

SIMULATION SCENARIO DESIGN WORKSHEET

Today's Date: Name of Scena				enario A	uthor:					
	Email: Phone:									
GENERAL SCENARIO INFORMATION										
Est. Pre-briefing T	ime:	Est. Scenar			Debriefin		Course	e #:		
Title of Scenario:	<u>'</u>						I			
A. Hypertension i	n pregnar	icy-assessme	ent of patient							
Brief Description: 39.2 W HTN, induct	ion for lab	or Placed in	lahor room at 060	00 Con	sants sign	ned and na	tiont nlac	ed on EHR	monitor	
		Ji. Flaced III			iserits sigi	ieu anu pa	tient plac	Lea on Trik		
Setting of Sim: L/D	room									
Facilitators:										
Dates of Sims:					Pilot Da	to :				
Dates of Sillis.					12/17/19					
					1/9/20					
Tune of Cinevilation	- / ala a al (a	المرسمة عاملا	Tools	Tueinen	. V	Manna		A at a w	/CD	
Type of Simulation	п (спеск а	ii that apply)	1:1ask	Trainer	X	ivianne	quin			
Scenario record	ding reque	ested		Classroom needed			Debriefing Room needed			
X_yes	no		yes	X_nc				Xyes	no	
			PARTICIPAN	IT INF						
Disciplines:	Total N	lumber:			N	umber pe	r Sim:			
RNs		2	2-4							
MDs										
RTs										
Pharmacists										
CSTs										
Other										



LEARNING OUTCOMES

*Team STEPPS® competencies (leadership, mutual support, situation monitoring, communication) are to be incorporated into every simulation to promote patient safety (ahrq.gov, 2017)

General Learning Outcomes (to be disclosed to participants)

Appropriate nursing care of OB HTN pt

Scenario Specific Outcomes (for facilitator only)

Objectives:

- 1. Learner will perform a head-to-toe assessment on an HTN patient.
- 2. Learner will perform DTR assessment appropriately.
- 3. Learner will assess BP appropriately.
- **4.** Learner will identify elevated blood pressure.
- 5. Learner will document assessment in EMR.

Expected cognitive skills to be demonstrated by participant:

Assess•

Understands what it means to have a hypertensive disorder in pregnancy diagnosis. Discuss signs and symptoms of hypertensive disorder in pregnancy.

Document

Discuss the appropriate documentation guidelines.

Expected psychomotor skills to be demonstrated by participant:

- -Performs proper assessment of hypertensive patient.
- -Recognizes signs and symptoms, lab values, and vital signs associated with hypertensive disorder.
- -Performs neuro assessment, including level of consciousness, DTRs, presence of visual disturbance, headache, and epigastric pain.

Expected affective skills to be demonstrated by participant:

Demonstrates assessment of patient and notifies physician using SBAR. Documents assessments and practices appropriately in the EMR. Commits to providing patient comfort and safety.

PRE-BRIEFING INFORMATION



Pre-requisite Knowledge/Reading/Testing (provide references on last page):

Simulation Center 421 N. Emerson Avenue Greenwood, IN 46143

POEP:	
Module 8 Complications of Pregnancy, Part 2 CBT:	
FHCI Hypertensive Disorders in Pregnancy	
Policy:	
Hypertensive Disorder in Pregnancy	

NOTE TO FACILIATORS: Prior to beginning the simulation, participants must be oriented to simulator and/or setting, understand guidelines and expectations for their scenario(s), have completed all pre-work, and understand their assigned roles.



Pre-Briefing Report to Participants																
PATIENT	Tony	Tonya AGE,					32 yr	32 yr old ADMISSION W					I WE	IGHT		
PRIMAR	Y MD			Tripl	ett and	d/or I	Fam. N	Лed	MD		PRO	CEDU	RE			
CONSUL	.TS									CODE STATUS			Full	Full		
DX				HTN	in pre	gnan	су					SWOR	RD.			
CURREN	IT PROBLE	M		Elev	ated bl	lood	pressu	res i	n		NEX	T OF k	ΚIN	Husba	and	l: Matt
				preg	nancy,	indu	iction							5155		
														DIET	NI	PO
нх		I	39.2 wee	ks ge	station											
			Induction	_												
			Chronic I	lyper	tensior	n- not	t on m	edic	ations	;						
ALLERG			NKDA													
MEDICA			PNV													
SAFETY	PRECAUT	IONS	none													
RESTRA	INTS		none													
		1								1 -			1		_ [_
	IT CONDIT	ION					VENT	Ш	ETT	Ц_	SIZE		LO	CATION		
SKIN	/DUIN/TUIN 6	,	PAII	N 0	/10	MOI				-	RATE			PEEP		
PULSES	/RHYTHM	'				FIO2	4		☐ PS	•			IC		ΈΔ¦	P/BIPAP
	Clear lung	sound	S			\boxtimes I	V LINE	:S					l.		,1 / (1	17511711
NEURO	A/Ox3, [OTRs n	ormal			□ PICC/CVL □ ART										
GI/GU	ВМ		VOID			⊠ MIVF LR at 125 ml/hr										
		□ F	OLEY			☐ DRIPS										
TUBES	□ NG/O	G [□ JP	□ ст	-											
I/O			L													
VITALS	Routine															
ACTIVIT	Y Up ad	lib														
SUCCES	TIONS/RE	CON 41	AEND ATI	ANIC /E	PEOLIE	стс т	.O MD	/NII I	DCE	1						
SUGGES	TIONS/ RE	COIVII	VIENDATIO	JIN3/ F	(EQUE	313 1	O IVID	/ NU	NOE							
ORDERS	Admit t	o inna	atient.													
	Full Cod															
	Activity	as to	lerated													
	Vital signs, routine															



	Pain assessment, routine				
	Intake and output, routine				
	Diet Clear liquid				
	Insert peripheral IV				
	CBC with dif STAT				
	Hold Specimen-blood bank STAT				
	UDS STAT				
	LR 125ml/hr				
ANTICIPATED CHANGES OR OTHER ISSUES					
PENDING LABS					

	CETAL	A / DECOLIDEE						
SET UP/RESOURCES (for simulation center staff)								
Simulation Setting								
□ ER		⊠ Women's & 0	Children's					
☐ Med-Surg		☐ Behavioral H	ealth					
☐ Pediatrics		☐ Home Health						
□ ICU		☐ Pre-Hospital						
□ OR / PACU		☐ Doctor's office	ce/clinic (table, chairs and exam table)					
		☐ Other:						
Time of Day: morning								
Is the patient a mannequin or a Stan	Is the patient a mannequin or a Standardized Patient (SP)? mannequin							
Appearance of Mannequin								
Clothing	Moulage		Incisions/Dressings					
gown								
	Appeara	ance of Actor/SP						
Clothing	Moulage		Incisions/Dressings					
	Monitor	Waveform Setup						
EKG/HR □	RR 🗆		O2 Sat					
ВР 🗆	Arterial Line		PAP					
ETCO2	Other: FHR, con	tractions every						
	5 minutes							
	Equipment	attached to patie	ent					
ECG Monitor	BP Cuff ⊠		Arterial/PA lines □					
Oxygen Sat Probe 🛛	NG tube		Foley Urine Color:					
Chest Tube	Vent □		IV line ⊠					



ID Band/MRN ⊠ Allergy Band □ IO □ SCDs □									
Fall Blanket/Footies Other:									
IV Type									
PIV ⊠ Saline Lock □ Central Line □	Central Line								
PICC UVC/UAC UVC/UAC									
IV Fluids/Rate									
NS D5 D10									
LR running @ 125 Other:									
Rate of Fluids:									
Medications (to be retrieved from Pyxis)									
PO IVP IVPB									
Pitocin 500ml bag infusing at 1ml/ (1mu/hr)	hr								
Medication Equipment Available in the Room									
IV Pump Number of channels 2 IV Pump Tubing □	IV Pump Tubing								
IV Piggyback tubing □ IV gravity tubing □ Extra IV tubing □	Extra IV tubing								
Syringes/#/Size Needles/#/size Med cart/Pyxis	Med cart/Pyxis								
IV start supplies/angio gauge									
Pressure bag ☐ Syringe pump ☐ Syringe pump tubing ☐	Syringe pump tubing								
IO □ Umbilical Line □ Other	Other								
Cardiac Equipment Available in the room									
12 lead ECG machine ☐ Code Cart ☐ Defibrillator ☐									
Temp Pacemaker □ Telemetry Pack □ AED □									
Respiratory Equipment Available in the room									
Nasal cannula ⊠ Simple Facemask □ Venturi Mask □									
Non-rebreather ⊠ IS □ Trach □									
BiPAP/CPAP □ Vent □ Suction □									
	Other: suction set up on table so that during prebrief learners can learn to set up								
GI Equipment Available in the room									
NG/OG □ G tube □ Feeding pump □	Feeding pump								
Feeding bag Dining tray Other:	Other:								
GU Equipment Available in the room									

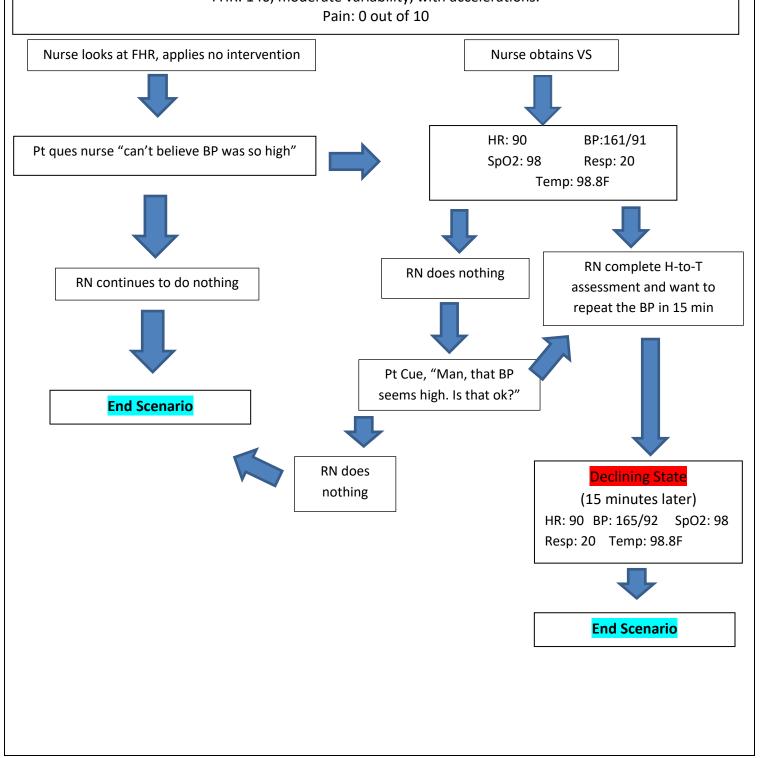


Foley	Condom catheter	SP catheter						
Urinal	Bedpan	Other:						
Other Supplies								
TED hose	SCDs \square	Dressing Supplies						
Venipuncture	Blood tubes	Culture tubes						
Thermometer 🗵	Pen light	Fall blanket/footies						
Any additional set up notes for sim staff: stethoscope. Reflex hammer, Assessment QR codes (or something for clonus and reflexes)								
Scenario Progression Storyboard								



Patient Initial State

Tonya is here today for her scheduled induction of labor for 39.2 weeks. Induction started at 0600. Night shift has started her admission and has signed consents, started her IV, and placed her on the EFM/TOCO. FHR: 140, moderate variability, with accelerations.





Progression Outline								
Timing	ming Patient verbal and/or non- verbal communication		Patient Response (potential cues for participant if needed?)					
Beginning (0-2 mins)	 Sitting up in bed has the EFM/TOCO on not in any pain. 	 RN asks pt how she is feeling and why being induced Takes VS (HR, BP, SpO2, Resp, Temptape temp on thermometer) 	I have been having elevated blood pressures during my pregnancy (140s/80s).					
2-5 mins	Patient starting to be concerned about her elevated blood pressure.	 RN notices that the BP is elevated Inform patient that her BP is above call orders at this time and is going to retake in 15 min. 	Is my blood pressure okay?					
5-12 mins	Pt slightly nervous, otherwise normal	 Start performing H-to-T assessment Ask questions: HA? Blurry vision/vision changes? Epigastric pain? Listen to lung and heart sounds Perform clonus and reflex assessment (DTR) Document findings in EPIC 	No HA, blurry vision, or pain					



12-15 mins	Still slightly anxious	Re-take VS (BP, HR)	Is my BP better?
End of Scenario (When objectives met? At specified time period)		Informs pt of results and calling MD	

	SP role	description	
Name and Role in scenario			
(Patient? Family member?)			
Brief Scenario Summary			
,			
Patient location			
History pertinent to simulation			
Mental State/Demeanor			



Questions/comments SP may verbalize during scenario								
SP Observations	How does the staff commun	icate with you and with each other?						
	DEBRIEFING GUIDE							
⊠ V	Vith Video	☐ Without Video						



Debriefing/Guided Reflection Questions:

- 1. How did you feel throughout the simulation experience
- 2. Tell me what went well.

General learning outcome(s)

Appropriate nursing care of OB HTN pt

Scenario Specific Outcomes
Copy from page 2 of this form

Objectives:

- 1. Did you patient have elevated blood pressure? How did you know this?
- 2. I see you performed a head-to-toe assessment, tell me about this?
- **3.** Tell me how you performed reflexes assessment? Have you ever done this before? Do we need more practice?
- **4.** Tell me how you knew which blood pressure cuff to use? Tell me how you took her blood pressure.
- 5. Tell me how you document your assessment

- 3. Let's review the objectives and discuss whether we were successful or not
- 4. If you were able to repeat the scenario, what would you do differently?
- 5. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?
- 6. Talk about how you will transfer what is learned during this experience to your work setting.
- 7. Is there anything else you would like to discuss?

Evaluation Tools

Attach to this page the evaluation tools (surveys, tests) that you plan to use



References *List references for your educational content*

ahrq.gov. (2017, August). TeamSTEPPS 2.0 Team Strategies and Tools to Enhance Performance and Patient Safety.

Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.pdf

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3119563/



SIMULATION SCENARIO DESIGN WORKSHEET

Today's Date:			Name of Sce Email: Phone:							
GENERAL SCENARIO INFORMATION										
Est. Pre-briefing T	Est. Pre-briefing Time: Est. Scenario Time:					. Debriefing Time: Course #:				
Title of Scenario: B. Hypertension p	panels			1			1			
Brief Description:										
39.2 W HTN, induct elevated blood pres					_	•	•		IR monito	or. 2
Setting of Sim: L/D		can orders.	KIN WIII Call IVID,	give 31	DAN TEPOT	, and obtai	in paner	nuers.		
	7100111									
Facilitators:										
Dates of Sims:					Pilot Dat	to :				
Dates of Sillis.					12/17/19					
					1/9/20					
					, - ,					
Type of Simulation	n (check all	that apply)	:Task	Traine	rX	Manne	quin	Acto	or/SP	
Scenario record	ding reque	sted	Classroom	neede	ed .		Debriefing Room needed			
Xyes	no		yes	yesX_noXyesno						
			PARTICIPAN	T INF	ORMAT	ION				
Disciplines:	Total Nu	ımber:			N	umber pe	r Sim:			
RNs		2	-4							
MDs										
RTs										
Pharmacists										
CSTs										
Other										



LEARNING OUTCOMES

*Team STEPPS® competencies (leadership, mutual support, situation monitoring, communication) are to be incorporated into every simulation to promote patient safety (ahrq.gov, 2017)

General Learning Outcomes (to be disclosed to participants)

Appropriate nursing care of OB HTN pt

Scenario Specific Outcomes (for facilitator only)

Objectives:

- 1. Learner will complete an SBAR report to a Physician.
- 2. Learner will find and place the appropriate orders given in EMR.
- 3. Learner will give Labetalol appropriately.
- 4. Learner will follow blood pressure protocol after medication administered.

Expected cognitive skills to be demonstrated by participant:

Plan•

Discusses warning signs of a hypertensive disorder.

Implement

Identify precautions used for hypertensive disorders (seizure precautions, timing of checks, decrease environmental stimuli, etc).

Document

Discuss the appropriate documentation guidelines.

Expected psychomotor skills to be demonstrated by participant:

- -Performs proper assessment of hypertensive patient.
- -Recognizes signs and symptoms, lab values, and vital signs associated with hypertensive disorder.
- -Performs neuro assessment, including level of consciousness, DTRs, presence of visual disturbance, headache, and epigastric pain.

Expected affective skills to be demonstrated by participant:

Demonstrates assessment of patient and notifies physician using SBAR.

Documents assessments and practices appropriately in the EMR.

Commits to providing patient comfort and safety.

PRE-BRIEFING INFORMATION

Pre-requisite Knowledge/Reading/Testing (provide references on last page):

POEP:

Module 8 Complications of Pregnancy, Part 2

CBT:

FHCI Hypertensive Disorders in Pregnancy

Policy:

Hypertensive Disorder in Pregnancy



NOTE TO FACILIATORS: Prior to beginning the simulation, participants must be oriented to simulator and/or setting,
NOTE TO TACILIATORS. That to beginning the simulation, participants must be offented to simulator analytic setting,
understand guidelines and expectations for their scenario(s), have completed all pre-work, and understand their
anderstand galdennes and expectations for their scenario(s), have completed an pre-work, and understand their
assigned roles.
ussigned roles.



Pre-Briefing Report to Participants																
PATIEN	т 1	Tonya AGE			/SEX	32 yr	old		ADMISSION WEI				IGHT			
PRIMAR	RY MD)		Т	Triplett a	nd/or	Fam. N	∕led N	MD	P	RO	CEDU	RE			
CONSUI	LTS									C	OD	E		Full		
											TAT					
DX				F	HTN in pr	egnar	ісу			P	ASS	WOR	D			
CURREN	NT PRO	DBLEM			Elevated		-	ıres iı	า	١	IEXT	OF k	IN	Husl	band	d: Matt
				ļ	oregnanc	y, indi	uction							DIET	- 6	ears
														DIEI	Ci	
нх			39.2	weeks	gestatio	n										
					of labor											
			_		pertension	on- no	t on m	edica	ations							
ALLERG	IES		NKDA	١												
MEDICA	NOITA	S	PNV													
SAFETY	/PREC	AUTIONS	none	9												
RESTRA	INTS		none													
			1													1
CURREN	NT CO	NDITION				☐ VENT ☐ ETT SIZE ☐ L				LO	OCATION					
SKIN				PAIN	0/10	МО				-	ATE	<u> </u>		PEE	P	
CARDIO PULSES	-	ТНМ/				FIO	2		□ PS				IC			P/BIPAP
		ung soun	ds			\boxtimes	IV LINE	S							Cr	F/DIFAF
NEURO	A/C)x3, DTRs	normal			□ PICC/CVL □ ART										
GI/GU	BM		VOID	,		\boxtimes	MIVF	LRa	at 125	ml/	hr					
			FOLEY				DRIPS									
TUBES		NG/OG	□ ЈР		CT											
1/0																
VITALS	·															
ACTIVIT	IVITY Up ad lib															
	SUGGESTIONS/RECOMMENDATIONS/REQUESTS TO MD/NURSE															
ORDERS	Call MD for orders ORDERS Admit to inpatient.															
UNDERS		mit to inj Il Code.	Jacient.													
		tivity as t	olerated	d												
	Vital signs, routine															



	Pain assessment, routine			
	Intake and output, routine			
	Diet Clear liquid			
	Insert peripheral IV			
	CBC with dif STAT			
	Hold Specimen-blood bank STAT			
	UDS STAT			
	LR 125ml/hr			
ANTICIPATED CHANGES OR OTHER ISSUES				
PENDING L	ABS			

SET UP/RESOURCES (for simulation center staff)					
	Simu	llation Setting			
□ ER		⊠ Women's & Children's			
☐ Med-Surg		☐ Behavioral Health			
☐ Pediatrics		☐ Home Health			
□ ICU		☐ Pre-Hospital			
□ OR / PACU			ee/clinic (table, chairs and exam table)		
		☐ Other:			
Time of Day: morning					
Is the patient a mannequin or a Stan	dardized Patient	(SP)? mannequin			
	Appearance of Mannequin				
Clothing	Moulage		Incisions/Dressings		
gown					
	Appear	ance of Actor/SP			
Clothing	Moulage		Incisions/Dressings		
	Monitor	Waveform Setup			
EKG/HR □	RR 🗆		O2 Sat		
ВР 🗆	Arterial Line		PAP		
ETCO2	Other:				
	Equipment attached to patient				
ECG Monitor ⊠ have ready, staff will have to place it on patient	BP Cuff ⊠		Arterial/PA lines		
Oxygen Sat Probe 🗵	NG tube \square		Foley Urine Color:		
Chest Tube	Vent □		IV line ⊠		



ID Band/MRN ⊠	Allergy Band	10 🗆	SCDs				
Fall Blanket/Footies ⊠	Other: FHM attached to pt						
	IV Type						
PIV 🗵	Saline Lock	Central Line					
PICC	UVC/UAC	IVC/UAC					
IV Fluids/Rate							
NS	D5	D10					
LR running @ 125	Other:						
Rate of Fluids:							
	Medications (to be retrieved from	n Pyxis)					
PO	IVP	IVPB					
	 Labetalol 20/40/80 (ask Gina to make fake meds) 						
N	ledication Equipment Available in	the Room					
IV Pump ⊠	Number of channels 2	IV Pump Tubin	g 🗵				
IV Piggyback tubing	IV gravity tubing □	Extra IV tubing	g 🗵				
Syringes/#/Size 3 10 ml flushes	Needles/#/size	Med cart/Pyxis Pyxis needs to have Labetalol					
IV start supplies/angio gauge	Art Line	PA Catheter					
Pressure bag	Syringe pump	Syringe pump	tubing \square				
10 🗆	Umbilical Line	Other					
	Cardiac Equipment Available in th	e room					
12 lead ECG machine	Code Cart \Box	Defibrillator					
Temp Pacemaker	Telemetry Pack	AED 🗆					
R	espiratory Equipment Available in	the room					
Nasal cannula 🗵	Simple Facemask	Venturi Mask \Box					
Non-rebreather 🗵	IS 🗆	Trach \square					
BiPAP/CPAP □	Vent	Suction					
Suction cath/#/size	Intubation box	Other					
	GI Equipment Available in the r	oom					
NG/OG □	G tube	Feeding pump					
Feeding bag	Dining tray	Other:					



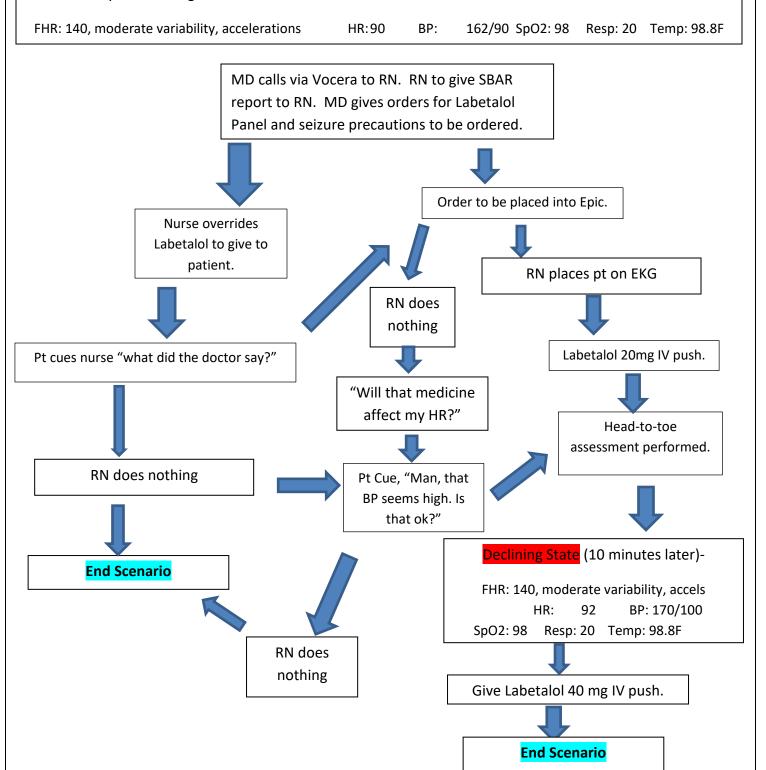
GU Equipment Available in the room						
Foley 🗵	Condom catheter	SP catheter				
Urinal	Bedpan	Other:				
Other Supplies						
TED hose □	SCDs \square	Dressing Supplies				
Venipuncture	Blood tubes	Culture tubes				
Thermometer \boxtimes	Pen light	Fall blanket/footies				
Any additional set up notes for sim staff: stethoscope. Reflex hammer, Assessment QR codes (or something for clonus and reflexes), seizure precautions equip (blankets, cloth tape)						



Scenario Progression Storyboard

Patient Initial State

Tonya is reclining in her bed. She is anxious and nervous when the RN returns to the room.





Progression Outline						
Timing	Patient verbal and/or non- verbal communication	Participant expected behaviors/interventions	Patient Response (potential cues for participant if needed?)			
Beginning (0-2 mins)	Pt getting more nervous/anxious, otherwise normal	 RN informs patient on the order received and answers any questions. Places order in Epic Puts patient on EKG 	What did the doctor say?			
2-5 mins	Pt questions about the medication and will this affect my baby	 RN gets medication out of Pyxis Scans appropriate amount Pushes med over 2 minutes 				
5-7 mins	Pt nervous/ anxious, otherwise normal	 Performs H-to-t assessment. Seizure precautions placed on patient Ask questions: HA? Blurry vision/vision changes? Epigastric pain? Listen to lung and heart sounds Perform clonus and reflex assessment (DTR) Document findings in EPIC and seizure precautions. 	 Pt Cue, "Man, that BP seems high. Is that ok?" No HA, blurry vision, or pain 			



7-10 mins	Pt is questioning about the reading	 Re-take VS (BP, HR) Recognizes it is high Informs pt of results 	Is my BP better?
End of Scenario (When objectives met? At specified time period)		Gives another dose of medication	

	SP role description	
Name and Role in scenario (Patient? Family member?)		
Brief Scenario Summary		
Patient location		
History pertinent to simulation		
Mental State/Demeanor		



Questions/comments SP may verbalize during scenario		
SP Observations	How does the staff commun	nicate with you and with each other?
	DEBRIEFING GUID	E
⊠ W	ith Video	☐ Without Video



Debriefing/Guided Reflection Questions:

- 1. Let's start with the series of events. Let's walk through what happened.
- 2. How did you feel throughout the simulation experience?
- 3. Tell me what went well.

General learning outcome(s)

Appropriate nursing care of OB HTN pt

Scenario Specific Outcomes
Copy from page 2 of this form

Objectives:

- 1. Tell me about your SBAR with the physician. How did you feel/concerns/questions?
- 2. Tell me about how placing the orders in the EMR went.
- 3. What medication did you give your patient? How did that feel? Comfortable/need more practice?
- 4. Tell me about your next steps once you are in the HTN protocol.

- 4. Let's review the objectives and discuss whether we were successful or not.
- 5. If you were able to repeat the scenario, what would you do differently?
- 6. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?
- 7. Talk about how you will transfer what is learned during this experience to your work setting.
- 8. Is there anything else you would like to discuss?

Evaluation Tools

Attach to this page the evaluation tools (surveys, tests) that you plan to use



References *List references for your educational content*

ahrq.gov. (2017, August). TeamSTEPPS 2.0 Team Strategies and Tools to Enhance Performance and Patient Safety.

Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.pdf

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3119563/



MD speaking points

Actions	Statements
SBAR called to MD	Hello, What is going on?
	Yes, that is my patient.
	Any signs and symptoms?
	How is her DTRs?
	Blurry vision?
	Headache?
	Epigastric pain?
RN answers	Start the Labetalol panel and call me back with an update
	in an hour.



SIMULATION SCENARIO DESIGN WORKSHEET

Today's Date:			Name of Scenario Author: Email: Phone:						
			RAL SCENAR	RIO INFORI	MATION				
Est. Pre-briefing T	ime: Est. Sc	enario Tin		st. Debriefi		Course #:			
Title of Scenario: C. Hypertension v	vith seizure								
	39.2 W HTN, induction for labor. Placed in labor room at 0600. Consents signed and patient placed on monitor. 2 elevated blood pressures above call orders. RN will continue to assess patient. Patient seizes.								
Facilitators:									
Dates of Sims: Pilot Date: 12/17/19 1/9/20									
Type of Simulation	n (check all that a	pply) :	Task Tra	ainerX	Manne	quin Actor/SP			
Scenario recoro	ding requested no		Classroom ne	eeded Debriefing Room needed _X_noXyesno					
			RTICIPANT						
Disciplines:	Total Number	:		<u> </u>	Number pe	er Sim:			
RNs		2-4							
MDs									
RTs									
Pharmacists									
CSTs									
Other									



LEARNING OUTCOMES

*Team STEPPS® competencies (leadership, mutual support, situation monitoring, communication) are to be incorporated into every simulation to promote patient safety (ahrq.gov, 2017)

General Learning Outcomes (to be disclosed to participants)

Appropriate nursing care of OB HTN pt

Scenario Specific Outcomes (for facilitator only)

Objectives:

- 1. Learner will turn patient to side during seizure.
- 2. Learner will have suction and yankauer set up.
- 3. Learner will have oxygen turned on.
- 4. Learner will perform after care of a seizure by keeping pt on side, assess LOC, and perform VS.
- 5. Learner will notify MD of event.

Expected cognitive skills to be demonstrated by participant:

Implement

Identify precautions used for hypertensive disorders (seizure precautions, timing of checks, decrease environmental stimuli, etc). Discusses seizure precautions and decreased environmental stimuli (low lights, quiet environment, and padded side rails).

Evaluate

Understands warning signs of a hypertensive disorder.

Document

Discuss the appropriate documentation guidelines.

Expected psychomotor skills to be demonstrated by participant:

- -Performs proper assessment of hypertensive patient.
- -Recognizes signs and symptoms, lab values, and vital signs associated with hypertensive disorder.
- -Performs neuro assessment, including level of consciousness, DTRs, presence of visual disturbance, headache, and epigastric pain.

Expected affective skills to be demonstrated by participant:

Demonstrates assessment of patient and notifies physician using SBAR. Documents assessments and practices appropriately in the EMR.

Commits to providing patient comfort and safety.

PRE-BRIEFING INFORMATION

Pre-requisite Knowledge/Reading/Testing (provide references on last page):

POEP:

Module 8 Complications of Pregnancy, Part 2

CBT:

FHCI Hypertensive Disorders in Pregnancy

Policy:

Hypertensive Disorder in Pregnancy



NOTE TO FACILIATORS: Prior to beginning the simulation, participants must be oriented to simulator and/or setting, understand guidelines and expectations for their scenario(s), have completed all pre-work, and understand their assigned roles.



Pre-Briefing Report to Participants																
PATIENT	PATIENT Tonya				AGE/	/SEX 32 yr old			А	ADMISSION WEIGHT						
PRIMARY MD				Triplett and/or Fam. Med MD					PROCEDURE							
CONSULTS									CODE FU STATUS			Full	Full			
DX				HTN in pregnancy					PASSWORD							
CURREN	T PROBLEM	VI		Elevated blood pressures in pregnancy, induction				NEXT OF KIN Husband: M		: Matt						
				pregnancy			, induction				<u>I</u>			DIET	cle	ears
нх			39.2 weeks gestation Induction of labor Chronic Hypertension- not on medications													
ALLERGI	ES		NKDA													
MEDICA	TIONS		PNV													
SAFETY/	PRECAUTION	ONS	none													
RESTRAI	NTS		none													
CURREN	T 661151T1					□ VENT □ ETT CIZE □ LOCATION □										
	T CONDITI	ON	1							Ц	SIZE LOCATION					
SKIN	/RHYTHM/	,	PAII	N 0	/10	MOI FIO2			☐ PS	+	RATE		<u> </u>	PEEP	<u>' </u>	
PULSES	/ KITT I HIVI/					FIO2 PS D					CPAP/BIPAP					
RESP C	Clear lung s	ound	S			⊠ IV LINES						l				
NEURO A/Ox3, DTRs no			iormal			☐ PICC/CVL							□ AI	RT		
GI/GU BM VOID			VOID			☑ MIVF LR at 125mL/hr										
☐ FOLEY			OLEY			☐ DRIPS										
TUBES	□ NG/O	G [□ JP	□ ст	-			.11								
I/O			L													
VITALS																
ACTIVITY Up ad lib																
SUGGESTIONS/RECOMMENDATIONS/REQUEST				STS T	O MD	/NII	IRSF	1								
Call MD for orders																
	ORDERS Admit to inpatient. Full Code. Activity as tolerated Vital signs, routine															



Notify Physician Vitals/other: SBP >159, DBP >109	
Assess DTRs q4h	
Weigh patient daily	
Pain assessment, routine	
Intake and output, every shift	
Nonrebreather mask oxygen at 10-12 liters, routine	
Diet Clear liquid	
Insert peripheral IV	
CBC with dif STAT	
Hold Specimen-blood bank STAT	
UDS STAT	
LR 125ml/hr	
Labetalol (Nordomyne) panel: 20mg, 40mg, 80mg prn	
ANTICIPATED CHANGES OR OTHER ISSUES	
PENDING LABS	

SET UP/RESOURCES							
(for simulation center staff)							
	Simulation Setting						
□ ER	□ ER □ Women's & Children's						
☐ Med-Surg		☐ Behavioral Health					
☐ Pediatrics		☐ Home Health					
□ ICU		☐ Pre-Hospital					
□ OR / PACU		☐ Doctor's office/clinic (table, chairs and exam table)					
		☐ Other:					
Time of Day: morning							
Is the patient a mannequin or a Standardized Patient (SP)? mannequin							
Appearance of Mannequin							
Clothing	Moulage		Incisions/Dressings				
gown							
Appearance of Actor/SP							
Clothing	Moulage		Incisions/Dressings				
Monitor Waveform Setup							
EKG/HR □	RR 🗆		O2 Sat				
ВР 🗆	Arterial Line		PAP				
ETCO2	Other:						



Equipment attached to patient								
ECG Monitor	BP Cuff ⊠	Arterial/PA lines						
Oxygen Sat Probe 🗵	NG tube	Foley Urine Color:						
Chest Tube	Vent □	IV line ⊠						
ID Band/MRN ⊠	Allergy Band □	IO □ SCDs □						
Fall Blanket/Footies ⊠	Other: FHM attached to pt							
	IV Type							
PIV 🗵	Saline Lock	Central Line						
PICC	UVC/UAC							
	IV Fluids/Rate							
NS	D5	D10						
LR running @ 125	Other:							
Rate of Fluids:								
	Medications (to be retrieved from	n Pyxis)						
PO	IVP	IVPB						
N	n Medication Equipment Available in	the Room						
IV Pump ⊠	Number of channels 2	IV Pump Tubing ⊠						
IV Piggyback tubing	IV gravity tubing	Extra IV tubing						
Syringes/#/Size 3 10 ml flushes	Needles/#/size	Med cart/Pyxis Pyxis needs to have Mag and Labetalol, and						
		Ca Gluconate						
IV start supplies/angio gauge	Art Line □	PA Catheter						
Pressure bag	Syringe pump	Syringe pump tubing \Box						
10 🗆	Umbilical Line	Other						
Cardiac Equipment Available in the room								
12 lead ECG machine	Code Cart	Defibrillator						
Temp Pacemaker □	Telemetry Pack □	AED						
Respiratory Equipment Available in the room								
Nasal cannula 🗵	Simple Facemask	Venturi Mask □						
Non-rebreather 🗵	IS 🗆	Trach \square						
BiPAP/CPAP	Vent □	Suction						



Suction cath/#/size	Intubation box \Box	Other					
GI Equipment Available in the room							
NG/OG □	G tube	Feeding pump					
Feeding bag \Box	Dining tray	Other:					
	GU Equipment Available in the	room					
Foley 🗵	Condom catheter \Box	SP catheter					
Urinal	Bedpan	Other:					
Other Supplies							
TED hose	SCDs \square	Dressing Supplies					
Venipuncture \square	Blood tubes	Culture tubes					
Thermometer 🗵	Pen light	Fall blanket/footies					
Any additional set up notes for sim staff: stethoscope, pads for side rails, reflex hammer, Assessment QR codes (or something for clonus and reflexes)							



Scenario Progression Storyboard

Patient Initial State Tonya is reclining in her bed. She is anxious and nervous when the RN returns to the room. It has been 10 minutes since last dose of Labetalol. FHR: 140, moderate variability, BP: 170/100 HR: 92 SpO2: 98 Resp: 20 Temp: 98.8F Patient states HA blurry vision and right sided abdomen pain. RN assess VS. RN does nothing. **Declining State** FHR: 140, moderate variability, accels HR: 92 BP: 180/105 SpO2: 98 Resp: 20 Temp: 98.8F Pt cues nurse "can you do anything for my headache?" Patient seizes fo 60 sec. FHR: 80 bpm, minimal variability (decel) RN does nothing RN retakes VS RN does nothing and assesses **End Scenario Declining State** FHR: 130 minimal variability HR: 92 BP: 165/94 SpO2: 98 Resp: 20 Temp: 98.8F

©Franciscan Health 8

End Scenario



	Progres	sion Outline	
Timing	Patient verbal and/or non- verbal communication	Participant expected behaviors/interventions	Patient Response (potential cues for participant if needed?)
Beginning (0-2 mins)	HA, blurry vision, epigastric pain	RN to take next blood pressure.	 I don't feel good. HA 6 out of 10 Seeing spots. Stabbing, sharp pain on right side, continuous
2-3 mins	Pt actively seizing	 RN assist patient to her side RN calls for additional help Monitor patient so that she does not hurt self. RN times seizure Suction PRN 	
3-5 mins	Pt feeling fuzzy, dazed	 Pt stay left turn Assesses VS (BP, HR, SpO2) LOC Discontinue Pitocin (If in L/D; PP not needed) 	
7-10 mins			



End of Scenario (When objectives		 "What happened?" "Is my baby ok?"
met? At specified time period)		, ,

			-
	SP role d	escription	
Name and Role in scenario			
(Patient? Family member?)			
Brief Scenario Summary			
Patient location			
History pertinent to simulation			
Mental State/Demeanor			



Questions/comments SP may verbalize during scenario				
SP Observations	How does the staff commun	icate with you and with each other?		
	DEBRIEFING GUID)E		
		_		
⊠ V	Vith Video	☐ Without Video		
Debriefing/Guided Reflection Questions:				
1. How did you feel through	out the simulation experience			
2. Tell me what went well.				
3 Let's review the objectives and discuss whether we were successful or not				



	General learning outcome(s)
Appro	opriate nursing care of OB HTN pt
	Scenario Specific Outcomes *Copy from page 2 of this form*
2.	· · · · · · · · · · · · · · · · · · ·

scenario, what would you do differently?

- 5. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?
- 6. Talk about how you will transfer what is learned during this experience to your work setting.
- 7. Is there anything else you would like to discuss?

Evaluation Tools

Attach to this page the evaluation tools (surveys, tests) that you plan to use

References

List references for your educational content

ahrq.gov. (2017, August). TeamSTEPPS 2.0 Team Strategies and Tools to Enhance Performance and Patient Safety. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculumtools/teamstepps/instructor/essentials/pocketguide.pdf



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3119563/



Charge RN/person who answers vocera to help

Actions	Statements
RN calls via vocera for help	Hello, What is going on?
My patient is seizing	Comes to bedside. What can I do to help?
	Cues to RN (after a few seconds) Let's turn her on her side. (the primary RN as not done this) Have we called the MD yet? Let me call someone to page the MD?
Seizure is complete	Let's put her back on her back with a wedge. We should take a set of Vital signs.



SIMULATION SCENARIO DESIGN WORKSHEET

Today's Date:			Name of Scenario Author:				
Email:							
Phone:							
		GE	NERAL SCEN	IARIO INFORI	MATION		
Est. Pre-briefing T	ime: E	st. Scenario	Time:	Est. Debriefi	ng Time:	Course #:	
Title of Scenario:							
D. Hypertension v	with magnes	sium drip					
Brief Description:							
					•	tient placed on monitor. 2 elevated	
•		s. RN will co	ontinue to asses	ss patient. Patier	nt seizes. N	lagnesium ordered by MD.	
Setting of Sim: L/[) room						
=							
Facilitators:							
Dates of Sims:				Dilat Da			
Dates of Sims.					Pilot Date : 12/17/19		
					1/9/20		
				1/9/20			
Type of Simulation	n (check all t	hat apply)	: Task	Trainer X	Manne	quin Actor/SP	
						·	
Scenario record	ding request	:ed	Classroom		Debriefing Room needed		
Xyes	no		yes	X_no		Xyesno	
			PARTICIPAN	NT INFORMA	TION		
Disciplines:	Total Nur	mber:		N	Number pe	er Sim:	
RNs		2-	4				
MDs							
RTs							
Pharmacists							
CSTs							
Other							



LEARNING OUTCOMES

*Team STEPPS® competencies (leadership, mutual support, situation monitoring, communication) are to be incorporated into every simulation to promote patient safety (ahrq.gov, 2017)

General Learning Outcomes (to be disclosed to participants)

Appropriate nursing care of OB HTN pt

Scenario Specific Outcomes (for facilitator only)

Objectives:

- 1. Learner will be able to utilize SBAR to MD.
- 2. Learner will be able to place Magnesium order.
- 3. Learner will be able to start a magnesium infusion.
- 4. Learner will state intake maximum per hour while on magnesium.
- 5. Learner will be able to state management of magnesium.
- 6. Learner will be able to perform appropriate patient assessments while on magnesium.

Expected cognitive skills to be demonstrated by participant:

Plan•

Discusses use of Magnesium Sulfate for pre-eclamptic patient during antepartum/intrapartum management, including double checks, assessments, and precautions.

Implement

Identify precautions used for hypertensive disorders (seizure precautions, timing of checks, decrease environmental stimuli, etc). Discusses seizure precautions and decreased environmental stimuli (low lights, quiet environment, and padded side rails).

Evaluate

Understands warning signs of a hypertensive disorder.

Discusses elevated lab values for hypertensive disorders in pregnancy.

Document

Discuss the appropriate documentation guidelines.

Expected psychomotor skills to be demonstrated by participant:

- -Performs proper assessment of hypertensive patient.
- -Recognizes signs and symptoms, lab values, and vital signs associated with hypertensive disorder.
- -Performs neuro assessment, including level of consciousness, DTRs, presence of visual disturbance, headache, and epigastric pain.
- -Minimizes stimulation (low lighting and noise levels, minimize visitors, anchor foley catheter (as indicated), or offer bedside commode/bedpan if ordered; while on Magnesium infusion.
- -Identifies signs and symptoms of changes in mental status related to disease process and/or Magnesium administration (confusion, agitation, irritability, somnolence, diminished DTRs).

Expected affective skills to be demonstrated by participant:

Demonstrates assessment of patient and notifies physician using SBAR. Documents assessments and practices appropriately in the EMR.

Commits to providing patient comfort and safety.

PRE-BRIEFING INFORMATION

Pre-requisite Knowledge/Reading/Testing (provide references on last page):

POEP:



Module 8 Complications of Pregnancy, Part 2

CBT:

FHCI Hypertensive Disorders in Pregnancy

Policy:

Hypertensive Disorder in Pregnancy

Critical Element:

Magnesium Sulfate

NOTE TO FACILIATORS: Prior to beginning the simulation, participants must be oriented to simulator and/or setting, understand guidelines and expectations for their scenario(s), have completed all pre-work, and understand their assigned roles.



Pre-Briefing Report to Participants							
PATIENT	Tonya		AGE	/SEX 32 y	r old	ADMISSION WE	EIGHT
	- 1		'	•			
PRIMARY	RIMARY MD Triplett ar			nd/or Fam.	Med MD	PROCEDURE	
CONSULT	S		Rapid/AC	LS trained		CODE	Full
			Anesthesia		STATUS		
DX			HTN in pr			PASSWORD	
CURRENT	PROBLEM			blood press y, inductior		NEXT OF KIN	Husband: Matt
			pregnanc	y, induction	ı		DIET NPO
нх			ks gestatio	n			
		Induction					
ALLERGIE	<u> </u>	NKDA	Typertensic	on- not on i	nedications)	
MEDICAT		PNV					
	RECAUTIONS						
RESTRAIN		none					
1120110111		110116					
CURRENT	CONDITION			☐ VENT	ETT	SIZE LC	CATION
SKIN		PAII	N 0/10	MODE		RATE	□ PEEP
-	CARDIO/RHYTHM/						
PULSES							CPAP/BIPAP
	ear lung sound			⊠ IV LIN			
NEURO	A/Ox3, DTRs r		this time	☐ PICC/		L A	ART
GI/GU I		VOID		⊠ MIVF	1,		
	□ F	OLEY		☐ DRIPS	5		
TUBES	□ NG/OG	□ JP	□ СТ				
I/O	1/0						
VITALS							
ACTIVITY Up ad lib							
SUGGESTIONS/RECOMMENDATIONS/REQUESTS TO MD/NURSE							
	Call MD for orders						
ORDERS Admit to inpatient. Full Code. Activity as tolerated Vital signs, routine							



Pain a	ssessment, routine			
Intake	and output, routine			
Diet C	lear liquid			
Insert	peripheral IV			
CBC w	ith dif STAT			
Hold S	pecimen-blood bank STAT			
UDS S	ГАТ			
LR 125	iml/hr			
ANTICIPATED CHANGES OR OTHER ISSUES				
PENDING LABS				

SET UP/RESOURCES (for simulation center staff)					
	•	lation Setting	,		
□ ER	□ ER □ Women's & Children's				
☐ Med-Surg		☐ Behavioral He	ealth		
☐ Pediatrics		☐ Home Health			
□ ICU		☐ Pre-Hospital			
□ OR / PACU		☐ Doctor's offic	ee/clinic (table, chairs and exam table)		
		☐ Other:			
Time of Day: morning					
Is the patient a mannequin or a Stand	dardized Patient ((SP)? mannequin			
	Appearar	nce of Mannequir	n		
Clothing	Moulage		Incisions/Dressings		
gown					
	Appeara	ance of Actor/SP			
Clothing	Moulage		Incisions/Dressings		
	Monitor	Waveform Setup			
EKG/HR □	RR 🗆 O2 Sat 🗆		O2 Sat		
ВР 🗆	Arterial Line		PAP		
ETCO2	Other:				
Equipment attached to patient					
ECG Monitor	BP Cuff ⊠		Arterial/PA lines □		
Oxygen Sat Probe	NG tube \square		Foley Urine Color:		
Chest Tube	Vent □		IV line ⊠		



Allergy Band ⊠	IO SCDs					
Other: fetal monitor						
IV Type						
Saline Lock	Central Line					
UVC/UAC						
IV Fluids/Rate						
D5	D10					
Other:						
Medications (to be retrieved from	n Pyxis)					
IVP	IVPB					
 Mag 1000 ml bag Ca Gluconate syringe 						
ledication Equipment Available in	the Room					
Number of channels 2	IV Pump Tubing ⊠					
IV gravity tubing \Box	Extra IV tubing 🗵					
Needles/#/size	Med cart/Pyxis Pyxis needs to have Mag and Ca Gluconate					
Art Line □ PA Catheter □						
Syringe pump	Syringe pump tubing					
Umbilical Line	Other					
Cardiac Equipment Available in th	ne room					
Code Cart	Defibrillator \Box					
Telemetry Pack □	AED 🗆					
espiratory Equipment Available in	the room					
Simple Facemask	Venturi Mask \Box					
IS 🗆	Trach \square					
Vent	Suction					
Intubation box	Other					
GI Equipment Available in the I	room					
G tube	Feeding pump					
Dining tray	Other:					
GU Equipment Available in the room						
	Other: fetal monitor IV Type Saline Lock					



Foley 🛛	Condom catheter	SP catheter
Urinal	Bedpan ⊠	Other:
	Other Supplies	
TED hose □	SCDs ⊠	Dressing Supplies
Venipuncture	Blood tubes	Culture tubes
Thermometer \boxtimes	Pen light	Fall blanket/footies
Any additional set up notes for sim st	taff: stethoscope, reflex hammer	

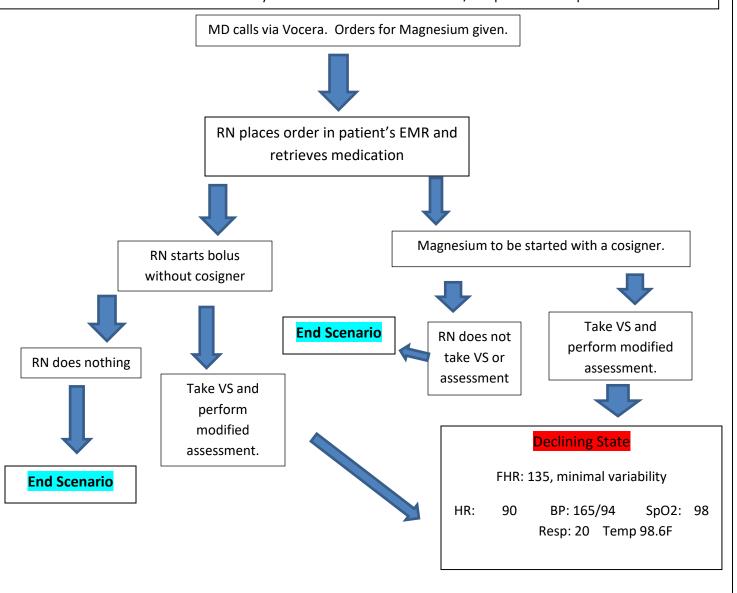


Scenario Progression Storyboard

Patient Initial State (5 minutes since post-ictal)

Patient laying in bed and awake. Patient unaware of what happened. RN to explain what happened. RN awaiting MD to call to give SBAR.

FHR 130 minimal variability HR: 100 BP: 165/95 SpO2: 98 Resp: 20



End Scenario



Progression Outline					
Timing	Patient verbal and/or non- verbal communication	Participant expected behaviors/interventions	Patient Response (potential cues for participant if needed?)		
Beginning (0-2 mins)	Dazed, confused	 RN to give SBAR report to MD. Inform MD to VS, seizure and patient's current status. Order for Magnesium 	What happened?Is my baby ok?Am I ok?		
2-5 mins	Nervous, confused, questioning	 RN explains order to patient and answers questions. RN places order in patient's EMR. RN receives medication and other materials (ie. pads for rails, labels for tubing) 	 Will this hurt? Will this affect my baby? What will it do to me? 		
5-7 mins	Nervous, questioning	 RN uses EPIC and pump to program dose of medication A bolus is given and then a continuous rate. LR at 75ml/hr Mag after bolus at 50ml/hr Stay at bedside during bolus VS should be taken once the infusion is 	 What are these for (pads for rails)? Can I still use the restroom? 		



7-10 mins	started and every 15 minutes x 1 hr. RN performs a modified H-to-T assessment (DTRs, Heart and lung sounds, reflexes, HA, blurry vision, epigastric pain.)	
End of Scenario (When objectives met? At specified time period)	 RN explains how often blood pressures to be taken (15 min x1 hr, 30 min x1 hr, 1 hr until infusion complete). RN explains that modified assessments are completed as well. 	How often do you have to take my blood pressure?

SP role description

©Franciscan Health 10

Name and Role in scenario (Patient? Family member?)



Brief Scenario Summary				
Patient location				
History pertinent to simulation				
Mental State/Demeanor				
Questions/comments SP may verbalize during scenario				
CD Ol	the death of form	etaria di tanan anda di ta		
SP Observations	How does the staff commu	nicate with you and with each other?		
DEBRIEFING GUIDE				
⊠ V	Vith Video	☐ Without Video		
v v				



4.

you were able to repeat the

lf

Debriefing/Guided Reflection Questions:

- 1. How did you feel throughout the simulation experience
- 2. Tell me what went well.
- 3. Let's review the objectives and discuss whether we were successful or not

General learning outcome(s)			
Appropriate nursing care of OB HTN pt			
Scenario Specific Outcomes			
Copy from page 2 of this form			
Objectives:			
 Tell me about your SBAR with the physician. How did you feel/concerns/questions? 			
Your physician ordered Magnesium, tell me about placing that order. Comfortable/more practice/concerns?			
3. Tell me about your experience with starting the infusion.			
4. Tell me about the process after the infusion is started, what do you do next and following.			
enario, what would you do differently?			

scenario, what would you do differently?

- 5. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?
- 6. Talk about how you will transfer what is learned during this experience to your work setting.
- 7. Is there anything else you would like to discuss?



Evaluation Tools

Attach to this page the evaluation tools (surveys, tests) that you plan to use



References *List references for your educational content*

ahrq.gov. (2017, August). TeamSTEPPS 2.0 Team Strategies and Tools to Enhance Performance and Patient Safety.

Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.pdf

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3119563/



MD speaking parts

Actions	Statements
SBAR called to MD	Hello, What is going on?
	Yes, that is my patient.
If RN does not state info on seizure:	How is she now?
	How long did the seizure last?
	Do you know what triggered it?
After answers seizure	Any signs and symptoms now? How is her DTRs? Blurry vision? Headache? Epigastric pain? What are her current vital signs?
RN answers	Start Magnesium Sulfate infusion. 6gm bolus and then 2g/hr



Charge RN or RN help speaking parts

Actions	Statements
Can you come help sign off on Magnesium? Dr gave	RN at bedside.
orders to bolus and start?	What can I help you with?
	How did you program the pump?
	Did you do a bolus?
After bolus started:	Do you need any more help?
Bedside RN says no.	Okay. Did you set your vital signs to go off?
	Have you done your checks?
	Did the MD give orders for a foley or what can she use?
	If you need any help let me know.