

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Swallowing Deficit-IPE Speech Pathology & Nursing
Original Scenario Developer(s):	N. Nouredine EdD RN MSN; D. Brady DNP RN CN, D. Hagge, Ph.D., CCC-SLP
Date - original scenario	04/14
Validation:	04/14 M. Miller, MA, RN, CHSE
Revision Dates:	04/14, 10/18 (reviewed: dh, db, mm)
Pilot testing:	04, 05/14
QSEN revision:	04/14
<p><u>Estimated Scenario Time:</u> this is an unfolding scenario of two phases with a total estimated time of one hour and 30 minutes</p> <p>Phase I Sim: 15 minutes Phase I debriefing: 20 minutes Phase II Sim: 25 minutes Phase II debriefing: 40 minutes</p> <p><u>Target group:</u> BSN students in acute care setting; pre-licensure Speech and Language Pathology graduate students in acute care setting rotation</p> <p><u>Core case:</u> A 60 year old male admitted the day before for MCA ischemic stroke.</p> <p><u>QSEN Competencies:</u> Patient Centered Care; Patient Safety; Teamwork and Collaboration; and informatics.</p> <p><u>Brief Summary of Case:</u> T. D. is a 60 year old male admitted the day before early morning for ischemic stroke to the left Middle Cerebral Artery (MCA) anterior branch infarct. Patient was found by wife in the morning unable to get out of bed, weakness to the upper/lower extremities, unable to state his name, garbled speech, and disoriented. He was last seen normal the evening before at 930 when he went to bed. She called 911 and patient was brought to ER by ambulance.</p>	

EVIDENCE BASE / REFERENCES (APA Format)

Lewis, Sharon, Shannon Dirksen, Margaret Heitkemper, Linda Bucher. <i>Medical-Surgical Nursing: Assessment and Management of Clinical Problems, 9th Edition</i> . Mosby, 2014. VitalBook file.
Leder, S. B., Suiter, D. M., Warner, H. L., Acton, L. M., & Siegel, M.D. (2011). Safe initiation of oral diets in hospitalized patients based on passing a 3-ounce (90 cc) water swallow challenge protocol. <i>QJM: An International Journal of Medicine, 105</i> , 257-263.
Schepp, S. K., Tirschwell, T., Miller, R. M., & Longstreth, W. T. (2012). Swallowing screens after acute stroke: A systematic review. <i>Stroke, 43</i> , 869-871.
Suiter, D. M., & Leder, S. B. (2008). Clinical utility of the 3-ounce Water Swallow Test. <i>Dysphagia, 23</i> , 244-250.
Swiger, N., Riquelme, L., & Steele, C. (2009). Frequently asked questions on swallowing screening: Special emphasis on patients with acute stroke. <i>ASHA Special Interest Division 13: Swallowing and Swallowing Disorders (Dysphagia)</i> . Retrieved from http://www.asha.org/uploadedFiles/FAQs-on-Swallowing-Screening.pdf
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SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

IPE Learning Outcomes
1. Provide patient centered care
2. Work effectively in IP teams
3. Utilize informatics
4. Employ evidence based practice
IPE Learning Objectives
1. Practice Interprofessional communication
2. Demonstrate Interprofessional teamwork for optimal patient outcome
3. Implement values/ethics for IP practice
4. Implement roles and responsibilities for collaborative practice
Critical Learner Actions Phase 1
1. Washes Hands
2. Introduces self (and role) to patient and family (if present).
3. Identifies patient using double identifiers/Updates white board in room
4. Assesses environment for safety and corrects identified problems Safety check of room
5. Checks vital signs: HR, RR, BP, Temp, pain, O ₂ Sat
6. Engages family and addresses concerns.
7. Positions patient with head of bed up.
8. Completes focused assessment for neuro status/ airway.
9. Performs swallow screening before administering meds
10. Communicates in a professional/collaborative way; requests SLP assistance to perform swallow screening
11. Accurately identifies swallowing behaviors that indicate “fail” on swallow screen (cough &/or throat clear)
12. Evaluates lab data/lung assess w/SLP students to determine if patient has potential aspiration pneumonia
13. Calls provider and request orders to restart patient on home meds, CXR, and swallow evaluation
Critical Learner Actions Phase 2
1. Washes Hands
2. Introduces self (and role) to patient and family (if present).
3. Identifies patient using double identifiers/Updates white board in room
4. Assesses environment for safety and corrects identified problems Safety check of room
5. Engages family and addresses concerns.
6. Positions patient with head of bed up.
7. Consults with SLP on new order and collaborates on bedside swallow evaluation
8. Administers medications using 6 rights and 3 checks.

B. PRE-SCENARIO LEARNER ACTIVITIES (Prerequisite Competencies)

Knowledge	Skills/ Attitudes
<input type="checkbox"/> Normal Adult head to toe physical assessment	<input type="checkbox"/> Vital signs, O ₂ administration, Univ.Precautions
<input type="checkbox"/> Read monitors/interpret basic O ₂ , HR, RR	<input type="checkbox"/> Use emergency equip. & operate a hospital bed.
<input type="checkbox"/> Oxygen titration	<input type="checkbox"/> Professional & therapeutic communication skills.
<input type="checkbox"/> Problem solving/managing abn. Med. responses.	<input type="checkbox"/> Neuro Assess (cogn impair, oral/peri, swallow eval)
<input type="checkbox"/> S/S CVA, aspiration, dysphagia	<input type="checkbox"/> Swallow screen with 3 oz of water
<input type="checkbox"/> Professional SBAR communication	<input type="checkbox"/> Administering crush PO meds

SECTION III: SCENARIO SCRIPT

A. Case summary

T. D is a 60 yo male admitted 6 am the day before for ischemic stroke to ant. branch of (L) Mid Cerebral Artery. Patient was found by wife in bed, unable to get up, with weakness to the RA & RL, unable to state his name, garbled speech & disoriented. She called 911 and patient was brought to ER by ambulance. Wife reports patient was fine last night at 930 when he went to bed.

Medical History: Asthma, COPD, and hypertension

Surgical History: Gallstones with removal of gall bladder 10 years prior.

Social History: Lives w/wife, daughter, 2 grandchildren. Retired univ. prof., active as a hospital volunteer.

Current Assessment:/handoff report

Is oriented to his name, confused about date/time, understands he is in the hospital. Current Vital Signs: BP: 190/86; HR: 100; RR: 24; T: 98.7; SPO2: 94% and pain 0/10. Right arm and leg weakness, unable to state name of family members, states same word repeatedly.

B. Key contextual details

- Patient has orders for introducing soft diet and switching to P.O. meds
- Daughter at the bedside insisting patient be fed
- Need bedside swallow screening to be able to give meds
- A.M. Labs have been drawn; waiting for results

C. Scenario Cast

Patient/ Client	<input type="checkbox"/> High fidelity simulator	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input checked="" type="checkbox"/> Standardized male patient (age 60)	
Role	Brief Descriptor	Standardized Participant (SP) or Learner (L)
RN 1	RN to BSN student on rounds w/ ST. (Phase 1) perform swallow screen, lab anal (Phase 2) participate in swallow eval, adm med using new diet restrictions.)	Learner
RN 2	RN to BSN student on rounds with ST. Same as RN 1	Learner
RN 3	Recorder, responsible SBAR call if needed (Phase 1 & Phase 2)	Learner
SLP 1	SLP (Phase 1 observe/instruct RN in Swallow screen) (Phase 2 complete swallow eval & instruct RN in diet/liquid modifications; collaborate on medication administration)	Learner
SLP 2	Same as SLP 1	Learner
Daughter	Neatly dressed in clean button blouse and jeans; hair combed.	Standardized Participant
Doctor	Voice on Phone	Standardized Participant

D. Patient/Client Profile				
Last name:	Dixon		First name:	Don
Gender: Male	Age: 60	Ht: 6'0"	Wt: 190 lbs	Code Status: Full
Spiritual Practice: none		Ethnicity: Caucasian		Primary Language spoken: English
1. History of present illness				
Primary Medical Diagnosis		Left Middle Cerebral Artery Ischemic Cerebral Vascular Accident		

2. Review of Systems	
CNS	No prior impairments; Currently: PERL; Garbled Speech, Oriented to Name, not to time or location; right arm and leg weakness;
Cardiovascular	HTN Hx
Pulmonary	Asthma COPD Hx
Renal/Hepatic	
HEENT	
Gastrointestinal	Gallbladder removal hx
Endocrine	
Heme/Coag	
Musculoskeletal	right arm and leg weakness; unable to get up to chair without assistance;
Integument	
Developmental Hx	Retired (?) husband, father and grandfather
Psychiatric Hx	none
Social Hx	Lives with wife, daughter and grandchildren at home
Alternative/ Complementary Medicine Hx	None

Medication allergies:	None	Food/other allergies:	None
Meds taken at home	Metoprolol 25mg po daily, Aspirin 81mg po daily, Multi vitamin once daily, Albuterol Inhaler 2 puffs PRN as needed		

3. Current medications	Drug	Dose	Route	Frequency
	Oxygen; to keep O ₂ sat equal to or greater than 94%	2L	NC	<ul style="list-style-type: none"> • Call if more than 6L required • Humidify if more than 4L required
	Tylenol	650mg	PR	Q 6 hr PRN for temp greater than 100.4 F
	Protonix	40mg	IV	daily
	Lovenox	40mg	Sub-q	bid
	Morphine	2mg	IVP	q 2 hrs PRN for severe pain (7-10)
	Norco	5mg	PO	q 4 hrs PRN for mild (1-3) to moderate(4-6) pain
	Albuterol inhaler	2 puffs	Inh	As needed
	Metoprolol	25mg	PO	Daily hold for greater than 50; SBP less than 120
	Aspirin	81mg	PO	daily
	Multi vitamin	1 Tablet	PO	Daily

4. Laboratory, Diagnostic Study Results NONE

Na: 140	K: 3.6	Cl: 100	CO ₂ : 25	BUN: 20	Cr: 1.1
Ca: 8.6	Mg: 2.1	Phos:	Glucose: 115	HgA1C: 5.4	
Hgb: 11.7	Hct: 35.2	Plt: 480	WBC: 6,000	RBCs: 4.1	
PT	PTT:26 sec	INR: 1.8	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO ₂ :	paCO ₂ :	HCO ₃ /BE:	SaO ₂ :	
VDRL:	GBS:	Herpes:	HIV:		
CXR:	ECG: NSR occasional PACs				
CT the head: initial ER CT was negative for hemorrhage. Follow up CT in 24 hours showed left MCA anterior branch infarct.					

E. Baseline Simulator/Standardized Patient State

1. Initial physical appearance

Gender: male	Attire: Patient in a hospital bed wearing a hospital gown and eye glasses				
Alterations in appearance (moulage): age appropriate wig Right side weakness; Fluent Aphasia.					
X	ID band present, accurate info		ID band present, inaccurate info		ID band absent or N/A
	Allergy band present, accurate		Allergy band present, inaccurate	X	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	X	Monitor on, standard display
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BP: 190/86	HR: 100	RR: 24	T: 98.7° F /37°C	SpO ₂ : 94
CVP:	PAS:	PAD:	PCWP:	CO:
Lung Sounds	Left: clear		Right: Clear	
Heart:	Sounds:	S1S2		
	ECG rhythm:	NSR		
Bowel sounds:	hyperactive		Other:	

3. Initial Intravenous line set up

	NS lock #1	Site:			IV patent (Y/N) Yes
x	IV #1	Site:		Fluid type:	Initial rate:
x	Main	R FA		NS	75
	Piggyback				
	IV #2	Site:		Fluid type:	Initial rate:
	Main				
	Piggyback				

4. Initial Non-invasive monitors set up

X	NIBP		ECG First lead:		ECG Second lead:
X	Pulse oximetry		Temp monitor/type		Other:

F. Environment, Equipment, Essential props

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

Patient room in Sim room: hospital bed, wall suction/oxygen/air equipment, IV stand/ IV NSS bag.

2. Equipment, supplies, monitors

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

Stethoscope/apple sauce/ disposable spoons

X	Bedpan/ Urinal		Foley catheter kit		Straight cath. kit		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	X	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:	1000ml 0.9% NS to run at the rate of 75 mls/hr			IV fluid additives:		Blood product ABO Type: # of units:

3. Respiratory therapy equipment/devices

X	Nasal cannula		Face tent		Simple Face Mask		Non re-breather mask
	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
X	Progress Notes		Graphic record		Anesthesia/PACU record		ED Record
X	Medication reconciliation		Transfer orders	X	Standing (protocol) orders		ICU flow sheet
X	Nurses' Notes	X	Dx test reports		Code Record		Prenatal record
	Actual medical record binder				Electronic Medical Record		

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

#	Medication	Dosage	Route	#	Medication	Dosage	Route
1	Metoprolol	25mg	po				

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
<p>Initiation of Scenario Frame I: Nursing students receive a handoff report from the previous shift nurse. Nursing students perform morning assessment and note BP meds due in the morning, family at the bedside, family demanding to feed, need screening to be able to give meds. Nursing students will perform initial swallow screen. SLP student (s) will observe and instruct nursing students on the swallow screening if requested. The swallow screening fails. See attached scripting within the Case Flow for case.</p>			
STATE / PATIENT STATUS		DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE	
<p>Patient: (Inconsistently speaks in 1-2 word utterances). “Hey”. “Hey”. “Yeah”. “Water”. “Good”.</p> <p>Daughter: (Emotional tone-5/10 anxiety) What is his blood pressure? When are you going to be able to give him his medications? He normally takes his Metoprolol 25mg twice daily. I don’t want him to have another stroke.</p> <p>Standardized patient: “Yeah, ok water”. “Good ...water”.</p> <p>Daughter: Explains she needs to go and get children to school, but will be calling in; Leaves the room.</p>	<p>Operator: BP: 190/86 HR: 100 RR: 24 T: 98.7°F /37°C SpO₂: 94 %</p> <p>Intermittently coughing</p> <p>Breath sounds: coarse breath sounds on left</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Nurse enters room, greets patient and daughter, gels in 2. Introduces self and identifies role; updates white board in room. 3. Informs patient of need to take vital signs and perform assessment. 4. Interacts with daughter, answering questions as able and informing both that oral liquids, food and medications will be withheld until safe swallowing can be assured. 5. Performs environmental safety assessment with focus on side rails, Yankur suction equipment 6. Assesses vital signs noting occasional coughing 7. Calls SLP to assist with swallow screen 	<p>Debriefing Points:</p> <p><u>Reaction Phase:</u></p> <ol style="list-style-type: none"> 1. How did the experience of caring for this patient feel for you and your team? 2. Is there anything really concerning you that you need to discuss right now? 3. Strategies for decreasing personal, team and family anxiety in this initial encounter. <p><u>Analysis Phase:</u></p> <ol style="list-style-type: none"> 1. National Patient Safety Goals 2. Priority Assessment – airway & breath sounds
STATE / PATIENT STATUS		DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE	

<p>2. standardized patient: “Oh God”. “Wow”. “Ok”.</p>	<p>Operator: drop O₂ sat to 92%.</p> <p>Patient coughing with water test</p> <p>Operator: Drop sat further to get to the alarm to trigger if students do not notice drop in saturation</p> <p>Trigger: Lab person drops off current lab reports or voice calls into room that labs have resulted.</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. SLP enters room and introduces self to patient 2. Nurse gives brief report to SLP and discusses patient, involving patient in discussion. 3. Nurse initiates swallow screen while SLP observes 4. SLP explains or demonstrates proper swallow screen if needed. (See Protocol) 5. Nurse notices drop in O₂ sats. 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Interprofessional communication - Was there additional information either of your groups felt you needed? 2. <u>NRS/SLP</u> students what were key elements of the bedside swallow screening that you will be able to implement in future practice settings? 3. <u>SLP students</u> what did you think were key elements of the swallow screening to teach the RN students? 4. <u>SLP students</u> what assessment findings indicated that the patient needed a SLP Swallow Evaluation? 5. <u>RN students</u>, what are you assessing on the labs that help you evaluate if the patient? What are you concerned with?
<p>STATE / PATIENT STATUS</p>	<p>DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE; Phase 2 of unfolding Case: Swallow Evaluation and Medication Administration at the Bedside</p>		
<p>Patient with high blood pressure and heart rate</p>	<p>Operator: Continue current VS setting</p>	<p>Learner Actions:</p>	<p>Debriefing Points:</p>

<p>needing Metoprolol medication and swallow evaluation so that medications can be given.</p> <p>Daughter has returned to bedside and remains anxious</p>	<p>Triggers: Physician indicates that she wants meds given po if at all possible so that we do not need to put a tube in and restrain the patient.</p> <p>Trigger: MD “When the Speech Therapist is there see if you can get his medications given.</p>	<ol style="list-style-type: none"> 1. <u>RN students</u> have report on need to obtain an order; 2. SBAR call to MD requesting at Swallow Evaluation by SLP. 3. <u>RN students</u> initiate call to SLP to conduct swallow test 4. <u>RN student</u> verbalizes to SLP priority to administer medications for BP and that patient is hungry. 	<ol style="list-style-type: none"> 1. NRSNG/SLP: How did the experience of caring for this patient feel for you and your team? 2. Is there anything that is really concerning you that you want to discuss right now? 3. NRSNG: What are your thoughts about implementing the SBAR communication format? 4. NRSNG/SLP: In what ways did you feel the team performed well?
<p>State/Patient Status</p>	<p>Desired Actions and Triggers to Move to Next State</p>		
<p>PATIENT: “Yeah, ok water. Good ...water.” Patient gurgles with water”</p>	<p>Operator: Gurgling sounds when nursing student administers medications</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. <u>SLP student</u> explains how the swallow evaluation will proceed and then completes this. Pt will be able to take pureed food. 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. <u>SLP:</u> Key aspects of the patient assessment data that determined the type of diet?

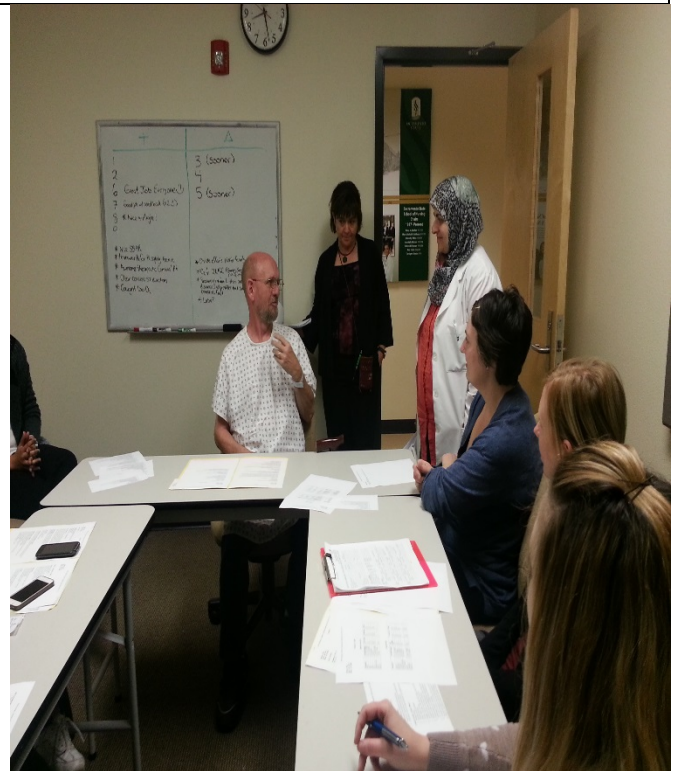
<p>Daughter: What is his blood pressure now? Can we try and give him his meds? He normally takes his Metoprolol 25mg twice daily. I don't want him to have another stroke.</p> <p>PATIENT: "Yeah, ok pill. Good."</p> <p>Daughter: IF SLP and NRSNG students do not discuss how to communicate about patients diet (sign above bed, note in chart, update on EMR to dietary) then state "How are nurses going to know how to give him medications so he does not choke?"</p>	<p>Patient takes pill in apple sauce.</p>	<ol style="list-style-type: none"> 2. <u>SLP student</u> explains diet restrictions to family member and patient. 3. <u>SLP student</u> completes recommendation and any signage. 4. <u>RN student</u> observes evaluation, asks about giving medications then pulls medications. 5. <u>RN student</u> explains medication and crushes and administers the medications using 6 rights and 3 checks 6. <u>SLP and NRSNG</u> collaborate on how diet will be communicated and what to monitor; provide teaching for the daughter and patient. 	<ol style="list-style-type: none"> 2. <u>SLP:</u> Key safety factors discovered in Swallow Eval to be reviewed with nursing to focus subsequent assessments 3. <u>NRSNG:</u> Priorities of care in patient with swallow impairment? 4. <u>NRSNG:</u> Given the list of medications, what did you see as the priority medication to administer? <p><u>Teamwork/Collaboration</u></p> <ol style="list-style-type: none"> 5. <u>NRSNG/SLP:</u> What did you learn about each other's professional role/ responsibility? 6. Describe team communication in this scenario. <p><u>Summary Phase:</u></p> <ol style="list-style-type: none"> 1. Gaps in knowledge base or preparation? 2. Two significant factors for transfer to the clinical setting? 3. How do you see the care you provided as Patient focused?
<p>Scenario End Point: Assessment complete; nurses and SLP leave room when called for another patient.</p>			
<p>Suggestions to <u>decrease</u> complexity: No daughter in scenario Suggestions to <u>increase</u> complexity: Patient aspirates</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Don Dixon		Diagnosis: Left MCA CVA
DOB: 7/15/1954 Age: 60		
MR#: 424 501 1		
† No Known Allergies		Allergies & Sensitivities
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Phase I: Admission Orders
		<i>Admit to neuro unit</i>
		Dx: left MCA CVA
		Allergies: NKA
		Code Status: Full code
		Diet: Low Na, soft diet after swallow screen
		Activity: OOB with assist only post PT evaluation
		Bed side commode with assist
		SCDS bilateral lower extremities while in bed
		O2: 2L NC, to keep O2 sat >= 94%
		IV: NS at 75 ml/hr
		<i>Medications:</i>
		Tylenol 650 PR, q6 hrs, PRN for temp > 100.4 F
		Protonix 40mg IV daily
		Lovenox 40 mg SQ bid
		Norco 5mg PO q 4hrs PRN for mild to moderate pain (1-6)
		Albuterol inhaler 2puffs as needed
		<i>Consults:</i>
		ST consult for evaluation and development of plan to address expressive aphasia.
		PT consult for mobility prior to transfer to Rehab
Signature		

Patient Name: Don Dixon		Diagnosis: Left MCA CVA
DOB: 7/15/1954		
Age: 60	MR#: 424 501 1	
† No Known Allergies		
† Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Phase II orders:
		CXR
		Labs: CBC, Chem 7 in am
		Continue pt s home medication Metoprolol 25mg daily, hold for HR<50 or SBP< 120
Signature		

APPENDIX B: Digital images of manikin and/or scenario milieu
Nursing Students working with SLP students on solving the case and in debrief



APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	X Group	<input type="checkbox"/> With Video	X Without Video
Debriefing Materials			
<input type="checkbox"/> Debriefing Guide	<input type="checkbox"/> Objectives	X Debriefing Points	X QSEN
QSEN Competencies to consider for debriefing scenarios			
X Patient Centered Care	X Teamwork/Collaboration	<input type="checkbox"/> Evidence-based Practice	
X Safety	<input type="checkbox"/> Quality Improvement	<input type="checkbox"/> Informatics	
Sample Questions for Debriefing			
<ol style="list-style-type: none"> 1. How did the experience of caring for this patient feel for you and the team? 2. How did the experience of working and collaborating with other members of the health care team feel for you? 3. How do you evaluate the Interprofessional communication that took place? Give examples? 4. How do you evaluate the Interprofessional team work that took place? Give examples? 5. Did you have the knowledge and skills to meet the learning objectives of the scenario? 6. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience? 7. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP? 8. How would you handle the scenario differently if you could? 9. In what ways did you check feel the need to check ACCURACY of the data you were given? 10. In what ways did you perform well? 11. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members? 12. What three factors were most SIGNIFICANT that you will transfer to the clinical setting? 13. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome? 14. Discuss actual experiences with diverse patient populations. 15. Discuss roles and responsibilities during a crisis. 16. Discuss how current nursing practice continues to evolve in light of new evidence. 17. Consider potential safety risks and how to avoid them. 18. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care. 			
Notes for future sessions:			