

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Transgender Female (TGF) Trauma Patient Part C: Recognition of pelvic pain and bladder distension.	
Original Scenario Developer(s):	Michele Solakian, Jessica Dorthalina, Alyssa Becerra and Lisa Aloy	
Date - original scenario	February 3, 2016	
Validation:	February 2020	
Pilot testing:	December 4, 2017	
Revisions:	Included in original scenario	
<u>Estimated Scenario Time</u>	20 Minutes	<u>Debriefing time</u> 30 minutes
<u>Target group:</u> Senior Nursing Students with concurrent critical care didactic course or newly graduated staff nurses. The scenario takes place on a monitored trauma patient in a Telemetry Unit.		
<u>Core case:</u> Students will perform a focused assessment on a trauma patient, assess pain, administer oxygen and monitor chest tubes, review Incentive Spirometry, assess chest tube dressing, monitor intake (IV fluids) and output (urine), administer medications for pain and communicate effectively with patient & care team.		
<u>Brief Summary of Case:</u> Victoria Bowie is a 49-year old (5' 11") 180 lb. (82 kg.) white English-speaking transgender (female). She was with a friend after leaving a night-club and was "hit by that crazy driver" according to her acquaintance. The car was traveling an estimated 30 miles per hour. She arrived by ambulance with rigid cervical spine collar in place, hypotensive with moderate blood loss, but neurologically intact. Blood tests revealed an elevated blood alcohol concentration (BAC). Cervical neck X-rays (5 views) were later completed and C-spine was cleared. Chest x-rays show two fractured ribs and hemo-pneumothorax on the left side.		
<u>QSEN & Team STEPPS Competencies</u>		
X Patient Centered Care		<input type="checkbox"/> Evidence based practice
X Patient Safety		<input type="checkbox"/> Quality Improvement
X Teamwork and Collaboration		<input type="checkbox"/>

EVIDENCE BASE / REFERENCES (APA Format)

Arnold, J.D., Sarkodie, E.P., Coleman, M.E., & Goldstein, D.A. (2016). Incidence of Venous Thromboembolism in Transgender Women Receiving Oral Estradiol. *The Journal of Sexual Medicine*, 13(11), 1773-1777. doi.org/10.1016/j.jsxm.2016.09.001

Deglin, J. H., & Vallerand, A. H. (2019). *Davis's Drug Guide for Nurses (11th Ed.)*. Philadelphia, PA: F. A. Davis Company

Deutsch, M.B. (2017). Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Non Binary People. Retrieved from <http://transhealth.ucsf.edu/trans?page=guidelines-feminizing-therapy>

Dickey, I.M., Karasic, D.H., Sharon, N.G. (2017). Mental health considerations with transgender and gender nonconforming clients. Retrieved from <http://transhealth.ucsf.edu/trans?page=guidelines-mental-health>

Hashemi, L. (2018). Transgender care in the primary care setting: a review of guidelines and literature, *Federal Practitioner*, 30-37.

Mancini, M.C. (2016). Blunt Chest Trauma Treatment & Management. *Medscape*. Retrieved from <https://emedicine.medscape.com/article/428723-treatment>

Roberts, T., Kraft, C., French, D., Ji, W., Wu, A., Tangpricha, V., & Fantz, C. (2014). Interpreting Laboratory Results in Transgender Patients on Hormone Therapy. *The American Journal of Medicine*, 127(2), 159-162. Retrieved from <http://www.sciencedirect.com/summit.csuci.edu:2048/science/article/pii/S0002934313008966>

Weinand, J.D., & Safer, J.D. (2015). Hormone therapy in transgender adults is safe with provide supervision; A review of hormone therapy sequelae for transgender individuals. *Journal of Clinical & Translational Endocrinology*, 2(2), 55-60. Retrieved from <https://doi.org/10.1016/j.jcte.2015.02.003>

Inaba, K. et al., (2016). Cervical spine clearance: a prospective Western trauma association multi-institutional trial. *Journal of Trauma Acute Care Surgery*, 81(6), 1122-1130.

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes
1. Determine the essential physical assessment in the trauma client, correctly prioritize needs in a timely manner. Correctly analyze assessment and lab data.
2. Demonstrate timely and efficient nursing interventions to promote oxygenation, hydration, mobility, comfort, elimination and skin integrity.
3. Communicate effectively with the client, family and healthcare team; utilize SBAR format; empathetic communication with a transgender patient
4. Administer medications safely; demonstrate attention to standard precautions, handwashing, use of PPE when appropriate.
Specific Learning Objectives
1. Perform a focused and complete physical assessment including: neurological, respiratory, cardiac, abdominal, GU, skin integrity and pain/comfort.
2. Assess hydration status intake & output, chest tube dressing & output, laboratory and diagnostic data.
3. Integrate nursing interventions in a timely manner: administer oxygen, assist client with incentive spirometry, turn cough deep breathe (TCDB), monitor fluid balance, and administer medications safely.
4. Communicates effectively with client and family regarding the plan of care, communicate with the nursing and medical team, including SBAR report.
5. Provide a safe environment and administer medications using the 3 checks and 6 rights.
6. Demonstrate attention to the National Patient Safety Goals for postoperative care, the care of the patient with pain, and safe medication administration, including intoxicated patients.
7. Demonstrate therapeutic communication with the transgender patient. Use of appropriate language, respectful use of appropriate pronouns, gender neutral terms and recovery from mistakes in communication.
Critical Learner Actions
1. Assess pain (pain level 0-10, detailed pain assessment)
2. Administer appropriate pain medication
3. Administer Narcan if patient becomes over-sedated with altered level of consciousness
4. Assist with chest tube management
5. Successful insertion of Foley catheter in TGF
6. Communicate therapeutically with patient and family

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies	
Knowledge trauma care: assessment and expected outcomes.	Skills/ Attitudes therapeutic communication with traumatized patient
<input type="checkbox"/> Lung atelectasis: pathophysiology and anticipated interventions.	<input type="checkbox"/> Chest tube drain care
<input type="checkbox"/> DVT Prophylaxis/treatments r/t trauma & estrogen therapy	<input type="checkbox"/> Insertion of Foley catheter in partial transition TGF
<input type="checkbox"/> I &O fluid monitoring	<input type="checkbox"/> Side effects of morphine administration and BAC 0.25% on admission

SECTION III: SCENARIO SCRIPT

A. Case summary

Victoria Bowie is a 49-year old (5' 11") 180 lb. (82 kg.) white English-speaking transgender (female). She was with a friend after leaving a night-club and was "hit by that crazy driver" according to her acquaintance. The car was traveling an estimated 30 miles per hour. She arrived by ambulance with rigid cervical spine collar in place, hypotensive with moderate blood loss, but neurologically intact. Blood tests revealed an elevated blood alcohol concentration (BAC) was 0.25%. CT scan of the patient's cervical spine was completed, negative, rigid collar was removed. Chest x-rays reveal three left rib fractures with a hemo-pneumothorax. The patient has been medicated for pain and needs medications administered for DVT prophylaxis and incentive spirometry. Patient has low urine output.

B. Key contextual details

The patient will have pain, atelectasis, hemo-pneumothorax, and respiratory compromise due to history of smoking. There will be blood pressure instability with DVT development in lower right extremity. Patient has low urine output.

C. Scenario Cast

Patient/ Client	<input checked="" 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)	Confederate/Actor (C/A) or Learner (L)
Team Leader		Learner
Assessing RN		Learner
Interventionist	Medication administration	Learner
Recording RN	Assists team and gives the SBAR report	Learner

D. Patient/Client Profile

Last name:	Bowie	First name:	Victoria	
Gender:	Age: 49 years	Ht: 5'11"	Wt: 180 lbs. (82 kg)	Code Status: Full Code
Spiritual Practice: Christian	Ethnicity: Irish	Primary Language spoken: English		
1. Past history				
Social History: Actress, dance teacher. Divorced with 3 adolescent children who live nearby. Partially transitioned from male to female; heavy smoker; history of drug use but says she is "clean".				
Medical History: smoking for 30 years (1 pack/day), mild hypertension diagnosed and treated four years ago; underwent surgical sex reassignment (partial). HIV status not known.				
Past Surgical History: Breast Augmentation (10 years ago), Reduction Thyroid-chondroplasty (9 years ago).				
Family History: Mild Depression in first-degree family members (she denies any depressive symptoms).				
Prior hospitalizations: Substance Rehab (2000, 2010). Hospitalized for substance abuse (alcohol and opioids).				
Primary Medical Diagnosis	Left Hemo-pneumothorax, Rib Fx. 5-7. S/P Trauma Auto vs. Pedestrian.			

2. Review of Systems	
CNS	Drowsy; migraine head aches
Cardiovascular	No murmur or arrhythmia
Pulmonary	Cough and dyspnea
Renal/Hepatic	Urinary retention, Bladder infections
Gastrointestinal	No vomiting; Occasional constipation
Endocrine	No diabetes; post-thyroidectomy
Heme/Coag	Bruising to scalp, hip, and trunk
Musculoskeletal	No arthritis or joint swelling
Integument	Eczema; MRSA
Developmental Hx	Adult self-actualizing
Psychiatric Hx	Flat affect; two previous psychiatric admission for Substance Rehabilitation
Social Hx	Divorced with 3 adolescent children, all are in the waiting room
Alternative/ Complementary Medicine Hx	

Medication allergies:	NKDA	Reaction:	
Food/other allergies:	None	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Aldactone	200 mg	PO	Daily
	MVI	1 tablet	PO	Daily
	Aspirin	81 mg	PO	Daily
	Estrace	1 mg	PO	Daily
	Provera	2.5 mg	PO	Daily
	Estradiol Valerate	10 mg	IM	Monthly

4. Laboratory, Diagnostic Study Results					
Na: 138 mEq/L	K: 5 mEq/L	Cl: 100 mEq/L	HCO3: 22	BUN: 49	Cr: 1.9
Ca: 9 mg/dl	Mg: 2	Phos:	Glucose: 99	HgA1C:	
Hgb: 14	Hct: 38%	Plt: 350 X1000	WBC: 12.3 X 1000	ABO Blood Type:	
PT	PTT 77 sec	INR 1	Troponin:	D-Dimer: 5	
ABG-pH: 7.34	paO2: 88	paCO2: 48	HCO3/BE:	SaO2: 90%	
VDRL: P	GBS:	Herpes: P	HIV: P	BAC: 0.24	
CXR: Rib Fx: 5,6 & 7; Hemo-pneumo thorax			ECG: P		

E. Baseline Simulator/Standardized Patient State

1. Initial physical appearance

Gender: Male genitalia Female: Breast Attire: Hospital gown, wig, bra (gel inserts)

Alterations in appearance (moulage): Left lateral chest dressing with chest tube and sanguineous drainage (400 mls), cigarettes at bedside. Rice Krispies under left lateral chest to mimic crepitus.

Pleuravac connected to chest tube with serosanguinous drainage bubbling

<input checked="" type="checkbox"/>	ID band present, accurate	<input type="checkbox"/>	ID band present, inaccurate	<input type="checkbox"/>	ID band absent or not applicable
<input type="checkbox"/>	Allergy band present, accurate	<input type="checkbox"/>	Allergy band inaccurate	<input checked="" type="checkbox"/>	Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room:

<input type="checkbox"/>	No monitor display	<input type="checkbox"/>	Monitor on, but no data displayed	<input type="checkbox"/>	Monitor on, data displayed
BP:	145/90	HR:	110	RR:	20
		T:	100.3	SpO ₂ :	88
Lungs:	Left: decreased		Right: Crackles,; Shallow, diminished, coughing		
Heart:	Sounds: S1 S2		ECG rhythm: NSR-Sinus Tach		
Bowel sounds:	Hypoactive		Other:		

3. Initial Intravenous line set up

<input type="checkbox"/>	Saline lock	Site:		<input type="checkbox"/>	IV patent (Y/N)
<input type="checkbox"/>	IV #1	Site:	RAC	Fluid type: NS	Initial rate: 100 ml/hr
<input type="checkbox"/>	Main	RA			IV patent (Y/N) yes
<input type="checkbox"/>	Piggyback				
<input type="checkbox"/>	IV #2	Site:		Fluid type:	Initial rate:
<input type="checkbox"/>	Main	RA			IV patent (Y/N)
<input type="checkbox"/>	Piggyback				

4. Initial Non-invasive monitors set up

<input checked="" type="checkbox"/>	NIBP	<input checked="" type="checkbox"/>	ECG First lead: Sinus Tachycardia	<input type="checkbox"/>	ECG Second lead:
<input checked="" type="checkbox"/>	Pulse oximeter	<input type="checkbox"/>	Temp monitor/type: Oral	<input type="checkbox"/>	Other:

5. Initial Hemodynamic monitors set up

<input type="checkbox"/>	A-line Site:	<input type="checkbox"/>	Catheter/tubing Patency (Y/N)	<input type="checkbox"/>	CVP Site:	<input type="checkbox"/>	PAC Site:
--------------------------	--------------	--------------------------	-------------------------------	--------------------------	-----------	--------------------------	-----------

6. Other monitors/devices

<input checked="" type="checkbox"/>	Foley catheter	Amount: 350 ml	Appearance of urine: concentrated
<input type="checkbox"/>	Epidural catheter	<input checked="" type="checkbox"/>	Infusion pump: Pump settings:

Environment, Equipment, Essential props

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

Telemetry Unit on central monitoring. Lays supine, in bed.

2. Equipment, supplies, monitors

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

X	Bedpan/ Urinal	X	Foley catheter kit		Straight cath. kit	x	Incentive spirometer
X	IV Infusion pump		Feeding pump		Pressure bag	X	Wall suction
	Nasogastric tube	X	ETT suction catheters	X	Oral suction catheters	X	Chest tube kit
	Defibrillator	X	Code Cart	X	12-lead ECG	X	Chest tube equip
	PCA infusion pump		Epidural inf. pump		Central line Insert. Kit	X	Dressing Δ equip.
	IV fluid .		IV fluid additives:		IV Piggy back		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		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms

X	Health Care Provider orders	X	Med Admin Record		Anesthesia/PACU record		Lab Results
	Progress Notes		Graphic record	X	H & P		ED Record
	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
	Nurses' Notes	X	Dx test reports		Code Record		Prenatal record
	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
	Morphine Sulfate 10 mg/ml	5 mg	IVP			Provera	2.5 mg	PO
	Multivitamin	1 tab	PO			Estrace	1 mg	PO
	Narcan	0.2 mg	IVP			Heparin	5000 units	IVP
	Estradiol Valerate	10 mg	IM			Aspirin	81 mg	PO

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario: Time: 1:30 AM night shift Victoria Bowie was brought to Emergency Room by paramedics. Victoria Bowie is a 49-year old (5' 11") 180 lb. (82 kg.) white, English-speaking transgender (female). She was with a friend after leaving a night-club and was "hit by that crazy driver" traveling an estimated 30 miles per hour, according to her acquaintance. She arrived by ambulance with rigid cervical spine collar in place, hypotensive with moderate blood loss, but neurologically intact. Blood tests revealed an elevated blood alcohol concentration (BAC) of 0.25%. CT scan of the patient's cervical spine was negative; rigid collar was removed. Chest x-rays found three left rib fractures with a hemo-pneumothorax. She is stabilized, a chest tube has been placed on the left side, for hemo-pneumothorax due to rib fractures. Students are to perform an assessment, assist the patient to perform Incentive Spirometry and evaluate the patients output.

STATE / PATIENT STATUS		DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE	
1. Baseline	Operator	Learner Actions	Debriefing Points:
<p>State 1 (Group 3) HR: 115 ST RR: 24 Coarse Sats: 92 % on 3 L/ NC BP: 100/70 Temp: 37.9 C Oral Pain: 4/10</p> <p>OLDCART: Gradual onset Groin pain "It's been hurting just today" Cramping</p> <p>"My bladder is going to burst!" "I feel nauseated!"</p>	<p>Assessment Palpation: bladder firm with sausage shaped mass in lower quadrants.</p> <p>Patient moans with bladder palpation</p> <p>Bladder scan approximately 800 ml</p> <p>Triggers:</p> <p>Telephone order: Obtain bladder scan.</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. WII 2. Head to toe assessment 3. Bladder scan: Volume: 800 ml 4. Call MD to report assessment findings using SBAR communication. 5. Encourage patient to urinate. 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Assessment findings for bladder distension, decreased UOP or bladder or renal trauma. 2. VS, I & O, absence of urine output.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
Frame 2	Operator	Learner Actions:	Debriefing Points:
<p>HR: 120 ST RR: 24 Sats: 92 % on 3 L/ NC BP: 130/90 Temp: 37.9 C Oral Pain: 7/10</p> <p>Patient attempts to urinate in a bedpan and a second attempt in a urinal. Both unsuccessful.</p>	<p>Patient moans that he cannot get the urine to release from her bladder.</p> <p>UOP less than 25 mls/ hour</p>	<ol style="list-style-type: none"> 1. Focused reassessment 2. Bladder scan: Volume: 800 ml 3. Call MD to report assessment findings using SBAR communication. 4. Order for insertion of foley bladder catheter. 5. Premedicate with Ativan 2 mg IVP 6. Specimen collection: UA, UC & Urine culture 7. Therapeutic communication with patient regarding the necessity of the tube insertion. 	<ol style="list-style-type: none"> 1 Role play communication with patient regarding anticipated procedure 2 Explain results of bladder scan and the reason for the urinary drainage catheter. 3 Explain benefits of premedication, and importance of continuous patient monitoring.
Triggers:	<p>Verbal order for Ativan 2 mg IVP</p> <p>Patient snores and sleeps through procedure with Ativan.</p>		

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>Frame 3</p> <p>HR: 90 RR: 18 Sats: 92 % on 3 L/ NC BP: 110/70 Temp: 37. 8 C Oral Pain: 4/10</p> <p>SBAR HAND-OFF REPORT</p>	<p>Operator:</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1 Focused reassessment 2 Sterile technique with placement of foley catheter. 3 Continuous monitoring of patient with sedation using cardiac monitor and saturations. 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Use therapeutic communication. 2. Explain characteristics of urine following Foley catheterization.
<p>Triggers:</p> <p>Order given to place an indwelling urinary drainage catheter. Urine output is concentrated= 850 ml, pink tinged</p>			
<p>Scenario End Point: Patient is comfortable, foley catheter is inserted and vital signs return to stable baseline.</p>			
<p>Suggestions to <u>decrease</u> complexity: Identify constipation (mass and no BM for 6 days)</p> <p>Suggestions to <u>increase</u> complexity:</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS (Page 1)

Patient Name: Victoria Bowie DOB: 1/10/XX Age: 49 years old MR#: 00220044		Diagnosis: Hemopneumothorax, left rib fractures; History of trauma: auto vs. pedestrian
<input checked="" type="checkbox"/> No Known Allergies <input type="checkbox"/> Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Admit to trauma team Telemetry Unit
		Respiratory: Oxygen via NC to keep sats > 92%, Incentive Spirometry teaching hourly while awake; Chest tube to continuous suction at -20cm H2O
		Activity: Bedrest, TCDB, SCD's to legs
		Turn Q2 Hours
		Diet: NPO
		IV: NS @ 100 ml/hr.; decrease fluids to 60 ml/hour
		Strict I & O; Include chest tube output every shift.
		Vital Signs: Q 1 Hours, include Pulse Oximetry; with neuro checks.
		Continuous telemetry monitoring
		Labs: CBC with Differential; CMP 13 Daily
		Medications: Morphine Sulfate 10 mg IV push every 4 hours PRN severe pain 7-10/10 and greater; Morphine Sulfate 7 mg for moderate pain 5-6/10;
		Morphine Sulfate 4 mg for pain 3-4/10
		Motrin 400 mg PO every 6 hours for mild pain 1-3/10 or Fever > 101.6 F
		Versed 1 mg IV push every 6 hours PRN anxiety
		Aldactone 200 mg PO/NGT Daily
		Lovenox 30 mg SQ BID
		Estradiol Valerate 10 mg IM once monthly
		Estrace 1 mg tab Daily
		Aspirin 81 mg daily
		Multivitamin 1 tab PO daily
		Provera 2.5 mg PO daily
		Call MD: UOP<25 mls/hr.; Sats < 92%, BP> 150/90 or < 100/70; T > 101.6;
		HR>110 or < 50
Signature		Jim Sweet, MD

APPENDIX B: HEALTH CARE PROVIDER ORDERS (Page 2)

Patient Name: Victoria Bowie DOB: 1/10/XX Age: 49 years old MR#: 00220044	Diagnosis: Hemopneumothorax, Left Rib Fracture; History of trauma due to auto vs. pedestrian
--	---

No Known Allergies
 Allergies & Sensitivities

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Diet: NPO
		Respiratory: Oxygen via NC or NRB mask to keep sats > 92%
		Vital Signs: Q 1 Hours, continuous Pulse Oximetry
		IV: NS to 150 ml/hr.
		Versed 2 mg IV push every 6 hours PRN anxiety
		Bladder scan. Call MD with results
		Place indwelling urinary catheter; send UA, UC and C & S
Signature		Jim Sweet, MD

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

Insert digital photo here

Insert digital photo here

Insert digital photo here

Insert digital photo here

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"> 1. How did the experience of caring for this patient feel for you and the team? 2. Did you have the knowledge and skills to meet the learning objectives of the scenario? 3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience? 4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP? 5. How would you handle the scenario differently if you could? 6. In what ways did you check feel the need to check ACCURACY of the data you were given? 7. In what ways did you perform well? 8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members? 9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting? 10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome? 11. Discuss actual experiences with diverse patient populations. 12. Discuss roles and responsibilities during a crisis. 13. Discuss how current nursing practice continues to evolve in light of new evidence. 14. Consider potential safety risks and how to avoid them. 15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care. 			
Notes for future sessions:			