

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 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 dropdown. 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 dropdown by 0800. Meet with assigned faculty after class.)	12	
8	Completed Storyboard submitted to the Student Develop Simulation Scenarios Dropdown 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	
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Student Developed Simulation Scenario Storyboard EXAMPLE	
<p>Identified Problem/Scenario Topic and Related Resources:</p> <p>Post-Operative Respiratory Depression</p> <p>Textbook Chapter 13</p>	<p>Desired Overall Goal:</p> <ol style="list-style-type: none"> 1. Recognize Respiratory Depression 2. Correctly identify cause 3. Intervene appropriately 4. Effective ventilation returns
<p>Case Summary:</p> <p>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.</p>	<p>Expected Interventions of Students:</p> <ol style="list-style-type: none"> 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
<p>Supplies:</p> <ol style="list-style-type: none"> 1. SimMan 2. Nasal cannula 3. O2 mask 4. Morphine 5mg/1mL injection 5. Narcan 10mg/5mL injection (x2) 6. NS @ 125 IV 7. IV pump 	
<p>NCLEX Questions</p> <p>1.</p> <ol style="list-style-type: none"> a. b. c. d. <p>Answer:</p> <p>2.</p> <ol style="list-style-type: none"> a. b. c. d. <p>Answer:</p>	

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

<p>Identified Problem/Scenario Topic and Related Resources:</p> <p>-Pediatric Glomerulonephritis</p> <p>- <i>What is glomerulonephritis?</i>. Cleveland Clinic. (2024, May 1). https://my.clevelandclinic.org/health/diseases/16167-glomerulonephritis-gn</p>	<p>Desired Overall Goal:</p> <ol style="list-style-type: none"> 1. Recognize low and discolored urine output 2. Recognize Abd and Lower extremity edema 3. Recognize pulmonary edema and intervene appropriately 4. Blood pressure normalizes, urine output increases and improved lung function
<p>Case Summary: Ben is a 10-year-old boy that has arrived to the emergency room with his parents. Their son is complaining of an increase in general fatigue and is also having some trouble breathing. Recently he has had less urine output and current output is dark brown. While in the ER he has only had 150mL of urine output in the last 8 hours. His current blood pressure is 177/96 automatic and 174/94 manual and is starting to develop a headache with pain 5/10. Heart rate is 94- Respiration are 19 with SOB on exertion- SPO2 is 90% on room air and Temperature is 99.4F. Currently has non-pitting edema in his bilateral lower extremities along with some swelling in his abdomen. Lungs have some inspiratory wheezes in the lower lobes and the formation of a rash is noticed on the lower extremities.</p>	<p>Expected Interventions of Students: (Minimum of 5 required.)</p> <ol style="list-style-type: none"> 1. Obtain bedside report of patient 2. Perform head to toe assessment and notice abnormalities 3. Obtain vital signs, notice hypertension and low SPO2 4. Administer Hydralazine for hypertension 5. Administer oxygen via nasal cannula for low SPO2 6. Notice edema in lower extremities and abdomen 7. Notice decreased and concentrated urine output 8. Administer IV Lasix to pull fluid and reduce edema, educate to lessen fluid and salt intake 9. Elevate the head of the bed to promote lung expansion and reduce pooling of fluid. 10. Educate on promotion of lung function with incentive spirometer and communicate with family effectively
<ol style="list-style-type: none"> 1. Sim man 2. IV access 3. Hydralazine 10mg/mL Injection 4. Lasix 10mg/mL Injection 5. Penicillin 125mg 6. Prednisolone 24 mg 7. Tylenol 325 mg 8. Nasal Cannula 9. Incentive spirometer 	
<p>NCLEX Questions</p> <ol style="list-style-type: none"> Question: A nurse is taking frequent blood pressure readings on a child diagnosed with acute glomerulonephritis. The parents ask the nurse why this is necessary. Which statement by the nurse most accurately addresses their concerns? <ol style="list-style-type: none"> “Blood pressure fluctuations are a sign that the condition has become chronic.” “Blood pressures fluctuations are a common adverse effect of the antibiotic therapy your child is on.” “Hypotension can lead to sudden shock and can develop at any time s a part of the disease process.” Acute Hypertension must be anticipated and identified.” <p>Answer: D</p> When obtaining a child’s daily weight, the nurse notes that he has lost 6 lbs (2.7 kg) after 3 days of hospitalization for acute glomerulonephritis. The nurse determines that this is most likely the result of which factor? <ol style="list-style-type: none"> Poor appetite Reduction of edema Decreased Salt intake Restriction to bed rest 	

Answer: B

Case Flow (15-20 Minute Simulation Time)

Initiation of Scenario:														
Case Study: Patient resting In bed – Hand off report received Patient is currently stable 10 mg of IV hydralazine received in ER														
Vital Signs	T	99.4	HR	94	RR	19	BP	174/94	SpO2	90% RA	Pain	5/10	BS	96
Cardiac	WNL													
Respiratory	Expiratory wheezes in lower lobes													
Neuro	Generalized weakness and Fatigue													
Skin	Rash formation on Bilateral lower extremities													
GI	Bowel sounds active and within normal limits													
GU	150 mL of urine over 8 hours – Urine dark brown													
Other	Formation on swelling in abdomen and edema in BLE													
First Frame:														
Case Study: Nurse introduction and first assessment Notice of low SPO2 and apply nasal cannula Administer Tylenol for pain														
Vital Signs	T	99.9	HR	94	RR	19	BP	157/90	SpO2	90% RA	Pain	5/10	BS	96
Cardiac	WNL													
Respiratory	Expiratory wheezes in lower lobes													
Neuro	Generalized weakness and fatigue													
Skin	Rash on BLE													
GI	Bowel sounds active and WNL													
GU	50 mL of dark brown urine													
Other	Abdominal swelling and BLE edema													
Second Frame														
Case Study: Vital signs change and blood pressure increases (administer hydralazine) Wheezes in lungs become worse Edema in BLE changed from non-pitting to +1 (Administer Lasix)														
Vital Signs	T	98.4	HR	90	RR	26	BP	166/96	SpO2	96% 2L	Pain	2/10	BS	95
Cardiac	WNL													
Respiratory	Wheezes now in upper and lower lobes													
Neuro	Generalized weakness													
Skin	Rash on BLE													
GI	WNL													
GU	No output													
Other	Abdominal swelling and +1 edema in BLE													
Third Frame														
Case Study: Administer PCN for positive strep A Administer Prednisolone to improve lung function														

Vital Signs	T	98.6	HR	90	RR	17	BP	136/78	SpO2	97% on 2L	Pain	2/10	BS	95
Cardiac	WNL													
Respiratory	Lungs clear and diminished													
Neuro	Generalized weakness													
Skin	Rash on BLE improving													
GI	WNL													
GU	375 mL of amber color urine output													
Other	Abdominal swelling decreased and BLE puffy													

Scenario End Point

Case Study:
Nurse communication with patient and family
Patient responds well the PCN and prednisolone
Educate on incentive spirometer to maintain proper lung function

Vital Signs	T	98.4	HR	87	RR	18	BP	135/80	SpO2	99% on 2L	Pain	1/10	BS	90
Cardiac	WNL													
Respiratory	Lungs clear													
Neuro	Weakness improves with mild fatigue													
Skin	Rash greatly improves and almost resolved													
GI	WNL													
GU	Producing about 30 mL of urine per hour													
Other	Abdominal swelling and BLE edema resolved													

Debriefing Questions:

1. What were your initial thoughts upon the first head to toe assessment?
2. What would be some interventions you would perform for the edema and low urine output if the IV Lasix did not work?

- **Patient Report:** Ben is a 10-year-old boy that has arrived to the emergency room with his parents. Their son is complaining of an increase in general fatigue and is also having some trouble breathing. Recently he has had less urine output and current output is dark brown. While in the ER he has only had 150mL of urine output in the last 8 hours. His current blood pressure is 177/96 automatic and 174/94 manual and is starting to develop a headache with pain 5/10. Heart rate is 94- Respiration are 19 with SOB on exertion- SPO2 is 90% on room air and Temperature is 99.4F. Currently has non-pitting edema in his bilateral lower extremities along with some swelling in his abdomen. Lungs have some inspiratory wheezes in the lower lobes and the formation of a rash is noticed on the lower extremities. Generalized weakness was noticed when assessing overall strength and general fatigue as stated by parents

Additional information, Medical History:

Patient data:

DOB: 10/31/2014

MR#: 10987654321

Prior medical history: Otitis media, Influenza, RSV, Conjunctivitis, Common cold,

Strep throat

Allergies: NKDA

Social history: Mother and Father smoke

Firelands Regional Medical Center
Sandusky, Ohio
Physician's Orders

NAME: _____	STATUS: SIGNED
DATE ORD: XX/XX/XX	ROOM: _____
ORD PHYS: _____	MR# _____
ATTENDING: _____	DOB: _____
AGE: ___ years old	DATE: XX/XX/XX

Date/Time	
XX/XX/XX	Admit to: Med/Surg
	Diagnosis: Glomerulonephritis
	VS every: 4 Hours
	Activity: Stand by assist with ambulation (no assistive devices)
	Diet: Low sodium and 1500 fluid restriction
	I&O: Strict monitor (every 2 hours)
	IV: 20 gauge in Right Lower Forearm
	Medications: Hydralazine, Lasix, Penicillin, Prednisolone, Tylenol
	Other:
	Maintain oxygen levels above 92%
	Administer scheduled medication
	Administer PRN medication as indicated
	Dr. _____

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

	xx/xx/xxxx		IV-push			
	Active		systolic above 160			
	xx/xx/xxxx	LASIX	40 mg			
	xx/xx/xxxx		IV – push			
	Active		0800 & 1600			
	xx/xx/xxxx	PREDNISOLONE	24mg			
	xx/xx/xxxx		Oral			
	Active		Every 8 hours			
	xx/xx/xxxx	PENICILLIN	125mg			
	xx/xx/xxxx		Oral			
	Active		Every 6 hours			
	xx/xx/xxxx	TYLENOL	325 mg			
	xx/xx/xxxx		oral			
	Active		Every 6 hours for pain			
<input type="checkbox"/> <input type="checkbox"/> Label Comments						
	xx/xx/xxxx					
	xx/xx/xxxx					
	Active					
<input type="checkbox"/> <input type="checkbox"/> Label Comments						

	Administer	Admin Comments	Non-Admin Reasons	Acknowledge	Undo	Admin Schedule	View Order	+/- Admin Instructions	Additional Functions	Display Options	
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Firelands Regional Medical Center
Sandusky, Ohio
LABORATORY

NAME: Ben Ten _____	STATUS: SIGNED
DATE ORD: XX/XX/XX	ROOM: 3005 _____
ORD PHYS: _____	MR# _____
ATTENDING: _____	DOB: _____
AGE: 10 years old	DATE: XX/XX/XX

HGB/HCT	XX/XX/XX Admission	Reference Range
HGB	9.6	11.2 – 14.5
HCT	33%	35% – 44%

CMP	XX/XX/XX Admission	Reference Range
Na	120	135 – 145
CL	101	96 – 106
K	5.7	3.5 – 5.0
BUN	47	6 – 20
Creatinine	2.9	0.6 – 1.3
Blood Glucose	96	70 - 100
Blood pH	7.39	7.35 – 7.45

URINALYSIS	XX/XX/XX Admission	Reference Range
pH	5.9	5 - 8
Specific Gravity	1.037	1.005 – 1.025
Glucose	Negative	Negative
Protein	Positive	Negative
Blood	Positive	Negative
Ketones	Positive	Negative
Nitrite	Negative	Negative
Leukocyte esterase	Positive	Negative
Clarity	Clear	Clear or Cloudy
Color	Dark Brown	Yellow

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: Wheezes in bilateral lungs

X-ray: Chest

IMPRESSION: No acute cardiopulmonary pathology, Findings suggest volume overload/CHF

CLINICAL DATA/Reason for Test: Decreased and concentrated urine output

Renal Ultrasound

IMPRESSION: Hydronephrosis with smooth contours and clear medullary/cortical boundaries

CLINICAL DATA/Reason for Test: Decreased urine output

Bladder Scan

IMPRESSION: 78 mL

CLINICAL DATA/Reason for Test: Throat red with swollen tonsils and white patches on tongue

Throat Swab

Impression-Strep A positive