations do you have about the patient prior to caring for them? Explain.

Although the patient is ordered to be bedrest, I still expect him to be very lethargic. I expect the patient to be at risk for dehydration and excess bleeding. Pain wasn't mentioned in report but I expect the patient to potentially be in pain too.

What previous knowledge do you have that will guide your expectations? Explain.

Previous knowledge that I have guiding these expectations is that every patient I've cared for with a low hemoglobin has been lethargic, some worse than others but all in some way. The patient's coagulation levels are elevated so this puts him at a greater risk for losing more blood and becoming dehydrated than a patient with normal coagulation levels. With the patient's history of PUD and diverticulitis, these could potentially be sources of bleeding and if so, I would expect him to be in pain.

Interpreting:

Interpret the following data:

Admitting medical diagnosis (definition of the diagnosis): A GI bleed is a bleed coming from anywhere in the digestive track.

Laboratory data (give rationale for all abnormal lab results):

Abnormal Lab Values	Rationale for Abnormal Lab Values
PT 17 seconds	Daily use of aspirin Q6h.
PTT 90 seconds	Daily use of aspirin Q6h.
INR 2.2	Daily use of aspirin Q6h.
Potassium 3.4	Pt has been vomiting for two days.
Glucose 122	Pt has a hx of Diabetes Type 2 and his body is in a state of stress so it's somewhat expected to be elevated, this isn't necessarily concerning.
Hemoglobin 9.5	Pt has had black tarry stool for two days.
Hematocrit 30.2%	Pt has had black tarry stool for two days.

Diagnostic testing (explain what diagnostic tests were done with results):

Diagnostic Testing	Results of Diagnostic Testing
Stool Occult Blood	The reason for this test is that the patient has had black tarry stools for two days so this test will confirm if there is blood in the stool. Results pending via provider order.

Medications (provide a list of all medications with classification, indication for use, and nursing interventions):

Medication (generic and trade name)	Classification (therapeutic and pharmacologic)	Indication for use (specific to this patient)	Nursing Interventions (Assessment, Education, Safety Measures)
Phenergan (promethazine)	Antiemetic, antihistamine, sedative/hypnotic	The specific indication for this patient would be the treatment and prevention of nausea and vomiting.	As a nurse you want to assess the patient's vitals frequently, assess their level of sedation, and monitor for extrapyramidal side effects. If fall risk and orthostatic hypotension manifest, implement precautions. Educate the patient on potential side effects/drug interactions.
Morphine	Opioid analgesic, opioid agonist	The specific indication would be pain severe enough to require daily treatment, in this case it is the headaches. These problems have potentially manifested from taking aspirin so alternate pain management is necessary.	Assess the patient's pain level frequently. One hour after administration besides IV (20 minutes). Assess their vitals frequently especially respirations, if less than 10 then assess level of sedation and o2 status. Educate on abuse prevention.