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Kansas State Board of Nursing Simulation Scenario Library Form

Student Handouts Prior to Simulation

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Simulation Evaluation Form

Kansas State Board of Nursing

Simulation Scenario Library

Level of the Scenario:

Beginning _____ Intermediate __X__ Complex __X__

Specialty: **Medical/Surgical**

Brief Overview of the Scenario:

Bi-level nursing clinical experience in Simulation Lab

2 Scenarios, 2 sessions each

Participants:

8 NSG First year students in Med/Surg

4 students in each scenario for the "Morning Shift"

Switching scenarios for "Afternoon Shift"

4 NSG Second year students in Med/Surg

2 Second year students to be Clinical Leaders (CL), one for each scenario

2 Second year students to be Teaching Assistants (TA) and technical support, one for each scenario, CL & TA will switch roll and scenarios for "Afternoon Shift"

Scenario A:

Day 2 Post –OP Hemi-colectomy with new colostomy. Hx: Crohnes

Scenario B

Fresh post-op Tracheotomy. Hx: of Parathyroid CA

Contributed by: Debra K. Brown RN, BSN & Pam Covault RN, MSN, (Faculty)

Mary Grimes School of Nursing

Neosho County Community College - Ottawa

Date of Submission: _____

Simulation Design Template

Discipline: **PN & RN**
Course:**NSG 3 & NSG 7**
Expected Simulation Run Time: **2 hours**

Reviewed by:
Prep/report: **30 minutes**
Debrief/ Guided Reflection Time: **20 minutes**

Both scenarios were designed to run in one day, allowing each group of students to participate in each of the scenario.

Scenario A will be presented in full.

Brief Description of Patient:	Psychomotor Skills Required prior to Simulation:
Name: **Shawn Callahan** Gender: **male** Age: **44** Race: **Caucasian** Weight: **160 lb / 73 kg** Height: **5'10" / 171.5 cm** Religion: **Christian** Major Support: **wife & brother** Phone: **785-555-3434** Allergies: **Reglan & Percocet** Immunizations: **Current** Attending Physician: **Justin Simulation MD** PMH: **Crohn's Disease** History of present Illness: **ABD Pain &** **Hematochezia for 2 weeks** Social History: **Married, 2 children, No smoking,** **Drinking or drugs.** Primary Diagnosis: **S/P Hemicolectomy w/ Colostomy** Surgeries/Procedures: **Hemicolectomy w/ Colostomy**	**Prioritize Patient Care** **Baseline Assessment** **Key Concepts of Post Op Nursing Care** **Providing Patient Safety** Cognitive Skills Required prior to Simulation: **Nursing care of pt with new colostomy** **Nursing care of pt with NG tube** **Identifying expected changes in Condition vs.** **adverse changes & reactions** Concepts needed for Review: **Identifying Abnormal Lab & Response** **Utilize Patient Chart as Source Document for:** **Orders & Communication** **Post-Op Complication**

Simulation Learning Objectives:

1. Prioritizing patient care from written orders, taped report, shift assessment, and analysis of lab data.
2. Differentiate changes in Pt conditions as expected vs. adverse
3. Verbalize plan of care with nursing diagnoses, measurable goals, interventions and effectiveness of care.
4. Perform assigned roles to facilitate Team work
5. Interact with Patient Model(mannequin) as if an Actual Patient

Fidelity

Setting/Environment:
- ER
- X **Med-Surg**
- ICU
- OR/PACU
- Women's Center
- Pre-Hospital
- Other

Simulator Manikin/s Needed:

Props:

Equipment attached to manikin:
- X **IV tubing with primary line of PPN running at 125 mL/hr.**
- **Secondary IV line SL for**
- X **Intermittent IV Antibiotics**
- X **Foley catheter 240 mL output and color Amber .**
- PCA Pump running
- X **O2**
- X **Monitor attached**
- X **ID Band/Allergy Band**
- **Other**

Equipment available in room:
- X **Bedpan/Urinal/Graduate**
- X **Foley kit**
- Straight catheter kit
- X **Incentive Spirometer**
- X **Fluids**
- X **IV start Kit**
- X **IV tubing**
- X **IV Pump**
- Feeding Bag
- Pressure Bag
- X **02 delivery device, type NC**
- **Crash Cart w/airways and Medications**
- Defibrillator/Pacer
- X **Suction**
- X **Other:**
  - X **Nasal Gastric tube**
  - X **Ostomy supplies.**
  - X **Swabs for oral care**

Medications and Fluids

IV Fluids:
- X **PPN**

Oral Meds:
- **Throat spray**

IVPB:
- X **Ancef 2 gm**

IM or SC:
- X **Demerol**
- X **Toradol**

Diagnostics Available:
- X **Labs**
- X-ray (Images)
- 12 lead EKG
- Other:

Documentation Forms
- X **Physician Orders**
- Admit Orders
- X **Flow sheet**
- X **MAR**
- X **Kardex**
- Graphic Record
- X **Shift Assignment**
- Triage Form
- Code Record
- Anesthesia Record
- Standing Orders
- Transfer Orders
- Other:
- X **Face sheet**
- X **PPN/TPN Standard Order Sheet**

Other Props:
- X **NG/Ostomy output (Green Liquid)**
- X **Urine Output (Yellow liquid)**
- X **Mid-line Incision**
- X **Ostomy Stoma**

Recommended Student Group Size: 4 level 1 Students & 2 Level 2 Students

Assignments of Roles	Student Information Needed Prior to Scenario:
SPN = First Year Student SN = F = Faculty	**Second Year Student received packet of information prior to coming to the Lab. (see attached)** **First year students are given pt information a day prior to Lab.(see attached)**
SPN Primary Nurse **SPN** Secondary Nurse (IN ORIENTATION) **SN** Clinical Leader Family Member #1 Family Member #2 Observer(s) Physician/Advanced Practice Nurse Respiratory Therapy Anesthesia Pharmacy Lab Imagining Social Services Clergy **SPN** Unlicensed Assistive Personal Code Team **SPN** Other: Ancillary **SN** Teaching Assistant	Report students will receive prior to starting the simulation (report from ICU nurse, OR, Night nurse, ect.) **Taped report from previous shift.** **Patient Kardex** Patient's chart includes: **Face sheet** **Physician's orders** **Prior days MAR, Nurse's flow chart, am labs** **Current MAR in book on med cart**
Identify Faculty Roles Needed: **HOUSE OFFICIER** Important information related to roles: **Listed on next page** Critical Values: Physician Orders (Use separate page(s)attached)	

STUDENT ROLES	Key Responsibilities
Clinical Leader	Assign roles Act as Clinical resource Assist with prioritizing and organizing care Administer IV Medications as Needed Moulage Pt before each scenario
Teaching Assistant	Establish Pt base line pathophysiology & VS Animate Pt : Verbal and physical responses to care Moulage Pt before each scenario Initiate changes as directed by instructor
Primary Nurse LPN	Focused Physical Assessment Delegation Prioritization Administer schedule and PRN meds Monitor for potential for Complication of Surgical Procedures
New Nurse in Orientation	Assist Primary nurse with assessments and documentation. Provide nursing care as directed by Primary nurse
CNA or Tech	Bathe, oral care, empty and report in put & output Do VS, Daily wt, & finger stick blood sugars and report to nurse Change beds and assist with pt activities
Ancillary (Lab, X-ray, RT, Family Member, & Dietary)	Provide food trays, x-ray ,lab, PT, OT, & RT If directed by the instructor, respond as a family member or Chaplin.

References, Evidence-Based Practice Guidelines, Protocols,

or Algorithms used in this Scenario:

(site source, author, year, and page)

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McHugh-Schuster, Pamela. Concept Mapping, F.A. Davis, Philadelphia, 2002
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Walling, Anne D. Multidimensional Care of Patients with Colostomy American Family Physician. Kansas City: Jan 1, 2004. Vol. 69, Iss. 1; pg. 193

Weber, Janet. Nurses' Handbook of Health Assessment, 5th ed., J. B. Lippincott, Philadelphia, 2005.

Williams, Sue Rodwell. Essentials of Nutrition & Diet Therapy, 8th ed., Mosby, Inc., St. Louis, MO, 2003.

Scenario Progression Outline

Timing	Programming Data (Manikin Actions)	Expected Interventions	Teaching Points for Debriefing
Initial stage: Baseline Vital Signs:			1. Prioritizing problems
T	99	Assess lungs, & incision	2. Selecting Interventions
P	82		
R	20		3. Providing routine care
BP	142/88	Re-assess p/ Meds	
Cardiac Rhythm	NSR		
Breath Sounds	Diminished in bases BLL	Incentive Spiromerty	4. Documentation & charting tool
Heart Sounds	S1 S2		
Abdominal Sounds	Hypoactive	Assess BS w/o NG suction	5. Goals = pt & Nursing Success
Other Symptoms	Sore throat	Assess & provide spray	
Verbalization(s) of the simulator	Pain 6 of 10	Give scheduled NSAID	
Stage 1 Worsening of Condition	Pain 8 of 10	PRN Analgesic	
	BP 156/92	Provide abd splint/pillow	
	Coughing	IS and Up to Chair	
		Monitor temp	
		Assess sputum if present	
Multiple stages are possible depending on the complexity of the scenario	One is added: (dizzy+low BP + low 02 sat)	after MS04, call	
		give Narcan, re-assess	
	Green incision drainage	Call, culture wound with dressing change	
	T>101.0F	call, collect UA, PCXR, & blood cultures	
Conclusion of the scenario	after 1.5 hrs a 20 minutes "to wrap it up" is announced.		6. Discuss post-op complications

Debriefing/Guided Reflection Question for Simulation

(Remember to identify important concepts or curricular threads that are specific to your program)

Lead by Second level students.

What were your primary nursing Diagnoses in the scenario?

What nursing interventions did you use?

What outcomes did you measure?

Where is your patient in terms of these outcomes now?

What did you do well in the scenario?

If you were able to do this again, what would you do differnetly?

Closing Small Group Activity

Instruct all student participants to share compliments with each team member as to their contribution in the pt care or learning environment.

Complexity – Simple to Complex

Suggestions for changing the complexity of this scenario to adapt to different levels of learners:

Post op temp: Bilateral lower lobe crackles; Sediment in Urine; Wound Drainage

NG Problems: Nausea; Sore throat; Pt removed

Ostomy Problems: Leaking Appliance; Changes in stoma color; Blood Output

Suggestions to change the presentation of the scenario from one group to another to allow for "on the fly":

Any of the above additions.

NCLEX - RN Test Plan Categories Areas addressed in this Scenario are highlighted.

Second Level Students

Safe Effective Care Environment		**Health Promotion & Maintenance**	**Psychosocial Integrity**
Management of Care	*Safety& Infection Control*		
Advance Directives Advocacy Case Management Client Rights Collaboration with multidisciplinary Team Management Confidentiality Consultation Continuity of Care Delegation Prioritization Ethical Practice Informed Consent Quality Assurance Referrals Resource Management Staff Education Supervision Legal Rights & Responsibilities	Accident Prevention Disaster Planning Emergency Response Plan Error Prevention Home Safety Injury Prevention Medical & Surgical Asepsis Safe use of Equipment Security Plan Use of Restraint/Safety Devices Reporting of Incident/ Events/Irregular Occurrence/Variance Handling Hazardous & Infectious Materials	Aging Process Disease Prevention Family Planning Family Systems Growth & Development Health & Wellness Health Promotion Health Screening High Risk Behaviors Human Sexuality Immunizations Lifestyle Choices Teaching/Learning Self care Techniques of Physical Assessment Developmental Stages & Transitions Expected Body Image Changes Ante/Intra/Postpartum & Newborn Care	Abuse / Neglect Behavior Interventions Chemical Dependency Coping Mechanisms Crisis Intervention Cultural Diversity End of Life Family Dynamics Grief & Loss Mental Health Concepts Psychopathology Situational Role Changes Stress Management Support System Therapeutic Environment Sensory/Perceptual Alteration Religious & Spiritual Influences on Health

Physiological Integrity			
Basic Care & Comfort	*Pharmacological & Parenteral Therapies*	*Reduction of Risk Potential*	*Physiological Adaptation*
Alternative & Complementary Therapies Assistive Devices Elimination Mobility/Immobility Non-Pharmacological Comfort Interventions Nutrition & Oral Hydration Palliative/Comfort Care Personal Hygiene Rest & Sleep	Adverse Effects Contraindications Side Effects Blood & Blood Products Central Venous Access Devices Dosage Calculation Expected/Outcomes/Effects Intravenous Therapy Medication Administration Parenteral Fluids Pharmacological Agents/ Action Pharmacological Interactions Pharmacological Pain Management Total Parenteral Nutrition	Diagnostic Tests Laboratory Values Monitoring Conscious Sedation Potential Alterations in Body Systems Potential Complication of Diagnostic Tests/ Treatments/Procedures Potential for Complication of Surgical Procedures & Health Alterations System Specific Assessments Therapeutic Procedures Vital Signs	Alteration in Body Systems Fluid & Electrolytes Imbalance Hemodynamics Illness Management Infectious Diseases Medical Emergencies Pathophysiology Radiation Therapy Unexpected response to Therapies

Bi-Level Fall 2007 NCCC Ottawa

NCLEX - PN Test Plan Categories Areas addressed in this Scenario are highlighted.

First Level Students

Safe Effective Care Environment		**Health Promotion & Maintenance**	**Psychosocial Integrity**
Management of Care	*Safety& Infection Control*		
Advance Directives	Accident Prevention	Aging Process	Abuse / Neglect
Advocacy	Error Prevention	Data Collection Techniques	Behavior Interventions
Assignments	Home Safety	Disease Prevention	Chemical Dependency
Client Rights	Injury Prevention	Family Planning	Coping Mechanisms
Consultation with multidisciplinary Team	Medical & Surgical Asepsis	Family Interaction Patterns	Crisis Intervention
Management	Safe use of Equipment	Growth & Development	Cultural Diversity
Confidentiality	Security Plan	Health & Wellness	End of Life
Concepts of management & Supervision	Use of Restraint/Safety Devices	Health Promotion	Family Dynamics
Continuity of Care	Reporting of Incident/ Events/Irregular Occurrence/Variance	Health Screening	Grief & Loss
Delegation	Handling Hazardous & Infectious Materials	High Risk Behaviors	Mental Health Concepts
Prioritization		Human Sexuality	Mental Illness Concepts
Ethical Practice		Immunizations	Sensory/Perceptual Alteration
Informed Consent		Lifestyle Choices	Situational Role Changes
Legal Responsibilities		Teaching/Learning	Stress Management
Quality Assurance		Self care	Substance-Related Disorders
Referral Process		Techniques of Physical Assessment	Suicide/Violence Precaution
Resource Management		Developmental Stages & Transitions	Support System
		Expected Body Image Changes	Therapeutic Environment
		Ante/Intra/Postpartum & Newborn Care	Therapeutic Communication
			Religious & Spiritual Influences on Health

Physiological Integrity			
Basic Care & Comfort	*Pharmacological & Parenteral Therapies*	*Reduction of Risk Potential*	*Physiological Adaptation*
Alternative & Complementary Therapies	Adverse Effects	Diagnostic Tests	Alteration in Body Systems
Assistive Devices	Expected Effects	Laboratory Values	Basic Pathophysiology
Elimination	Side Effects	Potential Alterations in Body Systems	Fluid & Electrolytes Imbalance
Mobility/Immobility	Medication Administration	Potential Complication of Diagnostic Tests/ Treatments/Procedures	Medical Emergencies
Non-Pharmacological Comfort Interventions	Dosage Calculation	Potential for Complication of Surgical Procedures & Health Alterations	Radiation Therapies
Nutrition & Oral Hydration	Pharmacological Actions	Therapeutic Procedures	Unexpected response to Therapies
Palliative/Comfort Care	Pharmacological Agents	Vital Signs	
Personal Hygiene			
Rest & Sleep			

RM **126 B**

NAME **Shawn Callahan**

DR **Justin Simulation MD**

ALLERGIES

Reglan, Percocet

PATIENT #	PATIENT TYPE	ROOM	INITIATS	MEDICAL RECORD NUMBER
91007	IP	126 B	DKB	NSG333B

PATIENT INFORMATION	DATE OF SERVICE	TIME	AGE	DOB	SEX
Callahan, Shawn	T1	0600	46	10/20/60	M

PHONE	M/S	S.S. NUMBER	RACE
785-555-1212	M	333-22-4444	C

EMERGENCE CONTANT	REATIONSHIP	WORK PHONE	HOME PHONE	AUTH.
Callahan, Melissa	spouse	785-555-1212	785-555-3434	

INSURANCE 1	INSURANCE 2	INSURANCE 3
BCBS Deluxe Kansa City MO 64113	none	none
SUBSCRIBER: Shawn R. Callahan	SUBSCRIBER	SUBSCRIBER
CONTRACT # 77-77-76257	CONTRACT #	CONTRACT #
GROUP # 0111-7	GROUP #	GROUP #

ACCIDENT DATE	ACCIDENT PLACE	ACCIDENT TIME	WORK COMP
NA	NA	NA	YES ☐ NO ■

EVENTS OF HAPPENINGS:

GUARANTOR	RELATIONSHIP	ADDRESS CITY STATE ZIP
Shawn R. Callahan	self	1402 Gravel Rd, Garnett, KS 66069

EMPLOYER INFORMATION	PHONE
Univeristy of Kansas 722 Massachusetts Ave. Lawrence, KS 66049	785-785-7850
	OCCUPATION
	English Instructor

CHIEF COMPLIANT

ABD Pain & Hemochezia

ADMITTING PHYSICIAN	FAMILY PHYSICIAN	OTHER
Justin Simulation MD	DONALD SMITH MD	JOHN BROWN MD

DIAGNOSIS CODES

NEOSHO COUNTY COMMUNITY COLLEGE
MARY GRIMES SCHOOL OF NURSING

Date	Time	Physician's Orders and Signature	Noted b	Time
T - 1	0700	Transfere to: Med/Surg DX: S/P Hemicolectomy w/ colostomy HX: Crohn's Diesease Allergies: Reglan & Percocet Vital Signs: Q 4 hr Activity: up to chair X 30 minutes BID Diet: NPO Lab: CBC, Chem Panel, UA, in am NG to low continuous suction Medications: PPN Standard @ 125 mL/hr Toradol 30 mg IM Q 8hr Morphine 10 mg IM Q 3-4 hours prn pain Ancef 2 gm IV Q 12 hr Chloraseptic Spray at bed side ZOFRAN 4MG ODT Q 4 PRN Accu check q 6 while on PPN. Foley to DD Strict I&O record q 4 hours IS Q 1 WA Dressing change daily and PRN to keep dry Assess stoma q shift *Justin Simulation MD*		

	Rm. 126B
PT: Callahan, Shawn	**46 y/o Male**
DOB 10/20/60	**Hosp #91007**

NEOSHO COUNTY COMMUNITY COLLEGE
MARY GRIMES SCHOOL OF NURSING

Date	Time	Physician's Orders and Signature	Noted b	Time
T - 1	0700	Transfere to: Med/Surg DX: S/P Hemicolectomy w/ colostomy HX: Crohn's Diesease Allergies: Reglan & Percocet Vital Signs: Q 4 hr Activity: up to chair X 30 minutes BID Diet: NPO Lab: CBC, Chem Panel, UA, in am NG to low continuous suction Medications: PPN Standard @ 125 mL/hr Toradol 30 mg IM Q 8hr Morphine 10 mg IM Q 3-4 hours prn pain Ancef 2 gm IV Q 12 hr Chloraseptic Spray at bed side ZOFRAN 4MG ODT Q 4 PRN Accu check q 6 while on PPN. Foley to DD Strict I&O record q 4 hours IS Q 1 WA Dressing change daily and PRN to keep dry Assess stoma q shift *Justin Simulation MD*		
T	1700	D/C NGT when bowel sounds active, Re-insert if vomiting. Encourage Dangling or OOB to chair. Culture Incisional wound next dressing change. *Justin Simulation MD*		

Rm. 126B

PT: Callahan, Shawn **46 y/o Male**
DOB 10/20/60 **Hosp #91007**

AFTER OFFICE ROUNDS

ORDERS

24 Hour Medication Administration Record

DX: S/P Hemicolectomy w/ colostomy

HX: Crohn's Diesease Allergies: Reglan & Percocet

Dates effective: today Administration Times

Medication, Dose, Route, Frequency, and Indications for PRN	0701-1900	1901-0700
PPN Standard @ 125 mL/hr		O6
Toradol 30 mg IM Q 8hr *ketorolac tromethamine Inj.* 30 mg / mL	O9 17	O1
Ancef 2 gm IV Q 12 hr *cefazolin sodium*	O9	21
Chloraseptic Spray at bed side	Bedside	Bedside
Accu Check FSBS Q 6 hours Call if > 200	10 16	22 O4
Zofran ODT 4 mg orally Q 4 hr PRN nausea *ondansetron ODT* *4mg tab*		
Morphine 10 mg IM Q 3-4 hours prn pain *morphine sulfate* *!0 mg / mL*		

Initials/ Signatures

Rm. 126B

PT: Callahan, Shawn **46 y/o Male**

DOB 10/20/60 **Hosp #91007**

Hematology

	date	TODAY	T - 2	
	time	500	1300	Units
	WBC	**10.8 H**	7.2	4.0 - 10.0 x 10 3U
	NEUTROPHIL %	79 H	52	30.0 - 75.0 %
	LYMPHOCYTES %	**16 L**	38	18.0 - 40.0 %
	MOMOCYTES %	0	0	1.0 - 8.0 %
	EOSINOPHILS %	1	2	.0 - 3.0 %
	BASOPHILS %	2	1	.0 - 2.0 %
	RBC	4.27	4.86	4.20 - 5.00 MIL/UL
	HGB	13.1	13.5	12.0 - 15.0 MG/DL
	HCT	43	38	37.0 - 47.0 %
	MCV	94	87	80 - 100 FL
	MCH	27	32	26.0 - 35.0 PG
	MCHC	33	33	28.0 - 37.0 %
	RDW	12.1	12.1	10.5 - 14.5 % CV
	PLATELETS	156	177	150 - 400 x 10 3U
	SED RATE	14	8	0 - 19 MM/HR

ABG

date		STAT	Reference
time		1700	Range
	PO2	88	80 - 100
	HCO3	27	21 - 28
	PH	7	7.35 - 7.45
	Pco2	41	35 - 45
	02 sat	88	95 - 100

Chemistry

date		TODAY	T -2	Reference Range	Units
time		500	1300		
	GLUCOSE	**136 H**	102	65 - 100	MG/DL
	BUN	17	16	7.0 - 21	MG/DL
	CREATININE	1.4	O.9	0.7 - 1.5	MG/DL
	BUN/CRE RATIO	22	20	7.0 - 25.0	
	SODIUM	139	140	137 - 145	MMOL/L
	POTASSIUM	4.8	4.8	3.6 - 5.0	MMOL/L
	CHLORIDE	88 L	100	98 - 107	MMOL/L
	CO2	23	23	22 - 30	MMOL/L
	SGOT	38	38	8.0 - 39	U/L
	ALKALINE PHOS	104	104	20 - 155	U/L
	TOTAL PROTEIN	7.9	7.7	6.3 - 8.2	G/DL
	SGPT	38	38	9.0 - 52	U/L
	ALBUMIN	3.3	3.3	3.3 - 5.0	G/DL
	CALCIUM	8.2	8.O	8.4 - 10.9	MG/DL
	TOTAL BILI	0.5	0.5	0.2 - 1.3	MG/DL

SPECIAL CHEMISTRY

date	TODAY	Reference

No specials

Urinalysis

date		TODAY	T-2	Reference	
time		0600	1245	Range	Units
	METHOD:	CATH	CC		
	URINE COLOR	Amber	Straw	YELLOW	
	TURBIDITY	clear	clear	CLEAR	
	SPEC GRAVITY	1.007	1.014	1.005 - 1.015	
	pH	6.4	7.4	5.0 - 8.0	
	UR GLUCOSE	NEGATIVE	NEGATIVE	NEGATIVE	
	BILIRUBIN	NEGATIVE	NEGATIVE	NEGATIVE	
	PROTEIN	NEGATIVE	NEGATIVE	NEGATIVE	
	KETONES	NEGATIVE	NEGATIVE	NEGATIVE	
	BLOOD	NEGATIVE	NEGATIVE	NEGATIVE	
	UROBILINOGEN	NEGATIVE	NEGATIVE	0.2 - 1.0	EU'S
	NITRITE	NEGATIVE	NEGATIVE	NEGATIVE	
	LEUK ESTERACE	NEGATIVE	NEGATIVE	NEGATIVE	
	MICROSCOPIC				
	BACTERIA	**0**	**0**	NEGATIVE	
	RBC/HPF	**0**	**0**	NEGATIVE	
	WBC/HPF	**0**	**0**	NEGATIVE	
	MUCUS	**0**	**0**	NEGATIVE	
	EPPI CELLS/LPF	**0**	**0**	NEGATIVE	
	REFLEX CULTURE	NO	NO		
		0	0		

Coagulation

date		TODAY	T -2	Reference	
time		500	1300	Range	Units
	PTT	27	36	26.0 - 40	SECS
	PROTIME	9.7	11.7	9.0 - 13.0	SECS
	INR	2.7	2.4	2.0 - 3.0	

INR: Therapeutic range 2 0 - 3.0 Patients with prosthetic heart valves and/or cerebral emboli: 3.3 - 4.5

Reglan & Percocet

NSAIDs

PT: Callahan, Shawn **46 y/o Male**
DOB 10/20/60 **Hosp #91007**

PT: Callahan, Shawn **46 y/o Male**
DOB 10/20/60 **Hosp #91007**

RM 126 B
Callahan, Shawn

RM 126 A
Johns, Marie

RM 126 B
Callahan, Shawn

RM 126 A
Johns, Marie

Nursing Lab Incident Report

Date of Report _____

Date of Incident _____

Time of Incident _____

Instructor Supervising at the Time of Incident _____

Type of Incident (mark all that apply)

- [ ] Conduct in the lab was not professional.
- [ ] Damage to Lab Equipment
- [ ] Equipment malfunction.
- [ ] Injury to Staff
- [ ] Injury to Student
- [ ] Medication error
- [ ] Other
- [ ] Proper handling of supplies was ignored
- [ ] Sharps were not disposed in Sharp container.
- [ ] Staff & Students in Impending Danger
- [ ] Students did not receive instruction to avoid incident
- [ ] Students were not supervised

Brief narrative:

_____

_____

_____

_____

_____

Report completed by _____

Campus Coordinator Notified: Date _____, Time _____

Program Director Notified: Date _____, Time _____

Recommended Follow-up:

- [ ] Verbal Warning
- [ ] Addition Instruction
- [ ] Other
- [ ] Faculty training
- [ ] Replace or repair
- [ ] Scheduled re-test

NEOSHO COUNTY COMMUNITY COLLEGE
MARY GRIMES SCHOOL OF NURSING

Nurse's Notes

Date	Time	

Rm. 126B

PT: Callahan, Shawn
DOB 10/20/60

46 y/o Male
Hosp #91007

1	1
2	2
6	6
A	B

PT: Callahan, Shawn	**DOB 10/20/60**
Hosp #91007	**Room 126B**
Start: Today	

Standard Peripheral Nutrition

Standard Amino Acids		75 gm
Dextrose		150 gm
Base Solution		1000 mL
Lipids		10%/500 ml
Sodium Chloride		60 mEq
Sodium Acetate		60 mEq
Potassium Chloride		25 mEq
Potassium Acetate		
Phosphate	Potassium	22 mM
Phosphate	Sodium	20 mM
Calcium Gluconate		10 mEq
Magnesium Sulfate		10 mEq
Famotidine		40 mg
Folic Acid		1 mg
Zinc		2 mg

Total volume 1000 mL

Infusion rate 125 mL / hour

PT: Callahan, Shawn	DOB 10/20/60
Hosp #91007	Room 126B

Ancef 2 gm /D5W 100ml
cefazolin sodium

Infusion rate 100mL/Hour

PT: Callahan, Shawn	DOB 10/20/60
Hosp #91007	Room 126B

Ancef 2 gm /D5W 100ml
cefazolin sodium

Infusion rate 100mL/Hour

PT: Callahan, Shawn	DOB 10/20/60
Hosp #91007	Room 126B

Ancef 2 gm /D5W 100ml
cefazolin sodium

Infusion rate 100mL/Hour

PT: Callahan, Shawn	DOB 10/20/60
Hosp #91007	Room 126B

Ancef 2 gm /D5W 100ml
cefazolin sodium

Infusion rate 100mL/Hour

PT: Callahan, Shawn	DOB 10/20/60
Hosp #91007	Room 126B

Ancef 2 gm /D5W 100ml
cefazolin sodium

Infusion rate 100mL/Hour

Date:_____

NEOSHO COUNTY COMMUNITY HOSPITAL

MEDICAL/SURGICAL FLOW SHEET

PT: Callahan, Shawn	46 y/o Male
DOB 10/20/60	Hosp #91007

room : 126 B

Diagnosis/Surgery:_____

_____

Weight:_____

	INTAKE						OUTPUT				VITAL SIGNS				
HOUR	PO DIET	TUBE FEEDING	IV	IV	IV	BLOOD PRODUCTS	URINE	BOWEL	DRAIN or TUBE	DRAIN or TUBE	BLOOD PRESSURE	PULSES	RESPIRA-TIONS	TEMP.	Sat O2
7															
8															
9															
10															
11															
12															
13															
14															
15															
16															
17															
18															
12 hr total															
19															
20															
21															
22															
23															
24															
1															
2															
3															
4															
5															
6															
12 hr total															
24 hr total															

Date:_____

PUPIL REACTION	
B -	BRISH
S -	SLUGGISH
F -	FIXED

MOTOR FUNCTION			
MUSCLE STRENGTH		MUSCLE TONE	
+	STRONG	N	NORMAL
O	WEAK	F	FLACCID
A	ABSENT	R	RIGID

PERIPHERAL VASCULAR			
PULSE QUALITY		VASCULAR KEY	
F -	FULL	P -	PALPABLE
D -	DIMINISHED	S -	DOPPLER SIGNAL
A -	ABSENT		

RAMSEY SCALE FOR SEDATION		
LEVEL	1	PT ANXIOUX AND AGITATED OR RESTLESS OR BOTH
LEVEL	2	PT COOPERATIVE, ORIENTED AND TRANQUIL
LEVEL	3	PT RESPONDS TO COMMANDS ONLY
LEVEL	4	PT ASLEEP BUT RESPONDS TO BRISKLY TO LIGHT, GENTLE TAP OR LOUD AUDITORY STIMULI
LEVEL	5	PT ASLEEP BUT WITH SLUGGISH RESPONDS TO LIGHT, GENTLE TAP OR LOUD AUDITORY STIMULI
LEVEL	6	PT ASLEEP WITH NO RESPONSE TO STIMULI

PAIN INTENSITY SCALE 0 TO 10			
0	1 to 3	4 to 7	8 to 10
NONE	MILD	MODERATE	SEVERE

BEST MOTOR RESPONCE	
6	OBEYS COMMANDS
5	LOCALIZES PAIN
4	WITHDRAWS FROM PAIN
3	ABNORMAL FLEXION
2	ABNORMAL EXTENTION
1	NO RESPONSE

BEST VERBAL RESPONSE		EYES OPEN	
5	ORIENTATED	4	SPONTANEUOS
4	DISORIENTED	3	TO SOUND
3	INAPPROPRIATE	2	TO PAIN
2	INCOMPREHENSIBLE SOUNDS	1	NO REPONSE
1	NO RESPONSE		

	NEUROLOGICAL												PERIPHERAL VASCULAR					
VITAL SIGNS			PUPILS						MOTOR FUNCTION				LOCATION		LOCATION		LOCATION	
HOUR	PAIN INTENSITY	SEDATION SCALE	R SIZE REACTION	L SIZE REACTION	EYES OPEN	BEST VERBAL RESPONSE	BEST MOTER RESPONSE	GCS TOTAL	STRENGTH/TONE									
									LUE	RUE	LLE	RLE	L	R	L	R	L	R
7																		
8																		
9																		
10																		
11																		
12																		
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22																		
23																		
24																		
1																		
2																		
3																		
4																		
5																		
6																		

DATE _____

PT: Callahan, Shawn	46 y/o Male
DOB 10/20/60	Hosp #91007

HENDRICH FALL RISK MODEL

RISK FACTORS POINT	DAY	EVE	NIGHT
RECENT HISORY OF FALLS	7	7	7
DEPRESSOIN	4	4	4
ALTERED ELIMINATION	3	3	3
CONFUSION/DISORIENTATION	3	3	3
DIZZY/VERTIGO	3	3	3
POOR JUDGEMENT	3	3	3
POOR MOBILITY	2	2	2
TOTAL RISK SCORE			

KEY	
< 2	NORMAL/LOW RISK
3 TO 5	LEVEL 1/HIGH RISK
> 6	LEVEL 2/EXTREMELY HIGH RISK
> 3	REQUIRES FALL PREVENTION PLAN

BLOOD GLUCOSE MONITORING

METER	TIME	GLUCOSE	INITAILS	THERAPY

NOTES ARE REQUIRED ON ALL PRN MEDS

DATE / TIME	NURSES NOTES

SIGNATURES

SIGNATURE	STATUS	INITIALS	SHIFT	SIGNATURE	STATUS	INITIALS	SHIFT

This form was adapted from the med/surg flowsheet found at www.hospital-forms.com

Date _____

PT: Callahan, Shawn	46 y/o Male
DOB 10/20/60	Hosp #91007

SHIFT ASSESSMENT

SAFTEY

ACTIVITY _____

☐ PATIENT ID BRACELET ON ☐ ISOLATION

NEUROLOGICAL

LOC/ORIENTAION ☐ ALERT & ORIENTATED ☐ PERSON ☐ PLACE ☐ TIME
☐ LETHARGIC ☐ COMATOSE

GAG ☐ PRESENT ☐ ABSENT
SWALLOW ☐ PRESENT ☐ ABSENT
COUGH ☐ PRESENT ☐ ABSENT

PULOMARY

OXYGEN DELIVERY ☐ ROOM AIR ☐ O2 VIA _____ AT _____ LITERS/PERCENT
☐ PULSE OXIMETER / LOW ALARM SET AT _____
CHARATER OF RESP. ☐ UNLABORED ☐ LABORED
BREATH SOUNDS ☐ CLEAR R ☐ OTHER _____
☐ CLEAR L ☐ OTHER _____
CHEST TUBES _____
SECRETIONS ☐ NONE ☐ PRODUCTIVE _____

CARDIOVASCULAR

	#1	#2	#3	#4
IV LINE/GAUGE				
LOCATION				
DATE INSERTED				
REDNESS/SWELLING				
DRESSING	☐ DRY & INTACT	☐ DRY & INTACT	☐ DRY & INTACT	☐ DRY & INTACT

LAST DRESSING CHANGE _____
HEART SOUNDS _____
CARDIAC RHYTHM ☐ REGULAR ☐ IRREGULAR
CARDIAC MONITOR ☐ #_____ ☐ ALARMS ON / LIMITS SET AT _____
BLOOD PRESSURE ☐ ALARMS ON / LIMITS SET AT _____

GASTROINTESTINAL

BOWEL SOUNDS ☐ PRESENT 4 QUADRANTS ☐ HYPOACTIVE ☐ HYPERACTIVE ☐ ABSENT
CHARACTER OF ABDOMIN ☐ SOFT ☐ FIRM ☐ TENDER ☐ NON TENDER ☐ DISTENDED ☐ NON DISTENDED
LAST BM _____
NGT _____
JT/GT _____
TUBES/DRAINS _____

GENITO-URINARY

URINATION ☐ VOID ☐ FOLEY ☐ ANURIC ☐ INCONTINANT
COLOR/CLARITY ☐ YELLOW ☐ CLEAR ☐ CLOUDY

INTEGUMENTARY

TEMP ☐ WARM ☐ DRY ☐ COOL ☐ MOIST
COLOR _____
TURGOR ☐ ELASTIC ☐ TENTING
EDEMA ☐ ABSENT ☐ PRESENT - LOCATION _____
SKIN INTEGRITY ☐ INTACT ☐ IMPAIRED
WOUND/INCISION _____

SIGNATURE:_____ **SHIFT:**_____

Date _____

PT: Callahan, Shawn	46 y/o Male
DOB 10/20/60	Hosp #91007

SHIFT ASSESSMENT

SAFTEY

ACTIVITY _____

☐ PATIENT ID BRACELET ON ☐ ISOLATION

NEUROLOGICAL

LOC/ORIENTAION ☐ ALERT & ORIENTATED ☐ PERSON ☐ PLACE ☐ TIME
☐ LETHARGIC ☐ COMATOSE

GAG ☐ PRESENT ☐ ABSENT
SWALLOW ☐ PRESENT ☐ ABSENT
COUGH ☐ PRESENT ☐ ABSENT

PULOMARY

OXYGEN DELIVERY ☐ ROOM AIR ☐ O2 VIA _____ AT _____ LITERS/PERCENT
☐ PULSE OXIMETER / LOW ALARM SET AT _____

CHARATER OF RESP. ☐ UNLABORED ☐ LABORED

BREATH SOUNDS ☐ CLEAR R ☐ OTHER _____
☐ CLEAR L ☐ OTHER _____

CHEST TUBES _____

SECRETIONS ☐ NONE ☐ PRODUCTIVE _____

CARDIOVASCULAR

	#1	#2	#3	#4
IV LINE/GAUGE				
LOCATION				
DATE INSERTED				
REDNESS/SWELLING				
DRESSING	☐ DRY & INTACT	☐ DRY & INTACT	☐ DRY & INTACT	☐ DRY & INTACT

LAST DRESSING CHANGE _____

HEART SOUNDS _____

CARDIAC RHYTHM ☐ REGULAR ☐ IRREGULAR
CARDIAC MONITOR ☐ #_____ ☐ ALARMS ON / LIMITS SET AT _____

BLOOD PRESSURE ☐ ALARMS ON / LIMITS SET AT _____

GASTROINTESTINAL

BOWEL SOUNDS ☐ PRESENT 4 QUADRANTS ☐ HYPOACTIVE ☐ HYPERACTIVE ☐ ABSENT
CHARACTER OF ABDOMIN ☐ SOFT ☐ FIRM ☐ TENDER ☐ NON TENDER ☐ DISTENDED ☐ NON DISTENDED

LAST BM _____

NGT _____

JT/GT _____

TUBES/DRAINS _____

GENITO-URINARY

URINATION ☐ VOID ☐ FOLEY ☐ ANURIC ☐ INCONTINANT
COLOR/CLARITY ☐ YELLOW ☐ CLEAR ☐ CLOUDY

INTEGUMENTARY

TEMP ☐ WARM ☐ DRY ☐ COOL ☐ MOIST

COLOR _____

TURGOR ☐ ELASTIC ☐ TENTING
EDEMA ☐ ABSENT ☐ PRESENT - LOCATION _____

SKIN INTEGRITY ☐ INTACT ☐ IMPAIRED

WOUND/INCISION _____

SIGNATURE: _____ **SHIFT:** _____

DATE_____

PAIN ASSESSMENT **SHIFT:**

PAIN SITE

LOCATION OF PAIN _____

APPEARANCE OF PAIN SITE _____

PAIN INTENSITY _____ (INTENSITY SCORE)

WORST PAIN _____ (INTENSITY SCORE)

LEAST PAIN _____ (INTENSITY SCORE)

QUALITIES OF THE PAIN

☐ ACHE ☐ DULL ☐ SHARP ☐ OTHER: _____

ONSET/DURATION

When did your pain begin? _____

How long is the pain episode? _____

Is it ? ☐ constant ☐ intermittent

Does the pain radiate? _____ If yes, where? _____

What relieves the pain? _____

What causes or increases the pain? _____

What accompanies the pain?

☐ dizzy ☐ nausea ☐ vomiting ☐ other: _____

PAIN ASSESSMENT **SHIFT:**

PAIN SITE

_____ (INTENSITY SCORE)

_____ (INTENSITY SCORE)

_____ (INTENSITY SCORE)

☐ ACHE ☐ DULL ☐ SHARP ☐ OTHER:

ONSET/DURATION

☐ constant ☐ intermittent

_____ If yes, where? _____

☐ dizzy ☐ nausea ☐ vomiting ☐ other: _____

DAILY PROTOCOL LOG **SHIFT:**

- ☐ CARDIAC CATHERIZATION MGMT
- ☐ CONFUSED PAINT MGMT
- ☐ END OF LIFE
- ☐ FALL/INJURY PREVENTION
- ☐ GENERIC DIABETIES:
  - ☐ DKA ☐ INTERVENOUS ADMIN. D 50 W
  - ☐ HYPOGLYCEMIA ☐ INTERVENOUS PUMP
  - ☐ INSULIN INFUSION
- ☐ GENITOURINARY MGMT
  - ☐ ILEAL CONDUIT MGMT
- ☐ GI TUBE MGMT
- ☐ HYGIENE COMFORT
- ☐ INTERVENOUS THERAPY MGMT
  - ☐ CENTRAL LINE ☐ PERIPHERAL THERAPY
- ☐ PAIN MANAGEMENT
- ☐ RESPIRATORY MGMT ☐ EXTUBATION
  - ☐ CHEST TUBE MGMT ☐ OXYGEN MGNT
  - ☐ TRACHEOSTOMY TUBE MGMT
- ☐ SKIN AND WOUND CARE ☐ PRESSURE ULCER MGMT
  - ☐ PRESSURE ULCER PREVENTION
  - ☐ SKIN MGMT FOR INCONTINANCE
- ☐ _____
- ☐ _____
- ☐

DAILY PROTOCOL LOG **SHIFT:**

- ☐ CARDIAC CATHERIZATION MGMT
- ☐ CONFUSED PAINT MGMT
- ☐ END OF LIFE
- ☐ FALL/INJURY PREVENTION
- ☐ GENERIC DIABETIES:
  - ☐ DKA ☐ INTERVENOUS ADMIN. D 50 W
  - ☐ HYPOGLYCEMIA ☐ INTERVENOUS PUMP
  - ☐ INSULIN INFUSION
- ☐ GENITOURINARY MGMT
  - ☐ ILEAL CONDUIT MGMT
- ☐ GI TUBE MGMT
- ☐ HYGIENE COMFORT
- ☐ INTERVENOUS THERAPY MGMT
  - ☐ CENTRAL LINE ☐ PERIPHERAL THERAPY
- ☐ PAIN MANAGEMENT
- ☐ RESPIRATORY MGMT ☐ EXTUBATION
  - ☐ CHEST TUBE MGMT ☐ OXYGEN MGNT
  - ☐ TRACHEOSTOMY TUBE MGMT
- ☐ SKIN AND WOUND CARE ☐ PRESSURE ULCER MGMT
  - ☐ PRESSURE ULCER PREVENTION
  - ☐ SKIN MGMT FOR INCONTINANCE
- ☐ _____
- ☐ _____
- ☐

SIGNATURES

SIGNATURE	STATUS	INITIALS	SHIFT

SIGNATURE	STATUS	INITIALS	SHIFT

Bi-level nursing clinical experience in Simulation Lab

Handout for Second Year Students

Second level students should stop in for packet of pt information the week prior to assigned day in Simulation lab. the packet will include an overview of the day.

2 Scenarios, 2 sessions each

Participants:

- 8 first year students
  - 4 student in each scenario for the "Morning Shift"
  - Switching scenarios for "Afternoon Shift"
- 4 Second year students
  - 2 Second year students to be Clinical Leaders (CL), one for each scenario
  - 2 Second year students to Teaching Assistants (TA) and technical support, one for each scenarios, CL & TA will switch roll and scenarios for "Afternoon Shift"

Scenario A: 126 B

Day 2 Post –OP Hemi-colectomy with new colostomy. Hx: Crohnes

- NG to low intermittent suction
- Midline incision w/dressing change
- Ostomy appliance leaking and needs replaced
- I & O w/ NG, Ostomy, Foley and TPN
- IS Q 1 hr WA
- Pain Medication IM
- Shift assessment – focus on GI , Pain, ;Lungs and Mobility

Scheduling

- Morning shift
  - report
  - assignment by Clinical Leader (Second year student)
    - First Year Students Assignments

Primary Nurse LPN

New Nurse in orientation

CNA or Tech

Ancillary services (lab, X-ray, RT, Family Member, dietary)

Simulation

assume pt care

shift assessment and VS

am cares

ostomy care and change

morning medication

IS X 2

Pt Chair (Splinting) and Gait belt

Call AM labs and take & initiate new orders

Documentation, record I+O

10:00 Break

10:15 Debrief Lead by Second year students following printed format

11:00 Lunch Break

Afternoon Shift

1200 Report

12:30 Assignment by Clinical Leader (Second year student)

First Year Students Assignments

Primary Nurse LPN

New Nurse in orientation

CNA or Tech

Ancillary services (lab, X-ray, RT, Family Member, dietary)

Simulation

assume pt care

shift assessment and VS

am cares

ostomy care and change

PRN & scheduled medication

manage NG after X-ray not restarting

Pt Chair (Splinting) and Gait belt

Documentation, record I+O

14:00 Break

14:15 Debrief Lead by Second year following printed format

14:30 Evaluations then

15:00 Dismiss

Scenario B: 126A

Fresh post-op Tracheotomy and Parathyriodectomy. Hx: of Parathyriod CA

Simulation to match a **Scenario A** sequencing.

15:00 Dismiss

This schedule is a guide and the participants' actual times many vary...be flexible.

Debriefing

1. What were your primary nursing Diagnoses in the scenario?
2. What nursing interventions did you use?
3. What outcomes did you measure?
4. Where is your patient in terms of these outcomes now?
5. What did you do well in the scenario?
6. If you were able to do this again, what would you do differently?

This is what the NRS7 coordinator sent her student and Clinical instructor

The simulation experience (Sim Man) will be held on the Ottawa campus from 0800-1500. This will take the place of one of your two home health days. You will report to Deb Brown in the learning lab. She will have a simulation experience prepared for you. Nursing VII students will be acting as team leaders while Nursing III students will be team members. Each simulation experience will be unique, but your patients will be critical and will require you to prioritize, delegate, manage patient care, perform nursing skills, and think critically. We will expect you to be in your clinical uniform and behave in the learning lab in the same professional manner you would in the hospital setting.

Name tags are required.

First Year Student Hand-out

The simulation lab will be held on the Ottawa campus from 0800-1500. You will report to Deb Brown in the learning lab. She will have a simulation experience prepared for you. Second Level Nursing students will be acting as team leaders, First Yearstudents will be team members. Each simulation experience will be unique, but ,your patients will be critical and will require you to prioritize, perform nursing skills, and think critically. We will expect you to be in your clinical uniform and behave in the learning lab in the same professional manner you would in the hospital setting. Name tags are required. You will be expected to perpare by being familiar with the patients' conditions and the medications.

Scenario A:
DX: S/P Parathyriodectomy w/ tracheotomy
HX: Ca Parathyroid, Asthma
Allergies: NSAIDs
Medications:

- Zyrtec 10 mg po daily
- Singular 5 mg PO at hs
- D5 1/2 NS w/ 20 mEq Kcl at 100mL/hr
- Toradol 30 mg IM Q 8hr
- Ancef 1 gm IV Q 12 hrs
- Demerol 100 mg Q 3-4 hours prn pain
- Zofran 4 mg PO Q 6 hr PRN Nausea
- Albuterol Inh. Per nebulizer Q 4 hr WA

Scenario B:
DX: S/P Hemicolectomy w/ colostomy
HX: Crohn's Diesease
Allergies: Reglan & Percocet
Medications

- PPN Standard @ 125 mL/hr
- Toradol 30 mg IM Q 8hr
- Morphine 10 mg Q 3-4 hours prn pain
- Ancef 2 gm IV Q 12 hr
- Chloraseptic Spray at bed side

NEOSHO COUNTY COMMUNITY COLLEGE
Mary Grimes Schools of Nursing

Evaluation of Simulation Day

Date:_____

Utilize the scale below, mark your response to the statement.

	5 Strongly agree	4 Agree	3 Neither Agree or Disagree	2 Disagree	1 Strongly Disagree
1. The simulation scenario was helpful in reinforcing . classroom content.					
2. This size group of student allowed you to participate.					
3. The scenario allowed you to use your critical thinking skill.					
4. The amount of time was sufficient for learning.					
5. The information reviewed in the scenario was pertinent to clinical practice.					
6. The scenario increased your confidence level in your ability to provide nursing care.					
7. This experience was equal to a hospital clinical day.					
8. I would like to do 2-3 days in simulation even if it decrease the days at the hospital.					
9. What did you find the most valuable?					
10. What role would like to do next in simulation? (The role of Doctor is taken.)					

Comments:

Suggestions:

fall 2007

This simulation evaluation tool has been adapted from the one developed by Kathy Carver RN, MN at Johnson County Community College. Her expressed permission and support of Nursing Simulation in Education is greatly appreciated.