

## SECTION I: SCENARIO OVERVIEW

<b>Scenario Title:</b>	Eclamptic Seizure -MCH		
Original Scenario Developer(s)	C. Lopez, RNC, MSN, CNS, S. Cantrell, MSN, RNC		
Date - original scenario	04/08		
Validation:	02/09		
Revision Dates:	08/18 Connie Lopez, MSN, CNS, RNC-OB, CPHRM, CHSEA, 08/10		
Pilot testing:	02/09		
<u>Estimated Scenario Time:</u>	15 minutes	<u>Debriefing time:</u>	30 minutes
<u>Target group:</u>	Prelicensure students in OB, new graduates, orientees, staff in OB and IP teams		
<u>Core case:</u>	Eclamptic seizure		
<u>QSEN/IOM Competencies:</u>	<input type="checkbox"/> Patient Centered Care <input type="checkbox"/> Safety <input type="checkbox"/> Teamwork and Collaboration		
<u>Brief Summary of Case:</u>	16-year-old female G1P0 at 33 weeks gestation with late prenatal care and only her mother for support. Admitted to L&D the previous day with pre-eclampsia. Scenario occurs in post-partum unit with magnesium sulfate drip for continued observation and completion of 24-hour urine collection where she has a seizure.		
<i>Undergraduate students will complete the high-risk maternity content before participating in this scenario.</i>			

### EVIDENCE BASE / REFERENCES (APA Format)

Clements, C., Flohr-Rincon, S., Bombard, A. & Catanzarite, V. (2007). Rapid Response to Obstetrical Emergencies. <i>Nursing for Women's Health, 11</i> , 194-199.
Cunningham, F.G. (2018). <i>Williams Obstetrics</i> . New York: McGraw-Hill Education
Dix, D. (2016). Hypertensive Disorders in Pregnancy. In <i>Core curriculum for maternal-newborn nursing</i> . (5 <sup>th</sup> ed., pp. 435-451). Saint Louis, MO: Elsevier.
Druzin, M. L., Shields, L. E., Peterson, N. L., & Cape, V. (2013). <i>Preeclampsia Toolkit: Improving Health Care Response to Preeclampsia in California Maternal Quality Care Collaborative Toolkit</i> [Scholarly project]. In <i>CMQCC Preeclampsia Toolkit</i> . Retrieved August 16, 2018, from <a href="https://www.cmqcc.org/resources-toolkits/toolkits/preeclampsia-toolkit">https://www.cmqcc.org/resources-toolkits/toolkits/preeclampsia-toolkit</a>
Emery, S. (2005). Hypertensive disorders of pregnancy: Over diagnosis is appropriate. <i>Cleveland Clinic Journal of Medicine, 72</i> , 345-352.
Gaumard Scientific, Miami, FL. (2018) Noelle/Victoria maternal and neonatal simulation system: Instructor guide. Retrieved from <a href="https://www.gaumard.com/downloads">https://www.gaumard.com/downloads</a>
Gilbert, ES (2011) <i>Manual of High Risk Pregnancy &amp; Delivery</i> (5th ed., p 416-459). MD Hts, MO: Mosby/Elsevier
Harvey, C.J., Sibai, B.M. (2013). Hypertension in Pregnancy. In <i>H-Risk &amp; Critical Care Obstetrics</i> (3rd ed., pp. 109-124). Philadelphia, PA: Wolters Kluwer/Lippincott & Wilkins
Poole, J. H. (2014). Hypertensive Disorders of Pregnancy. In <i>Perinatal Nursing</i> (4th ed., pp. 122-142). Philadelphia, PA: Wolters Kluwer/Lippincott & Wilkins
Witcher, P. M. (2017). Caring for the Laboring Woman with Hypertensive Disorders Complicating Pregnancy. In <i>Intrapartum Management Modules</i> (5 <sup>th</sup> ed., pp. 276-315). Phil., PA: Wolters Kluwer/Lippincott & Wilkins

CSA REV template 04/18

**ALL DATA IN THIS SCENARIO IS FICTITIOUS**

## SECTION II: CURRICULUM INTEGRATION

### A. SCENARIO LEARNING OBJECTIVES

#### Learning Outcomes

1. Apply clinical decision-making skills in interpreting and analyzing complex patient data and assessment.
2. Provide patient/family centered care, utilizing safety principles to reduce risk and minimize risk of error.
3. Communicate with interprofessional team members valuing each role and using standard tools (SBAR) & closed loop communication.

#### Specific Learning Objectives

1. Demonstrate focused labor and delivery assessment.
2. Identify changes in maternal status that require further assessment and intervention.
3. Prioritize nursing care based on accurate assessment and interpretation of data.
4. Initiate/Activate Labor & Delivery emergency response system.
5. Communicate SBAR to each member of Emergency response team as they arrive on scene.
6. Utilize patient safety interventions throughout care.
7. Recognize emotional states of patient/family members and intervene, delegate one person to keep family informed.
8. Delegate required nursing interventions (IV start, Foley insertion and prep for C-section).
9. Maintain close monitoring of fetal status.
10. Position patient appropriately.
11. Explain procedures in clear, calm voice.

#### Critical Learner Actions

1. Demonstrate a systematic, focused assessment of patient and fetus.
2. Activate emergency response system
3. Accurately present change in patient status to interprofessional team using structured communication tool (SBAR)
4. Initiate IV. Deliver bolus with Lactated Ringers solution.
5. Demonstrate situation awareness with call outs, check backs and closed loop communication.

### B. PRE-SCENARIO LEARNER ACTIVITIES

#### Prerequisite Competencies

Knowledge	Skills/ Attitudes
<input type="checkbox"/> Pathophysiology, risk factors, clinical manifestations, interventions and expected outcomes for patient with Preeclampsia that escalates to Eclampsia	<input type="checkbox"/> Labor & delivery assessment and care <input type="checkbox"/> Preparation of patient for emergency delivery <input type="checkbox"/> Foley catheter insertion <input type="checkbox"/> IV insertion
<input type="checkbox"/> Physiology behind fetal heart pattern.	<input type="checkbox"/> Airway management techniques
<input type="checkbox"/> Effective communication for reporting change in patient condition to family & interprofessional team.	<input type="checkbox"/> Communication with interprofessional team, patient and family in escalating situations.
<input type="checkbox"/> Prioritization of interventions in preparation for emergency delivery.	<input type="checkbox"/> SBAR Communication
<input type="checkbox"/>	

### SECTION III: SCENARIO SCRIPT

#### A. Case summary

Tiffany is a 16-year-old female G1P0 at 33 weeks gestation. She was late to receive prenatal care and has only her Mom as a support person. She is under weight for her current gestation. The father of her baby is in and out of her life and cannot be relied upon for support.

She was admitted yesterday to labor and delivery with a BP of 150/88, HR 82, RR 20, T 97.9, FHR 150's. No c/o uterine contractions and membranes are intact. DTRs were 2+ and clonus was negative. On admission, she denied H/A, visual changes and epigastric pain. She had mild pedal edema. She was admitted with a diagnosis of Preeclampsia and was started on Magnesium sulfate with a 4gm loading dose followed by 2/gm/hr. maintenance dose. She was transferred to the post- partum unit, this morning, for continued observation and completion of a 24-hour urine collection.

#### B. Key contextual details

Post-Partum Unit

#### C. Scenario Cast

Patient/ Client	<input type="checkbox"/> High fidelity simulator – Moulage to represent full term pregnant teenager	
	or	
	<input type="checkbox"/> Mid-level simulator – Birthing Manikin	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input type="checkbox"/> Standardized patient	
Role	Brief Descriptor	Standardized Participant (SP) or Learner (L)
RN #1		L
RN #2		L
Charge Nurse	<i>Expert Nurse</i>	SP
Provider		L or SP
CRNA		L or SP
Mother		SP

D. Patient/Client Profile				
Last name:	Brown		First name:	Tiffany
Gender: Female	Age: 16	Ht: 5'3"	Wt: 124 lb.	Code Status: Full
Spiritual Practice: None identified		Ethnicity: Caucasian		Primary Language spoken: English
1. History of Present Illness				
<p>16-year-old female G1P0 at 33 weeks gestation late to receive prenatal care. Mom as only support person. She is under weight for her current gestation.</p> <p>She was admitted yesterday to labor and delivery with a BP of 150/88, HR 82, RR 20, T 97.9, FHR 150's. No c/o uterine contractions and membranes are intact. DTRs were 2+ and clonus was negative. On admission, she denied H/A, visual changes and epigastric pain. She had mild pedal edema.</p>				
<b>Primary Medical Diagnosis</b>		IUP at 3 weeks gestation/Preeclampsia		

2. Review of Systems	
CNS	wnl
Cardiovascular	HR 82, BP 150/88, Pedal edema
Pulmonary	wnl
Renal/Hepatic	Pedal edema
Gastrointestinal	wnl
Endocrine	wnl
Heme/Coag	wnl
Musculoskeletal	wnl DTR's 2+, clonus negative
Integument	wnl
Developmental Hx	wnl
Psychiatric Hx	N/A
Social Hx	Lives with mother, father of baby minimally involved
Alternative/ Complementary Medicine Hx	N/A

Medication allergies:	Betadine	Reaction:	rash
Food/other allergies:	None known	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	PNV	1 tablet	PO	Daily
	Magnesium Sulfate	2 gm/hr.	IVPB	Continuously
	Betamethasone	12.5 mg	IM	X 2 doses 24 hours apart
	Labetalol	20mg	IV	PRN BP > 160/105 -110

4. Laboratory, Diagnostic Study Results				
ALT/SGPT: 70U/L	AST/SGOT: 90 U/L	LDH: 708	BUN:	Cr: 12 mg/dL
Ca:	Mg: 5	Phos:	Glucose:	HgA1C:
Hgb: 14g/dl	Hct: 40%	Plt: 80,000	WBC:	ABO Blood Type:
PT	PTT	INR	Troponin:	BNP:
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:
VDRL: NR	GBS: unk	Herpes: neg	HIV: neg	Urine Protein: 400 mg
<i>Time labs for 4 hours after bolus given, then every 4-6 h and PRN for s/s of toxicity.</i>				
<i>Therapeutic level is 5-7 mcg/L</i>				

E. Baseline Simulator/Standardized Patient State				
1. Initial physical appearance				
Gender: female	Attire: patient gown			
Alterations in appearance (moulage): External fetal monitor is off but at bedside				
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	x	Fetal monitor off, at bedside	x	Monitor on, no display
BP: 173/103	Maternal HR: 100		RR: 24	T: 98 F	SpO <sup>2</sup> : 98%
	Fetal HR: 160 w/ min. variability				CO:
Lungs:	Left: clear	Right: clear			
Heart:	Sounds: S1, S2 no murmurs				
	ECG rhythm: sinus				
Bowel sounds:	positive			Other:	

3. Initial Intravenous line set up					
	Saline lock #1	Site: RAC		IV patent (Y/N)	
x	IV #1	Site: CVC	Fluid type: LR w/ Magnesium Sulfate	Initial rate: 50 mL/h	IV patent (Y/N)
x	Main				
4. Initial Non-invasive monitors set up					
x	NIBP		ECG First lead:	ECG Second lead:	
x	Pulse oximeter		Temp monitor/type	Other:	
5. Initial Hemodynamic monitors set up					
	A-line Site:		Catheter/tubing Patency (Y/N)	CVC Site:	PAC Site:
6. Other monitors/devices					
x	Foley catheter	Amount: 100 mL	Appearance of urine: dark amber		
	Epidural catheter		Infusion pump:	Pump settings:	
x	Fetal Heart rate monitor/tocometer		Internal	x	External

**Environment, Equipment, Essential props**

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

Perinatal patient room

**2. Equipment, supplies, monitors**

(In simulation action room or available in adjacent core storage rooms)

	Bedpan/ Urinal		Foley catheter kit	x	Oral airway	x	Wall suction w/ Yankaur suction tip
x	IV Infusion pump		Feeding pump	x	Pressure bag		
	Nasogastric tube	x	ETT suction catheters	x	Oral suction catheters	x	Bite block
	Defibrillator	x	Code Cart		12-lead ECG	x	Tongue guard
	PCA infusion pump		Epidural pump	x	Reflex hammer	x	Padded side rails
x	IV fluid Type: LR		IV fluid additives: Magnesium Sulfate 4 Gm.				

	Nasal cannula		Face tent	x	Simple Face Mask	x	Non-rebreather mask
x	BVM/Ambu bag		Nebulizer Tx kit		Flowmeters (extra supply)		

**4. Documentation and Order Forms**

x	Provider orders	x	Med Admin Record	x	Hx & Physical	x	Lab Results
x	Progress Notes	x	Graphic record		Anes/PACU record	x	ED Record/Triage
	Med Reconciliation		Transfer orders	x	Mag Sulfate Protocol in front of chart		
x	Nurses' Notes		Dx test reports	x	Code Record	x	Prenatal record
x	Actual medical record binder			x	Electronic Medical Record		

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

#	Medication	Dose	Route	#	Medication	Dosage	Route
	Calcium Gluconate	1000mg/10 ml Vial	IV		Mag Sulfate	4 – 6 gm Loading Dose/ 1-2 gm maintenance dose	IVPB
	Nifedipine	10 mg	PO		Labetalol	20 – 80 mg	IV
	Hydralazine	5 -10 mg	IV		Lorazepam	4 mg	IV

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

**Initiation of Scenario:** Tiffany is a 16-year-old female G1P0 at 33 weeks gestation. She was late to receive prenatal care and has only her Mom as a support person. She is under weight for her current gestation. The father of her baby is in and out of her life and cannot be relied upon for support. She was admitted yesterday to labor and delivery with a BP of 150/88, HR 82, RR 20, T 97.9, FHR 150's. No c/o uterine contractions and membranes are intact. DTRs were 2+ and clonus was negative. On admission, she denied H/A, visual changes and epigastric pain. She had mild pedal edema. She was admitted with a diagnosis of Preeclampsia and was started on Magnesium sulfate with a 4gm loading dose followed by 2/gm/hr. maintenance dose. She was transferred to the post-partum unit, this morning, for continued observation and completion of a 24-hour urine collection. Pt was transferred from L&D with report sheet stating she and fetus are stable for care by Antepartum RN. Urine is on the counter, on ice, the collection ends at 1300, today. Magnesium sulfate is infusing at 2gm/hr. (50 mL/hr.) and there is 50 ml left in the bag. LR is running at TKO rate of 33 mL/hr. and there is 200ml left in the bag. Fetal assessment is now NST's q4H.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>1. Baseline</b> Resting quietly in bed in semi-Fowlers position</p> <p>Mother at bedside</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>If asked, patient reports</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headache 10/10</li> <li><input type="checkbox"/> Epigastric pain 8/10</li> <li><input type="checkbox"/> New onset of blurred vision</li> </ul> </div>	<p><b>Operator</b> Display vital signs as learner assesses &amp; attaches pt. to oximetry RR: 24/min, Lungs: clear SpO<sub>2</sub>: 98% RA HR: SR @ 100 BP: 173/103 T: 98.0 F. FHR: 160's w/minimal variability</p> <p><b>Cues:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> If pain not assessed, patient will report pain status and blurred vision</li> <li><input type="checkbox"/> If EFM not applied, patient's mother will ask about "checking the baby"</li> </ul> <p><b>Triggers:</b> If assessment takes longer than 5 minutes, begin seizure</p>	<p><b>Learner Actions</b></p> <ol style="list-style-type: none"> <li>1. Introduces self and role to patient and mother.</li> <li>2. Identifies patient using 2 patient identifiers</li> <li>3. Updates white board in room</li> <li>4. Performs pain assessment</li> <li>5. Performs focused assessment based on patient's report of symptoms</li> <li>6. Takes maternal vital signs</li> <li>7. Applies EFM for NST</li> <li>8. Applies seizure pads on side rails.</li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Therapeutic communication with patient and mother</li> <li><input type="checkbox"/> Elements of focused assessment based on patient report of symptoms</li> <li><input type="checkbox"/> Significance of clinical manifestations in this situation</li> </ul>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2. Patient begins to complain of increasing pain</p> <p><b>Cues:</b> Patients mother becomes agitated and asks “Why isn’t the doctor here?”</p>	<p><b>Operator:</b> One minute after EFM applied vital signs: ↑ BP 188/110 HR 100 RR 28, O2 sats: 98% FHR:  <input type="checkbox"/> 160’s with minimal variability  <input type="checkbox"/> Prolonged variable deceleration to 130 for 2 minutes</p> <p>If learner does not call for 2<sup>nd</sup> nurse, next call for assistance will be delayed</p> <p>If learner does not notify MD, it will take longer to arrive when seizure begins</p> <p><b>Triggers:</b> Learner Actions complete within 5 minutes</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Calls for second nurse to bring Labetalol 20 mg IV</li> <li>2. Calls provider to notify of ↑ BP, pain status change using SBAR communication</li> <li>3. Explains change in status and rationale for current interventions to patient and mother in simple terms</li> <li>4. Prepares patient and mother for anticipated interventions in simple terms</li> <li>5. Prepare suction and oxygen</li> <li>6. Have bite block available at bedside</li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rationale for calling for help early</li> <li><input type="checkbox"/> Identification of risk factors for impending seizure</li> <li><input type="checkbox"/> SBAR communication with interprofessional team</li> <li><input type="checkbox"/> Communication with patient and mother to allay anxiety and keep informed</li> </ul>



STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>3.</b> 3 minutes later: Patient begins to seize</p> <p><b>Cues:</b></p> <ul style="list-style-type: none"> <li>❑ If not placed on left side, mother will scream “she’s choking”</li> <li>❑ If staff alert button not pushed, mother screams “get some help in here!”</li> <li>❑ If no education, mother screams “what is happening?”</li> </ul>	<p><b>Operator:</b> 3 minutes later: Begin seizure activity ↓O2 sats to 94%</p> <p><b>Triggers:</b> Learner Actions completed in 5 minutes</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Place patient on left side to prevent aspiration</li> <li>2. Calls for help – push staff alert button</li> <li>3. Assures integrity of pt.’s IV</li> <li>4. Assesses FHR during seizure</li> <li>5. Delegates patient monitoring to 2<sup>nd</sup> nurse while calling provider</li> <li>6. Administers Lorazepam 5 mg IV per provider order</li> <li>7. Notes time, length, type and characteristics of seizure</li> <li>8. Educates mother about what is happening and what to expect in simple terms</li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>❑ Patient and family communication</li> <li>❑ Patient safety measures</li> <li>❑ SBAR communication to health care team</li> <li>❑ When to call for assistance</li> <li>❑ Safe IV administration</li> </ul>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>4.</b></p> <p>Patient vomits and aspirates</p>	<p><b>Operator:</b></p> <p><b>Continuous vomiting and seizure sounds</b></p> <p><b>1 minute later:</b></p> <p>BP 90/60 HR 50 RR choking, gasping O2 sats 90% FHR rapid deceleration to 90's with absent variability</p> <p><b>Triggers:</b></p> <p>Learner Actions complete within 2 minutes</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Suctions patient</li> <li>2. Administers O2 @ 10L/mask</li> <li>3. Maintains left lateral position</li> <li>4. Assesses maternal vital signs</li> <li>5. Assesses FHR and contractions</li> <li>6. Calls for more assistance</li> </ol>	<p><b>Debriefing Points</b></p> <ul style="list-style-type: none"> <li>❑ Patient safety during seizure activity: maternal &amp; fetal</li> <li>❑ Interprofessional communication to assure safety – call outs, check backs, closed loop communication</li> <li>❑ SBAR</li> <li>❑ Elements of continuous assessment</li> </ul>
STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>5.</b></p> <p>Unresponsive</p>	<p><b>Operator</b></p> <p>2 minutes later Maternal and FH tones cease Maternal Cardiac Arrest</p> <p><b>Cues &amp; Triggers</b></p> <ol style="list-style-type: none"> <li>1. If no call for help, MD &amp; Charge Nurse will arrive and ask about FHR</li> <li>2. If Code Blue not called, possible maternal death</li> </ol>	<p><b>Learner Actions</b></p> <ol style="list-style-type: none"> <li>1. Calls a Code Blue/ Pushes Code button</li> <li>2. Notes time of cardiac arrest</li> <li>3. Begins resuscitation</li> <li>4. Overhead paging “Any physician to L&amp;D stat”!</li> </ol>	<p><b>Debriefing Points</b></p> <ul style="list-style-type: none"> <li>❑ Interprofessional communication in rapidly deteriorating condition</li> <li>❑ Strategies for keeping mother informed</li> </ul>

STATE/PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>6.</b> Patient unresponsive to resuscitation</p> <p>Pulse returns to 60 after 4 minutes of CPR</p> <p>Mother continues crying and asking for help. Is on cell phone calling family to come to hospital</p>	<p><b>Operator:</b> <b>4 minutes later:</b> Cardiac Arrest continues</p> <p>Pulse returns to 60 after 4 minutes of CPR</p>	<p><b>Learner Actions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Calls out “4 minutes of resuscitation”</li> <li><input type="checkbox"/> Team prepares for emergency C-section</li> <li><input type="checkbox"/> Primary nurse calls out “Code C.”</li> <li><input type="checkbox"/> Team continues CPR until there is a pulse</li> <li><input type="checkbox"/> Someone is delegated to stay with mother while patient is transferred to OR</li> </ul>	<p><b>Debriefing Points:</b></p> <ol style="list-style-type: none"> <li>1. Transfer to OR without interrupting CPR.</li> <li>2. Interprofessional team communication</li> <li>3. Family communication</li> </ol>
<p>Scenario End Point: Student learners: End scenario after seizure interventions are or are not performed. Health care professionals: Continue to onset of CPR and Transfer to OR</p>			
<p>Suggestions to <u>decrease</u> complexity: End scenario after seizure interventions Suggestions to <u>increase</u> complexity: Perform emergency cesarean section in the labor room because all ORs are occupied Could allow maternal and/or fetal death to allow for grief support and practice</p>			

**APPENDIX A: HEALTH CARE PROVIDER ORDERS**

<b>Patient Name:</b>	<b>Diagnosis:</b>
<b>DOB:</b>	
<b>Age:</b>	
<b>MR#:</b>	

† No Known Allergies

† Allergies & Sensitivities

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
<b>Signature</b>		

**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 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 considering 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>			