Simulation Design Template

Date: November 12, 2018
Discipline: Nursing
Expected Simulation Run Time: 20-30 min
Location: Emergency Department

File Name: Sepsis 2018
Student Level: Advanced Med-Surg
Guided Reflection Time: 60 min
Location for Reflection: Classroom

Admission Date:  |  Today’s Date:

Brief Description of Client

Name: Peter Daniels
Gender: M  Age: 40  Race: C  Weight: 91kg  Height: 72 inches
Religion: Catholic
Major Support: family member  Support Phone: 619-532-8742
Allergies: NKDA  Immunizations: Flu shot 3 months ago

Primary Care Provider/Team: Dr. McKay
Past Medical History: Pt states he is currently being evaluated for hypertension.
History of Present Illness: Pt arrives in ED after three weeks of “viral type” illness. Reports fatigue and malaise x3 weeks. Reports fevers 101-104 degrees F x 1 week. Pt has been rotating ibuprophen and Tylenol q4-6 hours to control fever and muscle aches.
Social History: 2 drinks per week
Primary Medical Diagnosis: rule out viral infection
Surgeries/Procedures & Dates: none
Nursing Diagnoses: Fluid volume deficit, Impaired peripheral perfusion, Risk for shock

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Psychomotor Skills Required Prior to Simulation:

- Priming IV tubing
- Obtain vital signs
- Physical assessment

Cognitive Activities Required Prior to Simulation:
[i.e. independent reading (R), video review (V), computer simulations (CS), lecture (L)]

Simulation Learning Objectives

General Objectives:

By the end of this simulation, the student will:

1. Implement the nursing process in the care of a patient with complex illness.
2. Demonstrate inter-professional collaboration.
3. Delegate nursing tasks to appropriate healthcare personnel.
4. Integrate patient teaching into plan of care.

Simulation Scenario Objectives:

By the end of this simulation, the student will:

1. Advocate for patient safety using a standardized communication tool.
2. Create an evidence based plan of care for a patient with sepsis.
3. Demonstrate clinical judgement during the care of a patient with sepsis.
References, Evidence-Based Practice Guidelines, Protocols, or Algorithms Used for This Scenario:
Surviving Sepsis Campaign: Updated bundles in response to new evidence
CUS tool-Improving communication and teamwork in the surgical environment (AHRQ)
Fidelity (choose all that apply to this simulation)

**Setting/Environment:**
- [ ] ER
- [ ] Med-Surg
- [ ] Peds
- [ ] ICU
- [ ] OR / PACU
- [ ] Women’s Center
- [ ] Behavioral Health
- [ ] Home Health
- [ ] Pre-Hospital
- [ ] Other:

**Simulator Manikin/s Needed:**
Standardized patient or high fidelity mannequin

**Props:**

**Equipment Attached to Manikin:**
- [ ] IV tubing with primary line fluids running at [ ] mL/hr
- [ ] Secondary IV line running at [ ] mL/hr
- [ ] IV pump
- [ ] Foley catheter [ ] mL output
- [ ] PCA pump running
- [ ] IVPB with running at [ ] mL/hr
- [ ] 02 [ ]
- [ ] Tele Monitor attached available
- [ ] ID band
- [ ] Other:

**Equipment Available in Room:**
- [ ] Bedpan/Urinal
- [ ] Foley kit
- [ ] Straight Catheter Kit
- [ ] Incentive Spirometer
- [ ] Fluids
- [ ] IV start kit
- [ ] IV tubing
- [ ] IVPB Tubing

**Medications and Fluids:** (see chart)
- [ ] IV Fluids
- [ ] Oral Meds
- [ ] IVPB
- [ ] IV Push
- [ ] IM or SC

**Diagnostics Available:** (see chart)
- [ ] Labs
- [ ] X-rays (Images)
- [ ] 12-Lead EKG
- [ ] Other:

**Documentation Forms:**
- [ ] Provider Orders
- [ ] Admit Orders
- [ ] Flow sheet
- [ ] Medication Administration Record
- [ ] Graphic Record
- [ ] Shift Assessment
- [ ] Triage Forms
- [ ] Code Record
- [ ] Anesthesia / PACU Record
- [ ] Standing (Protocol) Orders
- [ ] Transfer Orders
- [ ] Other: discharge orders

**Recommended Mode for Simulation:**
(i.e. manual, programmed, etc.)

**Student Information Needed Prior to Scenario:**
- [ ] Has been oriented to simulator
- [ ] Understands guidelines /expectations for scenario
- [ ] Has accomplished all pre-simulation requirements
- [ ] All participants understand their assigned roles
<table>
<thead>
<tr>
<th>IV Pump</th>
<th>Has been given time frame expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding Pump</td>
<td>Other:</td>
</tr>
<tr>
<td>Pressure Bag</td>
<td></td>
</tr>
<tr>
<td><strong>(i2 delivery device (type))</strong></td>
<td></td>
</tr>
<tr>
<td>Crash cart with airway devices and emergency medications</td>
<td></td>
</tr>
<tr>
<td>Defibrillator/Pacer</td>
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</tr>
<tr>
<td>Suction</td>
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<tr>
<td>Other: Stat for electrolytes, lactate, ABG</td>
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</tbody>
</table>

### Roles/Guidelines for Roles:
- Primary Nurse
- Secondary Nurse
- Clinical Instructor
- Family Member #1
- Family Member #2
- Observer/s
- Recorder
- Physician/Advanced Practice Nurse
- Respiratory Therapy
- Anesthesia
- Pharmacy
- Lab
- Imaging
- Social Services
- Clergy
- Unlicensed Assistive Personnel
- Code Team
- Other: Off-going shift nurse

### Important Information Related to Roles:
- Off going shift gives report to primary nurse.
- Secondary nurse plays roll of charge nurse.
- Off going nurse gives report and then documents interventions during crisis.
- Primary nurse uses standardized communication tool to advocate for patient safety.
- Nurse practitioner appears distracted and fatigued after working 5 shifts in a row.
Report Students Will Receive Before Simulation

This is Mr. Daniels. He is a 40-year-old male with no known drug allergies who came to the ED 4 hours ago complaining of fatigue, fevers, and malaise for the past three weeks. For the past week, he states that his fevers have ranged between 101 and 104 degrees F. It was 100.2 degrees F on admission. He has been taking acetaminophen and ibuprofen every 4-6 hours at home, which he says helps a little. His vital signs have been stable otherwise. His past medical history is significant for pre-hypertension and Reynaud’s disease. He denies past surgical history and home medications. His WBCs are normal, so the Nurse Practitioner wrote discharge orders. We are waiting for his ride to arrive.

Significant Lab Values: refer to chart

Provider Orders: refer to chart

Home Medications: none
## Scenario Progression Outline

<table>
<thead>
<tr>
<th>Timing (approx.)</th>
<th>Manikin/SP Actions</th>
<th>Expected Interventions</th>
<th>May Use the Following Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0-5 min</strong></td>
<td>Lying in bed—fetal position. Appears diaphoretic and pale.</td>
<td>Beside report from off going shift to primary nurse. Primary Nurse washes hands, identifies self and patient, provides privacy.</td>
<td>Role member providing cue: Patient “I’m feeling terrible and my last dose of ibuprophen was about four hours ago.”</td>
</tr>
<tr>
<td><strong>5-10 min</strong></td>
<td>HR 110 sinus tachycardia Temp 101 degrees F BP 113/80 mmHg RR 18 SpO2 95%</td>
<td>Primary nurse assesses patient, recognizes possible signs of sepsis.</td>
<td>Role member providing cue: Patient “I have been here for four hours and not getting any help. I guess I want to go home.” “I do not feel better but I would rather sleep in my own bed than stay here.”</td>
</tr>
<tr>
<td><strong>10-15 min</strong></td>
<td>Primary nurse approaches NP out paperwork. Primary nurse uses standardized communication tool to relay assessment findings (elevated temp and HR, PMH pre-hypertension).</td>
<td>Primary Nurse: Assess vital signs, attach patient to telemetry monitor, complete focused assessment</td>
<td>Role member providing cue: Patient rings call light, feels dizzy.</td>
</tr>
<tr>
<td><strong>15-25 min</strong></td>
<td>Patient in bed. Urinal on bedside table with 150 mL dark urine. HR=130 sinus tachycardia, BP=99/60 mmHg</td>
<td>Primary Nurse: Assess vital signs, attach patient to telemetry monitor, complete focused assessment</td>
<td>Role member providing cue: Patient “I feel dizzy and...”</td>
</tr>
<tr>
<td>Temp=102.5 F</td>
<td>Nurse Practitioner: Orders frequent vitals, stat lactate, CBC, Chem 7, ABG, blood cultures stat. NS 1 liter IV now. Start Vancomycin 1 gram after blood cultures completed.</td>
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<tr>
<td>RR=16</td>
<td>Primary Nurse: Asks for help. Assigns IV fluid administration to charge nurse. Assigns secondary nurse to document event.</td>
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<tr>
<td>Lactate=7 mmol/L</td>
<td>Team uses closed loop communication as orders are given and results are relayed.</td>
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</tbody>
</table>

**25-30 minutes**

| After IV fluid resuscitation started: | Primary Nurse notes slight improvement in vital signs and requests order for transfer to inpatient unit. |
| HR=115, sinus tachycardia | Primary Nurse provides patient education. |
| BP=102/62 mmHg | Role member providing cue: Patient “What is going on? Why are there so many people in my room? Am I still going home today?” |
| RR=16 | |
| SPO2=94% | |
Debriefing/Guided Reflection Questions for This Simulation
(Remember to identify important concepts or curricular threads that are specific to your program)

1. How did you feel throughout the simulation experience?
2. Describe the objectives you were able to achieve.
3. Which ones were you unable to achieve (if any)?
4. Did you have the knowledge and skills to meet objectives?
5. Were you satisfied with your ability to work through the simulation?
6. To Observer(s): Could the nurses have handled any aspects of the simulation differently?
7. If you were able to do this again, how could you have handled the situation differently?
8. What did the group do well?
9. What did the team feel was the primary nursing diagnosis?
10. How were physical and mental health aspects interrelated in this case?
11. What were the key assessments and interventions?
12. Is there anything else you would like to discuss?

Complexity – Simple to Complex
Suggestions for Changing the Complexity of This Scenario to Adapt to Different Levels of Learners