

## SECTION I: SCENARIO OVERVIEW

<b>Scenario Title:</b>	General Safety for Pneumonia: Supplemental O2 & PPE	
Original Scenario Developer(s):	C. O’Leary-Kelley PhD, RN, CNE; L. Sweeney MS, RN, CNS	
Date - original scenario	10/09	
Validation:	12/09 K. Bawel-Brinkley, PhD, RN, CNE	
Revision Dates:	12/10; 05/18 J. Hannans PhD, RN, CNE; C. Nevins DNP, RN, CNE	
Pilot testing:	01/10 M. Miller, MA, RN	
QSEN revision:	04/11 C. O’Leary-Kelley PhD, RN, CNE, M. Miller, MA, RN, CHSE;	
<p><u>Estimated Scenario Time:</u> 15-20 minutes      <u>Debriefing time:</u> 30 – 40 minutes</p> <p><u>Target group:</u> Pre-licensure Fundamental nursing students</p> <p><u>Core case:</u> Fundamentals; Basic safety-correct use of Personal Protective Equipment (PPE)</p> <p><u>QSEN Competencies:</u></p> <ul style="list-style-type: none"> <li>• Patient-Centered care</li> <li>• Safety</li> <li>• Teamwork and Collaboration</li> <li>• Evidence-Based Practice</li> </ul> <p><u>Brief Summary of Case:</u> Mrs. Kelly is a 68-year-old woman admitted three days ago for fever and respiratory distress and is diagnosed with Community Acquired Pneumonia (CAP). Her sputum sample results this morning are positive for MRSA. Learners are expected to follow droplet precautions, assess LOC and respiratory status, and recognize dyspnea and signs of oxygen desaturation. They are to apply oxygen, use PPE, and communicate assessment data to charge nurse using SBAR communication.</p> <p><i>This scenario is appropriate for beginning nursing fundamentals students. It can be made more complex by making the patient increasingly confused or agitated or deteriorating to respiratory failure.</i></p>		

EVIDENCE BASE / REFERENCES (APA Format)
Centers for Disease Control and Prevention. (2018). <u>Precautions to prevent spread of MRSA.</u> <a href="https://www.cdc.gov/mrsa/healthcare/clinicians/precautions.html">https://www.cdc.gov/mrsa/healthcare/clinicians/precautions.html</a>
Quality and Safety Education for Nurses (QSEN) Institute. (2018). QSEN Competencies. Retrieved May 13, 2018, from <a href="http://qsen.org/competencies/pre-licensure-ksas/#safety">http://qsen.org/competencies/pre-licensure-ksas/#safety</a>
Hinkle, J. L., & Cheever, K. H. (2018). <i>Brunner &amp; Suddarth’s Textbook of Medical-Surgical Nursing</i> (14 <sup>th</sup> ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
Shinoda, Y., et.al. (2016). Antibacterial therapy of aspiration pneumonia in patients with methicillin-resistant Staphylococcus aureus-positive sputum: Identification of risk factors, <i>Die Pharmazie International Journal of Pharmaceutical Science</i> , 71(2): 109-112.
The Joint Commission. (2018). 2018 Hospital National Patient Safety Goals. Retrieved from <a href="https://www.jointcommission.org/hap_2017_npsgs/">https://www.jointcommission.org/hap_2017_npsgs/</a>
Postma, D. F., van Werkhoven, C. H., van Elden, L. J. R., Thijsen, S. F. T., Hoepelman, A. I. M., Kluytmans, J. A. J. W., ... Bonten, M. J. M. (2015). Antibiotic treatment strategies for community-acquired pneumonia in adults. <i>New England Journal of Medicine</i> , 372: 1312-1323.

**SECTION II: CURRICULUM INTEGRATION**

**A. SCENARIO LEARNING OBJECTIVES**

**Learning Outcomes**

1. Provide patient care that promotes safety and minimizes risk of error.
2. Apply nursing process in clinical decision-making.
3. Integrate understanding of multiple dimensions of patient centered care.

**Specific Learning Objectives**

1. Apply principles of hand hygiene and infection control
2. Correctly wash hands, introduce self, and identify patients.
3. Gather relevant patient, environmental and contextual data.
4. Cluster relevant data to identify patient’s primary problem(s).
5. Recognize acute changes in patient condition or environment that need immediate intervention.
6. Perform timely nursing interventions to address urgent or primary problem(s).
7. Evaluate effectiveness of interventions.
8. Communicate patient needs, values, and preferences to other members of health care team.

**Critical Learner Actions**

1. Perform hand hygiene, introduce self and role, and identify patient using two patient identifiers.
2. Apply and remove personal protective equipment (PPE) according to current CDC Guidelines for droplet precautions.
3. Perform a general survey and focused respiratory assessment.
4. Position patient for optimal ventilation.
5. Review health care provider’s orders and initiate appropriate interventions.
6. Apply oxygen per orders based upon assessment findings.
7. Reassess relevant parameters to evaluate patient response to interventions.
8. Report pertinent data to health care team using standardized communication tool. (SBAR)

**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 & focused resp. assessment
<input type="checkbox"/> Respiratory pathophysiology	<input type="checkbox"/> Correct application/removal of PPE
<input type="checkbox"/> CDC guidelines for isolation precautions and hand hygiene	<input type="checkbox"/> Nursing interventions for acute respiratory conditions including oxygen therapy
<input type="checkbox"/> Current National Patient Safety Goals	<input type="checkbox"/> Engage patients to promote health, safety, well-being and self-care management
<input type="checkbox"/> Structured communication tools (i.e, SBAR)	<input type="checkbox"/> Communication using SBAR
<input type="checkbox"/> Dimensions of patient-centered care	<input type="checkbox"/> Value active patient participation in plan of care

### SECTION III: SCENARIO SCRIPT

#### A. Case summary

Mrs. Kelly is a 68-year-old woman admitted three days ago for fever and shortness of breath and is diagnosed with Community Acquired Pneumonia (CAP). The lab recently reported her sputum sample is positive for MRSA.

Learners are expected to perform the following specific learner actions: initiate isolation precautions-droplet precautions for MRSA positive sputum; complete a head-to-toe assessment, including LOC and focused respiratory assessment; and recognize dyspnea and signs of oxygen desaturation. They are to apply oxygen and communicate assessment data to charge nurse using SBAR communication.

It is expected that 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; demonstrating effective therapeutic communication; and educating the patient/family about isolation precautions.

#### B. Key contextual details

After receiving report, the student nurses wash hands/ don PPE and enter the room to find the patient sitting in bed. Vital Signs are stable, low-grade temperature and occasional coughing.

#### 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	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
RN 1	Assigned to care for patient	Learner
RN 2	Assigned to assist with assessment and interventions	Learner
Charge Nurse		Standardized Participant

D. Patient/Client Profile				
Last name:	Kelly		First name:	Janet
Gender: Female	Age: 68	Ht: 5'6"	Wt: 70 kg.	Code Status: Full
Spiritual Practice: None stated		Ethnicity: Caucasian		Primary Language spoken: English
1. History of present illness				
<p>68-year-old female admitted with chief complaint of cough and shortness of breath for one week worsening 2 days prior to admission with fever. Cough is productive of thick, tenacious greenish colored sputum. The patient has been diagnosed with Community Acquired Pneumonia (CAP). The lab reported this morning that her sputum sample is positive for MRSA. Droplet isolation has been ordered.</p> <p>No significant medical or surgical history.</p>				
<b>Primary Medical Diagnosis</b>		Pneumonia		

2. Review of Systems	
CNS	Anxious, alert and oriented to person, place, time and situation
Cardiovascular	NSR @ 98 bpm, BP 136/90; no bruits or murmurs heard
Pulmonary	Bilateral crackles/coarse rhonchi. Smoker x 30 yr, quit 10 years ago. Moderate dyspnea, productive cough of greenish thick sputum
Renal/Hepatic	GFR – 90 mL/min; Liver non-tender; normal size
Gastrointestinal	Abdomen soft, non-tender, non-distended. Active bowel sounds all quadrants
Endocrine	Post-menopausal female. No hx of diabetes or other endocrine conditions
Heme/Coag	No bruising or history of bleeding problems
Musculoskeletal	Active ROM all extremities 5/5
Integument	Clear and intact; no lesions
Developmental Hx	Normal female age 68
Psychiatric Hx	No psych hx
Social Hx	Lives with husband in trailer park; recently laid off from her bank teller job
Alternative/ Complementary Medicine Hx	None

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

3. Current medications	Drug	Dose	Route	Frequency
	Acetaminophen	650 mg	PO	Every 4 h PRN T ≥ 38.3 C (101° F)
	Vancomycin	500 mg	IV	Every 24 hours
	Zosyn	3.375 G	IV	Every 6 hours infused over 4 hr

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.4	Cl: 102	HCO3: 22	BUN: 18	Cr: 0.8
Ca:	Mg:	Phos:	Glucose: 110	HgA1C:	
Hgb: 14.5	Hct: 41.9	Plt: 221	WBC: 12.6	ABO Blood Type:	
PT	PTT	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH: 7.35	paO2: 88	paCO2: 43	HCO3/BE: 22	SaO2: 95%	
VDRL:	GBS:	Herpes:	HIV:		
CXR: Infiltrate Rt. Lobe; Bilat atelectasis		ECG: 12 lead - WNL			
CT:		MRI:			
Other: AFB	Negative	Sputum: MRSA +			

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)					
1. Initial physical appearance					
Gender: female		Attire: gown			
Alterations in appearance (moulage): Grey wig, Glasses Tissues in emesis basin with greenish thick sputum					
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		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

BP: 130/90	HR: 98	RR: 24	T: 99.0° F	SpO2: 90% RA	
CVP:	PAS:	PAD:	PCWP:	CO:	
AIRWAY:	ETCO2:	FHR:			
Lungs: Sounds/mechanics	Left: crackles		Right: crackles		
Heart:	Sounds:				
	ECG rhythm:	Sinus rhythm, no ectopy (if tele; continuous EKG not req.)			
	Other:				
Bowel sounds:	Active in 4 quadrants		Other:		

3. Initial Intravenous line set up						
x	Saline lock #1	Site:				IV patent (Y/N)
x	IV #1	Site:	RA	Fluid type: ½ NS @ 75 mL/hr	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						
x	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	x	Infusion pump:	Pump settings: 75 mL/hr		
	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)						
Patient Room Droplet Precautions signage and PPE: gloves, gowns, and standard masks						

2. Equipment, supplies, monitors						
(In simulation action room or available in adjacent core storage rooms)						
x	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	
x	IV fluid			Tubes/drains	Blood product	
	Type: Vancomycin IVPB (empty bag)			Type:	ABO Type: # of units:	

3. Respiratory therapy equipment/devices							
x	Nasal cannula		Face tent	x	Simple Face Mask		Non rebreather mask
	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Health Care Provider orders		Med Admin Record		H & P		Lab Results
	Progress Notes	x	Graphic record (paper or electronic)		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 or electronic record, constructed per institutional guidelines				Other Describe:		

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route
1	Acetaminophen	325 mg	PO					
	Vancomycin	500 mg	IV					

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

**Initiation of Scenario:** 0700 - Shift Report: Mrs. Janet Kelly is a 65-year-old female admitted 3 days ago with a chief complaint of fever, coughing, shortness of breath for one week, worsening in the 2 days prior to admission. On admission she had significant respiratory distress and was diagnosed with Community Acquired Pneumonia (CAP). At present, her vital signs are stable; she has a low-grade fever and occasional productive cough of thick green sputum. Her sputum is negative for AFB and positive for *Staphylococcus aureus*. She is on droplet precautions for MRSA in her sputum. The RNs are to assess the patient, completing a focused respiratory assessment, and report any abnormal findings.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>1. Baseline</b></p> <p>Patient lying in semi-fowler position with 2 side rails up; call light in reach.</p> <p>Alert and oriented to person, place, time and situation. Responds appropriately to learner’s questions.</p> <p>Occasional cough and complaints of cough, but no acute distress.</p>	<p><b>Operator</b></p> <p>BP – 130/90 HR – 98/sinus rhythm RR - 24 T – 37.7 C (99.9° F) O2 sat – 90-93% Room Air</p> <p>Vital signs not displayed on monitor until assessed or monitor turned on by learner</p> <p><b>Triggers:</b> Learner Actions completed or 5 minutes has elapsed</p>	<p><b>Learner Actions</b></p> <ol style="list-style-type: none"> <li>1. Wash hands</li> <li>2. Introduce self and role</li> <li>3. Don mask, gloves and gown per Droplet Precautions</li> <li>4. Communicate actions and rationale to patient</li> <li>5. Identify patient using 2 patient identifiers</li> <li>6. Perform general survey</li> <li>7. Assess vital signs</li> <li>8. Elevate HOB for comfort and respiratory status</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. Components of Droplet Precautions and rationale per CDC guidelines</li> <li>3. Significance of vital sign deviations from normal.</li> <li>4. Opportunities for patient teaching r/t promoting self-care with productive cough.</li> </ol>



STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>2.</b></p> <p>Patient continues to answer questions appropriately. Coughing more frequently and becomes more distressed.</p> <p>States “I don’t ... seem to be able ...to catch ...my breath.” “I’m ...so sick ... of this cough.” Interrupted speech</p>	<p><b>Operator:</b></p> <p>RR – 28 - 30 HR – 100 O2 sat – 88-90% RA</p> <p>If student does not apply oxygen, O2 sat continues to decrease and remain 86-89%, patient complaining of shortness of breath as an additional cue for students</p> <p>Lung sounds: bilateral coarse crackles/rhonchi</p> <p>Assessment findings not displayed on monitor until assessed by learner</p> <p><b>Triggers:</b> Learner actions completed or 5 minutes elapsed.</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Recognize O2 desaturation.</li> <li>2. Communicate findings to co-worker/team.</li> <li>3. Check health care provider orders.</li> <li>4. Administer O2 per nasal cannula at 2 Liters/min.</li> <li>5. Complete focused respiratory assessment.</li> <li>6. Inform patient of rationale for placing O2.</li> </ol>	<p><b>Debriefing Points:</b></p> <ol style="list-style-type: none"> <li>1. Anticipation of complications with pneumonia and recognition of assessment findings indicating a change in patient status.</li> <li>2. Cluster of relevant data to identify urgent problem related to desaturation of oxygen.</li> <li>3. Rationale for reassessment to determine effectiveness of interventions.</li> </ol>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>3.</b> “Why do I need ...that tube in my nose?”  “Does that mean ...I’m not going to be ...able to go home?”  “Does that mean I’m not getting better?”</p>	<p><b>Operator:</b> O2 sat – 92-94% HR – 100 RR – 20</p> <p><b>Triggers:</b> Performs learner actions within 3 minutes.</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Reassess O2 sat.</li> <li>2. Communicates pertinent information to patient therapeutically in calm, concise language.</li> <li>3. Responds and reassures patient concerns with sensitivity, respect and honesty.</li> </ol>	<p><b>Debriefing Points:</b></p> <ol style="list-style-type: none"> <li>1. Physiological responses to increased anxiety.</li> <li>2. Explore learner perceptions of the value of seeing the situation “through patient’s eyes.”</li> <li>3. Nurses’ role in relieving all types and sources of patient distress. (suffering)</li> </ol>
STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>4.</b>  Patient calms with communication from learners.</p>	<p><b>Operator:</b>  O2 sat – 94% with O2 2L/min HR – 92 RR – 16</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. Educate patient about isolation precautions for MRSA and plan of care re diagnosis of pneumonia.</li> <li>2. Document assessment findings on graphic record.</li> <li>3. Organize pertinent data for SBAR report.</li> </ol>	<p><b>Debriefing Points</b></p> <ol style="list-style-type: none"> <li>1. Effective strategies for reducing reliance on memory to minimize risk of error.</li> <li>2. Use of structured communication tool to organize data for report.</li> <li>3. Rationale for isolation precaution and importance of discussing information with patients/family</li> <li>4. Oxygen delivery with consideration of smoking history</li> </ol>
<p>Scenario End Point: Charge nurse enters room while making rounds Ask learners for update on patient. Learners expected to provide SBAR.</p>			
<p>Suggestions to <u>decrease</u> complexity: Learners to perform assessment only and document in patient record.            Suggestions to <u>increase</u> complexity:            1) Increasing agitation and deterioration requiring respiratory assessment, with increase airway adjunct therapy such as nebulizer treatment, Bipap and/or respiratory failure            2) Lack of response to interventions resulting in call to health care provider for orders: ABG’s, pending transfer to higher level of care            3) Include family members with multiple questions and concerns            4) Have students administer Vancomycin IVPB, Zosyn IVPB, and/or change maintenance IV fluid bag</p>			

**APPENDIX A: HEALTH CARE PROVIDER ORDERS**

<b>Patient Name: Kelly, Janet</b>  <b>DOB: xx/xx/xxxx</b>  <b>Age: 68 years old</b>  <b>MR#: 97254</b>		<b>Diagnosis: Pneumonia</b>
† No Known Allergies † Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
XX/XX (3 days prior)	1030	Admit Diagnosis Pneumonia
		IV NS 0.45% at 125 mL/hour continuous
		Daily CBC, BMP, and CXR
		Bathroom privileges with assist
		Levaquin 750 mg every 24 hours IVPB
		Sputum for Culture & Sensitivity
		Acetaminophen 650 mg po every 4 hours prn fever greater than or equal to 38.3 C (101 F) or headache
		Titrate Oxygen per Nasal Cannula to keep O2 sat above 91%
		Low sodium diet
		Zosyn 3.375 G IV every 6 hours, infused over 4 hours
XX/XX (2 days prior)	0845	Decrease IV fluids NS 0.45% to 75 mL/hr
XX/XX (day of care)	0530	
		D/C Levaquin
		Vancomycin 500 mg every 24 hours IVPB
		Vancomycin trough random in 72 hours
		Isolation: Droplet precautions
<b>Signature</b>		<b>Dr. Eileen Washington</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 checked="" type="checkbox"/> Group	<input checked="" type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
<input type="checkbox"/> Debriefing Guide	<input checked="" type="checkbox"/> Objectives	<input checked="" 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"> <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. Was there any RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?</li> <li>5. The main objective of the simulation was to recognize airway compromise in patient with pneumonia and appropriately intervene.               <ol style="list-style-type: none"> <li>a. With that in mind, can you identify aspects of your nursing care where you addressed the objectives?</li> <li>b. Are there any aspects of your care that you would handle differently if you could?</li> </ol> </li> <li>6. What risk factors did the patient have that pre-disposed her to airway compromise? Discuss considerations and potential issues with advanced aged pneumonia patients.</li> <li>7. In what ways did you check feel the need to check ACCURACY of the data you were given?</li> <li>8. In what ways did prioritization affect your performance?</li> <li>9. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members?</li> <li>10. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?</li> <li>11. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?</li> <li>12. Discuss actual experiences with diverse patient populations.</li> <li>13. Discuss roles and responsibilities when addressing acute needs of patients or during a crisis.</li> <li>14. Discuss how current nursing practice continues to evolve in light of new evidence.</li> <li>15. Discuss how each of the QSEN competencies for evidence-based practice, patient-centered care, safety, and teamwork &amp; collaboration impacted your care of the patient.</li> <li>16. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care.</li> </ol>			
<b>Notes for future sessions:</b>			