Firelands Regional Medical Center

School of Nursing

Student Developed Simulation Scenarios

Directions: Students will be required 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 3-4 to develop a simulation scenario on the assigned topics. Please only include skills in the scenario that students have been taught in the curriculum already.

The scenario should be should be roughly 15 minutes in length. Students should use the attached storyboard and patient chart to develop their scenario. The group will need to submit the completed storyboard by **October 28, 2024 by start of class** via the Student Developed Scenarios dropbox. You are required to wear your student uniform the day of the simulation. A group meeting with your assigned faculty will be at the beginning of the semester on **September 9, 2024**. A mid-semester checkpoint will be at week 7 (**October 7, 2024**) of the course. The first page of the document will be required to be turned in at the beginning of class. Faculty will review your submission and will contact you. You should not proceed with completing the remainder of the document until contacted by your assigned faculty.

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.	8	
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.	8	
3	Develop 2 questions NCLEX style questions with rationale related to the content in your developed scenario.	8	
4	Be creative and highlight the essential information to know about the assigned topic on the storyboard.	8	
5	Incorporate the core values of caring, diversity, excellence, integrity, and “ACE”- attitude, commitment, and enthusiasm throughout the group process.	8	
6	Complete initial meeting with assigned faculty on **September 9, 2024**.	12	
7	Mid-semester checkpoint with faculty on **October 7, 2024**. (Page 1 document to dropbox by 0800. Meet with assigned faculty after class.)	12	
8	Completed Storyboard submitted to the Student Develop Simulation Scenarios Dropbox on Edvance360 by **October 28, 2024 at start of class.**	13	
9	Actively participates throughout the entire process (Development/day of simulation) including being present on the day of the Student Developed Scenarios **November 19, 2024**.	23	

	Total	100	

Student Developed Simulation Scenario Storyboard EXAMPLE	
Identified Problem/Scenario Topic and Related Resources: Post-Operative Respiratory Depression Textbook Chapter 13	**Desired Overall Goal:** **1.** Recognize Respiratory Depression **2.** Correctly identify cause **3.** Intervene appropriately **4.** Effective ventilation returns
Case Summary: 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:** **1.** Receives bedside report **2.** Begins post-operative assessment **3.** Connects equipment **4.** Notices decreased O2 sats, decreased RR & depth, decreased LOC **5.** Changes nasal cannula to mask **6.** Increases O2 liter flow & reassesses **7.** Calls for help (Rapid Response Team) **8.** SBAR communication **9.** Administers Narcan & reassesses **10.** Communicates effectively with family throughout
Supplies: **1. SimMan** **2. Nasal canula** **3. O2 mask** **4. Morphine 5mg/1mL injection** **5. Narcan 10mg/5mL injection (x2)** **6. NS @ 125 IV** **7. IV pump**	
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:
Sickle Cell Disease

Desired Overall Goal:
1. **Maintain comfort**
2. **Maintain SpO2 above 98%**
3. **Intervene appropriately**
4. **Maintain adequate hydration**

Case Summary:
A 10-year-old patient, Jonny, has sickle cell disease and is presenting to the emergency department with severe pain in his joints. Jonny's mother reports that the pain started abruptly two days ago and has worsened despite using over-the-counter pain medications. Jonny also has a history of frequent pain episodes and has been hospitalized multiple times in the past for similar issues. Jonny's last hemoglobin level was 7.5 g/dL, and their most recent pain episode was six months ago.

Supplies:
1. **Nasal Cannula**
2. **IV Pump**
3. **IV fluids**
4. **Oral penicillin**
5. **Warm packs/compress**
6. **Wong Baker Faces pain Scale/numerical scale**
7. **Oral Morphine**

Expected Interventions of Students: (Minimum of 5 required.)
1. **Receives bedside report**
2. **Begins assessment and vital signs**
3. **Completes pain assessment**
4. **Notices decreased O2 sats**
5. **Notices increased bilirubin**
6. **Notices decreased Hgb**
7. **Notices increased temperature**
8. **Notice S/S of dehydration**
9. **Begin IV fluids**
10. **Administer pain medication**
11. **Administer oral penicillin**
12. **Apply warm packs to joints**
13. **Encourages oral hydration**
14. **Reassess pain**
15. **SBAR hand off report**
16. **Communicates with family and Dr throughout**

NCLEX Questions

1. **The nurse is caring for caring for a pediatric patient with sickle cell disease. Which physician order should the nurse question?**
    a. **Apply oxygen via nasal cannula for 24 hours after all surgical procedures.**
    b. **Offer warm packs to place on painful joints.**
    c. **Give pain medication around the clock as needed based on the pain scale score.**
    d. **Restrict oral fluids.**

   Answer: D

2. **You're assisting a physician with a sickle cell anemia screening. As the nurse you know that which of the following is a risk factor of sickle cell disease.**
    a. **Native Americans**
    b. **African Americans**
    c. **Pacific islanders**
    d. **Latino**

   Answer: B

Case Flow (15-20 Minute Simulation Time)

Initiation of Scenario:														
Case Study: **Patient in bed hand off received** **Patient shows signs of respiratory distress.** **Patient received 2 doses of oral morphine over night**														
Vital Signs	**T**	**98.6**	**HR**	**120**	**RR**	**25**	**BP**	**140/90**	**SpO2**	**95%**	**Pain**	**6/10**	**BS**	**96**
Cardiac	**Tachycardia**													
Respiratory	**Clear lung sounds, fast, shallow respirations and decreased O2 sats**													
Neuro	**WNL**													
Skin	**Jaundice, pallor**													
GI	**WNL**													
GU	**WNL**													
Other														
First Frame:														
Case Study: **Nurse introduces self and begins assessment** **Patient is responsive** **Vitals begin to change with increased in temperature, increased HR, increased RR, increased BP and decreased SpO2** **Apply nasal cannula to maintain above 98%** **Begin IV fluids** **Administer pain medication**														
Vital Signs	**T**	**101.5**	**HR**	**125**	**RR**	**28**	**BP**	**145/95**	**SpO2**	**91%**	**Pain**	**9/10**	**BS**	**92**
Cardiac	**Tachycardia**													
Respiratory	**Clear lung sounds, fast, shallow respirations and decreased O2 sats**													
Neuro	**WNL**													
Skin	**Jaundice, pallor, warm to touch**													
GI	**WNL**													
GU	**WNL**													
Other														
Second Frame														
Case Study: **Maintain O2 levels above 98% with NC** **Re-asses pain and vitals** **Charge nurse calls Dr for further instructions** **Apply warm packs to joints for pain rating** **Administer oral Penicillin to prevent infection**														
Vital Signs	**T**	**101.3**	**HR**	**98**	**RR**	**20**	**BP**	**134/90**	**SpO2**	**98%**	**Pain**	**4/10**	**BS**	**95**
Cardiac	**WNL**													
Respiratory	**Clear lung sounds, normal respiratory rate and SpO2**													
Neuro	**WNL**													
Skin	**Jaundice, pallor, warm to touch**													
GI	**WNL**													
GU	**WNL**													

Other	

Third Frame

Case Study:
Maintain O2 levels above 98% with NC
Re-asses pain and vitals
Educate about adequate oral hydration

Vital Signs	**T**	**98.6**	**HR**	**96**	**RR**	**18**	**BP**	**128/86**	**SpO2**	**98%**	**Pain**	**1/10**	**BS**	**92**

Cardiac	**WNL**
Respiratory	**WNL**
Neuro	**WNL**
Skin	**Jaundice**
GI	**WNL**
GU	**WNL**
Other	

Scenario End Point

Case Study:
Patient responds to all interventions
Nurse communicates with patient and family
All vitals remain normal

Vital Signs	**T**	**98.6**	**HR**	**96**	**RR**	**18**	**BP**	**126/86**	**SpO2**	**98%**	**Pain**	**1/10**	**BS**	**92**

Cardiac	**WNL**
Respiratory	**WNL**
Neuro	**WNL**
Skin	**Jaundice**
GI	**WNL**
GU	**WNL**
Other	

Debriefing Questions:

1. **What did you notice about the patient's lab values?**

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

Patient Report: **10-year-old male, Jonny Smith presented to the ED with severe joint pain. Jonny's mother reports that the pain started abruptly two days ago and has worsened despite using over-the-counter pain medications. Jonny has a history of sickle cell disease and frequent pain episodes. He has been hospitalized multiple times in the past for similar issues. His last set of vitals were: Temp 98.6 F, BP 140/90, HR 120, RR 25 and SpO2 95%. His last pain rating was 6/10 and he received 2 doses of oral morphine overnight. Jonny's last hemoglobin level was 7.5 g/dL, and his most recent pain episode was six months ago.**

Additional information, Medical History:

Patient data:

DOB: 6/17/2014

MR#: XXXX

Prior medical history: Sickle Cell Anemia

Allergies: NKDA

Social history: Both parents recessive for sickle cell anemia

Firelands Regional Medical Center
Sandusky, Ohio
Physician's Orders

NAME: Jonny Smith	STATUS: SIGNED
DATE ORD: XX/XX/XX	ROOM: _____
ORD PHYS: _____	MR# _____
ATTENDING: _____	DOB: 06/17/2014
AGE:10 years old	DATE: XX/XX/XX

Date/Time	
XX/XX/XX	Admit to PICU
	Diagnosis: Sickle Cell Anemia
	VS every 4HR
	Activity: Bed Rest with Bathroom Privileges
	Diet: Regular
	I&O: Monitor Q8HR
	IV: In place
	Medications: Morphine, Penicillin, Tylenol
	Other: Apply hot pack to joints PRN
	Dr. _____

√	Start	Medication	Dose	Next Sched ↓	History	Assoc
	Stop		Route	Ack	Monograph	Asmnt
	Current Status		Frequency	Adjustment	Co-sign	Ref Err
	xx/xx/xxxx	Tylenol	10 mg/kg			

	xx/xx/xxxx		PO			
	Active		Q6HR PRN			
	xx/xx/xxxx		0.3 mg/kg			
	xx/xx/xxxx	Morphine	PO			
	Active		Q4HR PRN			
	xx/xx/xxxx		125 mg			
	xx/xx/xxxx	Penicillin	PO			
	Active		Q12HR			
	xx/xx/xxxx					
	xx/xx/xxxx					
	Active					
	xx/xx/xxxx					
	xx/xx/xxxx					
	Active					
– –	Label Comments					
	xx/xx/xxxx					
	xx/xx/xxxx					
	Active					
– –	Label Comments					

	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: Jonny Smith	STATUS: SIGNED
DATE ORD: XX/XX/XX	ROOM: _____
ORD PHYS: _____	MR# _____
ATTENDING: _____	DOB: 06/17/2014
AGE:_10years old	DATE: XX/XX/XX

HGB/HCT	**XX/XX/XX Admission**	**Reference Range**
HGB	7.5g/dL	12.5-16.1 g/dL
HCT	29%	36-47%

CMP	**XX/XX/XX Admission**	**Reference Range**
Na	141 mEq/L	136-145 mEq/L
CL	99 mEq/L	90-110 mEq/L
K	4.2 mEq/L	3.4-4.7 mEq/L
BUN	13 mg/dL	7-20 mg/dL
Creatinine	0.7mg	0.4-1.1 mg
Blood Glucose	96 mg/dL	70-100 mg/dL
Blood pH	7.14	7.35-7.45

URINALYSIS	**XX/XX/XX Admission**	**Reference Range**
pH	5.2	4.5-8
Specific Gravity	1.008	1.005-1.030
Glucose	0.3	0-0.8 mmol/L
Protein	Positive	Negative
Blood	Negative	Negative
Ketones	Negative	Negative
Nitrite	Negative	Negative
Leukocyte esterase	Negative	Negative
Clarity	Clear	Clear
Color	Dark Yellow	Yellow

Firelands Regional Medical Center
Sandusky, Ohio
IMAGING DEPARTMENT

NAME: Jonny Smith	STATUS: SIGNED
DATE ORD: XX/XX/XX	ROOM: _____
ORD PHYS: _____	MR# _____
ATTENDING: _____	DOB: 06/17/2014
AGE: 10 years old	DATE: XX/XX/XX

CLINICAL DATA/Reason for Test: Joint Pain

CT-Scan: Shows slight inflammation of the knee joints.

IMPRESSION: