

CSEAC Scenario Development Form

(Items with * must minimally be filled out prior to submitting form or meeting with simulationist. Please fill out as much as possible to expedite the development process)

Scenario Name:

Author(s):

Course director:

Content expert:

Date of Development:

Targeted Audience:

Simulation Platform:

(HPS, SimMan3G, MetiMan, SimMom, SimNewbie, task trainers, or Other)

***Synopsis of Scenario:**

***Learning Objectives:**

***Scenario Intro (**read to learner**)**

Facilitator briefing/ Curricular information:

Competencies:

- **Patient Care**
- **Medical Knowledge**
- **Practice Based Learning**
- **Interpersonal/Communication**
- **Professionalism**
- **System Based Practice**

Educational Learning Model

Prerequisites:

Didactics Needs:

Learning Method:

Debriefing Method:

Outcome / Evaluation / Measurement / Research :

*Preparation

Supporting Files

-

Roles

-

Setting

-
-

Monitors Available to Participant

-

Other Equipment Required

-
-

Time Duration

- Set up:
- Simulation:
- Debriefing:
- Tear down:

Supplies

-

AV/I.T. Required

- Recording
- Laptop
- EMR

***Learner Information**

(Information given to learner during scenario)

Scenario Introduction (*give to learner*):

General Information (SBAR):

LOC:

Name:

Age:

Birth Date:

Weight:

Height:

Vital Signs:

Patient History:

History of Present Illness:

Allergies:

Medications:

Past Medical / Surgical History:

Intake/outputs:

Symptoms:

Events leading up to Illness:

Onset of symptoms:

Provocation / provokes:

Severity of pain:

Review of Systems

CNS:

Cardiovascular:

Pulmonary:

Abdominal:

Renal:

Psychiatric:

Physical Exam:

Head:

Chest:

Abdominal:

Legs:

Arms:

Back:

Current Interventions:

Laboratory, Radiology, and Other Relevant Studies: Labs:

Simulation Sequence

1. Initial Baseline

Vital signs:

| HR | BP | SPO2 | RR | ETCO2 | CVP | PAP | CO | Temp |
|----|----|------|----|-------|-----|-----|----|------|
| | | | | | | | | |

Patient Responses:

EKG:

Appearance/PE:

Further details:

Operator details:

Learner Objectives and Interventions:

Transition Cue:

Go to state:

2. State Name

Vital signs:

| HR | BP | SPO2 | RR | ETCO2 | CVP | PAP | CO | Temp |
|----|----|------|----|-------|-----|-----|----|------|
| | | | | | | | | |

Patient Responses:

EKG:

Appearance/PE:

Further details:

Operator details:

Learner Objectives and Interventions:

Transition Cue:

Go to state:

3. State Name

Vital signs:

| HR | BP | SPO2 | RR | ETCO2 | CVP | PAP | CO | Temp |
|----|----|------|----|-------|-----|-----|----|------|
| | | | | | | | | |

Patient Responses:

EKG:

Appearance/PE:

Further details:

Operator details:

Learner Objectives and Interventions:

Transition Cue:

Go to state:

4. State Name

Vital signs:

| HR | BP | SPO2 | RR | ETCO2 | CVP | PAP | CO | Temp |
|----|----|------|----|-------|-----|-----|----|------|
| | | | | | | | | |

Patient Responses:

EKG:

Appearance/PE:

Further details:

Operator details:

Learner Objectives and Interventions:

Transition Cue:

Go to state:

5. State Name

Vital signs:

| HR | BP | SPO2 | RR | ETCO2 | CVP | PAP | CO | Temp |
|----|----|------|----|-------|-----|-----|----|------|
| | | | | | | | | |

Patient Responses:

EKG:

Appearance/PE:

Further details:

Operator details:

Learner Objectives and Interventions:

Technician/Patient Notes

(Information for sim tech and facilitator about patient)

General Information (SBAR):

LOC:

Name:

Age:

Birth Date:

Weight:

Height:

Patient History:

History of Present Illness:

Allergies:

Medications:

Past Medical / Surgical History:

Intake/outputs:

Symptoms:

Events leading up to Illness:

Onset of symptoms:

Provocation / provokes:

Severity of pain:

Review of Systems

CNS:

Cardiovascular:

Pulmonary:

Abdominal:

Renal:

Psychiatric:

Physical Exam:

Head:

Chest:

Abdominal:

Legs:

Arms:

Back:

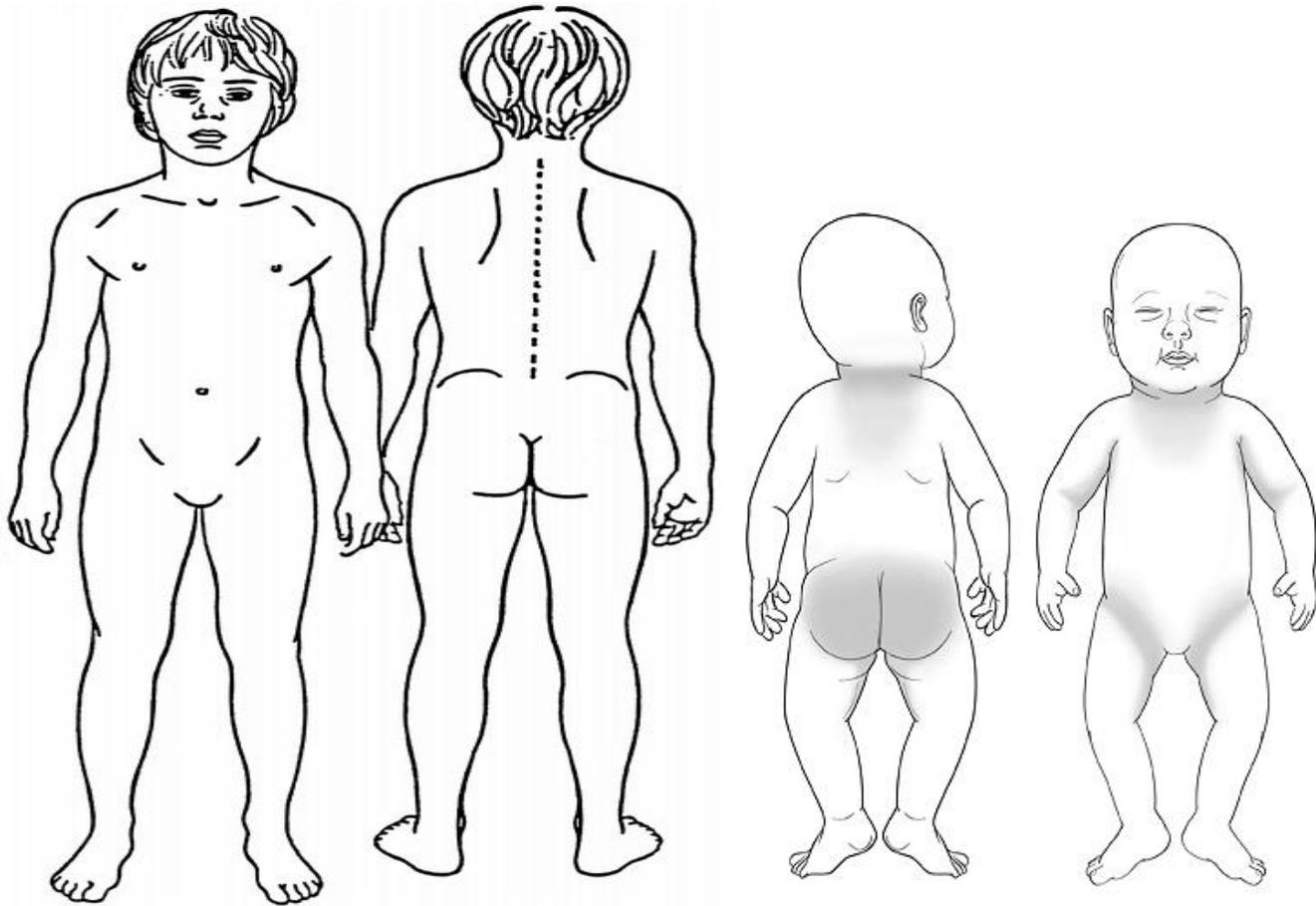
Current Interventions: Laboratory, Radiology, and Other Relevant Studies: Labs:

Moulage Sheet

Type label here and
drag to location

Type label here and
drag to location

Markers-drag to location



Head :

Chest:

Abdomen :

Hands/Feet:

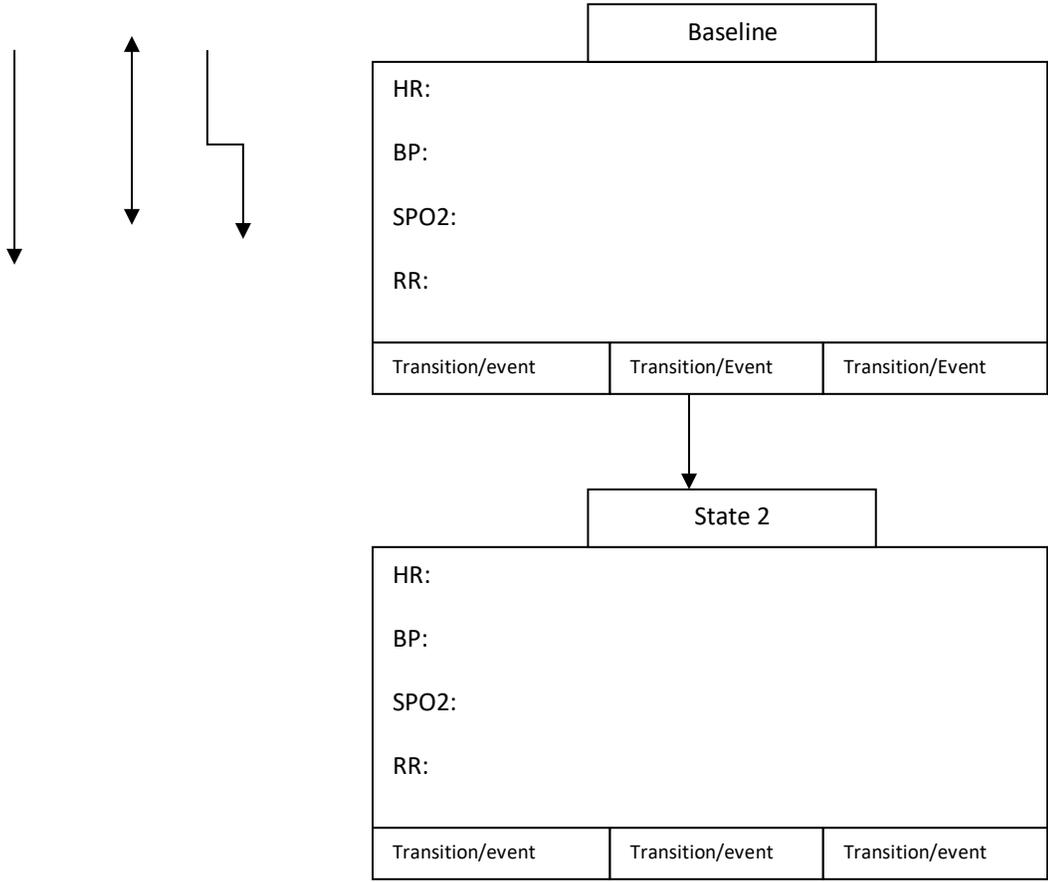
Arms :

Legs:

Back :

Other:

Scenario Algorithm



Instructions and Definitions:

Synopsis of scenario-: This is the who, what, and when of the simulation. Included should be information about the patient or conditions, how the simulation progresses, and learning objectives. After reading this the instructor/facilitator should have a good idea on how the scenario runs and what is going to happen when. This section should also include how the scenario presents (ie. You are called to room ## or in E.R.) and this is what is known

Learning objectives: List each specific result or action to be achieved. This also includes learning goals of the simulation. The objectives should also reflect items that you are assessing or evaluating.

Scenario Intro: This is what the learner or participant reads to get them started or engaged in simulation. Should provide minimal circumstance, patient assessment, and setting info. This can be given or read to each participant and/or group.

Facilitator and curricular information: This provides didactic and formal information for the facilitator to teach or enforce before, during, and after (debrief) the scenario. This might be information supporting the learning objectives, items to debrief, or evidence based research supporting the scenario/simulation. Examples: AHA guidelines for Vfib include compressions, airway, and breathing algorithm along with defibrillation. The current guidelines for sepsis treatment are..... The calculation for an epi drip is..... etc .

Educational learning model: These questions help define how each participant is learning the material or objectives for the scenario. If the learner or participant is complete a prerequisite like an online module, test, or reading material prior to attending the course. Should there be learning materials provided like a power point or documentation prior, during, or after the simulation. What learning method is preferred: facilitator is in room instructing as simulation progresses(instructional), learners experience on their own (experiential), all didactic, competency based (Ex. ACLS mega code). The debrief model can be as simple as plus/delta or any other model desired to facilitate feedback and confidence. Outcomes and research lets us know if the simulation is being evaluated by formative or summative methods or a part of a research project.

****all research projects when published or presented must include the acknowledgement of the CSEAC center's use for simulation and those individuals included in the development. IRB must be kept on file in CSEAC dept.

Preparation: Things needed to get the simulation or task training ready to go and supplied. The more details the better. Included should be supplies, medical equipment, and AV items.

Learner Information: This is the patient information you would want the learner/participant to have during the simulation. It may include more information that suggested in this form or less if you don't want the learner to know or not applicable. This can be any format not just the suggested. Example would be only providing demographic info and nothing else so the learner/participant solicits the info. Use a custom mnemonic ex. SBAR.

[****CNTRL Key and Click Here Back To Document****](#)

Instructions and Definitions (2):

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Simulation Sequence: This is the layout of the simulation program. How the simulator is doing and reacts to actions or interventions. Each “state” is a defined set of parameters, information, and objectives. Defines hemodynamics the user will see or need. The items below the hemodynamic table define items happening in this state with these hemodynamics.

Patient response: alertness, scripted responses, and movement

EKG: rhythm or condition (sinus, 3rd degree block, vfib)

Appearance/PE: How does the simulator look and/or bodily functions (pink, blue lips, start bleeding wound)

Further details: environment changes, scripted lines for confederates or extras. Do this or that

Operator details: notes to the person running the simulator. Ex. Close eyes when IV started. Start bleeding.

Learner objectives and interventions: What should the learner/participant be doing in this state. This can be one of your objectives or just a list of tasks or interventions to be completed based on the situation. Ex. Start IV, begin compressions, follow AHA guidelines for Asystole, or Call for help.

Transition Cue and Go to State: This is how you get from one state to another. Usually this is an intervention, time in state, or per instructor/facilitators direction. The transition is the action to move on or to another state; Go to state tells the simulation operator which pre-programmed state to go when the action or cue is given. Not all scenarios have to go in order, sometimes you can go between states or have a couple of transitions or states to go between. Think of this as a if-then statement: If Epi is given (transition) then go to Recovery state.

*** try to limit to no more than 5 states

Technician/patient notes: This is the details of the patient for the simulation operator and facilitator so they can answer questions or give results when needed or prompted. Learner does not see this info.

Moulage Sheet: Graphic representation and list of items needed to be made up to provide suspension of disbelief to the learner/participant. This includes makeup, wounds, conditions, and medical interventions (IV, nasal cannula, chest tube, etc)

Scenario Algorithm: This is a graphic representation for the simulator operator and facilitator of the scenario flow and transitions. Included is hemodynamics, transition events, and flow arrows to show the options for each scenario. ***** This is filled out by the simulationist after all scenarios and programming is completed