

SECTION I: SCENARIO OVERVIEW

Scenario Title:	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 Pagsuyu, RN; Kate Pisani, RN; Patricia White, RN	
Date - original scenario	12/2/13	
Validation:	01/30/14	
Revision Dates:	10/30/14, 4/30/18 (NParker)	
Pilot testing:	01/30/14	
<p>Estimated Scenario Time: 10-15 minutes Debriefing time: 10 minutes</p> <p>Target group: Pre-licensure nursing students, post Licensure Transition RNs</p> <p>Core case: Nursing Fundamentals: General assessment of a patient, recognition of signs & symptoms of hypoglycemia, implementation of nursing interventions</p> <p>QSEN Competencies: Patient-Centered Care, Teamwork & Collaboration, Safety</p> <p>Brief Summary of Case: 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 and HTN that has been managed by medication management and exercise. 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.</p>		

EVIDENCE BASE / REFERENCES (APA Format)
Service, J. F. & Vella A. (2018). Hypoglycemia in adults without diabetes mellitus: Diagnostic approach. (I. B. Hirsch, Ed.) Retrieved April 17, 2018 from Up-To-Date: http://www.uptodate.com/contents/hypoglycemia-in-adults-without-diabetes-mellitus-diagnostic-approach
Service, M. P., Cryer, P. E. & Vella, A. (2018). Hypoglycemia in adults: Clinical manifestations, definition, and causes. (I.B. Hirsch, Ed.) Retrieved April 17, 2018, from Up-To-Date: http://www.uptodate.com/contents/hypoglycemia-in-adults-clinical-manifestations-definition-and-causes
American Diabetes Association (July 1, 2015). Hypoglycemia (low blood glucose). Retrieved April 17, 2018 from: http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/hypoglycemia-low-blood.html
Joslin Diabetes Center (2018). How to Treat a Low Blood Glucose. Retrieved April 17, 2018 from: http://www.joslin.org/nfo/how_to_treat_a_low_blood_glucose.html
Joslin Diabetes Center and Joslin Clinic (October 18, 2016). Clinical guideline for pharmaceutical management of adults with type 2 diabetes. Retrieved April 17, 2018 from: http://www.joslin.org/docs/Pharma_Guidelines_10082016.pdf , eli Lilly Humalog (5/17)
Treating Severe Low Blood Glucose. Retrieved 4/17/18 http://www.lillyglucagon.com

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
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).
Specific Learning Objectives
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)
Critical Learner Actions
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. Identify potential infectious disease, implement assessment and precautions to prevent spread

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

SECTION III: SCENARIO SCRIPT

A. Case summary
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

B. Key contextual details
<p>Upon entering the room, the nurse finds the patient slumped in his chair with partner in a panic and stating they are not feeling well either. 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.</p>

C. Scenario Cast		
Patient/ Client	<input type="checkbox"/> High fidelity simulator <input type="checkbox"/> Mid-level simulator <input type="checkbox"/> Task trainer <input type="checkbox"/> Hybrid (Blended simulator) <input checked="" type="checkbox"/> Standardized patient	
Role	Brief Descriptor (Optional)	Standardized participant (SP) or Learner (L)
1. Mr. Jones	Patient who presents to the clinic	Either
2. Medical Assistant	Checks VS and reports abnormal findings to RN	Either
3. Primary RN	RN who first interacts & assesses patient	Either
4. Secondary RN	RN available to assist primary RN as needed	Either
5. Provider	MD/NP/PA at clinic	Either

D. Patient/Client Profile			
Last name:	Jones	First name:	Joe
Gender: Male	Age: 46	Ht:	Wt:
Spiritual Practice:	Ethnicity:	Primary Language spoken:	
1. History of present illness			
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. Accompanied by his partner.			
Primary Medical Diagnosis			

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 ² :	BUN:	Cr:
Ca: 9	Mg: 1.8	Phos: 2.5	Glucose: 206	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:	paO ₂ :	paCO ₂ :	HCO ₃ /BE:	SaO ₂ :	
AST:	ALT:	Herpes:	HIV:	Total Proteins:	
CXR:		ECG:			
CT:		MRI:			
Other: Ammonia = 22, Amylase = 35, Lipase = 115					

E. Baseline Simulator/Standardized Patient State
(This may vary from the baseline data provided to learners)

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		
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BP: 150/88	HR: 106	RR: 34	T: 37 (C)	SpO₂: 98% (RA)
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETCO ₂ :	FHR:		
Lungs: Sounds/mechanics	Left: Shallow & rapid		Right: Shallow & rapid	
Heart:	Sounds:			
	ECG rhythm:			
	Other:			
Bowel sounds:				Other:

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					
	IV #2	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 nd channel)		
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.						
Essential Props:						
Chair(s)						
Registration slip/paperwork						
BP machine						
Stethoscope(s)						
Pulse Oximeter						
Glucometer/Lancets						
alcohol swabs						
gloves						
Juice, Glucose Tablets or Glucose Gel, Glucagon Injection Pen Kit						
Educational Pamphlets http://main.diabetes.org/dforg/pdfs/2017/2017-cg-blood-glucose-products.pdf						
Glucagon Brochure http://pi.lilly.com/us/rglucagon-ppi.pdf						

2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)							
	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		#	Medication	Dosage	Route
15gm	Glucose Tablets	3 tablets	PO					
15gm	or Glucose Gel	15 gm + from supplied tube	PO					
15gm	Orange Juice	4 ounces	PO					
1 Kit	Glucagon Kit	1 vial (1 mg Glucagon, 49 mg lactose) and 1 vial sterile diluent	SQ or IM					

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>1. Baseline</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>Operator:</p> <p>BP – 150/88 HR – 106 RR – 34, shallow & rapid T – 37° C O₂ sat – 98% room air</p> <p>Triggers: Learner will quickly recognize patient's distress and discomfort.</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Wash hands or use hand gel 2. Introduce self and role 3. Identify patient using 2 patient identifiers 4. Assess physical status and vital signs 5. Blood sugar finger stick 	<p>Debriefing Points:</p> <p>Universal protocol</p> <p>Safety of patient to prevent falls</p> <p>General survey and LOC assessment</p> <p>Strategies for assessing blood sugar using glucometer</p>
STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2. Assessment</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>Operator:</p> <p>VSs remain unchanged. RR may increase and patient's confusion increase</p> <p>Triggers: Actions or time allotment to signal moving to next frame.</p>	<p>Learner Actions:</p> <ul style="list-style-type: none"> • Learner reorients the patient to his surroundings • Review chart to determine patient history • Get list of prescriptions, dosages and any OTC use • Asks patient what he was doing when symptoms started • Assess for s/sx of CVA (Symptoms onset, facial droop, slurred speech, palmer drift). • Asks patient about use of alcohol or other substances • Charts VS, assessment findings and results from point-of-care testing • Gives report to the Provider responsible for this patient using SBAR 	<p>Debriefing Points:</p> <ul style="list-style-type: none"> • Patient Safety • Patient Centered Care/Safety • Differential: Rule out trauma and other causes of AMS • Documentation of care • To assure all information is communicated to other team members

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3. Intervention</p> <p>Patient remains confused, diaphoretic, shaking, and nervous.</p>	<p>Operator:</p> <p>Assess patency of air way, regularity of breathing, O2 SAT, adequate circulation and CNS (level of consciousness, strength and motion of extremities, and pupillary response) Assess ability to swallow Test patient's blood glucose level.</p> <p>Triggers: If blood sugar is less than 70 to 75 mg/dL.</p> <p>Reassess patient responsiveness and appropriateness at 15 min. intervals</p> <p>Confirm patient ID prior to medication administration.</p>	<p>Learner Actions:</p> <p>If able to swallow sips of water, provides a cup of fruit juice, 15 gm glucose tablets or 15+gm glucose gel (depending on product) .</p> <p>Tests blood glucose again after 15 minutes and treat again if less than 70 to 75 mg/dL.</p> <p>RN determines that patient not competent to swallow and calls for another RN to bring emergency DM treatment box to room and to alert Provider.</p> <p>If unable to swallow or glucose does not respond, administers Glucagon IM</p> <p>Tests blood glucose again after 15 minutes and treat again if less than 70 to 75 mg/dL.</p> <p>Confirms patient ID prior to medication delivery Considers ID banding patient in case patient worsens and is unable to confirm identity.</p>	<p>Debriefing Points:</p> <p>Documentation of care Patient's response to treatment Teach the patient and family members about detection, prevention, and treatment of hypoglycemia</p> <p>Discuss 15-15 Rule in hypoglycemia care.</p> <p>Maintain safety of patient by assuring patient is not left alone and patient ID is confirmed.</p> <p>If patient not competent, method of ID confirmation must be modified.</p>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4. Follow-up</p> <p>Patient begins to relax and becomes alert and oriented</p>	<p>Operator:</p> <p>Takes VS, tests patient's blood glucose, assesses LOC</p> <p>Triggers:</p> <p>A&Ox3 Blood Glucose - 80 mg/dL BP – 145/85 HR – 98 RR – 22 T – 37o C O2 sat – 98% RA</p>	<p>Learner Actions:</p> <ul style="list-style-type: none"> Assesses and document patient's response to intervention – takes VS, blood glucose, LO Asks patient more thorough history leading up to this incident of hypoglycemia (meals, medication, exercise, alcohol, stress, sleep) Assesses patient's level of knowledge, understanding, and acceptance of Type II Diabetes and management of blood glucose levels Provides patient education and materials to take home Confirms patient's timing of next meal. Confirms next appt. is scheduled and if Diabetes Educator's visit is indicated. Instructs how to obtain Medical Alert bracelet/necklace if patient does not already wear 	<p>Debriefing Points:</p> <p>Documentation of care</p> <p>Risk factors for hypoglycemia</p> <p>Strategies for valuing and utilizing patient's expertise and control over own health and symptoms</p> <p>Provide patient tools and reminders for home self care</p> <p>Patient understands the importance of meal timing and meds.</p> <p>Provides guidance for ongoing patient safety</p>
<p>Scenario End Point:</p> <p>Patient becomes alert & oriented to his surroundings, his blood sugar returns to normal level (>70 mg/dL), his pulse returns to normal (<100), other signs & symptoms of hypoglycemia resolve (i.e. diaphoresis, trembling, decreased LOC, etc). Patient is provided with education on hypoglycemia</p>			
<p>Suggestions to <u>decrease</u> complexity (simple simulation): Patient recognizes own dropping blood glucose & describes situation to MA & RN. Pt. carries Glucose tablets with them. Glucose tabs or gel are stocked in the clinic. Standing Orders: 1) 15 gm. Glucose gel or tabs if RBS less than 70 and patient able to swallow. 2) Glucagon 1 mg. IM or SQ if RBS less than 70 and unable to take po.</p> <p>Suggestions to <u>increase</u> complexity (more complicated simulation): Nurse assesses client's family member appears pale, diaphoretic, weak as well. Nurse will obtain help from second nurse to attend to family member. As second nurse interviews client's family member it is found out that they have been running a fever for the past 24 hours, have had a severe sore throat, has felt tired and somewhat nauseated. Nurse will have to determine how to address family members illness while maintaining standards for infection prevention for strep throat. Consider patient masking if patient is coughing during oral exam unless the patient's respiratory status is compromised.</p> <p>http://www.cdc.gov/features/strepthroat/ http://www.nlm.nih.gov/medlineplus/ency/article/000639.htm http://www.healthline.com/health/strep-throat#RecommendedforYou7</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Jones, Joe DOB: 09/15/1967 Age: 46 MR#: 013487459		Diagnosis: Type II Diabetes/Hypoglycemia
† No Known Allergies † Allergies & Sensitivities: Penicillin (causes rash)		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		<u>If patient unconscious (& 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.
Signature		

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
<input checked="" 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 checked="" type="checkbox"/> Patient Centered Care	<input checked="" type="checkbox"/> Teamwork/Collaboration	<input checked="" type="checkbox"/> Evidence-based Practice	
<input checked="" 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 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			