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Inpatient Scenario

(designed for high-fidelity, but can be adapted for low-fidelity/table top)

SCENARIO: June Smith

SCENARIO LOCATION: Inpatient room

SCENARIO SYNOPSIS: Patient is an 87-year-old female with past medical history of hypertension, congestive heart failure, type II diabetes and dementia presenting with altered mental status

SCENARIO OBJECTIVES:

- Recognize positive sepsis screen
- Demonstrate initiation of the severe sepsis bundle
- Demonstrate appropriate calculation of the 30 mg/kg fluid bolus

PARTICIPANT ROLES:

- Primary RN
- Secondary RN
- Charge RN

FACILITATOR:

ASSISTIVE STAFF:

Simulation scenario courtesy of Pat Posa RN, BSN, MSA, CCRN-K, FAAN, St. Joseph Mercy Hospital. Ann Arbor, Mich.

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SETUP (for facilitator and simulation tech)

SCENARIO	Scenario Name	June Smith – Inpatient
	Prebrief Sheet	No
	Manikin/SP	Speaking manikin or standardized patient
	Programmed Name	June Smith
	Monitor Layout	No ECG needed

ROOM	Room	Sim. room or patient room
	Additional Equipment	IV pump with one channel

MANIKIN/SP	Dress	Gown
	Moulage	Arm band
		Grey/white wig

IV	Number	Two
	Site/s	#1 Antecubital #2 Forearm
	Fluid	1,000 mL normal saline attached to saline lock #1 with tubing and pump
	Rate	75 mL/hr
		Extra 1,000 mL lactated Ringers, macrodrip tubing and pressure bag in room

O2	Device	Nasal cannula
	Flow	2L
	Additional Devices	

PHONES	Number of Phones	One
	Who gets phones	Primary RN
		Phone and number to control room on bedside table

OTHER		Sepsis screening tool and checklist, pen

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PATIENT SCRIPT (if using standardized patient)

GENERAL	Pt. Name	June Smith
	Pt. Age	87
	Pt. DOB	09/19/19XX
	Pt. Weight	75 kg
	Pt. Chief Complaint	Cough, not feeling right

HISTORY	Pt. PMHx	Doesn’t remember
	Medications	Doesn’t remember
	Allergies	Doesn’t think so
	Surgical Hx	Doesn’t recall
	Social Hx	Doesn’t recall
	Family Hx	Doesn’t recall

SYSTEMS	Pt. Chief Complaint	Cough, not feeling well, fever
	Respiratory/pulmonary	Productive cough, no difficulty breathing
	Cardiovascular	No chest pain
	Abdominal	No abdominal pain, no nausea, no vomiting, no diarrhea
	Genitourinary	No problems urinating
	Musculoskeletal	No pain

SPECIFICS	When did it start?	A day or so ago
	Anything make it better/worse?	No
	Did you take any medications?	Nurse gave me something
	Do you take all your medications as prescribed?	Doesn’t recall
	Any other symptoms?	Doesn’t feel well

ETC.	**Pt. Name**: June Smith 87 y/o **CC**: Cough, not feeling well, altered mental status **PMHx**: HTN, CHF, T2DM, dementia **Allergies**: NKDA

SCENARIO SUMMARY (for simulation tech)

Patient is an 87-year-old female with PMH of HTN, CHF, T2DM and dementia presenting with altered mental status

PHASE 1	• To **PHASE 2** after 1 minute	**Rhythm**: Sinus • BP: 94/60 • HR: 90 • SpO2: 97% • RR: 24 • T: 98.5°F	**Pt. Name**: June Smith 87 y/o **CC**: Cough, not feeling well, altered mental status **PMHx**: HTN, CHF, T2DM, dementia **Allergies**: NKDA
PHASE 2	• Correct: > 1250 mL bolus (**PHASE 3**) • Incorrect: < 1250 mL bolus (**PHASE 5**)	**Rhythm**: Sinus • BP: 80/44 • HR: 98 • SpO2: 97% • RR: 24 • T: 98.4°F	
PHASE 3	• Bolus complete • One hour has passed • Additional bolus given	**Rhythm**: Sinus • BP: 96/48 • HR: 100 • SpO2: 95% • RR: 24	
PHASE 4	• Additional bolus complete • **END SCENARIO**	**Rhythm**: Sinus • BP: 104/54 • HR: 88 • SpO2: 97% • RR: 20	
PHASE 5	• Correct: > 1250 mL bolus (**PHASE 3**) • Incorrect: < 1250 mL bolus (**PHASE 5**)	**Rhythm**: Sinus • BP: 84/50 • HR: 118 • SpO2: 95% • RR: 24	

INSTRUCTOR BRIEF

- Patient is an 87-year-old female that presents with mental status changes and cough
- She has been diagnosed with a UTI and pneumonia in the ED, given antibiotics and one liter of fluid (1000 mL)
- She did **not** receive the full 30 mg/kg bolus
- Initial lactate was 3.3; **Repeat lactate is 3.5 if done in scenario**
- Participants need to calculate the total 30 mg/kg bolus (2,250 mL), then subtract the 1,000 mL given in the ED and infuse the remaining amount (1,250 mL) by taking the fluid off the pump and either free-flow or use a pressure bag. Do not leave on IV pump, even if set to 999 mL/hr.
- As the facilitator, you will be answering the phone as the physician and stat/RRT RN, if participants choose to contact them
- If they call for the physician:
    - Initially, only give an order for a 500 mL bolus. If the RN questions the order, make them do the calculation and provide the correct amount (1,250 mL)
- If they call for the stat RN:
    - Say you are busy at a code, that their patient sounds septic and ask if they have done the sepsis bundle

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ED LABS

Inpatient - June Smith

ABG		Reference Range
pH	7.31	7.35 – 7.45
CO2	32	35 – 45
PO2	82	80 – 100
HCO3	14	22 – 28
O2 Sat	91	> 75
Complete Blood Count with Differential		**Reference Range**
		Male | Female
White Blood Cell (WBC)	6.3	4,500 – 10,000 K/uL
Neutrophil Absolute	5.5	1.7 – 7.6 thou/mcL
Hemoglobin (HBG)	10.5	13.5 – 16.5 g/dL | 12.0 – 15.0 g/dL
Red blood cell (RBC)	3.45	4.5 – 5.5 M/uL | 4.0 – 4.9 M/uL
Hematocrit	32	36.0 – 48.0%
MCV	92	80 – 100 fL
MCHC	34.4	32 – 36%
Platelet	141	140 – 450 thou/mcL
Basic Metabolic Panel		**Reference Range**
Sodium	136	135 – 147 mmol/L
Potassium	4.5	3.5 – 5.2 mmol/L
Chloride	104	95 – 107 mmol/L
CO2	19	22 – 30 mmol/L
BUN	25	7 – 20 mg/dL
Creatinine	1.18	0.5 – 1.2 mg/dL
Glucose	150	60 – 110 mg/dL
Calcium Total	8.6	8.5 – 10.1 mg/dL
Lactate	3.3	0.5 – 2.2 mEq/L
Coags		**Reference Range**
Prothrombin Time	12	11 – 13.5 sec
INR	1.1	0.8 – 1.1
PTT	19	

Repeat Labs

Lactate		Reference Range
Lactate	3.5	0.5 – 2.2 mEq/L

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RN BRIEF/HANDOFF

Name: June Smith
DOB: 9/19/xx

Chief Complaint: Cough, not feeling right

Triage Vital Signs

B/P: 125/95	**HR:** 92	**RR:** 26	**T:** 102.9°F	**SpO2**: 93% RA

ED Discharge Vital Signs

B/P: 108/86	**HR:** 89	**RR:** 20	**T:** 99.0°F	**SpO2:** 100% 2L

Admitting Diagnoses

1) CAP Pneumonia
2) UTI
3) Altered mental status

Past Medical History

1) Hypertension
2) Atrial Fibrillation
3) Type II DM, non-insulin dependent
4) CHF
5) Dementia
6) Recurrent UTI

Allergies: NKA

Current Medications

1) Sotalol: 80 mg, PO, BID
2) Amlodipine: 10 mg, PO, QD
3) Spironolactone: 25 mg, PO QD
4) Metformin: 500 mg, PO, BID
5) Oxybutynin: 10 mg, PO, QD
6) Coumadin: 5 mg, PO QD
7) Pravastatin: 20 mg, PO, QS
8) Urea: 40% ointment to legs, QD
9) Vitamin B6: 100 mg, PO WD

Medications Given in ED: Tylenol, Rocephin, Zithromax

Weight: 75 kg

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OBSERVER CHECKLIST

CRITICAL PERFORMANCE STEPS	
Did the participants wash their hands?	Yes No
Did the participants recognize hypotension and contact physician?	Yes No
Did the participants recognize positive sepsis screen?	Yes No
Did the participants utilize the sepsis screening/checklist tool?	Yes No
Did the participants calculate the proper fluid bolus?	Yes No
Did the participants ensure all the bundle components were implemented?	Yes No
Did the participants recognize the need to monitor I&Os?	Yes No
Did the participants recognize the need to obtain a repeat lactate?	Yes No