Appendix A: Chest Pain Assessment Tool and Scenario

Data Collection *Orders diagnostic tests appropriate to and focused on the clinical setting*	*Differential Diagnosis* *Creates a differential diagnosis appropriate to the clinical setting*	*Medical Decision Making* *Appropriate to the clinical setting*	*Comm and interaction w/RN*	*Comm w/Senior Resident (SR)*	*Overall Approach* *Interaction w/pt and nursing staff to successfully evaluate the pt and obtain pertinent clinical info in a timely and organized fashion*
Critical Data Points: □ Vitals (≥3) [ ] Heart rate [ ] Blood pressure [ ] Respiratory rate [ ] Temperature [ ] O2 saturation □ Current medications □ Confirm pt is on telemetry □ Confirm pt has an IV *Labs:* □ Troponin* □ BMP/Electrolytes (≥2) [ ] Potassium, K [ ] Magnesium, Mg [ ] Phosphorus, P □ CBC □ ABG	*Critical Diagnoses:* □ Angina □ Demand ischemia □ NSTEMI □ STEMI □ Anxiety □ PE □ Pleuritic pain/PNA	□ Apply Oxygen *Administer medication:* □ Nitroglycerin □ Aspirin □ Reglan □ 2nd Nitroglycerin □ Beta-blocker □ Morphine □ Administer IV fluids □ Transfer to ICU or call code	□ Contact occurs w/in first 2 mins and 30 sec of sim* □ Request nurse's sign out/notes on pt □ Request pt PMH □ Obtain current/ home medications □ Order/discuss work up of pt** □ Communicates concerns/differential diagnosis □ Communicates medication order(s) □ Professional Communication (Please & Thank you)	□ Contact occurs w/ each evaluation interaction* □ Pt name □ Age □ Gender □ Hospital/post-op day □ Reason in the hospital or operation □ Reason for call □ Vitals (≥2) [ ] Heart rate [ ] Blood pressure [ ] Respiratory rate [ ] Temperature [ ] O2 saturation □ Lab and/or imaging results (≥2) [ ] Electrolytes [ ] Troponin [ ] EKG [ ] CXR □ Treatment thus far + any results (or thoughts/questions)	Scattered or disorganized approach that interferes w/ timely care & management of pt = 1 Provides appropriate medical care but disorganized approach hinders timing/ delivery of that care; required SR guidance in data and treatment = 2 Becomes sidetracked in evaluation of pt, loss of efficiency; required SR guidance in data or treatment = 3

Imaging: □ EKG* □ CXR					Organized but missed important aspect of care; 1 box; required minimal guidance = 4 Efficiently completed scenario; all boxes = 5
No tests ordered = 1 1-3 checkbox; missed * = 2 4-5 checkboxes, incl. * = 3 6-7 checkboxes = 4 8-10 checkboxes = 5	No diagnoses stated = 1 1-2 stated dx = 2 3-4 stated dx = 3 5+ stated dx, stumbled, scattered = 4 5+ stated dx, concise = 5	Stumped = 1 Verbalized idea(s) but nothing done = 2 1-3 checkbox = 3 4-6 checkboxes = 4 7-9 checkboxes = 5	Did not contact or had to be told by facilitator to contact RN; was rude, ignored or disregarded RN = 1 Delayed, missed *; repetitive = 2 3-4 checkboxes, incl. * but missed ** = 3 5-6 checkboxes, incl. * & ** = 4 7-8 checkboxes = 5	Did not contact; was rude or disregarded SR = 1 Delayed, missed *; had to be told by facilitator to contact SR = 2 1-4 checkboxes, incl. * =3 5-7 checkboxes, incl. * = 4 8-10 checkboxes, incl. * = 5	

Goals:

1. Evaluation and Management of Perioperative Chest Pain
2. Provide appropriate Communication to Nursing and Senior Resident, Assign level of care.
3. Differential Diagnosis: NSTEMI, STEMI, PE, Demand ischemia, Angina, Anxiety.

Setting:
You are the surgical intern on the Vascular surgery service. The patient was walking in the hall and developed chest pain. You were paged by the nurse and were just down the hall.

Scenario:
70 year old female POD 2 s/p Left Fem-pop Bypass.
Patient states, "I had a strange sensation in my chest. It feels like an elephant is sitting on my chest". She is dizzy, weak, and diaphoretic.

Current MEDS: Normal Saline 75mL/hr, Nitro SL, Plavix, Morphine, Reglan, Lovenox, ASA.
Social History: Smoker for 50 years, widowed, retired school teacher, enjoys playing bridge
Surgery History: Hysterectomy at age 50, Appy age 35, Lt. Mastectomy age 60, L Fem-pop
Medical Hisotry: PVD, CAD (sent 5 yrs ago), hypercholesterolemia, DM
Home Meds: Metformin, Lisinopril, ASA, Simvastatin, Boniva

Current Vitals: HR 70, BP 110/60, Resp 22, T. 99.5 95% RA
Chest pressure continues, Pain 7/10
Last Labs, CXR and EKG were taken prior to surgery.

DESIRED LEARNER ACTION:

Give ASA and Nitroglycerin
Give Oxygen 2L NC
Confirm IV access (18g L hand, 22g R forearm)
Order: 12 LEAD EKG Stat
Labs: CBC, BMP, Troponin,
CXR (portable)
Reassess, repeat vitals

Communication Challenge:
Inexperienced, nervous RN

SCORING NOTES

Start time: _____

Time nurse contacted: _____

Time of first treatment: _____

End time: _____

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5 MINUTES LATER: HR 82, BP 162/86, Resp 20, 98% 2L NC

Chest Pressure Continues, Pain 4/10 after Nitro. Patient states she *feels nauseated*.
EKG: NSR

DESIRED LEARNER ACTIONS:
- Repeat Nitroglycerin
- Consider/Give Morphine
- Give Reglan (4 mg IV push)

SCORING NOTES

30 MINUTES LATER: HR 84, BP 140/86, Resp 20, 100% O2 sat

Labs Return: Troponin 0.02

CBC 8>32<185

	141	24	9
BMP	3.9	109	1.1

<145 Mag 2.0 Phos 2.9

DIFFERENTIAL DIAGNOSIS: NSTEMI, STEMI, PE, Demand ischemia, Angina, Anxiety

THE NEXT NIGHT:
The nurse calls you because something is 'very wrong'.
The patient isn't responding. The nurse is *inexperienced and panicky* on the phone.

Current Vitals: HR 120 BP 70/40 RR 33 92% 2 LNC

DESIRED LEARNER ACTIONS:
- Order *over the phone*: STAT EKG, ABG, CXR
- Check IV Status
- Report immediately to the bedside

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The patient is lying in bed, obtunded, but currently protecting her airway. She is diaphoretic. Appears to have ST depression on the monitor. EKG is being completed. (Shows Elevated ST segments in V1-V6 consistent with LAD infarction)

DESIRED LEARNER ACTIONS:

Recognize patient in Cardiogenic Shock.
Have Senior Resident Paged.
Activate Rapid Response Team and/or Code Team.
Call for airway back-up (anesthesia, RRT, CCM).
Assess airway and provide adjuncts as needed.
Confirm IV Access.
Notify for need to transfer to higher level of care – ICU.

SCORING NOTES

IF NO TREATMENT OR CONTACT OCCURS UNTIL >75% OF SCENARIO = Delivery of care is delayed (overall perform.) or comm is excessively delayed, respectively.

Appendix B: Atrial Fibrillation Assessment Tool and Scenario

Data Collection *Orders diagnostic tests appropriate to and focused on the clinical setting*	*Differential Diagnosis* *Creates a differential diagnosis appropriate to the clinical setting*	*Medical Decision Making* *Appropriate to the clinical setting*	*Comm and interaction w/RN*	*Comm w/Senior Resident*	*Overall Approach* *Interaction w/pt and nursing staff to successfully evaluate the pt and obtain pertinent clinical info in a timely and organized fashion*
Critical Data Points: □ Vitals (≥3) [ ] Heart rate [ ] Blood pressure [ ] Respiratory rate [ ] Temperature [ ] O2 saturation □ Current medications □ Physical exam (≥3) [ ] General impression [ ] Check pulse [ ] Listen to heart [ ] Listen to lungs [ ] Examine extremities □ I & O's *Labs:* □ CBC □ Troponin □ BMP/Electrolytes (≥2) [ ] Potassium, K [ ] Magnesium, Mg [ ] Phosphorus, P	*Critical Diagnoses:* □ Atrial fibrillation □ A-fib w/RVR □ Atrial flutter □ MI □ Hyperthyroid □ Hypovolemia □ Electrolyte abn. □ Infection □ Other tachyarrhythmia *Other relevant dx:* □ Psychiatric cause/anxiety □ PE	□ Order an IV rate control medication* [ ] Metoprolol [ ] Diltiazem [ ] Amiodarone □ Decrease/Hold IV fluids □ Electrolyte Replacement (≥1) [ ] Mg [ ] PO4 [ ] KCl □ Order Diuresis (Lasix/Furosemide) □ Apply/ensure nasal cannula oxygen	□ Contact occurs within first 2 mins and 30 sec of sim* □ Request nurse's sign out/notes on pt □ Request pt PMH □ Obtain current/ home medications □ Order/discuss work up of pt** □ Communicate concerns/differential diagnosis □ Communicate medication order(s) □ Professional Communication (Please & Thank you)	□ Contact occurs before script mark or calls if/when stumped* □ Pt name □ Age □ Gender □ Hospital/post-op day □ Reason in the hospital or operation □ Reason for call □ Vitals (≥2) [ ] Heart rate [ ] Blood pressure [ ] Respiratory rate [ ] Temperature [ ] O2 saturation □ I & O's □ Lab and/or imaging results (≥2) [ ] Electrolytes [ ] Troponin [ ] EKG [ ] CXR	Scattered or disorganized approach that interferes w/ timely care & management of pt = 1 Provides appropriate medical care but disorganized approach hinders timing/ delivery of that care; required SR guidance in data and treatment = 2 Becomes sidetracked in evaluation of pt, loss of efficiency; required SR guidance in data or treatment = 3

Imaging: □ EKG* □ CXR □ Confirm pt is on telemetry				□ Treatment thus far + any results (or thoughts/questions)	Organized but missed important aspect of care; 1 box; required minimal guidance = 4 Efficiently completed scenario; all boxed = 5
No tests ordered = 1 1-2 checkboxes; missed * = 2 3-4 checkboxes (at least 1 lab and 1 image), incl. * = 3 5-6 checkboxes = 4 7-10 checkboxes = 5	No diagnoses stated = 1 1-2 stated dx = 2 3-4 stated dx = 3 5+ stated dx, stumbled, scattered = 4 5+ stated dx, concise = 5	Stumped = 1 Verbalized idea(s) but nothing done; missed * = 2 1-2 checkboxes, incl. * = 3 3-4 checkboxes = 4 5 checkboxes = 5	Did not contact or had to be told by facilitator to contact RN; was rude, ignored or disregarded RN = 1 Delayed, missed *; repetitive = 2 2-3 checkboxes, incl. * but missed ** = 3 4-5 checkboxes, incl. * & ** = 4 6-8 checkboxes = 5	Did not contact; was rude or disregarded SR = 1 Delayed, missed *; had to be told by facilitator to contact SR = 2 3-5 checkboxes, incl. *=3 6-8 checkboxes, incl. *=4 9-11 checkboxes = 5	

SETTING: You are the cross-covering night float intern. The nurse pages you to see a patient in the stepdown unit because the HR is 135 & irregular. HR had been 80s until 15 min. ago. You go to see the patient.

Scenario:
62 yo F POD #3 S/P emergent LOA for SBO secondary to adhesions.
The patient states, "I can't breathe", "Help me", "I need to sit up". She is moderately uncomfortable, some dyspnea, no chest pain/pressure

Current MEDS: IV Lactated Ringers at 150 ml/ hour, PPI, Morphine PCA, SQ Heparin
Medical History: HTN, OA, Endometrial CA
Surgical History: Hysterectomy, open appendectomy, Ex-lap LOA

Current Vitals: HR 135, BP 110/60, Resp 25, O2 Sat 93% 2 L NC

Moderate distress, anxious
Chest: Irreg, irreg. No murmers.
Lungs: Bilateral crackles bases to midlung fields
Abd: Soft , appr tender. Inc: C/D/I
BLE warm & symmetric 2+ pitting edema
Circulation: pale, CRT 3-4 seconds
Tele Monitor: Irregularly irregular = Atrial Fibrillation HR 135-150
EKG: Atrial Fib rate 135

DIFFERENTIAL DIAGNOSIS: A. Fib w/ RVR, A-Flutter, Other Tachyarrhythmia, Volume Overload

Desired Learner Actions -

1. ORDER Intervention:
a. Metoprolol, 5 mg, IV -OR- Diltiazem 2.5 mg IV –OR- Amiodarone 150 mg (give slowly 3-5 minutes; MAY INDUCE hypotension) ***If uncertain Call Senior!***
2. Consider/Order Lasix
3. **Order Electrolytes, EKG, CXR, Troponin**
4. Decrease IV fluids to 50cc/hr
5. Assess pt. Talk to pt. Attempt to calm her down. Check O2 applied.

Communication Challenge:
Distressed Patient

SCORING NOTES

Start time: _____

Time nurse contacted: _____

Time of first treatment: _____

End time: _____

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5 MINUTES LATER: HR 155, BP 100/58, Resp 28, O2 Sat 95% 2 L NC

- Increased HR TO 155-165, Slightly lower BP
- Pt complains of increasing difficulty with breathing

Desired Learner Action –

Confirm patient is on telemetry

GIVE Metoprolol or Diltiazem or Amiodarone

After CXR is back: HR 100-110, 110/70, Resp 20, O2 Sat 95% 2 L NC

****Show CXR** – B pulmonary edema

STAT Lab Results:

132 110 15

2.8 26 1.0 <112 Mag 1.5 Phos 2.1

Desired Learner Action:

Replete electrolytes:

Order: 2g Mag, 30mEq KPhos, and 40 mEq KCL

Order Lasix (20mg IV push)

Order frequent vital sign checks (q15mins)

Call Senior resident, assess level of care

Plan for rate control: q 6hr Metoprolol vs

Amiodarone ggt vs Dilt ggt

State DDx for periop A-fib: Vol Overload, MI, Demand

Ischemia, Hyperthyroid, Electrolyte abn

SCENARIO EXPECTED INTERVENTIONS:

- Treat A-fib with RVR appropriately: Beta Blocker, CCB or Amiodarone (NOTE: Don't expose Pt. to all 3!)
- Repleat electrolytes

SCORING NOTES

***MUST HAVE CONTACTED SENIOR**

IF NO TREATMENT OR CONTACT OCCURS UNTIL >75% OF SCENARIO = Delivery of care is delayed (overall perform.) or comm is excessively delayed, respectively.

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- Treat volume overload – Lasix, reduce IV fluids
- Troponin now & Q 8 hr X2
- Order ECHO
- Consider Anticoagulation Need
- Consider Level of Care Appropriateness

Appendix C: Oliguria Assessment Tool and Scenario

Data Collection *Orders diagnostic tests appropriate to and focused on the clinical setting*	*Differential Diagnosis* *Creates a differential diagnosis appropriate to the clinical setting*	*Medical Decision Making* *Appropriate to the clinical setting*	*Comm and interaction w/RN*	*Comm w/Senior Resident*	*Overall Approach* *Interaction w/pt and nursing staff to successfully evaluate the pt and obtain pertinent clinical info in a timely and organized fashion*
Critical Data Points: □ Vitals (≥3) [ ] [ ] Heart rate [ ] [ ] Blood pressure [ ] [ ] Respiratory rate [ ] [ ] Temperature [ ] [ ] O2 saturation □ Current medications □ Confirm pt has an IV □ Physical exam (≥2) [ ] [ ] Extremity edema [ ] [ ] Abdomen/ incision/drain [ ] [ ] Chest/heart/lungs *Labs:* □ CBC □ ABG □ UA* □ BMP* [ ] [ ] Creatinine [ ] [ ] BUN [ ] [ ] Potassium, K □ INR/Coags	*Critical Diagnoses:* □ ATN/Acute Renal Failure □ Foley obstruction □ Intra-abdominal bleeding/ hemorrhagic shock □ Hypovolemia □ UTI	□ IV Fluid Bolus* □ Hold Metoprolol □ Flush Foley □ Transfer to ICU □ Type & cross match blood	□ Contact occurs within first 2 mins and 30 sec of sim* □ Request nurse's sign out/ notes on pt □ Request pt PMH □ Obtain current medications □ Order/discuss work up of pt** □ Communicates concerns/differential diagnosis □ Relays order to flush foley □ Professional Communication (Please & Thank you)	□ Contact occurs upon change in phys exam* □ Pt name □ Age □ Gender □ Hospital/post-op day □ Reason in the hospital or operation □ Reason for call □ Vitals (≥2) [ ] [ ] Heart rate [ ] [ ] Blood pressure [ ] [ ] Respiratory rate [ ] [ ] Temperature [ ] [ ] O2 saturation □ Input and outputs □ Change in pt exam [ ] [ ] Abd distention □ Lab and/or imaging results (≥2) [ ] [ ] UA [ ] [ ] BMP [ ] [ ] CBC	Scattered or disorganized approach that interferes w/ timely care & management of pt = 1 Provides appropriate medical care but disorganized approach hinders timing/ delivery of that care; required SR guidance in data and treatment = 2 Becomes sidetracked in evaluation of pt, loss of efficiency; 1 box; required SR guidance in data or treatment = 3 Organized but missed important aspect of care; 2-3 boxes; required minimal guidance = 4

				□ Treatment thus far + any results (or thoughts/questions)	Efficiently completed scenario = 5
No tests ordered = 1 1-3 checkbox; missed * = 2 4-5 checkboxes, incl. * = 3 6-7 checkboxes = 4 8-9 checkboxes = 5	No diagnoses stated = 1 1-2 stated dx = 2 3-4 stated dx = 3 4-5 stated dx, stumbled, scattered = 4 5+ stated dx, concise = 5	Stumped = 1 Verbalized idea(s) but nothing done= 2 * checkbox = 3 2-3 checkboxes, incl. * = 4 4-5 checkboxes = 5	Did not contact or had to be told by facilitator to contact RN; was rude, ignored or disregarded RN = 1 Delayed, missed *; repetitive = 2 2-3 checkboxes, incl. * but missed ** = 3 4-5 checkboxes, incl. * & ** = 4 6-8 checkboxes = 5	Did not contact; was rude or disregarded SR = 1 Delayed, missed *; had to be told by facilitator to contact SR = 2 5-6 checkboxes, incl. * = 3 7-9 checkboxes, incl. * = 4 10-12 checkboxes = 5	

Goals:
1.) Learner will recognize and work up Oliguria (low urine output)
2.) Provide appropriate communication to nursing staff and senior resident.
3.) Differential Diagnosis: hypovolemia, post-op bleeding/hemorrhage, obstructed foley, acute renal failure (pre, post, intrinsic)

SETTING: You are the intern on the general surgery service at the VA and are paged by the nurse for low urine output in the afternoon.

Scenario:
65 year old woman POD 1 s/p lap splenectomy for CLL. Urine output of 100 ml, over the last 4 hours. The patient has a Foley catheter in place.
Previous Urine Output: 120-150 ml / 4 hours.

AM Labs:

140	112	6
3.8	25	0.2 <

110 Hct: 39

Past Medical History: CLL, Hypercholesterolemia
Past Surgical History: Rt Hemicolectomy
Medications: Morphine PCA, IVF D5NS 50mL/hr, IV Metoprolol, SQ Lovenox DVT Prophylaxis, SSI

Current Vitals: HR 65, BP 135/75, Resp 18, O2sat 99% RA, Temp 37.2

NAD, A x O x3
Chest: RRR, BCTA
Abd: soft, appr tender, not distended, Inc: c/d/i
Drain LUQ: 30 ml sero-sanginous fluid.
Urine: yellow
Extr: No Pedal Edema

DESIRED LEARNER ACTIONS:

Flush Foley
IV Fluid bolus 500 – 1000 mLs
Frequent Abdominal Exams
Recheck Vital Signs and UOP after bolus remains marginal: 25mL/hr.
Re-check Labs
Give appropriate sign-out to the night team.

Communication Challenge:
Distressed Patient

SCORING NOTES

Start time: _____

Time nurse contacted: _____

Time of first treatment: _____

End time: _____

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DIFFERENTIAL DIAGNOSIS: **Hypovolemia, Post-op bleeding, Obstructed Foley**

SCORING NOTES

POD 2: You are now rounding the following morning – 5:30 am.
Sign-out told you: No calls overnight. Last abdominal check was Midnight. "Soft"

VITALS: T 37.5 HR 110 BP 95/35 O2 Sat 99% RA RR 22 UOP: 20 ml/2 hrs

Gen: Mild Distress: moderate anxiety, Dizzy. Denies SOB, Chest Pain.
Chest: B CTA, RRR
Abd: Soft, mild distention
Urine: dark, clear
Drain: 20mL sero-sanguinous fluid.
Extrem: no Pedal Edema
HEENT: Conjunctiva pale

Desired learner action:
Flush Foley (again)
Give 1 Liter of fluid
Labs: CBC, CoAgs, ABG, BMP, Type & Cross
Confirm 2 Large Bore IVs

DIFFERENTIAL DIAGNOSIS: (Learner to state) Hypovolemia, post-op bleeding/hemorrhage, Obstructed Foley, Acute Renal Failure (pre, post, intrinsic)

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2 HRS LATER Vitals: T 37.5 HR 110 BP 90/60 O2Sat 99% RA RR 27
(ABDOMINAL DISTENTION)

RN Pages you: Urine Output 20 ml/ 2 hours and patient is complaining of increased dizziness. Bolus was given.

DESIRED LEARNER ACTION:
Go to Bedside to Evaluate Patient.

Physical Exam:
Subjective: No SOB, No chest pain, No abd. pain.
General: Mild diaphoresis, cool to touch, Increased anxiety
Chest: B TCA, Tachy, RR
Abd: distended, diffusely and mildly tender. Inc: C/D/I
Drain: 20mL Serosang (same as earlier)
Vascular: pulses weak & thread

LABS:

141	111	20
3.9	24	1.0

< 110

9.8>9.0 / 27<176 INR 1.0

DESIRED LEARNER ACTION:
Diff Dx: Intra Abdominal Bleeding
Call Senior Resident (repeat call if called earlier)

***CONTACT WITH SR MUST OCCUR AT THIS POINT. If not = excessively delayed.**

20 Minutes Later Re-Evaluation: You return to check on the patient as you were called away to another urgent call.

T 37.6 HR 125 BP 70/40 O2Sat 94% 2 L NC RR 30
Obtunded, Diaphoretic, Cool
B CTA, min air movement at bases
Tachy
Abd: Distended. Drain: unchanged, now with blood oozing out around drain tube
Extr: no PE

DESIRED LEARNER ACTION:
Transfer to ICU and Communicate to Senior Resident
Call ICU team
Consider Calling Rapid Response Team
Hypotension – Fluid bolus: Transfuse PRBCs, FFP if needed
Reconfirm IV Access
Call family with update (check with senior resident)

IF NO TREATMENT OR CONTACT OCCURS UNTIL >75% OF SCENARIO = Delivery of care is delayed (overall perform.) or comm is excessively delayed, respectively.

SCORING NOTES

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Appendix D: Altered Mental Status Assessment Tool and Scenario

Data Collection *Orders diagnostic tests appropriate to and focused on the clinical setting*	*Differential Diagnosis* *Creates a differential diagnosis appropriate to the clinical setting*	*Medical Decision Making* *Appropriate to the clinical setting*	*Comm and interaction w/RN*	*Comm w/Senior Resident*	*Overall Approach* *Interaction w/pt and nursing staff to successfully evaluate the pt and obtain pertinent clinical info in a timely and organized fashion*
Critical Data Points: □ Vitals (≥3) [ ] Heart rate [ ] Blood pressure [ ] Respiratory rate [ ] Temperature [ ] O2 saturation □ Current medications □ Physical exam (≥2) [ ] General impression [ ] Neuro exam [ ] Listen to heart/lungs [ ] Examine incision site/ abdomen □ I & O's *Labs:* □ CBC □ BMP □ UA □ Finger stick Glucose □ ABG □ CXR	*Critical Diagnoses:* □ Narcotics overdose/toxicity □ Benzos overdose/toxicity □ Hypoglycemia □ Hypoxia □ Infection □ Hypotension □ Delirium □ Stroke/CVA □ Hypercarbia	□ Stop meds (Ativan, Benadryl, & narcotic) □ IV fluid bolus □ Apply/ensure nasal cannula oxygen □ Order safety measures (≥1) [ ] Bed alarm [ ] Mitts [ ] Sitter □ Administer medication (≥1) [ ] Haldol [ ] Seroquel [ ] Trazadone	□ Contact occurs within first 2 mins and 30 sec of sim* □ Request nurse's sign out/notes on pt □ Request pt PMH □ Obtain current/home medications □ Relays order to stop medications □ Order/discuss work up of pt** □ Communicates concerns/differential diagnosis □ Professional Communication (Please & Thank you)	□ Contact occurs before script mark* □ Pt name □ Age □ Gender □ Hospital/post-op day □ Reason in the hospital or operation □ Reason for call □ Vitals (≥2) [ ] Heart rate [ ] Blood pressure [ ] Respiratory rate [ ] Temperature [ ] O2 saturation □ I & O's □ Lab and/or imaging results (≥1) [ ] ABG [ ] UA □ Treatment thus far + any results (or thoughts/questions)	Scattered or disorganized approach that interferes w/ timely care & management of pt = 1 Provides appropriate medical care but disorganized approach hinders timing/ delivery of that care; required SR guidance in data and treatment = 2 Becomes sidetracked in evaluation of pt, loss of efficiency; required SR guidance in data or treatment = 3 Organized but missed important aspect of care; required minimal guidance = 4

					Efficiently completed scenario = 5
No tests ordered = 1 1-2 checkboxes = 2 3-4 checkboxes = 3 5-6 checkboxes = 4 7-10 checkboxes = 5	No diagnoses stated = 1 1-2 stated dx = 2 3-4 stated dx = 3 5+ stated dx, stumbled, scattered = 4 5+ stated dx, concise = 5	Stumped = 1 Verbalized idea(s) but nothing done = 2 1 checkbox = 3 2-3 checkboxes = 4 4-5 checkboxes =5	Did not contact or had to be told by facilitator to contact RN; was rude, ignored or disregarded RN = 1 Delayed, missed *; repetitive = 2 2-3 checkboxes, incl. * but missed ** = 3 4-5 checkboxes, incl. * & ** = 4 6-8 checkboxes = 5	Did not contact; was rude or disregarded SR = 1 Delayed, missed *; had to be told by facilitator to contact SR = 2 1-4 checkboxes, incl. * =3 5-7 checkboxes, incl. * = 4 8-11 checkboxes, incl. * = 5	

1. Learner will Recognize and Work-Up Altered Mental Status
2. Provide appropriately complete update to senior resident in a timely fashion
3. DDx: Narcotics, Benzos, Hypoglycemia, Hypoxia, Infection, Hypotension, Delirium, Stroke

SETTING: Resident sign-out mentions that the patient has been intermittently, but increasingly confused over the past day. You see the patient on your evening rounds.

Scenario: 88 yo Female POD 2 Lap Appy for acute nonperforated appendicitis. She has become increasingly confused over last 12 hours.
Your exam: Pleasant & cooperative, but confused.
IVF 75mL/hr LR
Past Medical History: anxiety, htn, mild early dementia
Past Surgical History: Hysterectomy
Current Meds: Ativan, Benadryl, Lopressor, ASA

INITIAL ASSESSMENT: Current Vitals: Temp 37.8 HR 95 BP 130/80 Resp 22 O2 sat 99% RA

General: confused
Chest: Tachy, RR, BCTA
Abd: soft, port sites clean, intact
Skin: pink & warm.
No foley, No NG. IV intact.

Desired Learner Actions -

1. Assess patient – localizing?
2. Check Meds: STOP PRN Ativan & Benadryl Consider change H2Blocker to PPI
3. Order Labs: CBC, BMP, UA
   Immediately Avail: Accu Check Glu: 110
4. Order safety measures: Bed alarm, Mitts, Sitter.

---

2 HOURS LATER THE NURSE Pages: "I need you to look at the patient again. Something is not right…"

Vitals: Temp 38 HR 110 BP 110/70 Resp 25 O2 sat 99% RA

Communication Challenge:
Difficult communication with patient

SCORING NOTES

Start time: _____

Time nurse contacted: _____

Time of first treatment: _____

End time: _____

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Neuro: Patient lethargic but arousable. No complaints, not very interactive. Goes to sleep if not stimulated.
Chest: BCTA, RRR
Abd: soft, NT, ND
Extr: no Ped edema, warm

Labs Ordered Earlier: 13 - 12 - 210 / 36 / 141 – 110 - 18 / 3.6 - 22 - 1.2 < 100 / Mag 2.0

Desired Learner Actions -

1. Assess patient
2. Check for infection: Phys exam: IV sites, Neuro Exam, Chest, abd.
3. Work-up: CXR, WBC, UA, Bladder scan, FS Glu, ABG
4. Give IV fluid bolus (500 cc)
5. Hold narcotics
6. Increase level of care (IMCU) and frequency of VS.
7. Notify Senior

Results:

CXR: clear
EKG: NSR
UA: Neg
Glu: 113
ABG: wnl

AFTER FLUID BOLUS: Pt is hitting at staff, disoriented. The Nurse, clearly frustrated, tells you "this cannot keep going on….."

Current Vitals: Temp: 37.8 HR: 105 BP 100/65 O2 Sat: 98% RA RR: 24

Neuro: Disoriented to place, year, time. Combative.
Chest: Tachy, RR, BCTA
Abd: Soft, NT, ND, Inc: c/d/i
Extr: Flailing equally, warm

DIFFERENTIAL DIAGNOSIS: Narcotics, Benzos, Hypoglycemia, Hypoxia, Infection, Hypotension, Delirium, Stroke

SCORING NOTES

***MUST HAVE CALLED SENIOR BY THIS POINT. If not = excessively delayed.**

IF NO TREATMENT OR CONTACT OCCURS UNTIL >75% OF SCENARIO = Delivery of care is delayed (overall perform.) or comm is excessively delayed, respectively.

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Appendix E: Trauma Assessment Tool and Scenario

Data Collection *Orders diagnostic tests appropriate to and focused on the clinical setting*	*Differential Diagnosis* *Creates a differential diagnosis appropriate to the clinical setting*	*Medical Decision Making* *Appropriate to the clinical setting*	*Comm and interaction w/RN*	*Comm w/Senior Resident*	*Overall Approach* *Interaction w/pt and nursing staff to successfully evaluate the pt and obtain pertinent clinical info in a timely and organized fashion*
Critical Data Points: □ Vitals (≥3) [ ] Heart rate [ ] Blood pressure [ ] Respiratory rate [ ] Temperature [ ] O2 saturation □ Current medications □ Abd exam □ I & O's *Labs:* □ CBC or Hct* □ ABG* □ Serum glucose □ BMP/Electrolytes □ INR/Coags *Imaging:* □ Pan scan (≥2) [ ] CT of head [ ] CT of chest [ ] CT of abd/pelvis □ Focused assessment with Sonography in Trauma (FAST)	*Critical Diagnoses:* □ Hypovolemia □ Pain □ Bowel injury □ Bladder injury □ Bleeding □ Withdrawal	□ States pt needs to be checked on every 2-4 hrs* □ Insulin sliding scale □ Apply/confirm nasal cannula (O2) □ IV fluid (1L) □ Alert OR □ Antibiotics □ Contact family for consent	□ Contact occurs within first 2 mins and 30 sec of sim* □ Request pt PMH □ Order/discuss work up of pt** □ Communicates concerns/differential diagnosis □ Professional Communication (Please & Thank you)	□ Attempts to contact SR/Chief upon abd exam changes* □ Pt name □ Age □ Gender □ Reason in the hospital □ Reason for call □ State change in exam □ State need for OR □ Report critical data [ ] ABG [ ] CBC	Scattered or disorganized approach that interferes w/ timely care & management of pt = 1 Provides appropriate medical care but disorganized approach hinders timing/ delivery of that care; required SR guidance in data and treatment = 2 Becomes sidetracked in evaluation of pt, loss of efficiency; required SR guidance in data or treatment = 3 Organized but missed important aspect of care; required minimal guidance = 4 Efficiently completed scenario = 5

No tests ordered = 1 1-2 checkboxes; missed * = 2 3-5 checkboxes, incl. * = 3 6-8 checkboxes = 4 9-11 checkboxes = 5	No diagnoses stated = 1 1-2 stated dx = 2 3-4 stated dx = 3 3-4 stated dx & ≥ 3 course expectations = 4 5+, All course expected dx = 5	Stumped = 1 Verbalized idea(s) but nothing done; missed * = 2 1-2 checkboxes, incl. * = 3 3-5 checkboxes, incl. * = 4 6-7 checkboxes =5	Did not contact or had to be told by facilitator to contact RN; was rude, ignored or disregarded RN = 1 Delayed, missed *; repetitive = 2 2-3 checkboxes, incl. * but missed ** = 3 4 checkboxes, incl. * & ** = 4 All checkboxes = 5	Did not contact; was rude or disregarded SR = 1 Delayed, missed *; had to be told by facilitator to contact SR = 2 1-2 checkboxes, incl. * = 3 3-5 checkboxes, incl. * = 4 6-9 checkboxes, incl. * = 5	

Goals:

1. Assignment of and Follow-up of Serial abdominal Exams, Decision to OR
2. Obtain appropriate information at Sign out and Notify Senior of change in clinical status
3. Diffential Diagnosis: Hypovolemia, Pain, Occult bowel injury, Bleeding

SETTING: You are the night trauma intern. You are responsible for serial abdominal exams, new admissions and primary nursing calls.
You have just received signout from the day team

HPI: Healthy 27yo Female, PTD 0 belted passenger in car crash. CT Imaging showed no solid organ injury and trace free fluid in the pelvis, right pubic rami fracture with minimal displacement. Slight hematoma over Right Lower Quadrant (seatbelt sign).
Vital signs on arrival to Trauma Bay: HR 110, BP 120/60 RR 12 97% RA

Admission labs:
CBC: 15 > 12/38 < 300
BMP: Nml
Glucose: 300
BAL: 0.12
UA: + Glu, 5 RBC
FAST: Neg
She received 2L LR in ED and is now on LR 125ml/h. Foley placed without gross blood.
CT SCAN (Pan Scan): No solid organ injury. Trace free fluid in pelvis.
Right pubic rami fracture with minimal displacement.

REPORT AT SIGN OUT:
Sleepy, but arousable. Complaining of thirst and her C collar.

Vital Signs: 37.0 HR 110 BP 120/60 RR 12 97% RA
Light bruising right lower abdomen, soft, positive bowel sounds, minimal tenderness over right lower abdomen.
600ml urine in last 6 hours
Repeat HCT 35

Communication Challenge:
Chief Resident Unavailable
Clinical Decision making

SCORING NOTES

Start time: _____

Time nurse contacted: _____

Time of first treatment: _____

End time: _____

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DESIRED LEARNER ACTION: **(ask learner these questions)**

How often are you going to check on this patient?

- every 2-4 hours

What are you watching for (Differential Diagnosis)? What are your concerns?

- bleeding from pelvic fracture
- occult bowel injury
- occult bladder injury

Eval:
2 Hr Abd Check
4 Hr Abd. Check
6 Hr Abd. Check

SCORING NOTES

FIRST ABD CHECK: 2 HOURS: T 37.5 HR 95 BP 100/70 RR 12 98% RA

Patient is annoyed for being woken up.

Still very thirsty. Denies abdominal pain. Pain medicine is making her nauseated.

Urine Output: 100ml over last two hours

Abdomen: Diffusely tender

Increased tenderness in right lower quadrant over area of bruising, otherwise soft, +BS

DESIRED LEARNER ACTION: (ask learner these questions)

What will you look for on your exam and document in your note?

- thorough subjective
- vital signs, I/Os
- abdominal exam

DESIRED LEARNER ACTION:

Order: Hct (36)
Serum glucose (210)
If intern rechecks U/A: + glucose, no RBCs
Insulin Sliding Scale
Confirm mIVF @ 125mL/hr LR

NURSE CALLS IN 3 HOURS, STATING PATIENT HAD SMALL EMESIS

DESIRED LEARNER ACTION:

Intern goes to bedside to examine patient

VS: T 38 HR 130 BP 100/70 RR 18 92% RA

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Diaphoretic, uncomfortable appearing
Small bilious emesis in basin
Abdomen with diffuse tenderness, + Rebound, spreading ecchymosis
Place on Nasal Cannula O2
STAT Labs: ABG: 7.34/33/100/20 BE -5

20>35<112 INR 1.2
138 | 100 | 21
3.6 | 20 | 0.7 <110 (Glu 300 if ISS not ordered previously)

CALL CHIEF RESIDENT, *but* chief is in OR and can't come to bedside. Give Update.

Bolus 1 L LR
Abdomen: Diffuse tenderness, + Rebound, spreading ecchymosis, but worse nausea

REPEAT Vital Signs: Temp 38 HR 128 BP 108/65 RR 20 97% 2LNC

Repeat ABG: 7.28/32/92/18 **BE -8**
Stable Hct, Urine Output 10ml/Hr
Abdomen: Diffuse tenderness, + Rebound, spreading ecchymosis, worsened nausea

DESIRED LEARNER ACTIONS:

Bolus additional 1L LR
Plan for Close Pt Follow Up (When will they re-examine?)

15 Minutes Later:

Vital Signs: Temp 37.9 HR 135 BP 100/60 RR: 25 96% 2L NC
Appears Ill
Moaning, Legs Drawn up to Abdomen, Lying very still

DESIRED LEARNER ACTIONS:

UPDATE CHIEF RESIDENT (may need to go to OR)
Arrange for patient to go to OR for Ex Lap to examine for bowel injury
What do you need to do to prep for OR?
Active Type and Cross
Alert the OR "Drop A Card" – Stat Case as soon as Resident/Staff avail.
Order antibiotics now – suspect bowel perforation
Consent (for ex lap, possible bowel resection, possible ostomy)
- Call family

SCORING NOTES

*