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.

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**

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

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: **-Pediatric Head Injury** **Linnard-Palmer: Safe Maternity and Pediatric Nursing Care: Chapter 27**	**Desired Overall Goal:** **1. Recognize Risk factors for a head injury** **2. Recognize what Vital signs to look for in a head injury** **3. Intervene appropriately when signs of increased head injury are present** **4. Prevent increased intracranial pressure (ICP)**
Case Summary: **An 8 year old male patient brought into the emergency department by mother following a head injury from falling off a trampoline. He begins having altered mental status, visual disturbances, bradycardia, bradypnea and hypertension**	**Expected Interventions of Students: (Minimum of 5 required.)** **1. Receive bedside report** **2. Assess Patient's Vital Signs (bradypnea, bradycardia, and hypertension) LOC** **3. Administers the IV infusion**
Supplies: **1. SimMan** **2. Thermometer** **3. Hypertonic 3% Saline** **4. IV pump** **5. Corticosteroid** **6. Dieuretic** **7. Oxygen and Mask** **8. Tracheostomy equipment** **9. Stethoscope and Pen light** **10. Emesis basin** **11. Seizure precautions** **12. Glasgow coma scale**	**4. Raise the Head of the bed (HOB)** **5. Call the provider using correct SBAR** **6. Use the Glasgow Coma Scale (if the Patient is deemed to be 8 or less than they would need to be intubated)** **7. Accommodations to the environment that will decrease the patients intracranial pressure (turning down the lights and providing an environment with low visual and auditory stimulation)** **8. Monitor the patient's intake and output (patient may present with signs of Diabetes insipidus where the child will produce large amounts of diluted urine)** **9.**

NCLEX Questions

1. **An 8 year old child comes into the emergency department after falling off their scooter and hit their head. The child is able to communicate his concerns and states that he feels "a strong headache and feels very nauseous" what interventions would the nurse perform first**

    a. Let the child take a nap and reassess once the child wakes up

b. Administer a diuretic medication to the child and instruct them that they should monitor their I and Os
c. Perform a neurological assessment on the patien
d. Call the Imaging department and get the patient ready for a STAT CT scan

Answer: The answer would be C because the priority intervention in this situation would be to assess your patient to gather more information that will guide you in the next steps for care. The first steps in ADPIE would be to assess.

2. A 2-year-old pediatric patient is brought into the ER by his mother. The mother states that the child is coming in and out of consciousness and may have had a seizure.The toddler was being pushed on a swing by her older brother and fell off and hit their head on the swing set pole at a park and sustained a closed- head injury. What diagnostic testing would be a priority for this patient?

a. **Patient needs an X-ray to see if there is fluid around the brain.**
b. **Patient needs a CT scan of their head.**
c. **Patient needs a urinalysis to determine if there's blood in the urine.**
d. **Glasgow Coma Scale to determine the patient's ability to open their eyes.**

Answer: The answer is B because a CT scan is the first test performed to determine if the patient has any bleeding, bruising, or other damage to the brain.

Case Flow (15-20 Minute Simulation Time)

Initiation of Scenario:														
Case Study: *** Patient is lying Semi-fowlers in bed and patient hand-off received** ***Patient Vital signs are currently stable and patient current pain level is set at 3/10 with no pain medications given.** ***Patient is currently receiving no medication with the room lights being dim.**														
Vital Signs	**T**	**97.9**	**HR**	**100**	**RR**	**20**	**BP**	**97/76**	**SpO2**	**98**	**Pain**	**3/10**	**BS**	**N/A**
Cardiac	**Heart rate regular and no signs of distress**													
Respiratory	**Lung sounds crackles, Respirations: shallow breaths,**													
Neuro	**Numbness in fingertips and toes**													
Skin	**Warm, Pink skin and skin turgor less than 3 seconds,**													
GI	**Intermittent nausea**													
GU	**WNL**													
Other	**Capillary refill less than 3 seconds, Headache correlated with pain 3/10 radiating down there neck,**													
First Frame:														
Case Study:														

-Assessment nurse comes in and introduces self and begins head to toe assessment.
-Patient is awake and alert and oriented and cooperative with assessment.
-Patient Baseline starts to decline: Blood pressure increases, Bradypnea, Bradycardia, Patient is drowsy with intermittent confusion.
-initiated seizure precautions
-Mother at bedside: asking questions on patients current status.

Vital Signs	**T**	**10 0.4**	**HR**	**120**	**RR**	**10**	**BP**	**130/8 0**	**SpO2**	**92**	**Pain**	**8/10**	**BS**	**N/A**

Cardiac	**Heart rate becomes Bradycardic**
Respiratory	**Respiratory rate becomes shallow and has bradypnea.**
Neuro	**Pt is cooperative with care but still complains of his headache being a 8/10**
Skin	**Pt becomes diaphoretic**
GI	**Skin moist and patient is Pale**
GU	**WNL**
Other	**Patient is photosentive with visual disturbances noted.**

Second Frame

Case Study:
Switches room air to Nasal Cannula set to 5
-Reassess patient continues with current status with added emesis present at this point
-Primary nurse is going to call the doctor for medication orders
-Monitor Glascow coma scale
-Mother becomes worried and charge nurse comforting mother.

Vital Signs	**T**	**10 0.4**	**HR**	**120**	**RR**	**10**	**BP**	**130/8 0**	**SpO2**	**92**	**Pain**	**8/10**	**BS**	**n/a**

Cardiac	**Heart rate is bradycardic**
Respiratory	**Respirations bradypnea with crackles in the lungs, mouth breathing**
Neuro	**Decreased LOC**
Skin	**Wet and warm to touch**
GI	**Patient is vomiting**
GU	**Overactive bladder**
Other	

Third Frame

Case Study:

-Normal Saline 3% started at 40mL/hr
-Dexamethasone (corticosteroid) 2mg PO
-Furosemide (diuretic) 2mg PO
-checks order
-Reassesses patient
-Verifies dosage and administers

Vital Signs	**T**	**98. 7**	**HR**	**99**	**RR**	**20**	**BP**	**100/7 5**	**SpO2**	**100% on 5 liters Nasal cann ula**	**Pain**	**2/10**	**BS**	**n/a**

Cardiac	**WNL**
Respiratory	**Patients respirations are regular/lung sounds clear with nose breathing**
Neuro	**Pt becomes Alert and oriented x3 as medications were administered**
Skin	**Pink, warm and intact**
GI	**WNL**
GU	**WNL**
Other	**N/A**

Scenario End Point

Case Study:
-Reassess patient
-Patient is responsive to the medications given
-Nurse gets back to Mother about the patient's new status

Vital Signs	**T**	**98.7**	**HR**	**99**	**RR**	**20**	**BP**	**100/78**	**SpO2**	**100% on 5 liters Nasal cannula**	**Pain**	N/A	**BS**	**N/A**

Cardiac	**WNL**
Respiratory	**Patients respirations are regular/lung sounds clear with nose breathing**
Neuro	**Pt is Alert and oriented x3**
Skin	**Pink Warm and intact**
GI	**WNL**
GU	**WNL**
Other	**N/A**

Debriefing Questions:

1. **What did you take into consideration with this patient that caused you to be concerned**

2.Tell me something you learned from this simulation and something you did well?

Patient Report: Patient came into the Emergency Room with complaints of a Headache after falling off a trampoline. Patients begin having altered mental status, bradycardia, bradypnea and hypertension. Patient is currently is in the room with mom 1 and mom 2 at bedside.

Additional information, Medical History:

Patient data: Henry Jones

DOB: 1/27/XX
MR#:

Prior medical history: No known history of any accidents or surgeries
Allergies: peanuts
Social history: Patient has a baby brother and a newborn sister. Patient has both parents, Mom 1 and Mom 2.

Firelands Regional Medical Center
Sandusky, Ohio
Physician's Orders

NAME: _**Henry Jones**_____
STATUS: SIGNED
DATE ORD: XX/XX/XX
ROOM:_**101**_____
ORD PHYS: _____ MR# _____
ATTENDING: _____
DOB:1/27/XX_____
AGE:_8__years old DATE: XX/XX/XX

Date/Time	
XX/XX/XX	Admit to _**Peds ICU**_____
	Diagnosis: _**Head injury**_____
	VS every q30 minutes
	Activity:__Bed rest_____
	Diet:___NPO_____
	I&O **30 ml/hr for output no intake at this time**
	IV:_Normal Saline 3% started at 40mL/hr_____
	Medications:___Furosemide 2mg PO q4hrs_____
	Other:_____
	Dr. Dunbar

√	Start	Medication	Dose	Next Sched ↓	History	Assoc
	Stop		Route	Ack	Monograph	Asmnt
	Current Status		Frequency	Adjustment	Co-sign	Ref Err
	xx/xx/xxxx	Furosemide 2mg PO	2mg			
	xx/xx/xxxx		PO			

Active		Q4hrs				
xx/xx/xxxx	Normal Saline 3% started at 40ml/hr	3%				
xx/xx/xxxx		IV				
Active		40ml/hr				
xx/xx/xxxx						
xx/xx/xxxx						
Active						
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: _Henry Jones_____
STATUS: SIGNED
DATE ORD: XX/XX/XX ROOM: 101_____
ORD PHYS: _Dr. Dunbar_____ MR#
____
ATTENDING: _____ DOB:1/27/XX____
AGE:__8_years old
DATE:XX/XX/XX

HGB/HCT	XX/XX/XX Admission	Reference Range
HGB	9.2	11.5-15.5
HCT	40%	30%-44$

CMP	XX/XX/XX Admission	Reference Range
Na		
CL		
K		
BUN	8	7-20 mg/dL
Creatinine		
Blood Glucose		
Blood pH		

URINALYSIS	XX/XX/XX Admission	Reference Range
pH		
Specific Gravity		
Glucose	N/A	
Protein		
Blood		
Ketones		
Nitrite		
Leukocyte esterase		
Clarity	Clear	
Color	Yellow	

Firelands Regional Medical Center
Sandusky, Ohio
IMAGING DEPARTMENT

NAME: __**Henry Jones**_____
STATUS: SIGNED
DATE ORD: XX/XX/XX ROOM: 101_____
ORD PHYS: **Dr. Dunbar**
MR# _____
ATTENDING: __**Asst. Brian**_____
DOB:1/27/XX_____
AGE:_8__years old DATE: XX/XX/XX

CLINICAL DATA/Reason for Test: Head Trauma

X-ray: Head CT
IMPRESSION: coagulopathy