NURSING SIMULATION LEARNING EXPERIENCES
FACILITATOR’S GUIDE (SAMPLE)
Introduction

Simulation education has become an integral component in the preparation and development of healthcare professionals. This active learning strategy provides diverse learners with the opportunity to apply their knowledge and skills in a safe, controlled, and reproducible environment. Experiential learning obtained through the use of simulation can better prepare those participants to navigate a variety of clinical situations, which may be encountered in the current complex healthcare environment.

The evidence-based simulation learning experiences (SLEs) provided in this text are designed to provide nurse educators with outcome-focused simulated clinical patient encounters. While the Gaumard Nursing SLEs are intended for use with pre-licensure nursing students in an adult medical-surgical nursing course, they can be adapted for use in other courses to meet the needs of individual nursing programs. Each Gaumard SLE is mapped to the outcomes expected of graduates of nursing programs, including the Client Needs categories for the NCLEX-RN®, the BSN Essentials, QSEN competencies, and IPEC core competencies. Coupled with a SUSIE® S2000, S1001, or S901 manikin, these SLEs serve as a starting point for effective learning and can prepare novice nurses to successfully transfer their developing knowledge, skills, and attitudes to future clinical situations.

The Gaumard Nursing SLEs were designed to be adapted to most any simulation environment, depending on the available resources and the needs of the nursing program. Each SLE can allow the facilitator to speak as the voice of the patient, either through the streaming voice feature or an audio system. Several of the SLEs were also intended to utilize a standardized patient as a family member at the patient’s bedside. Cues for both the patient and the family member are included in the scenario timeline. By incorporating clinical expertise and experiential knowledge into the scenario, the facilitator can create a variety of meaningful learning experiences for all participants. Realism is enhanced by the addition of standardized patients, moulage, and equipment that is relevant to the healthcare environment.

These Gaumard Nursing SLEs provide a comprehensive strategy for planning, setting up, and facilitating an adult medical-surgical simulation. Sections of the SLE can be used to develop an electronic or paper health record for the patient in the SLE. Additionally, the prebriefing report can be read directly to students, as if it were the hand-off report for the oncoming nursing shift. The scenario timeline was developed for the facilitator(s) to use as a guide throughout the SLE. The graphical scenario flowchart provides an overview of potential participant actions.
Each of the ten SLEs includes the following sections:

- Purpose of the SLE
- Evidence-based rationale for the topic
- Learning objectives of the SLE
- Competencies addressed
- Psychomotor skills needed for successful participation
- Patient’s medical history
- Supplies needed for the scenario, including simulated medications
- Provider’s orders
- Prebriefing report to be given to students
- Scenario timeline with facilitator cues

After each simulation scenario, a trained debriefer engages participants in a theory-based debriefing session. During this time, participants reflect on the thought processes, decisions, and actions that occurred during the scenario. A collaborative debriefing session deepens the participants’ learning and promotes the transfer of knowledge.
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Acute Myocardial Infarction

Purpose

In this scenario, participants are expected to demonstrate a focused cardiac assessment, provide evidence-based care of the patient with an acute myocardial infarction (AMI), demonstrate ISBARR communication with a healthcare provider, and provide individualized patient education.

Rationale

It is estimated that more than 86 million American adults have one or more forms of cardiovascular disease. Of these, 7.6 million adults experience myocardial infarction. Every minute and 20 seconds, a woman in this country will die from cardiovascular disease, which is more than cancer, diabetes and lung disease, combined\(^1\). Often, the signs and symptoms of AMI are not readily recognized in women, as chest discomfort is typically described as an aching pressure or tightness, but not reported directly as pain\(^2\). Additionally, women are less likely to seek treatment in a timely manner, yet when they do, they are more likely to be treated more conservatively than men\(^3,4\). Increased awareness by both the patient and the health care team can reduce mortality and morbidity in women\(^4\).

Patient Information

This patient is a 68-year-old female who was brought into the Emergency Department (ED) with chest pain and a slight cough. She was admitted to a medical-surgical unit after reporting her chest pain decreased from a seven to a two, on a 10-point pain scale. The initial 12-lead EKG and the first set of cardiac enzymes were not significant for an AMI. Currently, the patient demonstrates increased anxiety, shortness of air and a sudden increasing chest pain.

Allergies: No known allergies
Code status: Full code

Learning Objectives

By the end of this SLE, the participant will be able to:

1. Demonstrate a focused cardiac assessment.
2. Demonstrate evidence-based care of the patient with an AMI.
3. Recognize the signs and symptoms of an AMI.
4. Provide individualized patient education for care of the patient with an AMI.
## Competencies Addressed

<table>
<thead>
<tr>
<th>BSN Essentials</th>
<th>NCLEX-RN</th>
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<tbody>
<tr>
<td>II, III, IV, VI, VIII, IX</td>
<td>Safe &amp; Effective Care Environment</td>
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<tr>
<td></td>
<td>• Management of Care</td>
</tr>
<tr>
<td></td>
<td>• Safety &amp; Infection Control</td>
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<td>Health Promotion &amp; Maintenance</td>
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<td>Psychosocial Integrity</td>
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<td>• Basic Care &amp; Comfort</td>
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<td>• Pharmacological &amp; Parenteral Therapies</td>
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<td></td>
<td>• Reduction of Risk Potential</td>
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<td>• Physiological Adaptation</td>
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<thead>
<tr>
<th>QSEN</th>
<th>IPEC</th>
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<tr>
<td>• Patient-centered care</td>
<td>• Roles/Responsibilities</td>
</tr>
<tr>
<td>• Safety</td>
<td>• Interprofessional communication</td>
</tr>
<tr>
<td>• Teamwork &amp; Collaboration</td>
<td>• Teams &amp; Teamwork</td>
</tr>
<tr>
<td>• Evidence-based practice</td>
<td>• Evidence-based practice</td>
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<tr>
<td>• Informatics</td>
<td>• Informatics</td>
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## Skills Needed for Participation

<table>
<thead>
<tr>
<th>Vital signs assessment</th>
<th>Use of pulse oximeter</th>
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<tbody>
<tr>
<td>Basic ECG interpretation</td>
<td>Cardiac assessment</td>
</tr>
<tr>
<td>Respiratory assessment</td>
<td>Auscultation skills</td>
</tr>
<tr>
<td>Oxygen administration</td>
<td>MONA chest pain protocol</td>
</tr>
<tr>
<td>Administration of oral medication</td>
<td>ISBARR communication</td>
</tr>
<tr>
<td>Therapeutic communication</td>
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## Prior Medical History

- Coronary artery disease
- Hypertension
- Type 2 diabetes
- Depression

## Prior Surgical History

- None

## Supplies

- S901 manikin (configured to female)
- ID band
- Nasal cannula
- Oxygen set up
- Telemetry leads
- IV pump & tubing

## Room Set-up

- The patient is positioned supine in bed
- ID band applied to wrist
- IV placed in manikin with 0.45% NS
- Infusing at 100 ml/hr
### Supplies cont’d

Normal Saline fluids  
Pulse oximetry  
Anti-embolism stockings  
Simulated medications:
- 0.45% NS 1000 ml IV bag  
- 0.9% NS 1000 ml IV bag  
- Morphine  
- Aspirin  
- Sublingual nitroglycerin  
- Lisinopril  
- Atenolol  
- Alteplase

### Room Set-up cont’d

Anti-embolism stockings are placed and rolled down the legs  
Telemetry leads placed on manikin  
Call light is not in reach  
No side rails are up  
Nasal cannula is not placed properly on patient (twisted, askew)  
Incentive spirometer on bedside table

### Provider’s Orders

Vital signs every 4 hours  
Continual telemetry  
Diet: 1800 calorie 2 gm sodium restriction  
Activity: Bedrest with bathroom privileges  
Intake and output every 8 hours  
Anti-embolism stockings  

Medications
- IV fluids; 0.45% NS at 100 ml/hr.  
- Aspirin 162 mg by mouth every 24 hours  
- Lisinopril 2.5 mg every 12 hours (ACE inhibitor)  
- Atenolol 5 mg IV over 5 minutes, wait 10 minutes then 2nd dose of 5 mg/5 min  
- Atorvastatin calcium 20 mg every 24 hours  
- 2L O2 nasal cannula, titrate to maintain SpO2 greater than 93%  
- Nitroglycerin 0.4 mg, sublingual, every 5 minutes x 3, as needed for chest pain  
- Morphine 2-4 mg IV, every 5 minutes, as needed for chest pain

Call orders
- If HR less than 60/min or greater than 120/min  
- If RR less than 10/min or greater than 24/min  
- If SpO2 less than 93%  
- If Systolic BP less than 90 mmHg or greater than 160 mmHg  
- If Diastolic BP less than 50 mmHg or greater than 95 mmHg
Prebriefing Report for Participants

Imelda Hernandez is a 68-year-old Hispanic female who was brought into the ED by EMS. She started having chest pain about 45 minutes before she called EMS. When they arrived, she described her pain as a seven on a scale of one to ten, even after 3 doses of sublingual nitroglycerin. She just came up from the ED and admitted to the unit. While in the ED, she was given 325 mg of aspirin and a total of 4 mg of morphine and later rated her pain as 2 out of 10. A 12-lead EKG in the ED showed no significant changes. She is on 2 liters of O₂ via nasal cannula with SpO₂ in the mid-90s. She has a history of coronary artery disease and Type 2 diabetes. Her first set of labs were insignificant. Her next set of cardiac enzymes are to be drawn in one hour. She is scheduled for a stress test in the morning, so make sure she doesn’t have any caffeine. She states that she is not a coffee or tea drinker, and has had no caffeine or chocolate today. Her biggest concern right now is that her pet Yorkie is now home alone and she is having trouble contacting anyone to watch her dog. She has an adult daughter, but she is at work and cannot be reached for several more hours. Ms. Hernandez is worried and extremely anxious. She has been crying off and on since she was admitted.
## Scenario Timeline

<table>
<thead>
<tr>
<th>Time</th>
<th>Expected Participant Actions</th>
<th>Facilitator Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5 min</td>
<td><strong>Introduces self</strong>&lt;br&gt;Performs hand hygiene upon entrance to the room</td>
<td>Patient is crying in bed&lt;br&gt;Diaphoretic&lt;br&gt;Slight cough&lt;br&gt;Responsive and talking, answers questions during assessment</td>
</tr>
<tr>
<td></td>
<td><strong>Identifies patient with 2 patient identifiers</strong>&lt;br&gt;<strong>Assesses the environment and resolves safety hazards</strong>&lt;br&gt;• Call light is not in reach&lt;br&gt;• Nasal cannula is twisted &amp; askew&lt;br&gt;• No side rails are up</td>
<td>Patient is anxious.&lt;br&gt;<strong>I’m so upset.</strong>&lt;br&gt;<strong>My dog is all alone.</strong>&lt;br&gt;<strong>Oh, I am so worried about my furry baby. He is so scared without me.</strong>&lt;br&gt;<strong>Who will take care of my dog? Can you send someone to check on him?</strong>&lt;br&gt;Rates pain as 3 or 4 out of 10&lt;br&gt;<strong>Why haven’t I taken my daily meds yet? I always take those first thing in the morning and no one has brought them to me.</strong>&lt;br&gt;<strong>I don’t think these are the right ones. These look different than what I take at home.</strong>&lt;br&gt;<strong>What are you giving me?</strong>&lt;br&gt;<strong>Will this help my chest pain? I keep feeling more pain.</strong>&lt;br&gt;<strong>It feels like a 9/10 now.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Begins assessment</strong>&lt;br&gt;Auscultates heart &amp; lung sounds**&lt;br&gt;Assesses vital signs**&lt;br&gt;• HR: 92&lt;br&gt;• BP: 118/87&lt;br&gt;• RR: 18&lt;br&gt;• SpO₂: 94%</td>
<td>Engages patient in therapeutic communication&lt;br&gt;Assesses level of pain</td>
</tr>
</tbody>
</table>
| 11 to 15 min | Implements MONA  
Calls for help / ISBARR  
Reevaluates patient  
Provides patient education  
Continually engages patient in therapeutic communication | Oohh...my chest hurts.  
What am I going to do?  
It really hurts.  
Someone needs to help me.  
I wish my daughter was here. Can you call her?  
Why are you turning up my oxygen?  
What is going on?  
Did you get someone to check on my dog? |
**Scenario Flow Chart**

**Hand hygiene**
- Introduce self
- Two patient identifiers
- Assess vital signs

**Presenting Vital Signs**
- RR: 18
- SpO\(_2\): 94%
- HR: 92
- BP: 118/87
- Pain level: 5/10
- Patient is anxious

**Potential actions**
- Sit patient up
- Tell her to: “just relax & breathe” “it will be fine…” etc.

**Sit patient up**
- Patient is anxious & complains of chest pain

**Condition Worsens**
- RR: 25
- SpO\(_2\): 89%
- HR: 121 irregular
- BP: 134/95
- Patient is anxious & complains of chest pain

**Recognize worsening condition**
- Increase supplemental O\(_2\)
- Call for help / ISBARR
- Prepare for MONA

**Condition Improves**
- RR: 20
- SpO\(_2\): 94%
- HR: 107
- BP: 124/90
- Patient is anxious & complains of chest pressure

**Reset & Debrief**
References


Gaumard Nursing SLEs – Summaries

Acute Myocardial Infarction

This patient is a 68-year-old female who was brought into the ED with chest pain and a slight cough. She was admitted to a medical-surgical unit after reporting her chest pain decreased from a seven to a two, on a 10-point pain scale. The initial 12-lead EKG and the first set of cardiac enzymes were not significant for an AMI. Currently, the patient demonstrates increased anxiety, shortness of air and a sudden increasing chest pain.

Learning Objectives

- Demonstrate a focused cardiac assessment.
- Demonstrate evidence-based care of the patient with an AMI.
- Recognize the signs and symptoms of an AMI.
- Provide individualized patient education for the patient with an AMI.

Acute Respiratory Distress Syndrome Secondary to Motor Vehicle Crash

This patient is a 40-year-old female who was in a motor vehicle crash that caused blunt thoracic trauma. She was a passenger in a car that was rear-ended by a distracted driver. Even though the air-bags deployed, she slipped in her seat and was caught in the neck and chest by the seat belt. She has significant bruising to her neck, right shoulder, and chest. She also sustained an open fracture to her right ankle. After stabilization in the emergency department (ED), she was transferred to the medical-surgical unit for observation and preparation for surgery to repair her right ankle fracture.

Learning Objectives

- Demonstrate a focused respiratory and physical assessment.
- Recognize signs and symptoms of ARDS.
- Demonstrate ISBARRR communication with a healthcare provider.
- Demonstrate evidence-based care for the patient with ARDS.

Asthma Attack

This patient is an 18-year-old patient who was having trouble breathing while playing lacrosse with her college classmates. She used her inhaler on the field, but because she had little improvement, she was brought to the ED by her friends. She is anxious, tachypneic, exhibiting inspiratory stridor. Through halting statements, she indicates that she has tingling in her hands and feet.

Learning Objectives

- Demonstrate evidence-based care of the patient with an asthma attack.
- Demonstrate a focused respiratory assessment.
- Recognize the signs and symptoms of asthma.
- Provide individualized patient education for the patient with an asthma attack.
- Implement appropriate communication techniques with healthcare members.
COPD Exacerbation

This patient is a 51-year-old male who has just been admitted directly from his primary care provider's office with exacerbation of COPD. He is sitting up in bed, leaning over the bedside table in apparent mild respiratory distress. His wife is at the bedside and appears anxious, worried, and talkative.

Learning Objectives

- Demonstrate evidence-based care of the patient with COPD.
- Demonstrate a focused respiratory assessment.
- Recognize the signs and symptoms of respiratory distress.
- Provide individualized patient education for the patient with COPD.

Fluid and Electrolyte Imbalance

This patient is a 57-year-old woman who was brought to the ED by her daughter, after experiencing three consecutive days of gastrointestinal distress. She does not speak English and her daughter is at the bedside to translate. She reports, via her daughter, numerous bouts of vomiting and diarrhea. She has a history of high blood pressure, hyperlipidemia and arthritis in both hands and is currently exhibiting intermittent episodes of confusion. Her skin is dry with decreased turgor and a delayed capillary refill.

Learning Objectives

- Demonstrate a focused history and physical assessment.
- Recognize the signs and symptoms of fluid and electrolyte imbalance.
- Demonstrate evidence-based care of the patient with a fluid and electrolyte imbalance.
- Provide individualized patient education for the hypovolemic patient.

Heart Failure

This patient is a 57-year-old male who came into the ED complaining of shortness of air, a cough, and increased swelling in his calves and feet bilaterally over the past several days. He has a history of hypertension and coronary artery disease. He has been admitted to the medical-surgical unit for treatment of heart failure.

Learning Objectives

- Demonstrate evidence-based care of the patient with heart failure.
- Demonstrate a focused cardiac assessment.
- Recognize the signs and symptoms of heart failure.
- Provide individualized patient education for the patient with heart failure.

Hypoglycemia

This patient is a 35-year-old female who is 18 plus hours post-operative following a surgical repair to her right knee. She has a history of Type I diabetes, which is normally well managed by her insulin pump. However, on the recommendation of her endocrinologist, she elected to stop using her pump the day before surgery and plans to control her blood glucose with pre-meal insulin.

Learning Objectives

- Demonstrate a focused physical assessment.
- Recognize signs and symptoms of hypoglycemia.
- Demonstrate evidence-based care for the patient with hypoglycemia.
- Provide individualized education for the patient with hypoglycemia.
New Onset Diabetes

This patient is a 48-year-old female who came into the ED complaining of severe thirst, increased urination, and blurred vision, all of which has worsened over the past 10 days. She was stabilized in the ED, and then ultimately transferred to the medical-surgical unit for monitoring, continued therapy and education. Her wife is present at her bedside and states that the patient has lost weight recently. The patient states that she has previously received a diagnosis of hyperlipidemia, but has been treating it with herbal medicine on the advice of her wife.

Learning Objectives

- Demonstrate evidence-based care of the patient with new-onset diabetes.
- Synthesize lab values, patient symptoms, and assessment findings to implement relevant nursing interventions.
- Recognize signs of potential domestic violence.
- Provide individualized patient education for a patient with new-onset diabetes.

Pneumonia

This patient is a 72-year-old female who was transferred from a local nursing home with shortness of air and a rapid heart rate. She has had a six-day history of a productive cough and fever, and has a history of pneumonia six months ago and vascular dementia for two years. She has been on a course of azithromycin for three days to treat an upper respiratory tract infection.

Learning Objectives

- Demonstrate evidence-based care of the patient with pneumonia.
- Demonstrate a focused respiratory assessment.
- Recognize the signs and symptoms of pneumonia.
- Provide individualized patient education for the patient with pneumonia.

Sepsis

This patient is a 36-year-old male who was brought to the ED by his wife, with complaints of fever, an aching pain in his left side, feeling “just awful” with occasional light-headedness, and occasional palpitations. He stated that he suffered a bicycle injury five days prior, resulting in two areas of abrasions to his left shoulder and hip. His wounds were cultured in the ED and then re-dressed. He has just been admitted to the medical-surgical unit for antibiotic therapy and follow-up treatment. Additionally, the patient has recently been diagnosed with Type 2 diabetes.

Learning Objectives

- Demonstrate a focused physical assessment.
- Recognize early signs and symptoms of sepsis.
- Demonstrate ISBARR communication with a healthcare provider.
- Demonstrate evidence-based care for the patient with sepsis.
Gaumard Nursing SLEs – Competencies Addressed

BSN Essentials
   II Basic Organizational & Leadership for Quality Care & Patient Safety
   III Scholarship for Evidence Based Practice
   IV Information Management & Application of Patient Care Technology
   VI Interprofessional Communication & Collaboration
   VII Clinical Prevention & Population Health
   VIII Professionalism & Professionalism Values
   IX Baccalaureate Generalist Nursing Practice

NCLEX-RN
   • Safe & Effective Care Environment
     o Management of Care
     o Safety & Infection Control
   • Health Promotion & Maintenance
   • Psychosocial Integrity
   • Physiological Integrity
     o Basic Care & Comfort
     o Pharmacological & Parenteral Therapies
     o Reduction of Risk Potential
     o Physiological Adaptation

QSEN
   • Patient-centered care
   • Safety
   • Teamwork & Collaboration
   • Evidence-based practice
   • Informatics

IPEC
   • Roles/Responsibilities
   • Interprofessional communication
   • Teams & Teamwork

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