

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Chest Trauma: Transgender Female (TGF) Part A: Pain Control and Respiratory Depression
Original Scenario Developer(s):	Michele Solakian, Alyssa Becerra, Jessica Dorthalina and Lisa Aloy
Date - original scenario	February 3, 2016
Validation:	February 2020, MMiller, MA, RN, CHSE
Pilot testing:	December 4, 2017
<p>Estimated Scenario Time: 30 Minutes Debriefing time: 45 minutes</p> <p>Target group: Senior Nursing Students with concurrent critical care didactic course; newly graduated nurses.</p> <p>Core case: chest trauma in transgender patient; assessment and management of care in monitored unit</p> <p>QSEN/IOM Competencies: Patient Safety, Teamwork & Collaboration; Communication</p> <p>Brief Summary of Case:</p> <p>49 year old transgender patient (partial reassignment completed). She was pedestrian in car vs. pedestrian accident at 30 mph. ED assessment reveals chest trauma (fx ribs, hemo-pneumothorax), increased blood alcohol and 30 year history of smoking.</p> <p>This is an unfolding scenario in 3 parts. Sensitivity to communication with transgender patient is woven throughout.</p> <p>Part A: assessment & pain management with relief or respiratory depression</p> <p>Part B: recognition of DVT; SBAR & administration of high alert drugs</p> <p>Part C: recognition & assessment of pelvic pain</p>	

EVIDENCE BASE / REFERENCES (APA Format)
Arnold, J.D., Sarkodie, E.P., Coleman, M.E., & Goldstein, D.A. (2016). Incidence of Venous Thromboembolism in Transgender Women Receiving Oral Estradiol. <i>The Journal of Sexual Medicine</i> , 13(11), 1773-1777. doi.org/10.1016/j.jsxm.2016.09.001
Deglin, J. H., & Vallerand, A. H. (2019). <i>Davis's Drug Guide for Nurses (11th Ed.)</i> . Philadelphia, PA: F. A. Davis Company
Deutsch, M.B. (2017). Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Non Binary People. Retrieved from http://transhealth.ucsf.edu/trans?page=guidelines-feminizing-therapy
Dickey, I.M., Karasic, D.H., Sharon, N.G. (2017). Mental health considerations with transgender and gender nonconforming clients. Retrieved from http://transhealth.ucsf.edu/trans?page=guidelines-mental-health
Hashemi, L. (2018). Transgender care in the primary care setting: a review of guidelines and literature, <i>Federal Practitioner</i> , 30-37.
Mancini, M.C. (2016). Blunt Chest Trauma Treatment & Management. <i>Medscape</i> . Retrieved from https://emedicine.medscape.com/article/428723-treatment
Roberts, T., Kraft, C., French, D., Ji, W., Wu, A., Tangpricha, V., & Fantz, C. (2014). Interpreting Laboratory Results in Transgender Patients on Hormone Therapy. <i>The American Journal of Medicine</i> , 127(2), 159-162. Retrieved from http://www.sciencedirect.com/summit.csuci.edu:2048/science/article/pii/S0002934313008966
Weinand, J.D., & Safer, J.D. (2015). Hormone therapy in transgender adults is safe with provide supervision; A review of hormone therapy sequelae for transgender individuals. <i>Journal of Clinical & Translational Endocrinology</i> , 2(2), 55-60. Retrieved from https://doi.org/10.1016/j.jcte.2015.02.003
Inaba, K. et al., (2016). Cervical spine clearance: a prospective Western trauma association multi-institutional trial. <i>Journal of Trauma Acute Care Surgery</i> , 81(6), 1122-1130.

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes
1. Determine the essential physical assessment in the trauma client, correctly prioritize needs in a timely manner. Correctly analyze assessment and lab data.
2. Demonstrate timely and efficient nursing interventions to promote oxygenation, hydration, comfort, elimination and skin integrity.
3. Communicate effectively with the client, family and healthcare team; utilize SBAR format; empathetic communication with a transgender patient.
4. Administer medications safely; demonstrate attention to standard precautions, handwashing, use of PPE when appropriate.
Specific Learning Objectives
1. Perform a focused physical assessment and a complete assessment including: neurological, respiratory, cardiac, abdominal, GU, skin integrity and pain/comfort.
2. Assess hydration status including intake & output, chest tube dressing & output, laboratory and diagnostic data.
3. Integrate nursing interventions in a timely manner: administer oxygen, assist client with incentive spirometry, turn cough deep breathe (TCDB), monitor fluid balance, and administer medications safely.
4. Communicates effectively with client and family regarding the plan of care, communicate with the nursing and medical team, including SBAR report.
5. Provide a safe environment and administer medications using the 3 checks and 6 rights.
6. Demonstrate attention to the National Patient Safety Goals for postoperative care, the care of the patient with pain, and safe medication administration, including intoxicated patients.
7. Demonstrate therapeutic communication with the transgender patient. Use of appropriate language, respectful use of appropriate pronouns, gender neutral terms and recovery from mistakes in communication.
Critical Learner Actions
1. Assess pain (pain level 0-10, detailed pain assessment)
2. Administer appropriate pain medication
3. Assist with chest tube management
4. Communicate therapeutically with patient and family

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies	
Knowledge: trauma care: assessment and expected outcomes.	Skills/ Attitudes therapeutic communication with traumatized patient
<input type="checkbox"/> Lung atelectasis: pathophysiology and anticipated interventions.	<input type="checkbox"/> Use of the Incentive Spirometer
<input type="checkbox"/> DVT Prophylaxis/treatments r/t trauma & estrogen therapy	<input type="checkbox"/> Chest tube drain care
<input type="checkbox"/> I &O fluid monitoring	<input type="checkbox"/> Communication with transgender female/family
<input type="checkbox"/> Side effects of morphine administration	<input type="checkbox"/>

SECTION III: SCENARIO SCRIPT

A. Case summary

Victoria Bowie is a 49-year old (5' 11") 180 lb. (82 kg.) white English speaking transgender (female). She was with a friend after leaving a night-club and was "hit by that crazy driver" according to her acquaintance. The car was traveling an estimated 30 miles per hour. She arrived by ambulance with rigid cervical spine collar in place, hypotensive with moderate blood loss, but neurologically intact. Blood tests revealed an elevated blood alcohol concentration (BAC) was 0.25%. CT scan of the patient's cervical spine was completed and results are pending. Chest x-rays found three left rib fractures with a hemo-pneumothorax.

B. Key contextual details

The patient will have pain, atelectasis, hemo-pneumothorax, and respiratory compromise due to history of smoking. There will be blood pressure instability with possible DVT development in lower right extremity. Patient will require Narcan if over sedated with narcotic pain medication.

C. Scenario Cast

Patient/ Client	<input checked="" type="checkbox"/> X High fidelity simulator <input type="checkbox"/> Mid-level simulator <input type="checkbox"/> Task trainer <input type="checkbox"/> Hybrid (Blended simulator) <input type="checkbox"/> Standardized patient	
Role	Brief Descriptor (Optional)	Imbedded Participant (IP) or Learner (L)
Team Leader		Learner
Assessing RN		Learner
Interventionist	Medication administration	Learner
Recording RN	Assists team and gives the SBAR report	Learner

D. Patient/Client Profile

Last name:	Bowie	First name: Victoria	Code Status: Full Code
Gender: Male/ Female	Age: 49 years	Ht: 5'11"	Wt.: 180 lbs. (82 kg)
Spiritual Practice: Christian	Ethnicity: Irish		
1. Past history			
<p>Social History: Actress, dance teacher. Divorced with 3 adolescent children who live nearby. Partially transitioned from male to female; heavy smoker; history of drug use but says she is "clean".</p> <p>Medical History: smoking for 30 years (1 pack/day), mild hypertension diagnosed and treated four years ago; underwent surgical sex reassignment (partial). HIV status not known.</p> <p>Past Surgical History: Breast Augmentation (10 years ago), Reduction Thyroid-chondroplasty (9 years ago).</p> <p>Family History: Mild Depression in first-degree family members (she denies any depressive symptoms).</p> <p>Prior hospitalizations: Substance Rehab (2000, 2010). Hospitalized for substance abuse (alcohol and opioids).</p>			
Primary Medical Diagnosis	Left Hemo-pneumothorax, Rib Fx. 5-7. S/P Trauma Auto vs. Pedestrian.		

2. Review of Systems

CNS	Drowsy; migraine head aches
Cardiovasc	No murmur or arrhythmia
Pulmonary	Cough and dyspnea
Renal/Hep	Urinary retention, Bladder infections
GI	No vomiting; Occasional constipation
Endocrine	No diabetes; post-thyroidectomy
Heme/Coag	Bruising to scalp, hip, and trunk
Musc/skeletal	No arthritis or joint swelling
Integument	Eczema; MRSA
Psychiatric Hx	Flat affect; two previous psychiatric admission for Substance Rehabilitation
Social Hx	Divorced with 3 adolescent children, all are in the waiting room

Medication allergies:	NKDA	Reaction:	
Food/other allergies:	None	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Aldactone	200 mg	PO	Daily
	MVI	1 tablet	PO	Daily
	Aspirin	81 mg	PO	Daily
	Estrace	1 mg	PO	Daily
	Provera	2.5 mg	PO	Daily
	Estradiol Valerate	10 mg	IM	Monthly

4. Laboratory, Diagnostic Study Results

Na: 138 mEq/L	K: 5 mEq/L	Cl: 100 mEq/L	HCO3:	BUN: 49	Cr: 1.9
Ca: 9 mg/dl	Mg: 2	Glucose: 99 mg/dl	BAC: 0.2	HgA1C:	D-Dimer: 5
Hgb: 14	Hct: 38%	Plt: 350, 1000mm3	WBC: 12 X 1000		
APTT: 36 Sec	PTT: 77 sec	INR: 1	Troponin:	ABO Blood Type: BAC: 0.24	
ABG-pH: 7.34	PaO2: 88	PaCO2: 48	HCO3/BE: 22/ -1		SaO2: 88
VDRL: P	GBS:	Herpes: PENDING	HIV: P	CXR: Left Rib Fx 5,6 & 7	EKG: P

E. Baseline Simulator/Standardized Patient State

1. Initial physical appearance

Gender: Male genitalia Female: Breast	Attire: Hospital gown, wig, bra (gel inserts)				
<u>Alterations in appearance (moulage)</u> : Left lateral chest dressing with chest tube and sanguineous drainage (400 ml), bubble wrap or Rice Krispies in a baggie under left skin flap and simulates SubQ emphysema, Foley catheter, cigarettes at bedside. Pleuravac connected to chest tube with serosanguinous drainage bubbling					
<input checked="" type="checkbox"/>	ID band present, accurate	<input type="checkbox"/>	ID band present, inaccurate	<input type="checkbox"/>	ID band absent or not applicable
<input type="checkbox"/>	Allergy band present, accurate	<input type="checkbox"/>	Allergy band inaccurate	<input checked="" type="checkbox"/>	Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room:

<input type="checkbox"/>	No monitor display	<input type="checkbox"/>	Monitor on, no data displayed	<input checked="" type="checkbox"/>	Monitor on, standard display
BP: 145/90	HR: 110	RR: 20	T: 100.3 F	SpO ² : 92%	
Lung sounds	Left: diminished	Right: Crackles diminished	Shallow breathing, coughing		
Heart:	Sounds: S1 S2		ECG rhythm: NSR -Sinus Tach		
Bowel sounds:	Hypoactive		Other:		

3. Initial Intravenous line set up

<input type="checkbox"/>	Saline lock	Site:	LAC	<input type="checkbox"/>	IV patent (Y/N)		
<input type="checkbox"/>	IV #1	Site:	RAC	Fluid type:	Initial rate:	<input type="checkbox"/>	IV patent (Y/N) Y
<input checked="" type="checkbox"/>	Main	RAC		NS	100 ml/hr.		
<input checked="" type="checkbox"/>	Piggyback						

4. Initial Non-invasive monitors set up

<input checked="" type="checkbox"/>	NIBP	<input checked="" type="checkbox"/>	ECG First lead: Sinus Tachycardia	ECG Second lead:
<input checked="" type="checkbox"/>	Pulse oximeter	<input type="checkbox"/>	Temp monitor/type: oral	Other:

5. Initial Hemodynamic monitors set up

<input type="checkbox"/>	A-line Site:	<input type="checkbox"/>	Catheter/tubing Patency (Y/N)	<input type="checkbox"/>	CVC Site:	<input type="checkbox"/>	PAC Site:
--------------------------	--------------	--------------------------	-------------------------------	--------------------------	-----------	--------------------------	-----------

6. Other monitors/devices

<input checked="" type="checkbox"/>	Foley catheter	Amount: 350 ml	Appearance of urine: concentrated		
<input type="checkbox"/>	Epidural catheter	<input checked="" type="checkbox"/>	Infusion pump: 100 ml/h	<input checked="" type="checkbox"/>	Rice Krispies cereal under chest skin (crepitus)
<input type="checkbox"/>	External: Chest tube Left side. 200 ml bloody drainage in chamber				

Environment, Equipment, Essential props

1. Scenario setting: (example: patient room, home, ED, lobby)

Telemetry Unit on central monitoring, supine, in bed.

2. Equipment, supplies, monitors

(In simulation action room or available in adjacent core storage rooms)

	Bedpan/ Urinal	X	Foley catheter kit	X	Incentive spirometer		
X	IV Infusion pump		Feeding pump		Pressure bag	X	Wall suction
	Nasogastric tube		ETT suction catheters	X	Oral suction catheters	X	Chest tube clamp
	Defibrillator	X	Code Cart		12-lead ECG		
	PCA infusion pump		Epidural pump		Central line Kit	X	Drsg Δ equip
X	IV fluid: NS @ 100 mL/h		IV fluid additives:		Blood products: _____	ABO Type: ____	# of units: __

X	Nasal cannula 3 L		Face tent	X	Simple Face Mask	X	Non-rebreather mask
X	BVM/Ambu bag		Nebulizer tx kit	X	Flow meters (extra supply)		

4. Documentation and Order Forms

X	Provider orders	X	Med Admin Record	X	Hx & Physical	X	Lab Results
	Progress Notes		Graphic record		Anes/PACU record		ED Record
	Med Reconciliation	X	Dx test reports		Standing orders		Nurses' Notes
	Actual medical record binder			X	Electronic Medical Record		

5. Medications (to be available in sim action room)

#	Medication	Dosage	Route		#	Medication	Dosage	Route
	Morphine Sulfate 10 mg/ml	5 mg	IVP			Provera	2.5 mg	PO
	Versed	1 mg	IVP			Estrace	1 mg	PO
	Narcan	0.2 mg	IVP			Estradiol Valerate	10 mg	IM
	Aspirin	81 mg	PO			Multivitamin	1 tab	PO
	Aldactone	200 mg	PO			Heparin	5000 units	IVP

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario: Time: 12:30 AM night shift on the Telemetry Unit. Victoria Bowie was brought to Emergency Room by paramedics. Victoria Bowie is a 49-year old (5' 11") 180 lb. (82 kg.) white, English-speaking transgender (female). She was with a friend after leaving a night-club and was "hit by that crazy driver" traveling an estimated 30 miles per hour, according to her acquaintance. She arrived by ambulance with rigid cervical spine collar in place, hypotensive with moderate blood loss, but neurologically intact. Blood tests revealed an elevated blood alcohol concentration (BAC) was 0.25%. CT scan of the patient's cervical spine was completed and results are pending. Chest x-rays found three left rib fractures with a hemo-pneumothorax. She is stabilized, a chest tube has been placed on the left side, for hemo-pneumothorax due to rib fractures, received 7 mg Morphine, 1 hour ago for a pain level of 6/10 and Versed was administered 20 minutes prior to transfer to telemetry monitored bed. The ED nurse has just given you a hand-off report. Students are to perform assessment and carry out orders.

STATE 1 / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
GROUP 1			
<p>1. Baseline Alert and Oriented: Moaning, "I really hurt!"; "Can I have something for this awful pain?"</p> <p>"Is there anything you can give me for my pain?"</p> <p>OLDCART: Acute onset Chest and ribs "Getting stronger in last 5 mins" Stabbing with each breath, radiating to chest Helps when she takes shallow breaths Tolerable pain level is 4/10 Minimal crepitus</p>	<p>Operator HR: 110 ST BP: 145/90 RR: 24 Sats 92 % on 3 L/ NC Breath sounds: (R) coarse, (L) absent Temp: 100.3 oral Pain: 10/10 Left lateral chest tube with dressing attached to pleur-evac bubbling <i>Chest tube volume: 200 ml. serous-sanguineous with active air leak</i></p> <p>Triggers: Pain 10/10 Grunting, diaphoretic, pallor Tachycardia HR: 110 UOP: 0 Medicated for pain</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. WII: Wash & ID patient 2. Perform a complete HTT assessment 3. Assess chest tube for drainage and air leak, suction settings, and assess dressing. 4. Pain assessment. 5. Give Morphine Sulfate 10 mg IVP 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Pain assessment: Include OLDCART 2. Focused assessment: Neuro, Cardiac/ Resp, Abdomen, Skin. 3. Chest tube assessment: site, dressing, drainage, suction appropriate. 4. Lab tests

STATE 2 / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2. Patient continues to complain of pain 10/10 and gradually becomes non responsive with snoring respirations</p> <p>Pain: unable to assess Neuro: pupils 1-2 mm, decreased LOC, unresponsive Sats: 77% over 1-2 minutes</p>	<p>Operator: “snores” If patient gets <i>morphine 10 mg</i>, change VS to: RR: 8 HR: 77 , BP 100/60 O2 Sats: 75 %</p> <p>Trend RR and Saturations decrease over 1-2 minutes Desaturation with respiratory depression until Narcan given</p> <p>Neuro: pupils 2-3 mm, awake with verbal stimuli Snoring, responds to painful stimuli</p> <p>If patient gets lesser dose of Morphine then move to State 3 and skip next frame.</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. NRB Mask to increase oxygenation 2. Stimulate to breathe; elevate HOB (reposition) 3. Call MD for Narcan order 4. Validate orders per agency protocol 5. Administer Narcan 0.2 mg IVP every 2-3 minutes reassessing after each dose 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Safety repositioning the HOB 2. Narcan action on opioid medications and indications for repeat dose. 3. Concepts related to different oxygenation modalities. 4. Assessment findings SBAR Report to next group.
<p>After Narcan dose: 3. RR: 20-24 Sats: 93% Pain 10/10 Patient abruptly awake “OUCH” Angry</p>	<p>Triggers: Narcan given IVP with NS Flush</p> <p>Cyanosis with Sats < 75 RR: 5 After Narcan Sats > 90%</p> <p>After Narcan: complaints of pain. “My ribs hurt! Do something!”</p>	<p>Change oxygen modality to maintain sats between 90-95%</p>	<p>Call Rapid Response Team (RRT) or administer repeat Narcan dose.</p>

STATE 3/ PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>If patient gets <i>less than 10 mg morphine:</i> RR: 16 HR: 90 BP: 130/80 Sats: 90%</p> <p>Pain reassessment: 4/10 (tolerable)</p> <p>SBAR HAND-OFF REPORT</p>	<p>TRIGGERS: PATIENT IS RESTING COMFORTABLY AFTER PAIN MEDICATION</p>	<ol style="list-style-type: none"> 1. Perform a focused HTT reassessment. 2. Provide distraction of decrease stimuli as patient requests. 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Safety repositioning the HOB 2. Narcan action on opioid medications and indications for repeat dose. 3. Concepts related to the different oxygenation modalities. 4. Nursing interventions related to pain and reassessment findings 5. Give SBAR Report to next group.
<p>Scenario End Point: After Students administer Narcan or lesser dose of Morphine Sulfate and reassessment of pain.</p>			
<p>Suggestions to <u>decrease</u> complexity: No chest tube; has a small pneumothorax with stable rib fracture. Medications indicated: Lovenox and morphine sulfate.</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS Group 1

Patient Name: Victoria Bowie DOB: 1/10/XX Age: 49 years old MR#: 00220044		Diagnosis: Hemopneumothorax, left ribs 5-7 fractured; History of trauma due to auto vs. pedestrian
X No Known Allergies †Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
	07:00	Admit to trauma team Telemetry Unit
		Respiratory: Oxygen via NC to keep sats > 92%, Incentive Spirometry teaching hourly while awake; Chest tube to continuous suction at -20cm H2O
		Activity: Bedrest, TCDB, SCD's to legs
		Turn Q2 Hours
		Diet: NPO
		IV: NS @ 100 mls/hr.; decrease fluids to 60 mls/hour
		Strict I & O; Include chest tube output every shift.
		Vital Signs: Q 1 Hours, include Pulse Oximetry; with neuro checks.
		Continuous telemetry monitoring
		Labs: CBC with Differential; CMP 13 Daily
		Medications: Morphine Sulfate 10 mg IV push every 4 hours PRN severe pain 7-10/10 and greater; Morphine Sulfate 7 mg for moderate pain 5-6/10;
		Morphine Sulfate 4 mg for pain 3-4/10
		Motrin 400 mg PO every 6 hours for mild pain 1-3/10 or Fever > 101.6 F
		Versed 1 mg IV push every 6 hours PRN anxiety
		Aldactone 200 mg PO/NGT Daily
		Lovenox 30 mg SQ BID
		Estradiol Valerate 10 mg IM once monthly
		Estrace 1 mg tab Daily
		Aspirin 81 mg daily
		Multivitamin 1 tab PO daily
		Provera 2.5 mg PO daily
		Call MD: UOP<25 mls/hr.; Sats < 92%, BP> 150/90 or < 100/70; T > 101.6; HR>110 or < 50
Signature		Jim Sweet, MD

APPENDIX B: HEALTH CARE PROVIDER ORDERS Group1: page 2

Patient Name: Victoria Bowie DOB: 1/10/XX Age: 49 years old MR#: 00220044		Diagnosis: Hemopneumothorax, left ribs 5-7 fractured; History of trauma due to auto vs. pedestrian
<input checked="" type="checkbox"/> No Known Allergies †Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
	07:00	Give Narcan 0.2 mg IVP and may repeat every 2 minutes until patient is awake
		Respiratory: Oxygen via NC or NRB mask to keep sats > 92%
		Diet: NPO
		Vital Signs: Q 1 Hours, continuous Pulse Oximetry
		Medications: Morphine Sulfate 6 mg IV push every 4 hours PRN severe pain
		7-10/10 and greater; Morphine Sulfate 4 mg for moderate pain 5-6/10;
		Morphine Sulfate 2 mg for pain 3-4/10
Signature		Jim Sweet, MD

APPENDIX C: HEALTH CARE PROVIDER ORDERS Group 2: Order 1

Patient Name: Victoria Bowie DOB: 1/10/XX Age: 49 years old MR#: 00220044	Diagnosis: Hemopneumothorax, left ribs 5-7 fractured; History of trauma due to auto vs. pedestrian
--	---

No Known Allergies
 † Allergies & Sensitivities

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
	07:00	Diet: NPO
		Respiratory: Oxygen via NC or NRB mask to keep sats > 92%
		Vital Signs: Q 1 Hours, continuous Pulse Oximetry
		IV: NS @ 100 mls/hr.
		Medications: Versed 1 mg IV push every 6 hours PRN anxiety
		Venous Doppler r/o DVT L lower extremity (STAT)
		Lab: Stat D-Dimer, PT/INR, PTT
Signature		Jim Sweet, MD

APPENDIX C: HEALTH CARE PROVIDER ORDERS Group 2: Order 2

Patient Name: Victoria Bowie DOB: 1/10/XX Age: 49 years old MR#: 00220044	Diagnosis: Hemopneumothorax, left ribs 5-7 fractured; History of trauma due to auto vs. pedestrian
--	---

No Known Allergies
 †Allergies & Sensitivities

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
	07:30	Diet: NPO
		Respiratory: Oxygen via NC or NRB mask to keep sats > 92%
		Vital Signs: Q 1 Hours, continuous Pulse Oximetry
		IV: Give 500 mls NS bolus then start NS maintenance @ 100 mls/hr.
		Medications: Heparin 50,000 units in 500 mls NS
		Give Heparin Bolus 5000 units, followed by 1000 units per hour, continuous drip.
		Discontinue Lovenox
		Versed 1 mg IV push every 6 hours PRN anxiety
		LABS: PTT in 6 hours. Add PT/PTT with INR to daily labs (start tomorrow).
Signature		Jim Sweet, MD

APPENDIX D: HEALTH CARE PROVIDER ORDERS Group 3

Patient Name: Victoria Bowie DOB: 1/10/XX Age: 49 years old MR#: 00220044		Diagnosis: Hemopneumothorax, Left Rib Fracture; History of trauma due to auto vs. pedestrian
<input checked="" type="checkbox"/> No Known Allergies <input type="checkbox"/> Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
	08:00	Diet: NPO
		Respiratory: Oxygen via NC or NRB mask to keep sats > 92%
		Vital Signs: Q 1 Hours, continuous Pulse Oximetry
		IV: Give NS fluid bolus 500 mls STAT; then increase NS to 150 mls/hr.
		Versed 1 mg IV push every 6 hours PRN anxiety
		Place Foley Catheter; send UA and C & S
Signature		Jim Sweet, MD

APPENDIX E: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
Debriefing Guide	<input type="checkbox"/> Objectives	Debriefing Points	<input type="checkbox"/> QSEN
QSEN Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Patient Centered Care	<input type="checkbox"/> Teamwork/Collaboration	<input type="checkbox"/> Evidence-based Practice	
<input type="checkbox"/> Safety	<input type="checkbox"/> Quality Improvement	<input type="checkbox"/> Informatics	
Sample Questions for Debriefing			
<ol style="list-style-type: none"> 1. How did the experience of caring for this patient feel for you and the team? 2. Did you have the knowledge and skills to meet the learning objectives of the scenario? 3. What gaps did you identify in your own knowledge base and/or preparation for the simulation experience? 4. What are the priority nursing assessments for trauma patients? <ul style="list-style-type: none"> • Vital signs (RR, Pox, T, HR, BP, LOC, fluid balance, pain) 5. What are the major complications associated with clients who have a chest tube? <ul style="list-style-type: none"> • DVT, PE, hemorrhage, pulmonary complications, shock, infection 6. Transgender clients are at higher risk for thromboembolic events due to estrogen therapy and smoking further increases this risk. List interventions that prevent or reduce the risk of DVT. <ul style="list-style-type: none"> • Supported by research • SCD's, aspirin/heparin, early ambulation, no smoking 7. How does the client's history of smoking affect his risk of lung complications? <ul style="list-style-type: none"> • It can cause atelectasis, pneumonia, bronchospasm, sputum volume. 8. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP? 9. How would you handle the scenario differently if you could? 10. In what ways did you check feel the need to check ACCURACY of the data you were given? 11. In what ways did you perform well? 12. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members? 13. What three factors were most SIGNIFICANT that you will transfer to the clinical setting? 14. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome? 15. Discuss actual experiences with diverse patient populations. 16. Discuss roles and responsibilities during a crisis. 17. Discuss how current nursing practice continues to evolve in light of new evidence. 18. Consider potential safety risks and how to avoid them. 19. Discuss nurse role in design, implementation, and evaluation of information technologies to support patient care. 			

Insert digital photo here

Insert digital photo here