



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 (CVSC), 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.californiasimulationalliance.org

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 and click documents. (Please send signed I.P. release forms to KT at kt@cinhc.org)

TABLE OF CONTENTS

SECTION I SCENARIO OVERVIEW

- A. Title
- B. Summary
- C. Evidence Base

SECTION II CURRICULUM INTEGRATION

- A. Learning Objectives
 - 1. Primary
 - 2. Secondary
 - 3. Critical Elements
- B. Pre-scenario learner activities

SECTION III SCENARIO SCRIPT

- A. Case Summary
- B. Key Contextual Details
- C. Scenario Cast
- D. Patient/Client Profile
- E. Baseline patient/client simulator state
- F. Environment / equipment / essential props
- G. Case flow /triggers / scenario development

SECTION IV APPENDICES

- A. Health Care Provider Orders
- B. Digital Images of Manikin / Milieu
- C. Debriefing Guide

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Inferior wall MI → Code Blue post-smoke inhalation
Original Scenario Developer(s):	Dorothy Nunn, MSN & Amy Flock, RN
Date - original scenario	8/15/07
Validation:	9/15/07 Cynthia Reid, RN
Pilot testing:	9/28/07
Revisions:	9/29/07, 3/02/08, 4/15/11, 12/2014 Marjorie A. Miller, MA, RN, CHSE Melissa Punnoose, MSN, RN-BC, CHSE Heidi Traxler, MSN, RN, CHSE
<u>Estimated Scenario Time:</u>	20 minutes
<u>Debriefing time:</u>	40 minutes
<u>Target group:</u>	Advanced Medical Surgical Nursing students; New Grad Transition students, staff nurses, critical care teams
<u>Core case:</u>	smoke inhalation followed by new onset chest pain after admission leading to code blue
<u>Brief Summary of Case:</u>	<p><i>This is Case B, the second of 2 scenarios with this patient. Case A involves a new onset of chest pain, inferior wall MI and a transfer to telemetry; Case B involves to Vfib arrest with recovery.</i></p> <p>48 year old male patient is admitted to the hospital post smoke inhalation, received while performing duties as a fire fighter. Originally, he was on the medical floor but was transferred to the telemetry unit post chest pain and inferior wall MI. Due to his history, dehydration, and decreased oxygen from the smoke inhalation and now inferior wall MI, he will progress into Vfib necessitating a full code.</p> <p>Telemetry Care Unit; The patient's wife will come in during the scenario and may wear a wire for prompting by the Simulation faculty. Initiation of a code, BCLS/ACLS and communication with the code nurse is the focus of this scenario. The scenario will end after defibrillation and epi are administered for Vfib arrest and the rhythm is reestablished.</p>
<u>QSEN Competencies</u>	<p>X Patient Centered Care</p> <p>X Patient Safety</p> <p><input type="checkbox"/> Quality Improvement</p> <p>X Teamwork and Collaboration</p>

EVIDENCE BASE / REFERENCES (APA Format)

Ryland, P., Byrd MD, Mosenifar, Zab MD (2014). Respiratory Alkalosis Clinical Presentation. <i>Medscape</i> , Retrieved from http://emedicine.medscape.com/article
Deglin, J.H. & Vallerand, A.H. (2011) Davis Drug Guide for Nurses. Philadelphia
Berg, R.A., Hemphill, R., Abella, B. S., Aufderheide, T. P., Cave, D. M., Hazinski, M. F., Lerner, E. B., Rea, T. D., Sayre, M. R., and Swor, R. A. (2010). 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science. <i>Circulation</i> , 2010; 122, pp. s685-s705.
Dilansky M.A., Moore, S.M., (September 30, 2013) Quality and safety education for Nurses (QSEN) The Key is Systems Thinking. <i>Online Journal of Issues in Nursing</i> , 2013; Vol 18, No. 3, Manuscript 1.

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes
1. Provide patient care that promotes safety and minimizes risk of error.
2. Apply effective clinical decision making skills in changing situations.
3. Recognize and emergent situation and identify resources.
4. Communicate effectively with nursing and members of interprofessional team
Specific Learning Objectives
1. Apply principles of hand hygiene, infection control and personal protection.
2. Introduce self, colleagues and role to involve patient and family members in attendance.
3. Gather relevant patient assessment and contextual data to identify patient's current problem.
4. Recognize acute changes in patient condition that require immediate intervention.
5. Call for additional nursing and interprofessional assistance
7. Perform timely interventions to address urgent primary problems as they unfold.
8. Communicate effectively with patient's wife during acute situation.
9. Communicate effectively with team members using SBAR and closed loop communication.
10. Perform ACLS according to AHA guidelines
Critical Learner Actions
1. Perform hand hygiene; correctly identify patient; introduce selves and role.
2. Demonstrate focused cardiopulmonary assessment; assess vital signs; O ² sats; check IV patency
3. Rapid identification of unresponsive patient, calls for help immediately.
4. Call Code; initiate BLS/ACLS
5. Discontinue Nitroglycerine drip and IV with KCl; initiate normal saline
6. Communicate clearly utilizing Team STEPPS procedures
7. Assign one staff to keep family member aware of changing situations.

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies	
Knowledge	Skills/ Attitudes
<input type="checkbox"/> Pathophysiology of ACS; chest pain protocols	<input type="checkbox"/> Pain Assessment (PQRST); differentiation
<input type="checkbox"/> Focused cardiopulmonary assessment	<input type="checkbox"/> Determining significance of change in status
<input type="checkbox"/> Pharmacology of nitroglycerine, KCl	<input type="checkbox"/> Therapeutic communication in acute situations
<input type="checkbox"/> Current National Patient Safety Goals	<input type="checkbox"/> BCLS/ACLS protocols
<input type="checkbox"/> Structured Communication Tools (SBAR)	<input type="checkbox"/> Discontinuing unsafe meds; initiating fluids
<input type="checkbox"/> Legal aspects of taking telephone orders	<input type="checkbox"/> Interprofessional communication; Team STEPPS
<input type="checkbox"/>	<input type="checkbox"/> Management of environment to maintain safety

SECTION III: SCENARIO SCRIPT

A. Case summary

48 year old male patient is admitted to the hospital post smoke inhalation, received while performing duties as a fire fighter. Originally, he was on the medical floor but was transferred to the telemetry unit post chest pain and 12L EKG showing inferior wall MI. He has a wife who will come in during the scenario. Due to his history, dehydration, and decreased oxygen from the smoke inhalation he will proceed while on the unit to code. In this scenario he continues to evolve into Vfib necessitating a full code. Learners are expected to assess the patient, recognize the change in patient's VS followed by Vfib Code; call the Code, perform BCLS/ACLS and communicate to Code Team. Team Leader should assign tasks to include communication with wife during scenario. Team STEPPS protocols should be utilized in situation monitoring.

B. Key contextual details

Medical/Surgical unit. Telemetry Care Unit; The patient's wife will come in during the scenario and may be wired for prompting by the Simulation faculty. Initiation of a code, BCLS/ACLS and communication with the code blue nurse is the focus of this scenario. The scenario will end when the team defibrillates and gives epi for Vfib and the rhythm and level of consciousness is reestablished.

C. Scenario Cast

Patient/ Client	<input checked="" type="checkbox"/> High fidelity simulator	
	<input type="checkbox"/> Mid-level simulator	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input type="checkbox"/> Standardized patient	
Role	Brief Descriptor (Optional)	Confederate/Actor (C/A) or Learner (L)
Primary RN		Learner
Secondary nurse	Comes in if called	Learner
Wife	Comes in after hearing a code called for her husband's room. Is very upset and frightened but responds to nursing communication.	Actor (wired)
Rapid Response or Code Team	Evaluates code progression. Receives SBAR and initiates ACLS. Administers atropine for bradycardia with patient response to end scenario	Actor – clinical faculty of subject matter expert
Respiratory Therapist	Comes in after hearing a code called, sets up Ambu bag if not already done, bags pt. with 100% O ₂ .	Actor or another learner with ACLS background

D. Patient/Client Profile				
Last name:	Jones		First name:	Robert
Gender: Male	Age: 48	Ht: 5'9"	Wt: 200#	Code Status: Full
Spiritual Practice: Christian	Ethnicity: Caucasian		Primary Language spoken: English	
1. Past history				
<p>Robert Jones, is a mildly obese (BMI 29.5) 48 year old white male, admitted to the medical-surgical floor for dehydration and smoke inhalation, developed while fighting a house fire. Mr. Jones (Bob) became dizzy, fatigued and short of breath. Fire chief referred the patient to the hospital for check-up.</p> <p>On arrival to the ED, he was alert and oriented with a slight, dry cough and no complaints of pain.</p> <p>VS: T. 37.8 C° (100°F.), P 120, RR 32. BP 102/62, O² Sats - 92% on 2LNC</p>				
Primary Medical Diagnosis	Dehydration, Smoke Inhalation,			

2. Review of Systems	
CNS	Alert and oriented; PERL, denies syncope or seizures, weakness or tremors, no recent memory problems, depression or mood changes. Visual acuity is intact.
Cardiovascular	Sinus tachycardia @ 120; no murmurs, thrills or ectopy . B/P 102/62; denies chest pain. Denies orthopnea. In Part A of scenario had inferior wall MI
Pulmonary	Smoker 30 pack years. RR-32, O ² sats 92% @ 2L /NC. c/o shortness of breath. Breath sounds: I/E wheezes throughout all lung fields, RR 20, occasional non-productive cough and no hemoptysis.
Renal/Hepatic	Voiding concentrated urine, no pain, frequency or nocturia; no liver tenderness or enlargement
Gastrointestinal	No abnormalities
Endocrine	Normal middle-aged male; no diabetes or other endocrine disease
Heme/Coag	No abnormalities
Musculoskeletal	Walking-gait with good balance.
Integument	Clear and intact.
Developmental Hx	Within normal limits
Psychiatric Hx	None reported
Social Hx	Married firefighter lives with wife of 20 + years
Alternative/ Complementary Medicine Hx	None reported

Medication allergies:	Morphine	Reaction:	Total body rash, dyspnea
Food/other allergies:	None known	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Lipitor	20 mg	PO	Every night at bedtime
	ASA	325 mg	PO	Daily
	Multivitamin	1 cap	PO	Daily

4. Laboratory, Diagnostic Study Results					
Na: 145	K: 4.0	Cl: 102	HCO ₃ : 24	BUN: 32	Cr: 1.8
Ca:	Mg:	Phos:	Glucose: 90	HgA1C:	
Hgb: 16.2	Hct: 47	Plt: 325	WBC: 12.3	ABO Blood Type:	
PT	PTT	INR	Troponin:	BNP:	
ABG-pH: 7.35	paO ₂ : 89%	paCO ₂ : 42	HCO ₃ /BE: 33/2	SaO ₂ :	
VDRL:	GBS:	Herpes:	HIV:		
CXR:	ECG:				

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)			
1. Initial physical appearance			
Gender: Male		Attire: Hospital gown	
<u>Alterations in appearance (moulage):</u> Grey mustache, black/gray wig			
X	ID band present, accurate	ID band present, inaccurate	ID band absent or not applicable
X	Allergy band present, accurate	Allergy band inaccurate	Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room:					
No monitor display		Monitor on, but no data displayed		X Monitor on, data displayed	
BP: 152/92	HR: 92	RR: 20	T: 100 F	SpO ₂ : 94%	
CVP:	PAS:	PAD:	PCWP:	CO:	
AIRWAY:	ETCO ₂ :	FHR:			
Lungs: Sounds/mechanics	Left: I/E wheezes throughout	Right: I/E wheezes throughout			
Heart:	Sounds:	S ¹ , S ²			
	ECG rhythm:	Sinus tachycardia			
	12 lead from MS floor	Inferior wall MI			
Bowel sounds:	Active bowel sounds x 4			Other:	

3. Initial Intravenous line set up						
	Saline lock #1	Site :			IV patent (Y/N)	
X	IV #1	Site :		Fluid type: D5/0.45 NS w/20 mEq KCl	Initial rate: 125 mL/hour	IV patent (Y/N)
X	Main Piggyback	RA				
X	IV #2	Site :		Fluid type: Nitro 50 mg in 250 mL D5W	Initial rate: 15 mL/hour	IV patent (Y/N)
	Main concurrent	RA				
4. Initial Non-invasive monitors set up						
X	NIBP		X	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: agency pump		Pump settings: 125 mL/hr.
						.
Environment, Equipment, Essential props						
1. Scenario setting: (example: patient room, home, ED, lobby)						
Telemetry Unit						

2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)						
X	Bedpan/ Urinal	X	Foley catheter kit	X	Straight cath. kit	x Incentive spirometer
X	IV Infusion pump		Feeding pump		Pressure bag	X Wall suction
	Nasogastric tube		ETT suction catheters	X	Oral suction catheters	Chest tube kit
X	Defibrillator	X	Code Cart	X	12-lead ECG	Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit	Dressing Δ equipment
	IV fluid Type:	D5/0.45 NS w/20 mEq KCl	IV fluid additives:		IV Piggy back	Blood product ABO Type: # of units:

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

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

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route
2	Lipitor	20 mg	Oral		1	Nitroglycerine drip	50 mg/250 mL D5W	IV concurrently
2	ASA	325 mg	Oral		1	Epi	1 mg	IVP
1	Albuterol	2.5 mg	Nebulizer Available in RT's coat					

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario : (Shift Report @ 0700)			
Learners hear “hand-off” report from learners in previous scenario. The learners in the scenario are given the chart after report and sent into the room to begin their assessment and care for the patient. Mr. Jones is alert and responsive, cooperative and agrees to have 2 nurses care for him. He is currently pain free on a Nitroglycerine drip. Wife has gone to get coffee for a few minutes.			
STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
1. Baseline Awake, alert and oriented X3. No complaints of chest pain c/o dry cough Sitting upright with O ² @ 2L/nc Responsive to questions Male voice; dry cough	Operator Gradually begin to drop the heart rate to 90, O2 sat to 90% and RR to 12 during assessment Monitor w/ VS: HR – 82, NSR RR – 20, O ₂ Sat- 96% on 2L/nc BP - 138/80 (standby) T - 37.6° C, 99.7°F. BP via NBP & T. is on standby Breath sounds: End expiratory wheezes bilaterally. Trigger: Learners perform initial assessment and actions within 2-3 minutes	Learner Actions 1. Performs hand hygiene. 2. Introduce selves and role 3. Identify patient using 2 patient identifiers 4. Engage patient in plan of care 5. Start initial assessment 6. Check IV for patency, accuracy 7. Responds to patient concerns 8. Check timing of last Albuterol treatment	Debriefing Points: 1. NPSG to minimize risk of error and infection 2. Components of focused cardiopulmonary assessment 3. Pharmacology – expected effects and side effects of Nitroglycerine 4. Strategies for engaging patient in plan of care 5. Strategies for minimizing patient anxiety regarding transfer to higher level of care 6. Division of tasks (check chart for lab results; etc.)

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2.</p> <p>Patient becomes non-responsive.</p> <p>Does not respond to shake and shout.</p> <p>Cue: If learners do not call a code, wife will enter room and excitedly draw attention to the fact that patient is not breathing.</p>	<p>Operator:</p> <p>Rhythm: effective CPR</p> <p>pulse - 0</p> <p>RR - 0</p> <p>O₂ Sat – unable to obtain</p> <p>BP - 0</p> <p>Triggers:</p> <p>Code called</p> <p>BLS initiated</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Assess no pulse, no respiratory rate 2. Call Code 3. initiate BCLS <ol style="list-style-type: none"> a. open airway b. begin CPR c. crash cart available d. place backboard e. Identify scribe 4. turn off Nitroglycerine drip 5. DC IV with KCl 6. Start NS IV fast rate 7. O₂@15L w/ Ambu resuscitation 8. Call out status/ activities 9. One person assigned to wife 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Identification of a code blue by determining no RR, no pulse 2. Components of teamwork & communication in rapidly deteriorating situations 3. Strategies for assuring all important assessments/ interventions are completed and not duplicated 4. BCLS/ACLS Protocols 5. Rationale for changing IV's – stopping nitroglycerine, changing to NS at rapid rate 6. Division of tasks and feedback from team – <i>Team STEPPS</i> 7. Role of nurse in charge of status communication with family member

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3.</p> <p>Pt. remains non-responsive</p>	<p>Operator:</p> <p>RT arrives to help with airway management Code RN arrives (checks previously done EKG)</p> <p>HR 0 RR 0 O₂ Sat 96% BP absent</p> <p>Triggers: Learner actions completed within 8-10 minutes</p> <p>Code MD or ICU RN orders (code leader): We have identified the rhythm as Vfib so let's shock now and immediately continue CPR Then give Epi 1 mg IVP now</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Give brief SBAR to rapid response nurse/Code Team 2. Identify rhythm as V-fib on defibrillator monitor 3. Work as a team to perform ACLS according to AHA. 4. Assure IV patency- NS at rapid rate 5. Adm shock then Epi 1 mg IV push per ACLS protocol 6. Reassess rhythm and pulse 7. Acknowledge wife's presence and realistically comfort, determine if she will stay in the room. 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Strategies for managing stress in escalating situations 2. ACLS protocol for Vfib 3. Teamwork before and after the code team arrives 4. Pastoral care for wife's support 5. Strategies for dealing with family in room during resuscitation efforts 6. Discussion about family in room during resuscitation efforts

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>Pt. begins to respond with a moan</p> <p>HR 54 RR 12 O₂ Sat 90% BP 96/66</p>	<p>Operator:</p> <p>Change – continued gradual improvement in vital signs over 2 minutes</p> <p>HR 62 RR 20 O₂ Sat 93% BP 108/72</p> <p>Triggers: Learner actions completed within 5 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Stop CPR with patient moan 2. Check ABCs, Repeat VS, 3. Focused assessment: LOC, Neuro, Cardio-pulmonary 4. Administer O₂ 6L by mask 5. Respond to patient’s questions <p>Code blue nurse: support nurses, call provider for ICU transfer orders Order Stat EKG Chem panel with Mg</p>	<p>Debriefing Points</p> <ol style="list-style-type: none"> 1. Transition steps from code once pt. responds to treatment 2. Strategies for debriefing critical incident and returning to patient care.
Scenario End Point: Rapid Response Nurse relieves nursing team			
<p>Suggestions to <u>decrease</u> complexity: Patient does not code, but instead becomes bradycardic requiring the administration of atropine</p> <p>Suggestions to <u>increase</u> complexity: Learners required to initiate Nitro drip; patient code requires 2 rounds of defibrillation and epi</p>			

Signature	
------------------	--

APPENDIX B: Digital images of manikin and/or scenario milieu	
<p>Insert digital photo here</p>	<p>Insert digital photo here</p>
<p>Insert digital photo here</p>	<p>Insert digital photo here</p>

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"> 1. How did the experience of caring for this patient feel for you and the team? 2. Did you have the knowledge and skills to meet the learning objectives of the scenario? 3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience? 4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP? 5. How would you handle the scenario differently if you could? 6. In what ways did you check feel the need to check ACCURACY of the data you were given? 7. In what ways did you perform well? 8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members? 9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting? 10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome? 11. Discuss actual experiences with diverse patient populations. 12. Discuss roles and responsibilities during a crisis. 13. Discuss how current nursing practice continues to evolve in light of new evidence. 14. Consider potential safety risks and how to avoid them. 15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care. 			
Notes for future sessions:			

