Firelands Regional Medical Center School of Nursing

Medical Surgical Nursing

Simulation Prebriefing

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Questions to answer in the prebriefing and reflection journal 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 (Sim #1 Prebrief, Sim #2 Prebrief) 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.
    - The first thing I noticed was the recent fall that the patient had. After the fall the patient's pain in the left leg started but the fall could have caused other complications. It's possible for the patient to have hit their head which would need a neuro assessment to make sure nothing is wrong. It's possible for other fractures to have occurred like a rib fracture so there needs to be a pain and respiratory assessment.
- What expectations do you have about the patient prior to caring for them? Explain.
    - Prior to caring for the patient, it is expected for them to have a lot of pain in their leg, this might make them agitated and restless. The patient also reported

noncompliance with medication regimens so they might require more education medication and physical activity post-op.

- What previous knowledge do you have that will guide your expectations? Explain.
    - The previous knowledge I have that will guide my expectations is an understanding that everyone reacts differently to pain. Some might be emotional, some might not show their pain, and some can become agitated or aggressive. I also know that the patient reported noncompliance with medication regimens, so I expect there to be a higher education need.

Interpreting:

Interpret the following data:

What is the patient's admitting diagnosis? Define the diagnosis.

The patient's admitting diagnosis was a left lower leg fracture. This means there was some type of break or fracture to either the tibia, fibula, or both. According to the x-ray preformed there is a complete, open, oblique fracture of the tibia and fibula. This means both bones are broken all the way through, the bone has broken skin and is protruding out, and the fracture is in a diagonal line across the bones.

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

Abnormal Lab Values	Rationale for Abnormal Lab Values (Use complete sentences.)
BUN: 40	It possible that this value is elevated because the patient is experiencing shock from the fall, fracture, and pain.
Creat: 2.1	This value goes along with the BUN value, so it is also possible the creatinine is elevated due to shock.

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

Diagnostic Testing	Results of Diagnostic Testing (Use complete sentences.)
Left lower leg x-ray	The x-ray showed a complete, open, oblique fracture of the left tibia and fibula.
Lab values drawn	The lab values that were drawn showed elevated levels of BUN and creatinine.

Medications (provide a list of all medications (home and on eMAR) 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) (List at least 3 per medication)**
Metoprolol, Lopressor	Antianginals, antihypertensives, beta blockers	Hypertension, angina pectoris, anxiety	1. Monitor BP 2. May cause elevated BUN 3. Monitor I/O with daily weights
Aspirin	Antiplatelet agents, antipyretics, nonopioid analgesics, NSAIDs	RA, OA, mild to moderate pain, fever	1. Assess for signs of hypersensitivity 2. Educate to take with a full glass of water 3. Administer after meals or with food to minimize GI irritation
Atorvastatin, Lipitor	Lipid-lowering agent, hmg coa reductase inhibitors	Management of hypercholesterolemia, prevention of coronary heart disease	1. Obtain a diet history 2. Avoid grapefruit juice 3. Education that med should be used with diet restrictions, exercise, and smoking cessation
Tamsulosin, Flomax	Benign prostatic hyperplasia bph agents, alpha adrenergic blockers	Benign prostatic hyperplasia	1. Assess pt for first-dose orthostatic hypotension 2. Rectal exams prior to therapy to assess prostate size is recommended 3. Educate to not double dose if a dose is missed
Montelukast, Singulair	Allergy, cold, and cough remedies, bronchodilators, leukotriene antagonists	Prevention and chronic treatment of asthma, seasonal or perennial allergic rhinitis, prevention of exercise-induced bronchoconstriction	1. Assess lung sounds and resp function prior and during therapy 2. Monitor changes in behavior 3. Educate to not discontinue therapy without consulting HCP
