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 have noticed when looking at the patient's chart is that the patient's allergies and assessment are not documented. This is important if I were to pre-medicate the patient for pain or start an antibiotic before surgery and I would like to know how the patient is presenting to them so that I can prepare for their arrival.
- What expectations do you have about the patient prior to caring for them? Explain.
  I expect a couple of things to go on when taking care of the patient:
    - I am expecting the patient to have a blood pressure issue due to the trauma she has received. She could either be in shock because it was stated that she is not claiming pain, so she may have low blood pressure. I would notice pale, cool,

clammy skin, rapid pulse, rapid breathing, altered mental status, weakness, dizziness, nausea, and decreased urinary output. On the other hand, she could have high blood pressure and not know it because she may have passed out from blood pressure decrease suddenly or her heart went into atrial fibrillation causing the fall.
    - I also expect that the ER has immobilized the patient's leg with an air cast or splint of the patient's entire leg from below the ankle to above the knee.
    - With an open fracture and elevated WBC, I am also going to be looking for a prescription for antibiotics to help decrease the possibility of sepsis and farther infections. The earlier you start an antibiotic for infection the better the outcome and recovery long term.
- What previous knowledge do you have that will guide your expectations? Explain.
    - What I know from previous experiences is that if a patient had a fall, there must be a reason for the fall. Was it due to a heart issue, like atrial fibrillation, or was the patient suffering from a side effect from one or more medications? The patient has a past medical history of atrial fibrillation, hypertension, and takes medication for benign prostatic hyperplasia (Tamsulosin), which causes adverse reactions of orthostatic hypertension, dizziness, and headaches.

Interpreting:

Interpret the following data:

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

- The patient is diagnosed with an open oblique fracture of the left lower leg. The fracture is broken through the skin and the bone is exposed. The path of the fracture (oblique) is a line that extends across and down the bone. To fix the fixture, the surgeon will need to correct the bone alignment with the use of internal fixation, such as wires, screws, pins, plates, intramedullary rods, and nails. With the open fixture, I would expect the patient to have the introduction of infection into the wound area also.

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

Abnormal Lab Values	Rationale for Abnormal Lab Values (Use complete sentences.)
White Blood Count (11.1)	With this slight elevation in WBC, we may have a start of infection going on within the blood system.
BUN (40)	Elevated BUN level can tell us that there is a possible impaired kidney, heart failure, or a dehydration issue going on within the body.
Creatine (2.1)	With the combination of the elevated BUN and Creatine levels, this result helps narrow down the possibility that the patient is suffering from kidney failure because of medication compliance

	or kidney injury from the fall, like a bruised kidney.

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

Diagnostic Testing	Results of Diagnostic Testing (Use complete sentences.)
X ray	The test results confirm the diagnosis of a complete open oblique fracture of the left tibia and fibula in the lower leg.
Laboratory	These test results showed an elevated WBC, BUN, and Creatine level. This indicates that the patient has some type of infection and impaired kidney issues going on within the body.

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	• Antihypertensive • Beta Blocker	• Hypertension • History of Atrial Fibrillation	• Monitor vital signs for changes every 4 hours • Monitor intake and output every 12 hours • Daily weights are done at 6am every day • Fall

			Precautions
Aspirin	• Antiplatelet • Antipyretic • Non-opioid analgesic	• History of past Atrial Fibrillation event	• Health history of Respiratory issues (asthma, allergies, or nasal polyps) • Monitor for signs and symptoms of allergic reaction • Pain assessment • Vital signs • Fall Precautions
Atorvastatin	• Lipid-lowering agent	• History of hypercholesterolemia	• Diet history • Education on heart healthy diet • Evaluate serum cholesterol and triglyceride levels monthly to trend for improvements
Tamsulosin	• Alpha adrenergic blocker	• Benign prostatic hyperplasia	• Orthostatic Blood Pressure check • Intake and output of consumption and daily weights • Bladder scans before and after urination to see if patient is emptying

			bladder fully. • Urinalysis
Montelukast	• Bronchodilator	• Allergy • Asthma	• Respiratory Assessment (lung sounds, respiratory effort) • Neurological Assessment (signs of depression or anxiety and suicidal thoughts) • Assess for signs and symptoms of allergies (rhinitis, conjunctivitis, and hives)