

## SECTION I: SCENARIO OVERVIEW

<b>Scenario Title:</b>	Community Acquired Pneumonia –Case A-Respiratory Distress		
Original Scenario Developer(s):	Marjorie A. Miller, MA, RN, CHSE	<a href="mailto:mmiller@nurse-edconsulting.com">mmiller@nurse-edconsulting.com</a>	
Date - original scenario	03/07		
Validation:	05/07 – A. Lucero, MSN		
Revision Dates:	06/09, 09/11, 07/18 (MMiller)		
Pilot testing:	01/08		
QSEN revision:	03/12 – M. Miller, MA, RN, CHSE		
<u>Estimated Scenario Time:</u>	15-20 minutes	<u>Debriefing time:</u>	30-40 minutes
<u>Target group:</u> Beginning Medical Surgical nursing students, new grads, RT students			
<u>Core case:</u> Acute Respiratory Distress, Community Acquired Pneumonia			
<u>QSEN Competencies:</u>			
	<input type="checkbox"/> Patient Safety <input type="checkbox"/> Teamwork and Collaboration <input type="checkbox"/> Patient Centered Care		
<u>Brief Summary of Case:</u>			
This is the first of a 3 or 4 part unfolding scenario that can be used as a single scenario or as stand alone scenarios. Case D can replace Case B if desired.			
Case A: Respiratory Distress			
Case B: Allergic reaction to antibiotic			
<p>Patient is a homeless middle aged woman with acute respiratory distress brought in by shelter workers due to increasing productive cough, fever and respiratory distress. R/O Community Acquired Pneumonia. In this scenario, learners are to assess and recognize the respiratory distress and intervene effectively to include: positioning, increasing O<sup>2</sup> liter flow, reassessing lung sounds, recognizing need for further orders and RT. Respiratory distress resolves with nebulizer treatment.</p>			

EVIDENCE BASE / REFERENCES (APA Format)
Lewis, et. al., Medical-Surgical Nursing (2018) Chapter 27/28 Lower Respiratory Problems, St. Louis
Mandell, et.al. Infectious Diseases Society of America/American Thoracic Society Consensus Guidelines on the Management of community-Acquired Pneumonia in Adults” <i>IDSA/ATS Guidelines for CAP in Adults. Clinical Infectious Diseases</i> , Volume 44, Issue Supplement_2. Retrieved from <a href="https://doi.org/10.1086/511159">https://doi.org/10.1086/511159</a>
Quality and Safety Education for Nurses (QSEN) Institute. (2018). QSEN Competencies. Retrieved on 5/13/18 from: <a href="http://qsen.org/competencies/pre-licensure-ksas/#safety">http://qsen.org/competencies/pre-licensure-ksas/#safety</a>
The Joint Commission. (2018). Targeted Solutions Tool for Preventing Falls. Retrieved May 13, 2018, from <a href="https://www.centerfortransforminghealthcare.org/tst_pfi.aspx">https://www.centerfortransforminghealthcare.org/tst_pfi.aspx</a>
Baer, S.L. Bronze, M.S. (2017) Community Acquired Pneumonia. Retrieved on 7/23/18 from: <a href="http://emedicine.medscape.com/article/234240-overview">emedicine.medscape.com/article/234240-overview</a>

## SECTION II: CURRICULUM INTEGRATION

### A. SCENARIO LEARNING OBJECTIVES

#### Learning Outcomes

1. Apply clinical decision making skills in interpreting and analyzing complex data.
2. Prioritize interventions based on accurate interpretation of assessment data.
3. Provide care to patients utilizing principles of safety.
4. Communicate effectively to members of interprofessional team.

#### Specific Learning Objectives

1. Apply principles of infection control to minimize risk of spread to self and others.
2. Identify findings in a psychosocial assessment that demonstrate risk for community acquired pneumonia.
3. Demonstrate accurate assessment of the patient with a focus on respiratory system.
4. Identify and interpret significant assessment findings requiring immediate reporting and/or intervention.
5. Accurately prioritize immediate interventions required for a patient with an unexpected change in status.
6. Evaluate effectiveness of interventions by reassessing critical parameters.
7. Effectively communicate change in status to physician/charge nurse/Respiratory Therapist utilizing accepted agency tool (eg. SBAR).
8. Effectively communicate with patient throughout simulation to keep informed, relieve anxiety and support active participation in care as able.

#### Critical Learner Actions

1. Performs hand hygiene, identifies self and role, identifies patient.
2. Contains biohazards.
3. Engages patient in plan of care and begins morning assessment.
4. Identifies respiratory distress; elevates head of bed; takes O<sup>2</sup> sats; performs focused respiratory assessment
5. Administers O<sup>2</sup> as ordered and reassesses patient; increases O<sup>2</sup> liter flow per order; reassesses patient.
6. Increases liter flow rate; reassesses; changes to mask @ 6L/minute; reassesses patient.
7. Calls charge nurse, health care provider or RT to report change of status and request assistance/orders.
8. Reassures patient throughout care with clear, calm statements of action.
9. Communicates assessment findings effectively with RT using SBAR format.

### B. PRE-SCENARIO LEARNER ACTIVITIES

#### Prerequisite Competencies

Knowledge	Skills/ Attitudes
<input type="checkbox"/> Pathophysiology, risk factors & treatment of CAP & acute respiratory distress	<input type="checkbox"/> National Patient Safety Goals/ hand hygiene / infection control
<input type="checkbox"/> Oxygen therapy	<input type="checkbox"/> Respiratory Assessment; adventitious breath sounds
<input type="checkbox"/> Communication with acutely ill, anxious patients	<input type="checkbox"/> Collaborative interventions / respiratory distress
<input type="checkbox"/> CDC Guidelines for precautions/hand hygiene	<input type="checkbox"/> Safe oxygen administration
<input type="checkbox"/> Principles of teamwork and collaboration	<input type="checkbox"/> SBAR communication with interprofessional team
<input type="checkbox"/> Dimensions of patient centered care	<input type="checkbox"/> Strategies for decreasing anxiety & ensuring active patient participation in respiratory distress

### SECTION III: SCENARIO SCRIPT

#### A. Case summary

45 year old patient admitted from emergency department at end of previous shift. Patient brought to the ED by homeless shelter volunteers because of coughing and inability to catch her breath. She reports being sick for one week, getting worse in the last 2 days, being unable to eat or sleep because of the coughing. Learners are expecting to perform a shift assessment. On entering the room they find the patient in respiratory distress with interrupted speech and coughing, without supplemental O<sub>2</sub>, lying in supine position. Learners are expected to: recognize change in status, ↑ HOB, check O<sub>2</sub> sats, administer O<sub>2</sub>, take vital signs, reassess O<sub>2</sub> sats, perform respiratory assessment, differentiate adventitious breath sounds, recognize continued deterioration of patient status, communicate with charge nurse using SBAR tool and communicate effectively with patient to ↓ anxiety, using clear, calm, brief explanation of interventions and status. Patient continues to deteriorate until nebulizer treatment given by RT. Scenario ends with either radiology technician taking portable chest x-ray or patient being transported to Radiology

#### B. Key contextual details

Scenario takes place in the med-surg setting right after report on the day shift. Emergency department was backed up and patient was transferred at the end of the previous shift after 3 hours in ED. Admission chest x-ray was performed, but needs to be repeated this morning. Sputum was collected and sent to lab but antibiotics not yet given. Patient is awake, slightly anxious, coughing and complaining of shortness of breath. Head of bed is flat with one pillow. O<sub>2</sub> per nasal cannula is off patient and is hanging from wall O<sub>2</sub> set up.

#### 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 type="checkbox"/> Standardized patient	
<b>Role</b>	<b>Brief Descriptor (Optional)</b>	<b>Standardized Participant (SP) or Learner (L)</b>
RN 1 - Primary	Assessment and delegation	L
RN 2 – New grad	Administer of meds, scans lab results, checks orders	L
Charge Nurse	Called to notify physician	SP
Respiratory Therapist	Called to administer nebulizer treatment	SP

D. Patient/Client Profile				
Last name:	Hanover		First name:	Suzanne
Gender: Female	Age: 45	Ht: 5'10"	Wt: 110 #	Code Status: Full
Spiritual Practice: None identified		Ethnicity: Caucasian		Primary Language spoken: English
<b>1. History of present illness</b>				
Patient brought in by homeless shelter volunteers because of coughing and inability to catch her breath. She reports being sick for a week, getting worse in the last 2 days. She states that she has not been able to sleep or eat due to coughing. Shelter volunteers indicate that she is alcoholic.				
<b>Primary Medical Diagnosis</b>		Acute respiratory distress r/o Community Acquired Pneumonia		

2. Review of Systems	
CNS	Slight tremors of both hands/ anxious/ A&O x 3 or 4 (agency protocol)
Cardiovascular	Sinus rhythm @ 96; no murmurs, thrills or ectopy . B/P 136/90
Pulmonary	Smoker 30 pack years. Cough productive of thick greenish tinged mucous. RR-28, Fine crackles over all lung fields; coarse rhonchi mostly over (R) base. O2 sats 94% on RA
Renal/Hepatic	No complaints of urinary difficulties. Slight liver tenderness to palpation. Daily ETOH (1 qt. whiskey per day) use when available. Last drink 12 hours ago
Gastrointestinal	No abnormalities
Endocrine	States that she bruises easily; no evidence of bruising noted
Heme/Coag	wnl, MAE
Musculoskeletal	wnl, no abrasions or pressure areas noted
Integument	wnl
Developmental Hx	wnl
Psychiatric Hx	None reported
Social Hx	Homeless x 10 years; divorced x 10 years; no family contact
Alternative/ Complementary Medicine Hx	unknown

Medication allergies:	NKDA	Reaction:	
Food/other allergies:	NKFA	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	IV's -1000 ml ½ NS @	125 ml/hr	IV	continuous
	Multivitamins	1 ampule	IV	} Add to 1 liter q 24 hr <i>Check agency guidelines</i>
	Thiamine	100 mg	IV	
	Folic Acid	200 mg	IV	
	Magnesium	1 gram	IV	
	Nicotrol Transdermal patch	15 mg	Transderm	q 24 hours
	Acetaminophen	650 mg	PO	prn T ↑ 101° F.

4. Laboratory, Diagnostic Study Results					
Na: 138	K: 3.8	Cl: 100	HCO3: 24	BUN: 22	Cr: 0.8
Ca: 9.0	Mg: 1.2	Phos: 3.5	Glucose: 98	HgA1C:	
Hgb: 11.2	Hct: 32	Plt: 145	WBC: 12.4	ABO Blood Type:	
PT	PTT	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:		
CXR: needs to be repeated		ECG: 12 lead - NSR			
CT:		MRI:			
Other:					

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)					
1. Initial physical appearance					
Gender: Female		Attire: Pt. gown, long messy hair wig, ? makeup, soiled sweater & handbag in bed			
Alterations in appearance (moulage): used tissues on bed & floor stained with green-gray colored secretions; kidney basin also on chest of patient with same stained tissues in basin.					
x	ID band present, accurate information		ID band present, inaccurate information		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	x	Monitor on, but no data displayed		Monitor on, standard display		Display vital signs when learner takes them

BP: 150/90	HR: 104	RR: 28	T: 101.4° F.	SpO <sup>2</sup> : 92% when sensor placed	
CVP:	PAS:	PAD:	PCWP:	CO:	
AIRWAY:	ETCO <sup>2</sup> :	FHR:			
Lungs: Sounds/mechanics	Left: loud crackles throughout		Right: loud crackles, coarse rhonchi over base		
Heart:	Sounds:	S <sub>1</sub> S <sub>2</sub>			
	ECG rhythm:	Sinus tachycardia			
Bowel sounds:	wnl x 4 quadrants			Other:	

3. Initial Intravenous line set up						
x	Saline lock #1	Site: right forearm				IV patent (Y/N)
x	IV #1	Site: right forearm	Fluid type: D5/0.45 NS w/20 mEq KCl tinted light yellow 750 mL	Initial rate: 125 mL/hr	Check agency guidelines	IV patent (Y/N)
x	Main					
	Piggyback					
	IV #2	Site:	Fluid type:	Initial rate:		IV patent (Y/N)
	Main					
	Piggyback					
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:	Pump settings:			
	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)						
Monitored med-surg 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		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
x	IV fluid Type: D5/0.45 NS w/ 20 mEq KCl		IV fluid additives MVI- I amp, Thiamine 100 mg, Folic Acid 200 mcg, Magnesium 1 gram <i>Check agency guidelines</i>				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		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record	x	H & P	x	Lab Results
	Progress Notes	x	Graphic record		Anesthesia/PACU record		ED Record
x	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
	Nurses' Notes		Dx test reports		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
4	Acetaminophen	650 mg	PO		1	Nicotrol Patch	15 mg	Transdermal
1	Ceftriaxone	Gm. 1	IVPB		1	Azithromycin	500 mg	IVPB
4	Saline flushes		IV flush					

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

**Initiation of Scenario :**

SH is a 45 year old female admitted during the night from the ED with a provisional diagnosis of community acquired pneumonia. She has a productive cough and slight dyspnea. Vitals: T. 101.6° F., P.96, R.28, BP 136/90, O<sub>2</sub> sats 94% on 2L O<sub>2</sub>. She is somewhat anxious and won't keep the oxygen on. Every time I go in there she has it off so I just left it off. Breath sounds: fine crackles over all lung fields and coarse rhonchi, mostly over (R) base. It's hard to be sure because she won't stop coughing long enough to listen. Sputum was collected and sent to lab. She is a smoker and has a nicotine patch. She has an IV of D5 ½ NS with 20 mEq KCl with vitamins and magnesium running (optional) in her (R) forearm. You have a credit of 750 ml. Oh ... one more thing... I think she is homeless so you had better get social service on this right away.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>1. Baseline</b></p> <p>Patient in low fowlers position, coughing, talking anxiously with interrupted speech. O<sub>2</sub> nasal cannula hanging from wall.</p> <p>HR-114/sinus tach. BP 140/90</p> <p>Breath sounds: (L) crackles (R) rhonchi</p> <p>RR - 30, labored</p>	<p><b>Operator</b></p> <p><b>Display when sensor applied</b> O<sub>2</sub> sats - 91% - RA</p> <p><b>Triggers:</b></p> <p>1. change in VS above 2. Learner performs expected actions within 5 minutes</p> <p><b>Cues:</b> If learner does not raise head of bed, Pt. cues "I can't breathe, help me sit up"</p>	<p><b>Learner Actions</b></p> <ol style="list-style-type: none"> <li>1. Introduce self, wash hands</li> <li>2. Identify patient, request permission to treat</li> <li>3. Raise HOB to 45 degrees</li> <li>4. Apply oximeter/<math>\sqrt</math> O<sub>2</sub> sat</li> <li>5. Apply O<sub>2</sub> @ 2L/min/NC</li> <li>6. Check vital signs</li> <li>7. Reassure patient with clear, calm statements of action</li> <li>8. Dispose of soiled tissues utilizing infection control measures.</li> <li>9. Divides tasks to assure safety</li> </ol>	<p><b>Debriefing Points:</b></p> <ol style="list-style-type: none"> <li>1. National Patient Safety Goals to minimize risk of error and transmission of infection.</li> <li>2. Significance of VS deviations from normal</li> <li>3. ↑ of head of bed drops diaphragm and facilitates lung expansion</li> <li>4. ↓ O<sub>2</sub> sats, ↑RR and distress indicates poor oxygenation</li> <li>5. clear, brief explanations ↓ anxiety which assists to ↓ respiratory distress</li> <li>6. Opportunities for patient teaching r/t promoting self-care</li> </ol>



STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2. Still anxious. c/o fatigue No relief from position change or other interventions.</p> <p>Verbalizes “I can’t breathe”.</p> <p>Starts to ask questions about cancer.</p> <p>Expresses concern about discolored tissues.</p> <p>O<sup>2</sup> sats – 91%</p> <p>RR – 30</p> <p>HR – 114 sinus tach</p> <p>BP 140/90</p>	<p><b>Operator:</b></p> <ol style="list-style-type: none"> <li>1. ↓ O<sup>2</sup> sats to 89-90%</li> <li>2. ↑ HR to 118</li> <li>3. ↑ RR to 34</li> <li>4. ↑ BP to 144/90</li> </ol> <p><b>Triggers:</b> Performs expected actions within 5 minutes</p> <p><b>Cues:</b> If not, patient prompts: “I can’t get enough air.... Last night they ... put something ...in my nose ... that helped ... a little. I prom... ise ..., I’ll keep it ....on this time...”</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Places O<sup>2</sup> @ 2L/NC</li> <li>2. Explains action to client</li> <li>3. Reassesses O<sup>2</sup> sats</li> <li>4. Auscultates breath sounds</li> <li>5. Request patient to stop talking while assessing breath sounds. Second nurse attempts to engage patient in coached breathing</li> <li>6. ↑ O<sup>2</sup> to 4L/NC</li> </ol>	<p><b>Debriefing Points:</b></p> <ol style="list-style-type: none"> <li>1. Supplemental O<sup>2</sup> to ↑ O<sup>2</sup> sats</li> <li>2. ↑ HR → ↑ anxiety → ↑ O<sup>2</sup> demand</li> <li>3. AIR – Assess-Intervene-Assess after each change of status or before intervention, perform focused assessment.</li> <li>4. Pathophysiology of adventitious BS vs. normal</li> <li>5. Significance of discolored sputum and significant nursing actions</li> <li>6. Strategies for dividing tasks so major priorities are handled initially</li> <li>7. Strategies for engaging anxious patients</li> </ol>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>3.</b> Anxiety increases – patient states “I feel ... like something ... is stuck ... in my chest”.</p> <p>Continued increase in respiratory effort</p> <p>Continues to talk about cancer and laments long history of smoking ...saying “I don’t .... want to die.”</p> <p>O<sup>2</sup> sats – 89-90%</p> <p>RR – 34</p> <p>HR – 118</p> <p>BP – 144/90</p>	<p><b>Operator:</b> <b>Change-</b></p> <ol style="list-style-type: none"> <li>1. ↓ O<sup>2</sup> sats – 88 %</li> <li>2. ↑ RR – 36-40</li> <li>3. ↑ HR – 120-124</li> <li>4. ↑ BP 150/92</li> <li>5. ↑ T – 102.6° F.</li> </ol> <p><b>Triggers:</b> Performs expected actions within 5 minutes</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Reassures patient that MD says she has pneumonia and that antibiotics will help.</li> <li>2. Change O<sup>2</sup> to mask @ 6L with humidifier</li> <li>3. Notifies charge nurse by phone of change of status using SBAR</li> <li>4. Charge nurse notifies MD for orders and calls RT if not already done by learners.</li> </ol>	<p><b>Debriefing Points:</b></p> <ol style="list-style-type: none"> <li>1. Implications of continuous O<sup>2</sup> in this patient</li> <li>2. Clinical manifestations of CO<sup>2</sup> retention</li> <li>3. Decision making – Management of dyspnea vs. prevention of CO<sup>2</sup> retention</li> <li>4. Explore learner perceptions of the value of seeing the situation “through the patient’s eyes”.</li> </ol>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>4.</b> Anxiety continues as respiratory effort increases</p> <p>O<sup>2</sup> sat ↓ - 88-89%</p> <p>RR ↑ - 36-40</p> <p>HR – 120</p> <p>BP 150/92</p> <p>T – 102.6 F.°</p>	<p><b>Operator:</b> <b>Change- After nebulizer Rx</b></p> <ol style="list-style-type: none"> <li>Breath sounds – faint crackles</li> <li>↑ O<sup>2</sup> sats – 93-94%</li> <li>↓ RR – 26</li> <li>↓ HR – 100</li> <li>↓ BP 130/85</li> </ol> <p><b>Triggers:</b></p> <ol style="list-style-type: none"> <li>Learners perform actions within 5 minutes</li> <li>Patient indicates ↓ distress and desire to rest.</li> </ol>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>RT enters room and takes SBAR from learners</li> <li>Introduces RT or RT identifies self and role</li> <li>RT validates breath sounds</li> <li>RT administers nebulizer treatment</li> <li>Learner reassesses following nebulizer treatment</li> <li>Communicates improvement to patient</li> <li>Communicates with x-ray re. transfer of patient for repeat chest x-ray</li> </ol>	<p><b>Debriefing Points</b></p> <ol style="list-style-type: none"> <li>Significance of improved status related to interventions</li> <li>Reassessment requirements</li> <li>Priority setting</li> <li>Nurses role in advocating for patient - delaying transport to Radiology if unstable.</li> <li>Behaviors indicating interprofessional teamwork &amp; collaboration</li> </ol>
<p><b>Scenario End Point:</b> Radiology arrives to take patient to x-ray for repeat films. If learners refuse to let patient go due to patient status, Charge Nurse enters to give them a break. Patient expresses feeling better, but exhausted.</p>			
<p><b>Suggestions to <u>decrease</u> complexity:</b> Medium complexity as written</p> <p><b>Suggestions to <u>increase</u> complexity:</b></p> <ol style="list-style-type: none"> <li>Previous history of active Tb – off meds for 6 months</li> <li>Administration of IV antibiotic that is incompatible with bivalent ions – eg. Levaquin with bivalent ions (Mg, Ca)</li> <li>No improvement after nebulizer treatment. ABG’s ordered. Indicates respiratory failure – further respiratory intervention needed</li> <li>Clinical manifestations of acute alcohol withdrawal requiring assessment, communication, interventions</li> </ol>			



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

<p><b>Insert digital photo here</b></p>	<p><b>Insert digital photo here</b></p>
<p><b>Insert digital photo here</b></p>	<p><b>Insert digital photo here</b></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"> <li>1. How did the experience of caring for this patient feel for you and the team?</li> <li>2. Did you 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 ways did you check feel the need to check ACCURACY of the data 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 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>			