VAUGHN
NEXTGEN EDUCATION

STUDENT ACTIVITY KIT

Neurological change

Seizures, traumatic brain injury and intracranial pressure

An unfolding case activity for prelicensure nursing students. Compare new findings, choose safe priorities, and explain your concerns.



AI-generated classroom scene illustrating team discussion. No real learners or patient records are depicted.

PARTICIPANT TIME	FORMAT	TEAM SIZE
60 minutes	Facilitated case and debrief	4 students

How the activity works

Work through four reveal cards, record your decisions, and discuss the reasoning in a structured debrief. The facilitator holds each card until its round. All care is verbalized within student training, RN supervision and facility policy.

Educator review draft | Version 1.2 | October 22 2026

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

Student activity sheets

Seizures traumatic brain injury and intracranial pressure

Follow a fictional adult patient through four case cards. Compare each update with the baseline, agree on priorities, and explain your decisions. Your facilitator releases each card after your team responds.

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

How to participate

Work in groups of four. Assign an assessment lead, action lead, communicator, and observer or timekeeper. Rotate the spokesperson each round. All care is verbalized under instructor supervision. No hands-on procedures, medications, painful stimuli, or acting out a seizure.

This is formative practice. You may pause, ask for information, make an error, and try again. Team performance is not a clinical competency assessment. The fictional case is an authored teaching example, not a prediction of patient response.

Your team decision record

For every round, name the change, choose immediate actions within student scope and facility policy, state who needs to know now, and plan reassessment. Do not wait for the final handoff to call for help.

Round	What changed	Act and escalate now	What to reassess
1 Baseline			
2 Change			
3 Event			
4 After			

Transfer handoff after round four

SBAR means Situation, Background, Assessment, Recommendation or request. Use the back of this sheet to prepare a 30-second handoff with the baseline, new findings, actions already taken, and the urgent request. This handoff follows earlier escalation.

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

Case cards one and two

FACILITATOR PREPARATION SHEET | Print single sided. Cut between the two cards. Hold each card until its round. Do not distribute this uncut sheet to students.

Card one Baseline

Alex Morgan is a fictional 24-year-old admitted to a monitored adult trauma unit after a fall from a bicycle. Initial CT reports a right frontal contusion. The treating team has chosen observation at this point and has cleared the cervical spine before this activity. No ICP monitor is present.

Assessment	Baseline findings
Consciousness	Eyes open spontaneously; correctly gives name, place, and date; follows a two-part command.
Neurological findings	Pupils 3 mm, equal and briskly reactive. Both arms and legs move equally. Headache 4 out of 10.
Vital signs	HR 88 beats/min; BP 124/76 mm Hg; RR 16 breaths/min; SpO2 98% on room air; temperature 36.8 C.

Team task: Describe the baseline, record eye, verbal, and best motor GCS components using the supplied assessment aid, and name what you will compare on the next card. Identify how you would obtain help per facility policy.

SIMULATION ONLY | All values and timings are fictional case observations, not treatment targets or expected trajectories.

Cut here before distribution

Card two A change from baseline

Ten simulated minutes later, Alex opens their eyes only after a spoken request. They speak coherently but cannot correctly identify the place or date. They still follow a two-part command. Headache is now 8 out of 10, with two episodes of vomiting. Pupils remain equal and reactive; limb movement remains equal.

HR 96 beats/min; BP 132/80 mm Hg; RR 18 breaths/min; SpO2 97% on room air. These are fictional observations.

Team task: Identify at least three changes. State your immediate assessment and escalation plan under instructor supervision and facility policy. What could the changes suggest, and what cannot be concluded about ICP? Record your decision before the next card.

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Case cards three and four

FACILITATOR PREPARATION SHEET | Print single sided. Cut between the two cards. Hold each card until its round. Do not distribute this uncut sheet to students.

Card three A witnessed event

Alex suddenly stops responding, stiffens, and develops rhythmic jerking of both arms and legs. No fall occurs. The facilitator announces the event onset. State your response as if you were present with your supervising RN.

Team task: State who calls for help now and who stays with Alex. Describe how you would protect the patient and assess breathing within your training and facility emergency procedures. Name the event details you will observe and record. Explain what you would avoid.

Choose and explain

For each proposal say use now, avoid, or need more information. Explain your reasoning: protect from nearby hazards; time the event; hold the arms still; place an object between the teeth; wait for a duration threshold before calling; offer oral water immediately after the movements stop.

The facilitator provides the event duration and next observations after your response. No medications or procedures are performed in this tabletop exercise.

SIMULATION ONLY | The next card is scripted. Your choices affect team support and communication, not a calculated patient outcome.

Cut here before distribution

Card four The movements stop

The event lasted 90 seconds. Immediately afterward, Alex is breathing spontaneously and regularly, has a pulse, and has SpO2 96% on room air. Eyes open to a spoken request. Speech is coherent but confused. Alex follows a two-part command with the right arm. The left arm now moves less strongly than it did at baseline. Pupils remain equal and reactive.

Team task: What must be reassessed and reported now under instructor supervision and facility policy? Does the end of the visible movements establish recovery? Explain what is known, what is suspected, and what requires urgent clinical evaluation. Prepare your transfer SBAR after stating your immediate response.

Do not name a final cause for the left arm change from these cards. No ICP measurement or repeat imaging result has been supplied.

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Individual exit check

Complete independently after the debrief. Name _____ Date _____

Use the case findings and the assessment aid. This checks classroom learning only. The instructor gives feedback and a second attempt when needed.

One Compare the findings

List three changes between baseline and the later cards. For each, give the baseline and the new finding. Include the eye, verbal, and motor components when describing consciousness.

1 _____

2 _____

3 _____

Two Prioritize the response

During card three, select the best plan and give one reason. All actions are under RN supervision and facility emergency procedures.

A. Call for immediate help, protect from injury, time the event, and assess breathing within training.

B. Hold the limbs still and place an object in the mouth to protect the tongue.

C. Wait for a duration threshold before deciding whether to call for help.

D. Offer water as soon as the jerking stops, then reassess later.

Choice and reason _____

Three Explain the pressure concern

What evidence in this case supports concern about neurological deterioration? Can you assign an ICP value or confirm increased ICP from these cards? Explain.

_____

_____

Four Communicate the change

Write a brief SBAR to the responding clinical team. Include the baseline, current findings, actions already taken in your simulation, and a request for urgent bedside reassessment. Report only actions you actually verbalized.

S _____

B _____

A _____

R _____

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