SECTION I: SCENARIO OVERVIEW

Scenario Title:	Sepsis Meningitis 8-year-old _Case B – AACN Essentials
Original Scenario Developer(s):	Solakian, M., MSN, RN, CPNP; Nevins, C., DNP, RN, CNE; Altamira, JV, BSN
Date - original scenario	06/11
Validation:	05/17
Pilot testing:	06/17, 07/ 2017
Revisions:	08/24 L. Catron, DNP, M.A.ED, BSN, RN, CHSE

Estimated Scenario Time 15-20 minutes	Debriefing Time 30-40 minutes

Target group: Pre-licensure nursing students in their Pediatric or critical care rotation

Core case: 8-year-old with sepsis secondary to meningitis with emergent admission via ER requiring care in the pediatric intensive care unit.

Brief Summary of Case: 8-year-old female patient presented in the ER with 4-day history of high fever (39.4-40 °C) and rash for 24 hours. The rash started yesterday on the trunk, arms, and legs. The rash is rapidly coalescing and becoming dark purple in color, resembling purpura. Patient was treated at home with antipyretics (Motrin suspension 20mg/kg every 4 hours) and cooling measures which failed to reduce the fever. Patient is irritable and lethargic.

Signs and symptoms are correlated with possible meningococcal meningitis. The primary diagnosis is sepsis, and signs and symptoms are consistent with septic shock. Treatment initiated for the underlying infection and hypotensive distributive shock. Treatments include: rapid assessment of the patient, fever management, intravenous fluid resuscitation (bolus), antibiotic therapy, and establishing Isolation ("droplet") precaution and vasopressor medications.

Other: *This scenario is appropriate for undergraduate nursing students in their pediatric rotation or new graduates. Complexity can be adjusted to level and needs of the learner.*

EVIDENCE BASE / REFERENCES (APA Format)

Center for Disease Control. (2020). CDC sequence for donning personal protective equipment (PPE). https://www.youtube.com/watch?v=1xy00pLT9M4

Cummings, B. M. (2024). *Treatment of Sepsis and Septic Shock in Children*. Medscape. https://emedicine.medscape.com/article/2072410-overview?form=fpf

Cruz, A. T., Lane, R. D., Balamuth, F., Aronson, P. L., Ashby, D. W., Neuman, M. I., Souganidis, E. S., Alpern, E. R., & Schlapbach, L. J. (2020). Updates on pediatric sepsis. *Journal of American College of Emergency Physicians Open, 1*(5), 981-993. https://doi.org/10.1002/emp2.12173

Hazinski, M. F. (2013). Nursing care of the critically ill child, 3rd Edition, St. Louis Missouri: Elsevier.

Mathias, B., Mira, J., & Larson, S.D. (2016). Pediatric sepsis. Current Opinion in Pediatrics, 28(3), 380-387. https://doi.org/10.1097/MOP.0000000000000337

Perry, S. E., Hockenberry, M. J. Cashion, K, Alden, K, R., Olshansky, E., & Lowdermilk, D. L. (2022). Maternal child nursing care (7th ed.). Mosby.

Pomerantz, W. J. (2024). *Children at risk for sepsis and septic shock in resource-abundant settings: Rapid recognition and initial resuscitation (first hour).* UpToDate. https://www.uptodate.com/contents/children-with-early-and-life-threatening-sepsis-in-resource-abundant-settings-rapid-recognition-and-initial-resuscitation-first-hour

Society of Critical Care Medicine. (2020). Surviving sepsis campaign pediatric patients. https://www.sccm.org/SurvivingSepsisCampaign/Guidelines/Pediatric-Patients

SECTION I: SCENARIO OVERVIEW

Society of Critical Care Medicine. (2020). Initial resuscitation algorithm for children. Society of Critical Care Medicine and the European Society of Intensive Care Medicine. https://www.sccm.org/sccm/media/ssc/Initial-Resuscitation-Algorithm-for-Children.pdf
Stanford Medicine. (2024). Meningococcal infections in children. Children's health. https://www.stanfordchildrens.org/en/topic/default?id=meningococcal-infections-in-children-90-P02529

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Recognize and identify the pediatric patient with signs and symptoms of septic shock.
2. Apply decision making skills for appropriate fluid resuscitation to pediatric patients exhibiting hypotensive, distributive shock based on physical assessment findings and the guidelines for pediatric sepsis.
3. Prioritize assessment and interventions to assure safe, effective outcomes of care.
4. Communicate using closed loop methods within the healthcare team.
Specific Learning Objectives
1. Complete a comprehensive initial assessment and focused patient reassessment.
2. Demonstrate critical thinking with prioritization of care & clinical reasoning with patient interventions.
3. Apply evidence based practice guidelines for the assessment and delivery of care for patients with sepsis.
Critical Learner Actions
1. WII: wash hands, introduce self, identify patient
2. Perform focused and comprehensive assessments: Vital Signs, and reassessment after providing treatment.
3. Recognize signs of shock based on evaluation of vital signs, decreased level of consciousness, poor peripheral perfusion and response to fluid resuscitation.
4. Assess parent's willingness to learn and initiate discussion about central line infection, and over dosage of home Motrin.
5. Communicate with healthcare team members including physician, charge nurse or pharmacist.
6. Administer medications safely, including rapid administration of fluid bolus, antibiotic and antipyretic.
7. Recognize the difference between IV fluid resuscitation (bolus) and IV fluid maintenance.
8. Wear the appropriate personal protective equipment (PPE) for Droplet & Contact Precautions.
9. Re-assess and evaluate patient following interventions, recognizing core measures for sepsis.

AACN Essential Learner Activities Based on Learning Objectives & Actions	
Domain	**Sub competencies**
1 Knowledge for Nursing Practice	1.2a; 1.2e; 1.3a; 1.3b
2 Person-Centered Care	2.1; 2.2; 2.3a-g; 2.4; 2.5a-e; 2.6c; 2.7a; 2.7b; 2.8b; 2.8c; 2.9e;
4 Scholarship for the Nursing Discipline	4.2c
5 Quality and Safety	5.1b; 5.1c; 5.2c; 5.2f
6 Interprofessional Partnerships	6.1b; 6.1e; 6.2c; 6.3b; 6.3c

State or Regional Core Tenet Learner Activities

QSEN Competencies	
☐ Patient Centered Care	☐ Teamwork and Collaboration
☐ Patient Safety	☐ Informatics
☐ Evidence Based Practice	☐ Quality Improvement

SECTION II: CURRICULUM INTEGRATION

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies	
Knowledge	**Skills/ Attitudes**
❑ Care of the child with sepsis or meningitis.	❑ Teamwork and Collaboration
❑ Developmental Level and Growth Ratio	❑ Safety
❑ Therapeutic Communication with parent of a critically ill child.	❑ Administration of vasopressor medication to support blood pressure.
❑ Nursing process	❑ IV Fluid and antibiotic administration
❑ Pathophysiology of meningitis and sepsis	❑ Administration of suppository medication
❑ Structured communication using SBAR	❑ Professionalism

SECTION III: SCENARIO SCRIPT

A. Case summary
History of Present Illness: 8-year old female with 3-day history of high fever 39.4-40 °C and rash for 24 hours. Parents brought their child today to the Emergency Room for evaluation. Parents report 3day prior history of upper respiratory symptoms, diarrhea, vomiting and cough. The rapid onset of rash to the trunk, arms and legs started yesterday. The rash is rapidly coalescing and becoming dark purple in color, resembling purpura. Patient is irritable. Parents provided antipyretics (Motrin suspension 20 mg/kg every 4 hours) and cooling measures, which failed to reduce the fever. PMH: Significant for prematurity, born at 32-week gestation, was intubated for 3 weeks and developed Necrotizing Enterocolitis at 2 weeks of age with 50% of jejunum small bowel resected. A Port-a-Cath is placed in left, upper chest to provide nightly TPN infusions. G-tube Mickey placed at 6 months of age, and used for supplemental feedings and medications.

B. Key contextual details
Child brought to the Emergency Room by parents after 3-day history of high fever and rash. Signs and symptoms are correlated with sepsis and probable meningitis. Initial treatment is to prevent sepsis shock. Treatment to implement includes fever management, intravenous fluid resuscitation (bolus), intravenous fluid maintenance, antibiotic therapy, initiation of vasopressors to improve hypotension and follow "droplet" precautions demonstrating the use of PPE. **Immunizations:** Not up-to-date: Influenza, Rotovirus, Prevnar, MMR. Received: Hepatitis B vaccine at birth, DTaP at 2 and 5 months

C. Scenario Cast		
Patient/ Client	❑ High fidelity simulator	
	✓ Mid-level simulator (Mega-code Kid) with Sim Pad	
	❑ Task trainer	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
Team Leader	Oversees and guides care; communicates with healthcare team	L
Primary Nurse	Performs Physical Assessment	L
Nurse Interventionist	Administers Medications	L
Recorder	Delivers SBAR Report	L
Charge Nurse/Physician	Support participants as needed	SP
Parent	At bedside	SP

D. Patient/Client Profile				
Last name: Dott	First name: Katie Scarlett			
Gender: F	Age: 8	Ht: 48 in	Wt: 20 kg	Code Status: Full
Spiritual Practice: Catholic	Ethnicity: Caucasian			Primary Language spoken: English

1. Past history

Chief Complaint: High fever and rash

History of Present Illness: 8-year old female with 3-day history of high fever 39.4-40 °C and rash for 24 hours. Parents brought their child today to the Emergency Room for evaluation. Parents report 3day prior history of upper respiratory symptoms, diarrhea, vomiting and cough. The rapid onset of rash to the trunk, arms and legs started yesterday. The rash is rapidly coalescing and becoming dark purple in color, resembling purpura. Patient is irritable. Parents provided antipyretics (Motrin suspension 20 mg/kg every 4 hours) and cooling measures, which failed to reduce the fever.

PMH: Significant prematurity born at 32-week gestation, was intubated for 3 weeks and developed Necrotizing Enterocolitis at 2 weeks of age with 50% of Jejunum small bowel resected. A Port-a-Cath was placed 3 years ago to provide nightly TPN infusions. G-tube Mickey placed at 6 months of age. Used for supplemental feedings and medications.

Immunizations: Not up-to-date: Influenza, Rotovirus, Prevnar, MMR. Received: Hepatitis B vaccine at birth, DTaP at 2 and 5 months

Primary Medical Dx	Septic Shock w/Meningitis; Short Bowel Syndrome; TPN Dependence w/Gall Stones

2. Review of Systems	
CNS	Irritable, lethargic, photophobia, nuchal rigidity; no noted seizures
Cardiovascular	Sinus Tachycardia, Port-a-Cath in left upper-chest; accessed with Huber needle
Pulmonary	Tachypnea, increased work of breathing, no chronic lung disease; oxygen sat 91%
Renal/Hepatic	No urinary tract infections, hepatomegaly or jaundice; gallstones
Gastrointestinal	No constipation, chronic diarrhea; poor appetite G-Tube Mic-Key
Endocrine	No diabetes, no hypothyroidism
Heme/Coag	Bruises easily; no epistaxis.
Musculoskeletal	Moves all extremities; decreased muscle bulk and tone
Integument	Dark purple petechial generalized rash, purpura to chest, trunk, arms, legs
Developmental Hx	Tanner Stage 1 Female, normal appearing genitalia.
Psychiatric Hx	None
Social Hx	Attends Second grade with IEP plan, mild learning delays; Participates in Girl Scouts
Alternative/ Complementary Medicine Hx	None

Medication allergies:	Penicillin	Reaction:	Rash
Food/other allergies:	None	Reaction:	
Diet:	Table foods, Pediasure 2 cans daily		

3. Current medications	**Drug**	**Dose**	**Route**	**Frequency**
	Vitamin B12 (Cyanocobalamin)	100 mcg	Sub-Q	Monthly
	Actigal	200 mg	G-Tube	BID
	Multivitamin	1 chewable	PO	Daily
	Total Parenteral Nutrition (TPN)	60 ml/hr for 15 hours	IV	Nightly
	Motrin	400 mg	GT	Every 4 Hours

4. Laboratory, Diagnostic Study Results: admit					
Na: 147	K: 3.5	Cl: 100	HCO3: 24	BUN: 34	Cr: 2.1
Ca: 9	Mg: 1.9	Phos: 3.5	Glucose: 124 mg/dl	HgA1C: 5	
Hgb: 11.2	Hct: 32	Plt: 248	WBC: 24	ABO Blood Type: AB+	
PT: 13	PTT: 32	INR: 0.92	Troponin: <0.04	BNP: 170	
ABG-pH: 7.25	paO2: 80	paCO2: 37	HCO3/BE: 24	SaO2: 91	
VDRL:	GBS:	CRP: 102	ESR: 14	Lactate: >4	
CXR:	ECG:	Herpes:	HIV:		

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)					
1. Initial physical appearance					
Gender: Female	Attire: Wearing hospital gown and sports shorts				
Alteration in appearance (moulage): Presence of Port-a-Cath on left upper chest, accessed with Huber needle. Attach pictures of petechial rash seen on abdomen, and lower extremities. PIV in left hand with saline lock.					
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		Monitor on, data displayed
BP: 80/60	HR: 140	RR: 30	T: 38.4 °C	Sp O_2: 95%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	$ETCO_2$:	FHR:		
Lungs:	Left: Crackles		Right: Crackles	
Heart:	Sounds:		Systolic Murmur grade 3/6	
	ECG rhythm:		Sinus Tachycardia	
	Other: Friction Rub Left side at Erbs Point			
Bowel sounds:	Hypoactive, non-tender on palpation, mild distension		Other: G-Tube (Mic-Key 14 Fr.) Left mid-abdomen	

3. Initial Intravenous line set up							
✓	**Saline lock #1**	Site: LAC		✓	IV patent (Y/N) Yes		
	IV #1	Site: Left upper Chest	Fluid type: 0.9% NS	Initial rate: TKO (5 ml/hr)		IV patent (Y/N) Yes	
✓	Main						
4. Initial Non-invasive monitors set up							
✓	NIBP	✓	ECG First lead:		ECG Second lead:		
✓	Pulse oximeter	✓	Temp monitor		Other:		
5. Initial Hemodynamic monitors set up							

ALL DATA IN THIS SCENARIO IS FICTITIOUS

6. Other monitors/devices				
	Foley catheter	Amount:	Appearance of urine:	
	Epidural catheter	✓	Infusion pump: Alaris	Pump settings: 5 ml/hr

Environment, Equipment, Essential props

1. Scenario setting (For example: patient room, home, ED, lobby)

Scenario takes place in Emergency Department, then later transfers to the Pediatric Intensive Care Unit.

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 kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural infusion		Central line Insertion		Dressing Δ equip
✓	IV fluid NS; D51/2 NS		IV fluid additives:		IV Piggy back		Blood products

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	✓	H & P	✓	Med Admin Record	✓	Lab Results
	Progress Notes		Graphic record		Anesthesia/PACU record	✓	ED Record
	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
✓	Nurses' Notes	✓	Dx test reports		Code Record		Prenatal record
	Actual medical record binder, constructed per institutional guidelines				Other Describe: Consent Form Signed for Lumbar Puncture		

5. Medications (to be available in sim action room)

#	Medication	Dosage	Route		#	Medication	Dosage	Route
1	Acetaminophen	10 mg/kg	PR		4	Epinephrine Drip	0.5 mcg/kg/min	IV
2	Vancomycin	200 mg/100 ml	IVPB		5	Ursodiol	10 mg/kg/dose	GT
3	Meropenem	800 mg/100 mL	IVPB		6	Ativan	1 mg	IV

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario:			
8-year-old child in room with parent present; septic work-up being initiated **If continuing simulation following A, Group gives report to B group of students and received Order sheet 3.**			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
Baseline	**Operator**	**Learner Actions**	**Debriefing Points:**
STATE / PATIENT STATUS **1. Baseline – Group 2** If parent is not present patient says: "I want my Mommie." Neuro: lethargic, moaning, pain, not responsive to answering questions. Neck pain PERL sluggish 3-4 mm Lips: dry, cracked Resp: Moderate retractions, crackles bilaterally. With neuro exam: Complains that "the lights hurt my eyes" Cardiac: CRF> 3 seconds, peripheral pulses are 1+, pale, generalized rash (petechial) GI: Hypoactive BS No UOP	BP – 100/60 HR – 120 RR – 34 TEMP: 38.1 °C SpO2: 92% if on Room air; 95% if on oxygen Within 2 minutes, drop saturations to 92% Increase HR to over 140. **Triggers** Provide Lab results if participants call the lab.	1. WII: wash hands, introduce self, identify patient. 2. Dress in appropriate PPE 3. Conduct general survey including head-to-toe assessment and Central-Cath site/dressing check 4. Note IV rate of 3 ml/hour. 5. Initiate maintenance fluid on the second IV pump 6. Initiate antibiotics 7. Titrate oxygen concentration and mode to maintain saturations over 95% 8. Note generalized rash and assessment findings: decreased LOC, poor peripheral perfusion, no UOP. Report back to team 9. Communicate with physician regarding findings and obtain a NS fluid bolus (20 ml/kg) after antibiotic administration. 10. Take telephone orders, verify and read-back.	1. Rationale for proper hand washing and correct use of PPE 2. Identify the patient ID with a second RN prior to medication administration 3. Note allergy to Penicillin. 4. Cooling measures following administration of antipyretic. 5. Clinical reasoning/evidence for fluid bolus as the top priority including all of the assessment findings indicate septic shock. 6. Pathophysiology to explain the hypotension that results from antibiotic administration in sepsis. Differentiation between antibiotic anaphylaxis and endotoxin release. 7. Assessment of Neurological status, CV, Respiratory, Poor perfusion, Skin, GI and GU systems. 8. Criteria for safely administering medications to non-verbal patients and taking verbal orders.

ALL DATA IN THIS SCENARIO IS FICTITIOUS

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
Frame 2	**Operator**	**Learner Actions:**	**Debriefing Points:**
Blankets removed or cooling measures initiated Assessment findings with HTT Signs/Symptoms: • Lethargic • Headache • Nuchal Rigidity • Photophobia • Poor skin turgor • Weak peripheral and central pulses (1+) • Capillary refills > 4 seconds	Patient moans, not answering questions. Reassessment of VS: ***If no antibiotics administered*** *HR 135, BP 90/60* *RR 28,* T 38.7 °C ***If antibiotics given:*** *HR – 160 BP – 80/60* No urine output ↓BP/poor perfusion persists until additional fluid bolus is given **Triggers:** Antibiotics administered (Vancomycin or Meropenem) Antibiotic adm↓BP to 80/60. HR increases to 145.	1. Perform focused Head-To-Toe assessments, followed by complete assessment. 2. Give acetaminophen PR. If student attempts to give PO parent may refuse the medication or patient will have emesis. 3. Remove blankets. 4. Update parent with the initiation of fluid bolus, oxygen, administration or antipyretic & cooling measures. 5. Review signs of shock, hypotension with parent. 6. Review or request lab results; including gram stain, lactate levels or differential from earlier CBC test. 7. Repeat set of VS 8. Updates MD on abnormal assessment findings 9. Requests additional fluid bolus order.	1. Proper assessment techniques such as auscultation of the chest or noting the skin rash on chest, upper thigh and feet. 2. Notify the provider of the assessment findings after complete assessment is obtained and after reassessment following fluid bolus. 3. Additional fluid bolus for unresolved hypotension and poor peripheral perfusion. 4. Initiation of antibiotics within the first hour or as soon as possible. 5. Therapeutic communication skills to alleviate parental anxiety during rapidly evolving situations.

<table>
<tr><td colspan="2">STATE / PATIENT STATUS</td><td colspan="2">DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE</td></tr>
<tr><td>Frame 3</td><td>Operator:</td><td>Learner Actions:</td><td>Debriefing Points:</td></tr>
<tr><td rowspan="2">Assessment findings with HTT Signs/Symptoms:
• Lethargic
• Headache
• Nuchal Rigidity
• Photophobia
• Poor skin turgor
• Weak peripheral pulses
• Capillary refills > 4 seconds</td><td>If fluid bolus given:
HR 135, BP 100/65, RR 28

T 38.7 °C Blanket removed or cooling measures initiated

If no fluid bolus:
HR – 160 BP – 70/50</td><td rowspan="2">1. Initiate rapid bolus IV
2. Update parent with the administration of fluid bolus
3. Titration of oxygen
4. Cooling measures after administration of antipyretic
5. Initiate antibiotics without delay.
6. Review signs of shock and hypotension with parent.</td><td rowspan="2">1. Proper assessment techniques such as auscultation of the chest or noting the skin rash on chest, upper thigh and feet.
2. Notify the provider of assessment findings and after reassessment following fluid bolus.
3. Cooling measures following administration of antipyretic.
4. Initiation of antibiotics within the first hour and as soon as possible.</td></tr>
<tr><td>Triggers:

No urine output
Rapid NS IV bolus (20 ml/kg)
400 ml rapid infusion

BP and HR improve slightly</td></tr>
<tr><td colspan="4">Scenario End Point: Antibiotics given and NS fluid bolus rapid infusion started. Patients BP and HR stabilized.</td></tr>
<tr><td colspan="4">Suggestions to <u>decrease</u> complexity:
Suggestions to <u>increase</u> complexity:</td></tr>
</table>

APPENDIX A: HEALTH CARE PROVIDER ORDERS (Sheet 3)

Patient Name: Patient Name: Katie Scarlett Dotts **DOB: 05/20/XX** **Age: 8-Year Old Weight 20 KG** **MR#:**	**Diagnosis: Sepsis** **Possible Meningitis/Septic Shock** **Short Bowel Syndrome**

†Allergies & Sensitivities: PCN (Rash)

Date	Time	**Pediatric Intensive Care Unit**
		Admit to PICU service Dr. Sweet.
		VS: Continuous Cardiac monitoring including saturations, hourly neuro checks,
		LP complete: send CSF for culture, gram stain, protein, glucose, RBC and WBC
		Maintenance IV: D51/2 NS @ 60 ml/hour
		Diet: NPO; strict I and O
		EMLA cream for all IV starts and lab draws.
		Acetaminophen 200 mg PO/PR every 4 hours for T.38.6 °C, notify MD if T> 38.9 °C
		Vancomycin (10/mg/kg/dose) 200 mg IV every 4 hours; Pharmacy to adjust
		Dose. Peak and trough levels with 3rd dose.
		Meropenem 800 mg IVPB every 12 hours
		Ursodiol 200 mg GT Three times daily
		Notify MD of BP systolic< 70, HR >140, Saturations < 92 despite oxygen
		titration, RR> 30, urine output less than 1 ml/kg/hour.
Signature		Dr. Sweet

APPENDIX B: Digital images of manikin and/or scenario milieu

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
☐ Individual	☐ Group	☐ With Video	☐ Without Video
Debriefing Materials			
☐ Debriefing Guide	☐ Objectives	☐ Debriefing Points	☐ QSEN
QSEN Competencies to consider for debriefing scenarios			
☐ Patient Centered Care	☐ Teamwork/Collaboration	☐ Evidence-based Practice	
☐ Safety	☐ Quality Improvement	☐ Informatics	

Sample Questions for Debriefing

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: