# SIMULATION SCENARIO DEVELOPMENT TEMPLATE

Scenario name: Respiratory Distress
Date submitted: 06/20/2009
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Institution: Univ of Wash School of Nursing
Target audience: Undergrad ☑ Grad ☐ Other: Students ready to transition to practice
Goal/Purpose: To provide respiratory care while attending to patient's family.

## Lab Set-up

Patient simulator/Task trainer: High fidelity (e.g., SimMan) or VitalSim
Patient characteristics: Female; Age:67; Option: English second language or hard of hearing.
Vital parameters, beginning: P92, RR24, 02 Sat 88% on RA, BP 144/90.
Environment/setting/location: Inpatient MedSurg floor
Lab staff needed day of simulation: Wizard & voice of patient; Option: ESL or hard of hearing
Equipment, supplies & prop list: Bedside commode, IV Pump, O2 Tubing with NC, pulse oximeter,

2 telephones with SBAR poster, 1 Nebulizer with delivery system & tubing, albuterol for inhalation; Pt chart with med orders including O2@4L/min & MAR; IV Bag and antibiotics Optional hearing aid.

## Learning Objectives

During the scenario the student will...
1. perform a focused respiratory assessment and recognize respiratory distress.
2. implement appropriate interventions to relieve respiratory distress
3. check patient identifiers before giving medications.
4. communicate effectively with patient family concerning patient status, through nursing documentation of interventions and physician/NP contact; may be complicated by language barrier or hearing difficulty.

## Student Preparation

Pre-requisite knowledge/activities:

1. Respiratory assessment
2. 02 administration and use of respiratory equipment (flow rates, delivery devices, nebulizer, etc.)
3. Medications commonly used in treatment COPD, Asthma and pneumonia
3. Normal vital sign ranges
4. SBAR communication

## Clinical Case Information

Case description/Patient history (HPI, PMH, Social Hx, FH):

History of Present Illness: Ms. Brown has respiratory distress after getting up to the commode. Back in bed now. Hospitalized with RLL Pneumonia, has h/o COPD and asthma (steroid dependent).
Admitted 2 days ago for RLL pneumonia; presented with fever & malaise x 5 days PTA. She noticed decrease in exercise tolerance, loss of appetite and fatigue. Weight: 60kg. Height:5'2"
PMH: smoker (ppd x 40 yrs), COPD, asthma [optional: dec. auditory acuity one ear,HTN, CAD, PVD]
FH: Mother: A+W. Father: died at < 55 y/o, MI
Social History: Sedentary job- administrative assistant x 35yrs. Social ETOH- wine on weekends
PCP: Dr. Hurst

Medications and Allergies (MAR):

Drug/Supplement:
Advair diskus one puff bid, Oral prednisone PO 50 mg QD, IV antibiotics for pneumonia; Albuterol via nebulizer.
Allergies: NKDA



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## Actor Roles and Behavior Overview

Actor/Role – Brief overview of behavior during scenario

RN1 played by student: Answers call light
RN2 played by student: Assists RN1 in problem-solving and giving medications
Daughter played by student: Mildly anxious and asks questions about what is happening.
Hospital Attending Resident or NP played by student: Receive report of patient status and give new orders for neb treatment with albuterol for inhalation.
Patient voice: wizard (technician) may need to not understand English well or hear very well.

## Scenario Events and Expected Actions

Events in chronological order – Expected actions

Act 1: Call light on, patient in bed with the HOB low. Patient states "I can't catch my breath." Nasal cannula is lying on the pillow.
Expected student response: place nasal cannula on, check flow meter, raise HOB, take & document VS, start respiratory assessment. If O2 @ 4L/min NC goes unrecognized, pt worsens quickly--RR 28, O2sat 84%.
Act 2: Daughter asks "What happened?" Patient has wheezes on auscultation, diminished breath sounds at bases, VS unchanged except increase in RR to 28 if O2 restarted.
Expected student behavior: coach patient in pursed lip breathing, respond to daughter's questions and use good communication to address daughter's anxiousness.
Act 3: RR remains 28, O2 sat drops to 82%. Patient continues to report shortness of breath. The nebulizer treatment is not yet due.
Expected student behavior: SBAR call to resident or NP.
Act 4: Receives order for nebulizer treatment (resident or NP enters into computer). If given: Pt's RR drops to 22, O2 Sat 89%. Over the next few minutes, RR 20, O2 Sat 92%, P 86.
Expected student behavior: Before giving nebulizer treatment, checks 6 rights. Gives Neb treatment and then documents call to resident or NP, VS, and treatment.
OPTION: Patient has difficulty understanding because English is second language or hearing problem.

## Debriefing Points

1. Review debriefing rules and purpose (e.g., confidentiality).
2. How do you think it went?
3. What worked, what would you do differently?
4. Review the objectives and have student reflect on how well these were addressed.

## References

Evidenced-based practice guidelines, protocols or algorithms used in creating scenario:

Based on general medical care (e.g., Elkins, Perry, & Potter, Fundamentals of Nursing).

## Key Words:

Respiratory, COPD, pneumonia, SBAR, nebulizer, oxygen, Med-Surg, communication difficulty



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