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.
  In the initial medical history that this patient has would be she has COPD, A fib, and HTN which all or one could have reason to why she had fallen. For example, all of those diseases have the symptom of feeling dizzy and exactly that could have happened. Which would have led to her getting a left leg fracture that she can not bear weight on from falling off of the ladder 5 feet. Also, her BUN was way high which can indicate that there is something going on with her kidneys. Then her creatine was high as well which could affect kidney damage or she could have been dehydrated. Therefore, when I enter her room, I would assess her Left leg as well as all the vital signs especially heart rate and blood pressure.
- What expectations do you have about the patient prior to caring for them? Explain

I expect that this patient is going to be in a lot of pain from the fracture and falling off of the ladder. As well as I expect her not to be able to bear weight on her left leg so only moving as little as she can. This is because she had fallen down the ladder and it would be very painful.

- What previous knowledge do you have that will guide your expectations? Explain.
  The previous knowledge that I have that guides my expectations is that she fell 5 feet down from a ladder, she cannot bear weight on the left leg, and she was diagnosed with a Left oblique tibia and fibula fracture.

Interpreting:

Interpret the following data:

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

She was diagnosed with a Left Oblique tibia and fibula fracture which means that her bone is broken at a diagonal slant going from tibia to fibula in her left leg.

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

Abnormal Lab Values	Rationale for Abnormal Lab Values (Use complete sentences.)
Creatine 2.1	The Creatine is high with a normal range of 0.1-1.3 which means that the kidneys are not working properly or has some kind of trauma going on.
BUN 40	The BUN normal range is 8-21 which means that her kidneys are not working correctly and the BUN is building up or there is some trauma straight towards the kidneys.

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

Diagnostic Testing	Results of Diagnostic Testing (Use complete sentences.)
Labs	Lab resulted in Creatine and BUN to be abnormally high.
X-ray of Left Lower Leg	The result was the she has a Left oblique tibia and fibula fracture in her lower leg.

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	T: Antianginals, antihypertensive P: beta blocker	Hypertension	- Monitor BP, ECG, and pulse regularly - May cause increased BUN - If PO take apical pulse prior to administering for 50 bpm or higher or withhold medication
Aspirin	T: antiplatelet agents, antipyretics, nonopioid analgesics P: salicylates, NSAIDs	Prevention of MI since she has COPD and Afib	- Use lowest dose for shortest period of time - Advise patient to take with a full glass of water and sit up for 30 minutes after - Look for signs if tinnitus, abnormal bleeding, and black tarry stools
Atorvastatin	T: lipid-lowering agents P: hmg coa reductase inhibitor	Management of her hypercholesteremia	- Avoid grapefruit, it may increase toxicity - Look for signs of abdominal cramps, constipation, diarrhea, flatus, and heartburn - Monitor Liver function test
Tamsulosin	T: benign prostatic hyperplasia bph agents P: alpha adrenergic blockers	Management of her enlarged prostate	- Assess input and outputs, may have feeling of incomplete bladder emptying - Assess patients' orthostatic hypotension, as it can cause dizziness and hypotension - Administer daily 30

			minutes after meals
Montelukast	T: allergy, cold and cough remedies, bronchodilators P: leukotriene antagonist.	Used as an allergy medication. Prevention of bronchospasms.	- Assess lungs and respiratory function prior to giving medication - Monitor closely an tell her to report and behavioral changed (suicidal). - Report signs of rash, abdominal pain, aggression, agitation, fever.