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Facilitator guide

Seizures traumatic brain injury and intracranial pressure

Use this 60-minute activity to help students recognize neurological change, respond safely to a seizure, and communicate urgent concerns. Students work through one unfolding adult case using printed cards. No simulation laboratory is required.

Mode: tabletop simulation | Audience: prelicensure nursing students with introductory adult neurological assessment | Reading level: college nursing | Setting: adult acute-care classroom | Scope: educator review draft | Date: October 22 2026

Purpose and learning objectives

The educator request establishes interest in interactive teaching; no measured student performance gap was supplied. Use the prebrief to identify current knowledge. Prerequisites are introductory adult neurological assessment and the Glasgow Coma Scale (GCS).

By the end, each learner will: 1) identify three changes from baseline; 2) prioritize assessment, seizure safety, and escalation without an unsafe choice; 3) distinguish observed deterioration from suspected increased intracranial pressure (ICP); and 4) give an SBAR with baseline, new findings, actions, and an urgent request.

Session timing

Minutes	Facilitation task
0 to 7	Prebrief, roles, baseline knowledge check
7 to 10	Card one and baseline record
10 to 14	Card two and immediate escalation
14 to 18	Card three and seizure response
18 to 22	Card four and urgent reassessment
22 to 25	Transfer SBAR after earlier escalation
25 to 45	Protected structured debrief
45 to 55	Individual exit check and feedback
55 to 60	Targeted reteaching and close

Materials and preparation

Print student page 2 for each team and page 5 for every learner. Print pages 3 and 4 single sided, cut between cards, and place cards in four numbered envelopes per team. Keep all cards until their round. Supply pens, a timer, and access to the official GCS assessment aid [4]. Keep this guide and its answers with the facilitator.

This content is for education only and is not medical advice; it does not replace clinical judgment, facility policy, or provider orders.

Prebrief and first two rounds

Say before starting

"This is a learning exercise, not a competency trap. Mistakes are useful here. You can pause or ask for clarification. Verbalize care under RN supervision, within student scope and facility policy. Do not perform procedures or act out convulsions. The patient and all values are fictional. This case does not predict real patient responses."

Ask: "What neurological findings would you compare over time? What would make you call for immediate help?" Accept uncertainty and revisit it during the debrief. Assign assessment lead, action lead, communicator, and observer or timekeeper. Rotate the spokesperson.

Always follow your facility's policies and the provider's orders; when in doubt, escalate to the provider.

Card one Establish a baseline

Read the card and invite the team to use the official GCS aid. Expected description: E4 V5 M6, total 15. Pupils and limb findings provide additional information; they are not part of the standard GCS total [4]. Students record the actual findings so later changes can be recognized.

Ask: "If the numbers on the vital-sign display barely change, what else would matter?" The initial observation plan is a fictional starting decision, not assurance that the injury cannot worsen.

Card two Recognize and escalate

Expected comparison: spontaneous eye opening becomes opening to sound; orientation becomes confusion; headache worsens; vomiting appears. E3 V4 M6 gives a total of 13 [4].

Expected response: immediately involve the supervising RN and urgently notify the treating clinician or activate the facility response pathway as indicated. Under supervision, assess airway and breathing, repeat focused neurological observations, compare with baseline, and report the changes per facility policy [1,5]. Do not wait until the final SBAR or for another card.

Teaching rationale: worsening headache and vomiting with changed responsiveness after head injury warrant urgent clinical reassessment [1]. The cards support concern for neurological deterioration. Raised ICP is a concern for the clinical team to evaluate; these findings do not measure or confirm it [5].

Branches for these rounds

Specific call: respond, "Help is coming. Tell me the baseline, what changed, and what you need." Permit delegation to an assisting RN. Vague call: ask for the missing comparison and urgent request, then let the learner repeat. Never impose an artificial delay in emergency help.

No escalation: cue, "Which findings changed, and who needs to know now?" If needed, pause for the key and replay. Mark prompted performance. The same clinical cards still follow. Earlier calling does not guarantee improvement or prevent the scripted event.

Seizure response and reassessment

Card three State safe actions

The team calls immediately for the supervising RN and emergency clinical response under facility policy. A new seizure after head injury is not a reason to wait for a time threshold [1,3]. Keep one person with the patient and allocate tasks.

Expected safety actions: clear nearby hazards, protect the head without restraining movement, time the event, observe its features, and assess breathing within training and facility emergency procedures. When feasible, position gently on the side to support airway clearance; avoid forcing movement. Do not restrain or put objects in the mouth. Do not offer oral intake until fully alert and safe under the care plan [2].

If breathing is absent or abnormal after the event, learners must summon emergency help and initiate the appropriate resuscitation response within their training and facility protocol [3]. Oxygen, suction, and further airway care require trained personnel and local procedures. No treatments are physically performed here.

Answer to proposals: protect from hazards and time the event are appropriate. Restraint, objects in the mouth, delaying the call, and immediate oral water are unsafe choices in this case [1,2,3]. Pause and replay any unsafe proposal before continuing.

After the response, say: "The visible movements stop after 90 seconds. Here is card four." The duration is a fictional cue, not an intervention effect. Do not assign a reliable GCS during active convulsive movements.

Card four Reassess rather than assume recovery

Expected response: stay with Alex, reassess airway, breathing and neurological findings with the supervising RN, and urgently update the emergency or treating team under facility policy. Report the new left arm weakness and continued reduced responsiveness compared with baseline [1,5].

A postictal period can follow a seizure, but the case does not establish the cause of the new weakness. The new focal finding needs urgent evaluation. Students should describe it rather than diagnose its cause [1].

For the supplied observations, E3 V4 M6 remains 13 because the best motor response still obeys commands [4]. Report the left arm weakness separately. An unchanged GCS total can coexist with an important new finding.

Resolution for the tabletop

End with the response team at the bedside and a transfer handoff. The team directs further assessment and care. Do not invent a repeat CT, ICP reading, treatment response, recovery, or prognosis. If a learner asks for information absent from the cards, say it is not available and ask how they would seek it without delaying help.

Fidelity note: all stage values and time intervals are authored case observations. They are not normal ranges, action thresholds, or a validated physiological model.

Debrief and observation guide

Protect twenty minutes for debrief

Reactions, 2 minutes: "What felt hardest to notice or decide?" Description, 3 minutes: reconstruct the findings and when the team requested help. Keep description separate from judgment.

Analysis, 12 minutes: compare the baseline with each card (objective 1); examine safety priorities and the first escalation (objective 2); separate observed change from suspected ICP elevation (objective 3); repeat one communication with a clearer urgent request (objective 4).

Ask: "What did the GCS total miss?" "What made it unsafe to assume recovery after the movements stopped?" "Which action would you repeat sooner?" Use advocacy and inquiry: "I heard the new weakness described as expected recovery. I was concerned about treating its cause as certain. What findings were you using?"

Summary, 3 minutes: each learner names one finding they will compare and one communication action they will use in supervised practice.

Pressure teaching point

Ask learners to draw a skull and label brain tissue, blood, and cerebrospinal fluid (CSF). Discuss how added swelling or blood can challenge the limited space and increase pressure. Increased ICP can reduce cerebral perfusion [5]. This is a qualitative concept sketch, not a scale drawing or pressure calculator.

Sort statements aloud: "new confusion" is observed; "possible raised ICP" is a concern; "ICP is 25 mm Hg" cannot be concluded. This case has no invasive pressure measurement. GCS, pupils, and symptoms do not produce an ICP number [5].

Observe group performance

For each item record I for independent, P for prompted, or N for not yet demonstrated. A group observation does not establish individual achievement.

Item and objective	I P N
1 Establishes baseline and describes findings (1)	
2 Identifies three changes from baseline (1)	
3 Reports GCS components and limb asymmetry separately (1)	
4 Prioritizes supervised assessment and safety actions (2)	
5 Escalates at deterioration without waiting (2)	
6 Uses seizure safety without unsafe proposals (2)	
7 Reassesses and escalates new focal findings (2,3)	
8 Gives baseline, current findings, actions and urgent request (4)	

Critical learning concerns: delaying help for deterioration, restraint or an object in the mouth, and dismissing new weakness without reassessment. Stop, teach, and replay. These are formative teaching triggers, not an unannounced clinical pass or fail.

The brain within the skull

Use during the debrief, after students have recorded their case decisions.



AI-generated illustrative model of the brain within an opened skull. Not a diagnostic image, scale drawing or quantitative model. Membranes, blood vessels and CSF spaces are not fully represented. Qualified anatomical review is required before teaching from the image.

A limited space

Brain tissue, blood and cerebrospinal fluid occupy space within the skull. Added swelling or blood can challenge that limited space and increase intracranial pressure. Increased ICP can reduce cerebral perfusion. [5]

Ask learners to separate findings from conclusions

What is directly observed in the case? What concern could the findings raise? What would be needed to determine the pressure? Sort new confusion, possible raised ICP, and a measured ICP reading into those categories.

The case supplies no pressure measurement. The illustration cannot establish an ICP value, a diagnosis or a cause of deterioration. Escalate concerning changes through the supervising RN and facility response pathway.

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Assess the patient and the trend



AI-generated simulation scene illustrating preparation for a neurological assessment. This is not a demonstration of assessment technique and does not supply pupil findings, a GCS score or a diagnosis.

Use the components and the whole assessment

The Glasgow Coma Scale describes eye opening, verbal response and best motor response. Pupil findings and the strength of each side are additional observations. A total GCS score can stay the same while another important neurological finding changes. [1,4,5]

CASE MOMENT	GCS COMPONENTS	REPORT SEPARATELY
Baseline	E4 V5 M6 = 15	Equal limb movement
After the event	E3 V4 M6 = 13	New left arm weakness

Ask before explaining

Why does M6 remain correct when the right arm follows a two-part command? What information would be lost if the team reported only the total score?

Reassess and urgently report new neurological findings through the supervising RN and facility response pathway. The treating team determines further evaluation and care.

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Exit check answers and feedback

Scoring the individual tasks

Each task earns 1 point when all listed criteria are met. The local classroom target is 4 of 4 with no critical unsafe choice. This is an instructor-selected learning target, not a validated competency standard. Give focused feedback and a parallel retry for any missed task.

Task one, objective 1: names three accurate baseline-to-current changes. Accept spontaneous eyes to opening to sound, orientation to confusion, worsening headache, new vomiting, seizure, or new left arm weakness. If consciousness is used, require E4 V5 M6 to E3 V4 M6 [4].

Task two, objective 2: A, with a reason tied to timely help, injury prevention, timing or breathing assessment. B risks injury, C delays needed help in this injured patient, and D assumes oral intake is safe too early [2,3].

Task three, objective 3: cites changed responsiveness or other case findings, distinguishes concern from diagnosis, and states that the cards cannot supply an ICP value. Concern warrants escalation under facility policy; an invented pressure value is not an acceptable answer [1,5].

Task four, objective 4: includes the situation, relevant injury and baseline, current changes, actual actions verbalized, and urgent request. Accept a different clear order. No credit for claiming an action that was never stated.

Sample transfer SBAR

"Situation: I am a student with the supervising RN. Alex has new left arm weakness after a seizure. Background: Alex is 24 with a CT-reported right frontal contusion; baseline E4 V5 M6 and equal limb movement. Assessment: we observed a 90-second convulsive event. Alex now has E3 V4 M6, weaker left arm movement, spontaneous regular breathing and SpO2 96% on room air. We called for help, protected from injury, timed the event and reassessed. Request: urgent bedside reassessment now through our emergency response pathway."

Only use the actions sentence if those actions were actually verbalized. The clinical team determines further investigations and treatment per facility policy and orders.

Parallel retry and reinforcement

Retry: present a fresh written case of a head-injured adult who was oriented with equal grips and now has new confusion and weaker movement on one side. Ask the student to compare findings, state supervised assessment and urgent escalation, distinguish concern from measured ICP, and give an SBAR. No new numeric threshold is required.

At the next class, use a two-minute compare-and-report question. Record the individual tasks students still need to practice; do not claim bedside behavior or patient outcome improvement from this classroom activity.

A later five-minute microlearning version can reuse the comparison and SBAR task. Any CE course or public app adaptation requires its own design and review; this packet awards no contact hours.

Sources and educator review

Clinical sources checked online on October 22 2026. The case, time plan, branching and scoring are original instructional design. Reference numbers link the key to the sources below. No guideline tables, graphics or assessment forms are reproduced.

Clinical source list

[1] NICE Head injury assessment and early management NG232

Published 2023; recommendations 1.9.10 and 1.9.13 to 1.9.15 support observation and urgent reassessment. UK guidance informs recognition teaching, not adoption of a local US workflow. VERIFY the applicable facility observation and escalation policy before teaching.

[2] CDC First Aid for Seizures

Page dated May 15 2024. Supports basic seizure safety and actions to avoid. It is a public first aid reference, not an inpatient emergency protocol.

[3] AHA and American Red Cross Guidelines for First Aid 2024

Seizures section supports urgent help for first seizures, injury, breathing difficulty and prolonged or repeated events. In this hospital scenario use the local emergency pathway. The case requires an immediate call, not a wait for five minutes.

[4] Glasgow Coma Scale official assessment aid

Use the original aid for exact assessment descriptors. Students verbalize the supplied responses; no painful stimulation is performed on classmates.

[5] American College of Surgeons Management of Traumatic Brain Injury 2024

Pages 8 to 9 support assessment and separate GCS components; pages 22 to 25 address ICP monitoring and pressure-related secondary injury. Used for qualitative teaching, with no treatment algorithm or numeric target adopted.

Review before classroom use

This is an educator review draft. A qualified nursing educator should confirm learner readiness, clinical wording, local scope and supervision, and the facility emergency response pathway. VERIFY local seizure precautions, airway response, neurological observation practices, and provider-directed care before use. No medication, dose, device setting, or titration is specified.

Refresh sources before first use and whenever the cited guidance or local policy changes. Simulation learning and an AI content check do not establish clinical validation, accreditation, or regulatory approval.

Image provenance: three AI-generated educational images were created using Higgsfield for this packet. Scenes are staged illustrations, not documentation of real patients or learners. Anatomical artwork requires qualified subject-matter review before clinical teaching.

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