



### **California Simulation Alliance (CSA) Simulation Scenario Template**

The California Simulation Alliance (CSA) is comprised of simulation users from all disciplines from throughout the state. Several regional collaboratives have formed totaling 7 as of March, 2011: The Rural North Area Simulation Collaborative (RNASC), the Capital Area Simulation Collaborative (CASC), the Bay Area Simulation Collaborative (BASC), the Central Valley Simulation Collaborative (CVBSC), the Southern California Simulation Collaborative (SCSC), the Inland Empire Simulation Collaborative (IESC), and the San Diego Simulation Collaborative (SDSC). The CINHC, a non-profit organization focused on workforce development in healthcare provides leadership for the CSA.

The purpose of the California Simulation Alliance (CSA) is to become a cohesive voice for simulation in healthcare education in the state, to provide for inter-organizational research on simulation, to disseminate information to stakeholders, to create a common language for simulation, and to provide simulation educational courses. The goals of the alliance will include providing a home within the CINHC for best practice identification, information sharing, faculty development, equipment/vendor pricing agreements, scenario development, sharing and partnership models. More information can be found on the CSA website at [www.cinhc.org/programs](http://www.cinhc.org/programs).

All scenarios have been validated by subject matter experts, pilot tested and approved by the CSA before they were published online. All scenarios are the property of the CINHC/CSA. The writers have agreed to release authorship and waive any and all of their individual intellectual property (I.P.) rights surrounding all scenarios. I.P. release forms can be found at [www.bayareanrc.org/rsc](http://www.bayareanrc.org/rsc) and click documents. (Please send signed I.P. release forms to KT at [kt@cinhc.org](mailto:kt@cinhc.org))

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## SECTION I: SCENARIO OVERVIEW

<b>Scenario Title:</b>	Adult Clinic Setting: Hypoglycemia in Diabetic Patient	
Original Scenario Developer(s):	Jose Argumedo, RN; Stephen Forte, RN; Lyza Hiltner, RN; Helen Ho, RN; Edson Nunes da Silva, RN; Shermane Pagsuyuin, RN; Kate Pisani, RN; Patricia White, RN	
Date---originalscenario	12/2/13	
Validation:	Lillian Jones Bell, MSN, RN, PHN, Marjorie A. Miller, MA, RN, CHSE; Nancy Parker, MSN, RN, CNL	
Revision Dates:	November 7, 2014	
Pilot testing:	December 2, 2013; November 17, 2014	
QSEN revision:	QSEN included in original document	
<b>Estimated Scenario Time:</b> 10---15 minutes <span style="float: right;"><b>Debriefing time:</b> 10 minutes</span>		
<b>Target group:</b> Pre---licensure nursing students		
<b>Core case:</b> Nursing Fundamentals: General assessment of a patient, recognition of signs & symptoms of hypoglycemia, implementation of nursing interventions		
<b>QSEN Competencies:</b> Patient Centered Care Teamwork & Collaboration Safety		
<b>Brief Summary of Case:</b> Mr. Jones is a 46---year old male who presents to the clinic with s/s of decreased level of consciousness, disorientation, confusion, diaphoresis, shakiness, and inappropriate responsiveness. He has a recent history of Type II diabetes, HTN that has been managed by medication management and exercise. (Service J. F., 2011) (Service & Cryer, 2011) Learners are expected to assess physical status, LOC, and vital signs. They are to provide basic intervention(s) to address LOC related to diabetes and communicate assessment data to Physician using SBAR communication.		

EVIDENCE BASE / REFERENCES (APA Format)
Service, J. F. (2011, May 31). Diagnostic approach to hypoglycemia in adults. (I. B. Hirsch, Ed.) Retrieved October 12, 2013, from Up---To---Date: <a href="http://www.uptodate.com/contents/hypoglycemia---in---adults---without---diabetes---mellitus---diagnostic---approach">http://www.uptodate.com/contents/hypoglycemia---in---adults---without---diabetes---mellitus---diagnostic---approach</a>
Service, M. P., & Cryer, P. E. (2011, May 31). Overview of hypoglycemia in adults. (I. B. Hirsch, Ed.) Retrieved October 12, 2013, from Up---To---Date: <a href="http://www.uptodate.com/contents/hypoglycemia-in-adults-clinical-manifestations-definition-and-causes">http://www.uptodate.com/contents/hypoglycemia-in-adults-clinical-manifestations-definition-and-causes</a> ; <a href="http://www.joslin.org/docs/Pharm_Guideline_Graded.pdf">http://www.joslin.org/docs/Pharm_Guideline_Graded.pdf</a>
American Diabetes Association (May 20, 2014). Hypoglycemia low blood glucose. Retrieved August 14, 2014 from: <a href="http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose_control/hypoglycemia-low-blood.html">http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose_control/hypoglycemia-low-blood.html</a>
Joslin Diabetes Center (2014). How to Treat a Low Blood Glucose. Retrieved August 15, 2014 from: <a href="http://www.joslin.org/info/how_to_treat_a_low_blood_glucose.html">http://www.joslin.org/info/how_to_treat_a_low_blood_glucose.html</a>
Eli Lilly Humalog (2014) Treating Severe Low Blood Glucose. Retrieved August 15, 2014 from: <a href="http://www.humalog.com/Pages/Glucagon-severe-low-blood-sugar.aspx">http://www.humalog.com/Pages/Glucagon-severe-low-blood-sugar.aspx</a>



## SECTION II: CURRICULUM INTEGRATION

<b>A. SCENARIO LEARNING OBJECTIVES</b>	
<b>Learning Outcomes</b>	
1.	Apply nursing process in clinical decision---making (assessment, nursing diagnosis, planning, implementation/intervention, evaluation).
2.	Provide patient care that promotes safety and is patient---centered.
3.	Communicate effectively with other members of healthcare team (to integrate teamwork & collaboration into patient care).
<b>Specific Learning Objectives</b>	
1.	Assess patient and gather relevant patient data (including VS, overall LOC, blood glucose, patient history)
2.	Early recognition of patient deterioration (decreased LOC, altered mental status)
3.	Recognize signs & symptoms of hypoglycemia
4.	Identify priority nursing diagnosis for patient (hypoglycemia)
5.	Understand expected assessment data and diagnostic test findings for patient with hypoglycemia
6.	Recognize acute changes in patient condition that require immediate attention
7.	Implement nursing interventions to address urgent or primary problem
8.	Communicate patient situation with other members of healthcare team, including MD/provider (using SBAR)
<b>Critical Learner Actions</b>	
1.	Perform hand hygiene, introduce self and role, identify patient using two identifiers
2.	Perform general assessment
3.	Identify symptoms consistent with hypoglycemia
4.	Differentiate neurologic, adrenergic, and cholinergic symptoms associated with hypoglycemia
5.	Identify interventions in treating hypoglycemia
6.	
7.	
8.	

<b>B. PRE---SCENARIO LEARNER ACTIVITIES</b>	
<b>Prerequisite Competencies</b>	
Required prior to participating in the scenario	
Knowledge	Skills/ Attitudes
! Nursing Process	! General survey & physical assessment
! Signs & symptoms of hypoglycemia	! History taking
! Hypoglycemia prevention in diabetic patient	! Recognition of hypoglycemia
! Structured communication tools (i.e. SBAR)	! Nursing interventions to treat hypoglycemia
! Nursing interventions to treat & reverse hypoglycemia	! Communication using SBAR
!	! Patient education on prevention, signs & symptoms, and treatment for hypoglycemia

### SECTION III: SCENARIO SCRIPT

#### A. Case summary

Mr. Jones is a 46---year old male who presents to the clinic with s/s of decreased level of consciousness, disorientation, confusion, diaphoresis, shakiness, nervousness, and inappropriate responsiveness. He has a recent history of Type II DM and HTN that has been managed by medication and exercise.

The patient took his Metformin and Humalog insulin that morning, but did not eat, and he exercised in the morning. He consumed 5---6 alcoholic beverages the night before.

Learners are expected to perform the following specific learner actions: assess physical status and vital signs, recognize patient distress and discomfort, and perform focused mini---cog test. They are to provide basic intervention(s) to address LOC related to diabetes and communicate assessment data to Physician using SBAR communication.

Learners will demonstrate incorporation of QSEN competencies throughout scenario by including the patient/family members in the plan of care; evaluating patient response to nursing interventions; communicating observations related to hazards of safety; and practicing teamwork by coordinating follow---up care with the interdisciplinary team.

#### B. Key contextual details

Upon entering the room, the nurse finds the patient slumped in his chair. He is slow to respond to questions and, when he does respond, his speech is slurred, incoherent and occasionally inappropriate. He is complaining of a moderate headache, which had an onset one hour prior to arrival at the clinic. The patient is unable to determine if any event, traumatic or otherwise, precipitated the headache. He is also complaining of blurred vision and some mild GI cramping. Upon further examination, it is found that the patient is shaky, diaphoretic and his skin is cool. Here, the nurse(s) must do more investigation to determine the possible causes of the patient's symptoms and to gather enough information to develop a plan of care.

#### C. Scenario Cast

Patient/ Client		
	<ul style="list-style-type: none"> <li>‡ High fidelity simulator</li> <li>√ Standardized patient</li> </ul>	
Role	Brief Descriptor (Optional)	Confederate/Actor (C) or Learner (L)
1. Mr. Jones	Patient who presents to the clinic	Standardized Patient
2. Medical Assistant	Checks VS and reports abnormal findings to RN	Confederate/Actor
3. Primary RN	RN who first interacts & assesses patient	Learner
4. Secondary RN	RN available to assist primary RN as needed	Learner
5. Physician/Provider	MD/Provider at clinic	Confederate/Actor

*If this is for IPE,  
all except Pt. will  
be Learners*

D. Patient/Client Profile			
Last name:	<b>Jones</b>	First name:	<b>Joe</b>
Gender: <b>Male</b>	Age: <b>46</b>	Ht:	Wt:
Spiritual Practice:	Ethnicity:	Primary Language spoken:	
<b>1. History of present illness</b>			
46---year old male who presents to the clinic with s/s of decreased LOC, disorientation, confusion, diaphoresis, shakiness, dizziness, nervousness, inappropriate responsiveness, headache, blurred vision, rapid heartbeat. He has a history of Type II diabetes, HTN that has been managed by medication and exercise.			
<b>Primary Medical Diagnosis</b>			

2. Review of Systems	
CNS	Patient slightly disoriented, confused, displaying signs/symptoms of decreased LOC
Cardiovascular	Rapid HR, He denies shortness of breath, chest pain, palpitations, or syncope.
Pulmonary	Rapid and shallow breathing, lungs are clear to auscultation
Renal/Hepatic	He experiences nocturia 2 to 3 times per night and hesitancy with voiding; liver non---tender, normal size.
Gastrointestinal	Abdominal cramping, no n/v or change in bowel habits; Has no hepatosplenomegaly or abdominal tenderness.
Endocrine	Blood glucose from finger stick: 55 mg/dl
Heme/Coag	No history of bleeding or bruising problems
Musculoskeletal	Patient denies any muscle or joint pain
Integument	Patient denies rash, lesions, or ulcerations
Developmental Hx	Father had h/o tobacco use, HTN, and died at age 64 from a car accident. Mother had h/o CVD, type 2 DM, and died at age 78 from MI. Patient is only child.
Psychiatric Hx	Patient says he often feels alone, isolated, and depressed. Depression is poorly controlled and started Prozac 6 months ago but still feels depressed.
Social Hx	Divorced 2 years ago and has to pay child support for his 3 children. He drinks 4---5 glasses of alcohol nearly every day. He denies using illicit drugs
Alternative/ Complementary Medicine Hx	Multivitamins

Medication allergies:	Penicillin	Reaction:	Rash
Food allergies:	NKDA	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Metformin	1000mg	PO	BID
	Humalog (Lispro insulin)	5 units	SQ	Before meals
	Hydrochlorothiazide	25mg	PO	Every morning
	Amlodipine	5mg	PO	Bedtime
	Atorvastatin	10mg	PO	Bedtime
	Baby aspirin	81mg	PO	Daily

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 3.8	Cl: 104	CO <sup>2</sup> :	BUN:	Cr:
Ca: 9	Mg: 1.8	Phos: 2.5	Glucose: 55	HgA1C: 8.4%	
Hgb: 14	Hct: 45%	WBC:	MCV:	MCH:	MCHC:
PT: 12	PTT: 33	INR: 0.9	Troponin:	BNP:	
LDL: 154	HDL: 28	Chol: 210	Albumin: 3.7	Lactate:	
ABG---pH: 7.37	paO <sub>2</sub> : 82	paCO <sub>2</sub> : 38	HCO <sub>3</sub> /BE:	SaO <sub>2</sub> :	
Other:	Ammonia = 22		Amylase = 35		Lipase = 115

### E. Baseline Simulator/Standardized Patient State

1. Initial physical appearance					
Gender: Male		Attire: Personal clothes (Pants, T---shirt, shoes and socks)			
Alterations in appearance (moulage): Patient might present with some of the Whipple's triad (symptoms consistent with hypoglycemia that can be determined by measuring of low plasma glucose concentration, and that can be relieved when those levels are raised): behavioral changes, fatigue, altered consciousness, seizures, palpitations, tremors, anxiety, sweating, hunger, and/or altered sensations.					
	ID band present, accurate information		ID band present, inaccurate information	X	ID band absent or not applicable
	Allergy band present, accurate information		Allergy band present, inaccurate information	X	Allergy band absent or not applicable

2. Initial Vital Signs Monitor display in simulation action room:					
	No monitor display		Monitor on, but no data displayed	X	Monitor on, standard display

<b>BP:</b> 150/88	<b>HR:</b> 106	<b>RR:</b> 34	<b>T:</b> 37 (C)	<b>SpO<sub>2</sub>:</b> 98% (room air)
<b>CVP:</b>	<b>PAS:</b>	<b>PAD:</b>	<b>PCWP:</b>	<b>CO:</b>
<b>AIRWAY:</b>	<b>ETCO<sub>2</sub>:</b>	<b>FHR:</b>		
<b>Lungs:</b> Sounds	Left: Deep & rapid		Right: Deep & rapid	
Heart Sounds:	ECG rhythm:			
Bowel Sounds				



3. Initial Intravenous line set up						
	Saline lock #1	Site:				IV patent (Y/N)
	IV #1	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
	Main					
	Piggyback					
4. Initial Non---invasive monitors set up						
	NIBP			ECG First lead:		ECG Second lead:
X	Pulse oximeter	X		Temp monitor/type		Other:
5. Initial Hemodynamic monitors set up						
	A---line Site:			Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:
6. Other monitors/devices						
	Foley catheter		Amount:		Appearance of urine:	
	Epidural catheter		Infusion pump:		Pump settings: Primary Piggyback (2 <sup>nd</sup> channel)	
	Fetal Heart rate monitor/tocometer			Internal	External	
Environment, Equipment, Essential props						
Recommend standardized set ups for each commonly simulated environment						
1. Scenario setting: (example: patient room, home, ED, lobby)						
Scenario begins in lobby of clinic and moves into examination room.						
<b>Essential Props:</b>						
Chair(s)						
Registration slip/paperwork						
BP machine, Stethoscope(s), Pulse Oximeter						
Glucometer/Lancets, alcohol swabs, gloves						
Juice, Glucose Tablets, Glucagon Injection Pen Kit						
Educational Pamphlets: Glucagon Brochure –						
<a href="http://www.humalog.com/Documents/pdf/HI86519_Glucagon_Brochure.pdf">http://www.humalog.com/Documents/pdf/HI86519_Glucagon_Brochure.pdf</a>						

2. Equipment, supplies, monitors					
Bedpan/ Urinal		Foley catheter kit		Straight cath. kit	Incentive spirometer
IV Infusion pump		Feeding pump		Pressure bag	Wall suction
Nasogastric tube		ETT suction catheters		Oral suction catheters	Chest tube insertion kit
Defibrillator		Code Cart		12---lead ECG	Chest tube equip
PCA infusion pump		Epidural infusion pump		Central line Insertion Kit	Dressing Δ equipment
IV fluid Type:		IV fluid additives:			Blood product ABO Type: # of units:

3. Respiratory therapy equipment/devices					
Nasal cannula		Face tent		Simple Face Mask	Non re---breather mask
BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)	

4. Documentation and Order Forms					
Health Care Provider orders		Med Admin Record	X	H & P	Lab Results
Progress Notes		Graphic record		Anesthesia/PACU record	ED Record
Medication reconciliation		Transfer orders	X	Standing (protocol) orders	ICU flow sheet
X Nurses' Notes		Dx test reports		Code Record	Prenatal record
Actual medical record binder, constructed per institutional guidelines				Other Describe:	

5. Medications (to be available in sim action room)				
#	Medication	Dosage	Route	Glucagon Kit
15gm	Glucose Tablets	3 tablets	PO	1 vial (1 mg Glucagon, 49 mg lactose) 1 vial sterile diluent SQ or IM
15gm	Orange Juice	4 ounces	PO	



**CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES**

**Initiation of Scenario:** Medical Assistant (MA) meets patient in the lobby of the clinic and takes him back into an examination room in order to take his vital signs. Upon speaking with the patient and taking his VS, MA recognizes that the patient seems altered and believes something is wrong with the patient. MA relays this to primary RN, so that he/she can perform an assessment of the patient.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>1. Baseline</b></p> <p>Patient in high fowler's position, displaying improper body alignment.</p> <p>Patient disorientated, confused, and responds inappropriately to learner's questions.</p>	<p><b>Operator:</b></p> <p>BP – 150/88 HR – 106 RR – 34, deep &amp; rapid T – 37° C O<sub>2</sub> sat – 98% room air</p> <p><b>Triggers:</b> Learner will quickly recognize patient's distress</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Wash hands</li> <li>2. Introduce self and role</li> <li>3. Identify patient using 2 patient identifiers</li> <li>4. Assess physical status and vital signs</li> <li>5. Blood sugar finger stick</li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>• Universal protocol</li> <li>• Safety of patient to prevent falls</li> <li>• General survey and LOC assessment</li> <li>• Strategies for assessing blood sugar using glucometer</li> </ul>
<p><b>2. Assessment</b></p> <p>Patient continues to have poor body alignment. Responses from questions are still disorganized. Patient is noticeably diaphoretic. Patient rubs belly and grimaces</p> <p>States: "I wanna go to sleep on the sidewalk over here." and attempts to get off the exam table.</p> <p>Learner unable to get an accurate history from the patient due to altered mental status.</p>	<p><b>Operator:</b></p> <p>VS remain unchanged. RR may increase Patient's confusion increases</p> <p><b>Triggers:</b> Actions or time allotment to signal moving to next frame.</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Learner reorients the patient to his surroundings</li> <li>2. Review chart to determine patient history, prescriptions, dosages and any OTC use</li> <li>3. Ask patient what he was doing when symptoms started</li> <li>4. Assess for s/sxs of CVA (Symptoms onset, facial droop, slurred speech, palmer drift).</li> <li>5. Ask patient about use of alcohol or other substances</li> <li>6. Chart VSs, assessment findings and results from point-of-care testing</li> <li>7. Reports to physician using SBAR</li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>• Ongoing effort to keep patient safe and prevent falls</li> <li>• To get a complete history of ongoing illness and treatments</li> <li>• To rule out trauma</li> <li>• To rule out other potential causes of AMS (altered mental status)</li> <li>• To rule out other potential causes of AMS</li> <li>• Documentation of care</li> <li>• To assure that all relevant information is communicated to team members.</li> </ul>

STATE/Patient Status	Desired Actions and Triggers to move to the next state		
<p><b>3. Intervention</b></p> <p>Patient remains confused, diaphoretic, shaking, and nervous.</p>	<p><b>Operator:</b></p> <p>Vital signs remain about the same</p> <p><b>Triggers:</b> On reassessment, If blood sugar is less than 70 to 75 mg/dL.</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Assess <ul style="list-style-type: none"> <li>• patency of air way,</li> <li>• regularity of breathing,</li> <li>• O<sub>2</sub> Sats,</li> <li>• adequate circulation and</li> <li>• CNS (level of consciousness, strength and motion of extremities, and pupillary response)</li> <li>• Test patient's blood glucose level.</li> </ul> </li> <li>2. Intervene <ul style="list-style-type: none"> <li>• Provide a cup of milk, fruit juice, granola bar, or cheese and crackers.</li> </ul> </li> <li>3. Reassess <ul style="list-style-type: none"> <li>• Test blood glucose again after 15 minutes and treat again if less than 70 to 75 mg/dL.</li> </ul> </li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>• Documentation of care</li> <li>• Patient's response to treatment</li> <li>• Teach the patient and family members about detection, prevention, and treatment of hypoglycemia</li> </ul>
<p><b>Scenario End Point:</b></p> <p>Patient becomes alert &amp; oriented to his surroundings, his blood sugar returns to normal level (&gt;70 mg/dL), his pulse returns to normal (&lt;100), other signs &amp; symptoms of hypoglycemia resolve (i.e. diaphoresis, trembling, decreased LOC, etc). Patient is provided with education on hypoglycemia prevention, timing of diabetic medications and eating &amp; exercising, pathophysiology of diabetes &amp; action of insulin/metformin, early signs &amp; symptoms of hypoglycemia, and actions to take to treat early hypoglycemia in the future.</p>			



## APPENDIX A: HEALTH CARE PROVIDER ORDERS

<b>Patient Name: Jones, Joe</b>  <b>DOB: 09/15/1967</b>  <b>Age: 46</b>  <b>MR#: 013487459</b>		<b>Diagnosis: Type II Diabetes/Hypoglycemia</b>
No Known Allergies Allergies & Sensitivities: Penicillin (causes rash)		
<b>Date</b>	<b>Time</b>	<b>HEALTH CARE PROVIDER ORDERS AND SIGNATURE</b>
		<u>If patient unconscious (&amp; unable to take anything PO):</u> 50% Dextrose 25ml IV Push now D5W 125 ml/hr IV  Glucagon 1 mg IM or SC if IV access in not available  Check blood glucose after 15 minutes. Maintain blood glucose above 100 mg/dL, and administer the next meal as soon as possible.
<b>Signature</b>		

## APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
<input type="checkbox"/> Debriefing Guide	<input type="checkbox"/> Objectives	<input type="checkbox"/> Debriefing Points	<input type="checkbox"/> QSEN
QSEN Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Patient Centered Care	<input type="checkbox"/> Teamwork/Collaboration	<input type="checkbox"/> Evidence---based Practice	
<input type="checkbox"/> Safety	<input type="checkbox"/> Quality Improvement	<input type="checkbox"/> Informatics	
Sample Questions for Debriefing			
<ol style="list-style-type: none"> <li>1. How did the experience of caring for this patient feel for you and the team?</li> <li>2. Did you <del>have</del> have the knowledge and skills to meet the learning objectives of the scenario?</li> <li>3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?</li> <li>4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?</li> <li>5. How would you handle the scenario differently if you could?</li> <li>6. In what <del>ways</del> ways did you check feel the need to check ACCURACY of the data <del>you</del> you were given?</li> <li>7. In what ways did you perform well?</li> <li>8. What communication strategies did you use to validate ACCURACY of your information or decisions <del>with</del> with your team members?</li> <li>9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?</li> <li>10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?</li> <li>11. Discuss actual experiences with diverse patient populations.</li> <li>12. Discuss roles and responsibilities during a crisis.</li> <li>13. Discuss how current nursing practice continues to evolve in light of new evidence.</li> <li>14. Consider potential safety risks and how to avoid them.</li> <li>15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care.</li> </ol>			
<b>Notes for future sessions:</b>			