Simulation Learning System—Fundamentals

Implementation Guide

ELSEVIER

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SIMULATION LEARNING SYSTEM—FUNDAMENTALS
IMPLEMENTATION GUIDE
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Brief Contents

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Introduction

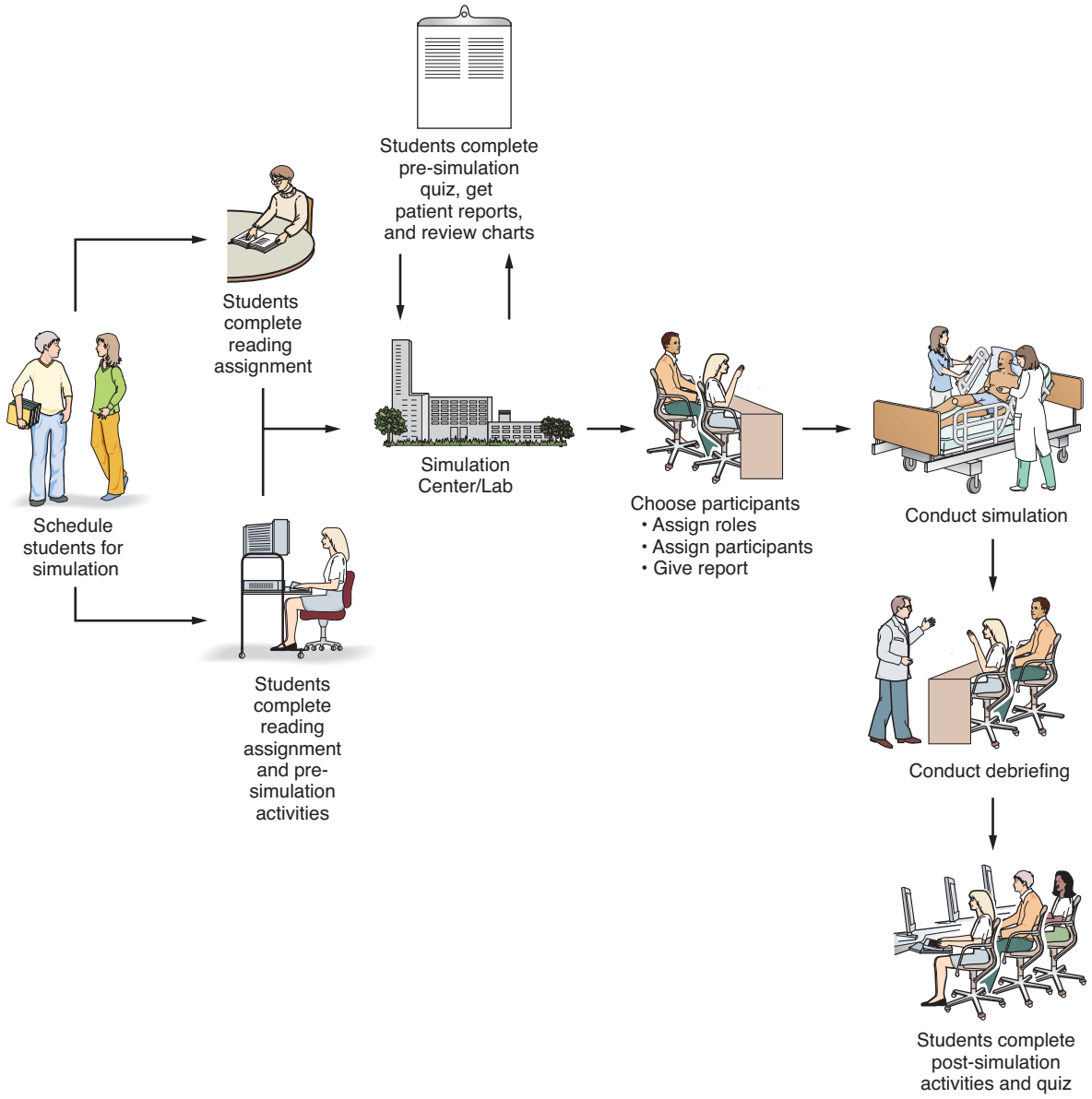
In today's health care climate, nurse educators are faced with the ever-increasing challenge of providing optimal clinical experiences for their students that truly reflect the realities of increased patient acuity, the nursing shortage, and the changing nature of the clinical unit. As a means of addressing these issues, clinical simulation has become an important component of nursing curricula. Human patient simulators can respond physiologically to disease, trauma, and care-very much like actual human beings would respond. Recent advances in technology have greatly enhanced the capability of human patient simulators to replicate the types of situations that students are likely to encounter in clinical practice.

Clinical simulation provides a controlled environment in which students can practice the nursing process and sharpen their critical thinking and decision-making skills before caring for real patients in the clinical setting. During clinical simulation, nursing students experience a realistic patient problem and use the nursing process to guide their interactions with the human patient simulator. Students collect and analyze assessment data and intervene based on their understanding of the patient situation. The human patient simulator is controlled by the simulation instructor (hereafter referred to as the facilitator) to respond to student interventions, whether they are appropriate or inappropriate. The human patient simulator can subsequently recover from the problem, worsen, or even die from a lack of intervention or as a result of an inappropriate intervention.

When using clinical simulation, instructors may need to remind students to suspend disbelief and immerse themselves in the experience. Students should interact with simulated patients as they would with live patients, asking questions and responding to all participants. They should be encouraged to talk and think "out loud" as they progress through the scenario. Simulation provides a safe environment in which to practice clinical decision-making skills without risking the health of real patients. The clinical simulation environment provides opportunities to practice not only skills related to the nursing process, but also skills of communication, delegation, and patient and family education.

Following the completion of the clinical simulation scenario, debriefing is conducted by the facilitator to provide students with the opportunity for self-reflection and to give students immediate feedback regarding their actions during the scenario. The debriefing phase is integral to the learning process; this structured reflection process helps students find relevance and meaning in the simulation experience.

Clinical simulation provides endless learning opportunities and can be used to reinforce understanding of difficult concepts and to allow students to practice skills and techniques related to communication, teamwork, and delegation. The Simulation Learning System (SLS) is an educationally sound program that provides extensive step-by-step instruction for integrating simulation into the nursing curriculum and features a comprehensive set of resources to assist both nursing educators and students. Developed, reviewed, and tested by nationally recognized simulation and nursing education experts, the SLS protocol emphasizes the teaching and learning possibilities of clinical simulation. By following this process, students and instructors alike can gain the maximum benefits of the simulation experience.



The SLS contains a library of clinical simulation scenarios featuring patients with a variety of conditions. Each scenario is accompanied by a complete electronic medical record. The clinical simulation experience begins with pre-simulation activities that prepare the student to enter the simulation laboratory; progresses to the simulation experience as the student provides care for the patient; and concludes with debriefing and post-simulation activities designed to promote reflection and deeper understanding. The pre- and post-simulation exercises, quizzes, and multimedia resources are designed to enhance learning outcomes and assist the facilitator in student evaluation.

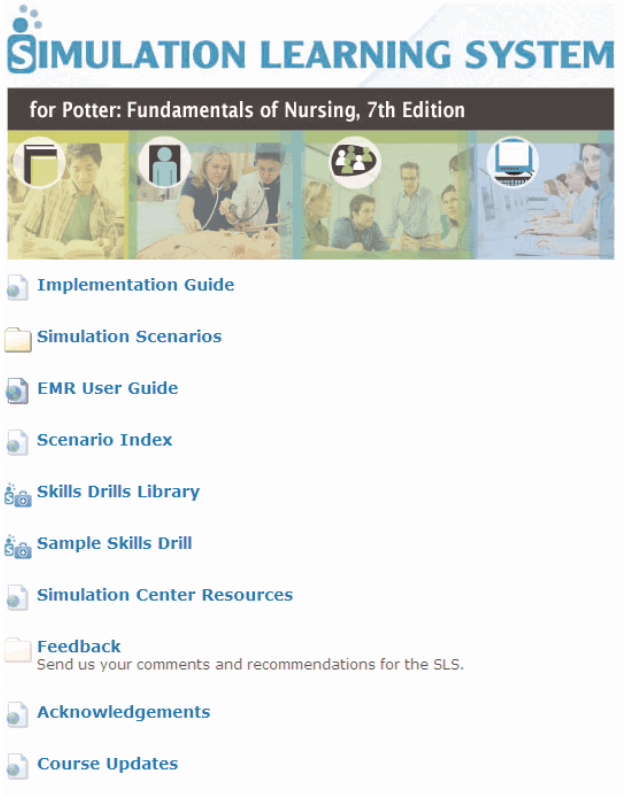
The SLS contains a wide array of resources. As you learn about the vast opportunities of this product, you will find that most of the work of running a simulation has been done for you. Before heading to the simulation lab or selecting a scenario to run with your students, take some time to familiarize yourself with the resources, tools, and guidelines of the SLS. Descriptions of each of these resources can be found in this guide.

The SLS Home Page

All SLS program data can be accessed via the *Evolve* online course portal. *Evolve* is the gateway to your textbook-specific simulation product. Simply select the SLS for your adopted textbook and you are on your way.

The SLS Home Page on *Evolve* contains links to all of the SLS materials. Once you are on the Home Page for the SLS, don't let the simplicity of the presentation fool you. Behind each click is an extensive set of resources for running successful simulations.

- The *Implementation Guide* is this document.
- The folder named *Simulation Scenarios* contains an expandable list of scenarios.
- The *EMR User Guide* provides comprehensive instructions for the SLS Electronic Medical Record for both faculty and student use.
- The *Scenario Index* lists each scenario that is currently available. This grid will continue to expand as new scenarios become available.
- The *Skills Drills Library* contains a library of modules, each focused on the demonstration of a single skill. Each skills drills module includes set-up instructions for the instructor, a mini-scenario challenge with a corresponding EMR, a performance checklist, and a multimedia demonstration.
- The *Simulation Center Resources* consist of select sites for purchasing equipment, locating resources to set up your lab, finding support organizations, and more. This list will continue to be updated as new sources are identified.



- The *Feedback* folder provides two ways to submit your comments and recommendations.
  - The *Request a Scenario* link gives you the opportunity to inform us of any specific scenarios that may enhance your particular curriculum. The suggestions will be routinely reviewed and will help us continue to develop timely and relevant scenarios.
  - The *Provide Feedback* link lets you send comments and questions directly to the SLS development team.
- The *Acknowledgements* link contains a list of the fantastic nursing and health care professionals who have worked to develop the SLS.
- The *Course Updates* link contains updates made to the SLS.

The SLS provides you with comprehensive resources to support your simulation mission, all of which are fully integrated with your adopted textbook. Each simulation scenario has been uniquely tagged to page-specific content within the textbook. As you work through the exercises, assignments, and scenarios, you will find text references providing rationales and related content.

In the next section, we will walk through the SLS product step-by-step. Please take the time to understand each step so that when you begin to run a scenario, you will have a complete grasp of the resources available to you.

Let's get started.

Simulation Learning System Recommended Protocol

The following is the recommended protocol for facilitating a simulation scenario from start to finish using the SLS. This protocol includes a variety of options for instructors to customize the simulation experience to meet the unique needs of their students. Individual steps of the protocol may be modified as desired to maximize the use of the SLS in your academic setting.

1. Instructor selects the appropriate simulation scenario using the ***Scenario Index*** and prepares for simulation using the ***Implementation Module***.
2. Instructor schedules students for simulation.
3. Instructor activates student *Evolve* access to pre-simulation activities as desired: **Reading Assignment**, **Concept Mapping**, **Pre-simulation Exercise**, **Pre-simulation Quiz**, ***Skills Drills***, **RN-to-RN Patient Report**, and ***Electronic Medical Record***.
4. Students access *Evolve* to complete the assigned pre-simulation activities.
5. Instructor prepares the simulation environment using the ***Facilitator's Packet***.
6. Students arrive at the simulation lab.
7. Instructor orients students to simulation environment.
8. Instructor assigns roles and distributes the **Participant Role Badges**, **Additional Participant Response Guide(s)**, and **Observer Evaluation Rubric**.
9. Instructor or student provides **RN-to-RN Patient Report** in written or verbal form to all participants.
10. Instructor signals start of scenario and students engage in simulation.
11. Students reference the ***Electronic Medical Record*** during the scenario to obtain patient care information, such as orders and patient data.
12. Instructor progresses scenario using the **Algorithm Quick Card**.
13. Instructor uses the **Patient Response Guide** to act as patient.
14. Instructor evaluates student performance using the **Performance Checklist**.
15. Non-participating students evaluate student performance using the **Observer Evaluation Rubric**.
16. Students document care during and after the scenario using the ***Electronic Medical Record***.
17. Instructor signals end of scenario.
18. Instructor leads scenario debriefing and guided discussion using the **Debriefing Procedure**, **Debriefing/Reflection Guide**, and **Guided Discussion** material.
19. Instructor activates student *Evolve* access to post-simulation activities as desired: ***Electronic Medical Record***, **Care Plan Constructor**, **Journaling**, **Interdisciplinary Communication**, **Post-simulation Exercise**, and **Post-simulation Quiz**.
20. Students access *Evolve* to complete the assigned post-simulation activities.
21. Instructor evaluates student work in the *Evolve* gradebook and communicates feedback to students.

SLS Skills Drills

SLS Skills Drills is a new feature added to the SLS to provide an opportunity for students to practice discrete skills outside of the multifaceted context of an SLS scenario. ***Skills Drills*** are designed so that they can be set-up by the instructor or learning laboratory personnel for students to complete with or without supervision. These mini-scenarios focus on the application of a single skill within the context of a patient situation. The patient context for each drill encourages basic critical thinking, rather than the simple memorization of skill steps. In addition, several variations of each skill are provided, facilitating skill procedure discernment.

In addition to helping prepare students for an SLS scenario, ***Skills Drills*** may be used for:

- Student practice after initial skill instruction
- Student self-testing prior to instructor-mediated skill testing
- Student skill practice prior to a clinical experience
- Student remediation
- Competency testing of student skill performance

The ***Skills Drills*** folder contains an entire library of drills appropriate for the fundamentals SLS course. Some of the drills are geared specifically to SLS scenarios, while others are meant for general skills practice. In all, the fundamentals ***Skills Drills*** library consists of 270 independent skills drills.

SLS SKILLS DRILLS RECOMMENDED PROTOCOL

The following is the recommended protocol for integrating ***Skills Drills*** into the SLS experience. This protocol provides the steps for implementing ***Skills Drills*** as preparation for an SLS scenario. Individual steps of the protocol may be modified as desired to maximize the use of ***Skills Drills*** in your academic setting.

1. Instructor views the ***Skills Drills*** recommendations from the menu of the selected SLS scenario.
2. Instructor reviews the ***Skills Drills*** library and assigns any of the recommended ***Skills Drills*** as preparation for the selected SLS scenario. Additional ***Skills Drills*** from the library can be assigned as desired.
3. Students access Evolve to view the **Student Challenge**, including reading assignment, the **Electronic Medical Record**, and a **Video Demonstration**.
4. Instructor prepares the skills lab environment following the staging instructions within the **Instructor Overview**.
5. Students arrive at the ***Skills Drills*** lab.
6. Students review the **Student Challenge** and **Electronic Medical Record** and complete the drill challenge.
7. Students reference the **Electronic Medical Record** during the drill to obtain patient care information, such as orders and previous assessments.
8. Students record care provided in the **Electronic Medical Record**.
9. Evaluation observer completes the **Performance Checklist** as desired.

ACCESSING SKILLS DRILLS

As seen in the above set of screen shots, the ***Skills Drills*** library is accessed from the SLS Home Page. Inside, the library is organized by core topic areas. Within each of the topic folders is a list of available ***Skills Drills***. A uniform set of resources is available within each drill folder.

Infection Prevention and Control
Hand Hygiene
Open Gloving
Personal Protective Equipment
Sterile Field
Isolation Procedures

Hygiene
Bathing
Oral Hygiene
Denture Care
Back Care
Perineal Care
Occupied Bed Making

Vital Signs
Blood Pressure
Temperature
Pulses
Respirations
Oxygen Saturation
Pain

Medication Administration
Medication Calculations
Oral Medications
Topical Medications
Ophthalmic Medications
Otic Medications
Nasal Instillations
Rectal Suppositories
Inhalers
Injections
Various Meds/Routes
IV Fluid Containers
IV Bolus
Various IV Routes

Parenteral/Intravenous Therapies
Initiating IV Therapy
Regulating IV Flow Rate
IV Maintenance
IV Dressing Change

Oxygenation
Suctioning
Artificial Airway
Chest Tubes
Oxygen Administration

Nutrition
Small-Bore NG Insertion
Tube Feedings
Intake and Output

Elimination
Nasogastric Tube
Gastrointestinal Aspiration for pH Measurement
Condom Catheter
Indwelling Catheter Care
Straight or Indwelling Catheter Insertion
Indwelling Urinary Catheter Removal
Closed Catheter Irrigation
Urine Specimen Collection
Enema
Ostomy Pouching
Drainage Pouch Emptying
Bedpan/Urinal Placement
Blood Test, Occult

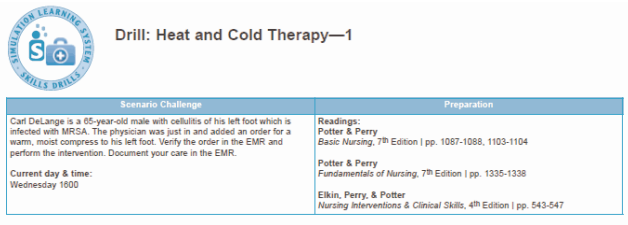
Mobility/Immobility
Transfer Techniques
Moving and Positioning
Restraints
Fall Risk Assessment

Skin and Wound Care
Pressure Ulcer Risk Assessment
Treating Pressure Ulcers
Wound Assessment
Dry/Moist Dressing Application
Wound Irrigation
Binder Application
Elastic Bandage Application
Dressing Change
Heat and Cold Therapy
Wound Culture

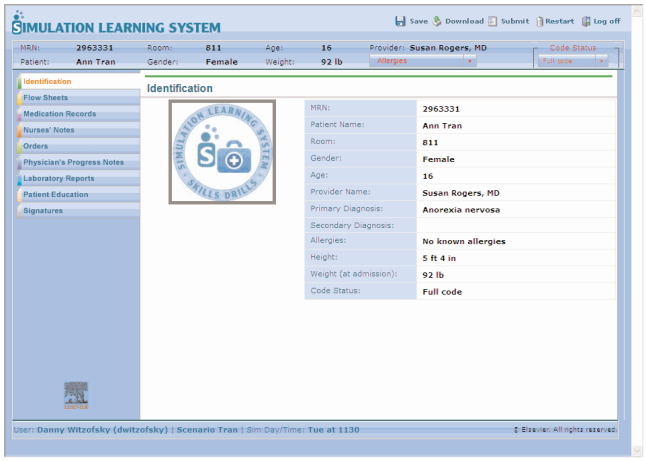
SKILLS DRILLS – STUDENT VIEW

For each drill, students have access to a **Student Challenge**, an **Electronic Medical Record (EMR)**, and a **Video Demonstration**.

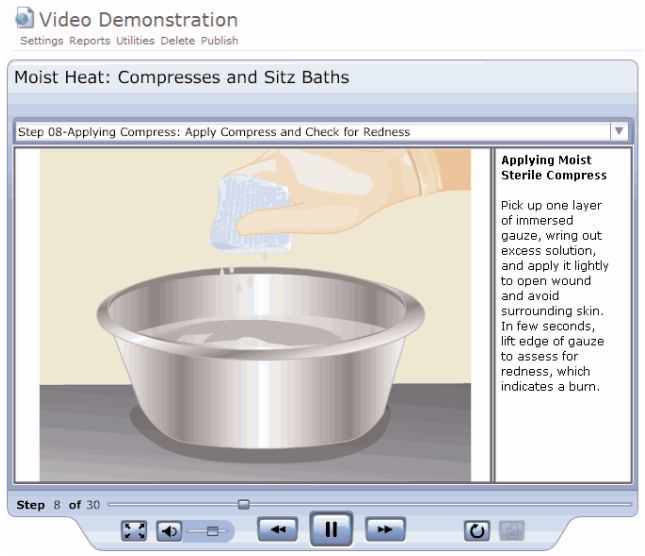
The **Student Challenge** includes a brief summary of the patient situation, a reading assignment, and a specific skill-related challenge. Each drill revolves around a simulated patient and the patient's **EMR**. The current day and time info serves as a grounding point and corresponds to the **EMR** data. A specific patient situation or order drives each challenge.



The **EMR** is an integral element of each skills drill. While students can review the record before arrival to the lab, access to the **EMR** within the lab setting is essential for successful completion of the drill challenge. Most ***Skills Drills*** direct students to review the **EMR** prior to initiating the challenge. Students will need to review vital patient information, such as prior assessment findings, medication administration history, and provider orders. Students also need **EMR** access in order to document their care. As with the SLS scenarios, all information recorded by the student during the skills drill can be submitted for instructor review. See the **EMR User Guide** for more information.



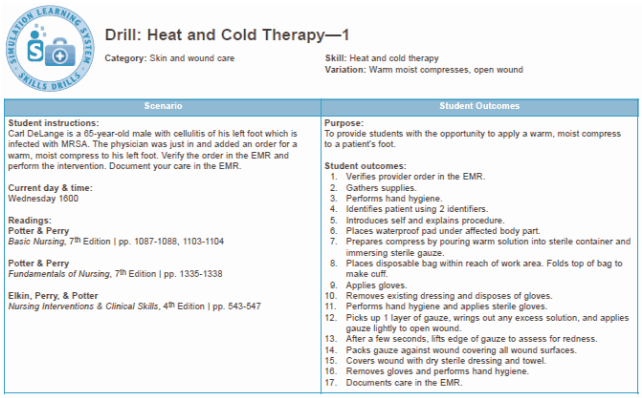
For most ***Skills Drills***, a **Video Demonstration** of the related skill is available for student review. These demonstrations are meant to serve as basic visual guides to the related skill. For the step-by-step skill process, students should refer to the textbook reading assignments included in the challenge.



SKILLS DRILLS – INSTRUCTOR VIEW

In addition to the student resources, instructors have access to an **Instructor Overview** and **Performance Checklist** for each skills drill.

The **Instructor Overview** contains the same information as the **Student Challenge**, along with the purpose of the drill, a list of expected student outcomes, and a complete set of staging instructions.



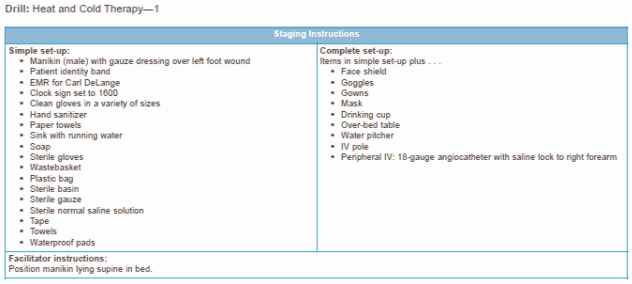
Drill: Heat and Cold Therapy—1

Category: Skin and wound care

Skill: Heat and cold therapy
Variation: Warm moist compresses, open wound

Scenario	Student Outcomes
Student instructions: Carl DeLange is a 65-year-old male with cellulitis of his left foot which is infected with MRSA. The physician was just in and added an order for a warm, moist compress to his left foot. Verify the order in the EMR and perform the intervention. Document your care in the EMR. **Current day & time:** Wednesday 1600 **Readings:** **Potter & Perry** *Basic Nursing*, 7th Edition | pp. 1087-1088, 1103-1104 **Potter & Perry** *Fundamentals of Nursing*, 7th Edition | pp. 1335-1338 **Elkin, Perry, & Potter** *Nursing Interventions & Clinical Skills*, 4th Edition | pp. 543-547	**Purpose:** To provide students with the opportunity to apply a warm, moist compress to a patient's foot. **Student outcomes:** 1. Verifies provider order in the EMR. 2. Gathers supplies. 3. Performs hand hygiene. 4. Identifies patient using 2 identifiers. 5. Introduces self and explains procedure. 6. Places waterproof pad under affected body part. 7. Prepares compress by pouring warm solution into sterile container and immersing sterile gauze. 8. Places disposable bag within reach of work area. Folds top of bag to make cuff. 9. Applies gloves. 10. Removes existing dressing and disposes of gloves. 11. Performs hand hygiene and applies sterile gloves. 12. Picks up 1 layer of gauze, wrings out any excess solution, and applies gauze lightly to open wound. 13. After a few seconds, lifts edge of gauze to assess for redness. 14. Packs gauze against wound covering all wound surfaces. 15. Covers wound with dry sterile dressing and towel. 16. Removes gloves and performs hand hygiene. 17. Documents care in the EMR.

When preparing the lab from the staging instructions, either the simple set-up or complete set-up can be used. The simple set-up includes only the props and equipment needed for the completion of the specific skill challenge. The complete set-up includes all the props and equipment needed to create the full patient situation. The complete set-up can be used for a richer simulation experience.



Drill: Heat and Cold Therapy—1

Staging Instructions	
Simple set-up: • Manikin (male) with gauze dressing over left foot wound • Patient identity band • EMR for Carl DeLange • Clock sign set to 1600 • Clean gloves in a variety of sizes • Hand sanitizer • Paper towels • Sink with running water • Soap • Sterile gloves • Wastebasket • Plastic bag • Sterile basin • Sterile gauze • Sterile normal saline solution • Tape • Towels • Waterproof pads	**Complete set-up:** Items in simple set-up plus . . . • Face shield • Goggles • Gowns • Mask • Drinking cup • Over-bed table • Water pitcher • IV pole • Peripheral IV: 18-gauge angiocatheter with saline lock to right forearm
Facilitator instructions: Position manikin lying supine in bed.	

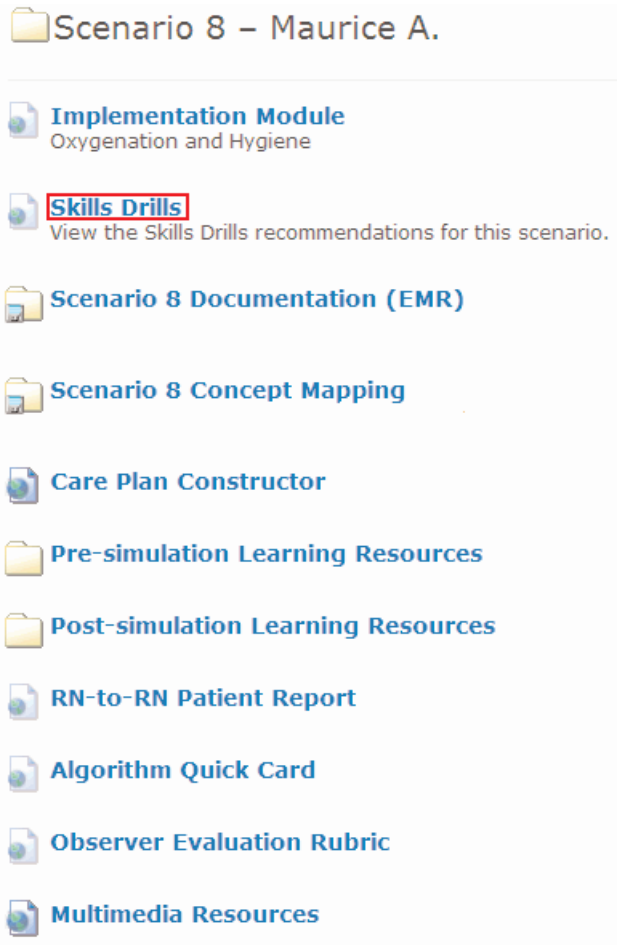
The **Performance Checklist** is comprised of the student outcome list in an easy-to-use evaluation-geared table. A printed copy of the **Performance Checklist** should be made available for the designated evaluation observer (instructor or peer). The checklist can also be made available for student self-evaluation.

Drill: Heat and Cold Therapy—1

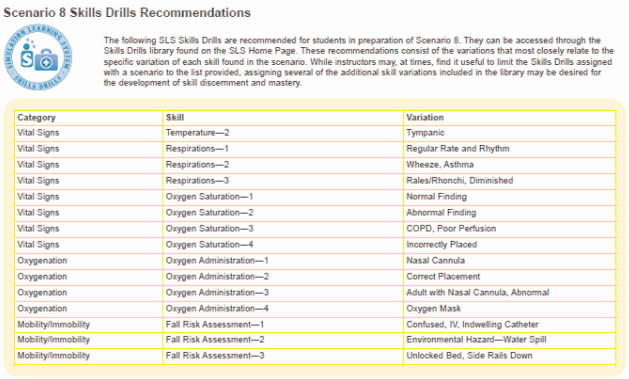
Evaluation Rating			Student Outcomes	Comments
Exceeds Expectations	Meets Expectations	Does Not Meet Expectations		
			Verifies provider order in the EMR.	
			Gathers supplies.	
			Performs hand hygiene.	
			Identifies patient using 2 identifiers.	
			Introduces self to patient and explains procedure.	
			Places waterproof pad under affected body part.	
			Prepares compress by pouring warm solution into sterile container and immersing sterile gauze.	
			Places disposable bag within reach of work area. Folds top of bag to make cuff.	
			Applies gloves.	
			Removes existing dressing and disposes of gloves.	
			Performs hand hygiene and applies sterile gloves.	
			Picks up 1 layer of gauze, wrings out any excess solution, and applies gauze lightly to open wound.	
			After a few seconds, lifts edge of gauze to assess for redness.	
			Packs gauze against wound covering all wound surfaces.	
			Covers wound with dry sterile dressing and towel.	
			Removes gloves and performs hand hygiene.	
			Documents care in the EMR.	

ASSIGNING SKILLS DRILLS

When assigning drills for the preparation of an SLS scenario, the first step is to review the ***Skills Drills*** recommendations from within the scenario documents. From the scenario menu, click on the ***Skills Drills*** link. This will pull up a list of the ***Skills Drills*** recommendations for the scenario. This list can also be accessed through several links within the **Implementation Module**.



Access the ***Skills Drills*** library from the SLS Home Page (see page 3) to review the details of recommended drills. While the recommendations provided for each scenario consist of the skill variations that most closely relate to the specific variation of each skill encountered in the scenario, additional variations from the library can also be assigned as desired. Students have access to the full ***Skills Drills*** library, so no action within the *Evolve* learning management system is required when assigning drills.



Scenario 8 Skills Drills Recommendations

The following SLS Skills Drills are recommended for students in preparation of Scenario 8. They can be accessed through the Skills Drills library found on the SLS Home Page. These recommendations consist of the variations that most closely relate to the specific variation of each skill found in the scenario. While instructors may, at times, find it useful to limit the Skills Drills assigned with a scenario to the list provided, assigning several of the additional skill variations included in the library may be desired for the development of skill discernment and mastery.

Category	Skill	Variation
Vital Signs	Temperature—2	Tympanic
Vital Signs	Respirations—1	Regular Rate and Rhythm
Vital Signs	Respirations—2	Wheeze, Asthma
Vital Signs	Respirations—3	Rales/Rhonchi, Diminished
Vital Signs	Oxygen Saturation—1	Normal Finding
Vital Signs	Oxygen Saturation—2	Abnormal Finding
Vital Signs	Oxygen Saturation—3	COPD, Poor Perfusion
Vital Signs	Oxygen Saturation—4	Incorrectly Placed
Oxygenation	Oxygen Administration—1	Nasal Cannula
Oxygenation	Oxygen Administration—2	Correct Placement
Oxygenation	Oxygen Administration—3	Adult with Nasal Cannula, Abnormal
Oxygenation	Oxygen Administration—4	Oxygen Mask
Mobility/Immobility	Fall Risk Assessment—1	Confused, IV, Indwelling Catheter
Mobility/Immobility	Fall Risk Assessment—2	Environmental Hazard—Water Spill
Mobility/Immobility	Fall Risk Assessment—3	Unlocked Bed, Side Rails Down

Scenario Index

Use the ***Scenario Index*** to review the scenario, diagnoses, primary challenge, and skills to identify the scenario best suited to the level of your students and your teaching needs.

The ***Scenario Index*** may be accessed from the SLS Home Page. The index provides the best overview descriptions of the scenarios.

Scenario	Patient Data Scenario Time* Debriefing Time*	Scenario Concepts	Scenario Skills	Simulation Presentation Patient Diagnoses	Primary Challenge
Fundamentals 1 	**Alice Morrison** 7 years Female **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts:** • Assessment • Pediatric patient • Nutrition • Skin integrity and wound care • Medication administration (G-tube) • Documentation and informatics	• Assess patient • Recognize elevated temperature • Recognize disconnected G-tube feeding, saturated dressing, and wet bed pad • Utilize age-appropriate communication • Respect mother's role as primary caregiver • Change G-tube dressing and provide hygiene • Delegate tasks appropriately • Administer antipyretic via G-tube • Restart G-tube feeding • Access and document care in the EMR	Pediatric patient with g-tube is admitted with acute bronchitis. Patient's G-tube feeding becomes disconnected just prior to start of scenario. **Primary diagnosis:** Acute bronchitis **Secondary diagnosis:** Esophageal atresia with gastrostomy	Learner assesses and implements care for a pediatric patient whose G-tube feeding has become disconnected while respecting the mother as the expert on the child's care.
Fundamentals 2 	**Bernadette Jackson** 85 years Female **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts:** • Vital signs • Assessment • Older adult • Urinary elimination • Medication administration (IV) • Patient safety • Patient education • Documentation and informatics	• Assess patient and lab results • Recognize confusion, tachycardia, discomfort, minimal urine output and positive urinalysis as abnormal findings • Report abnormal findings to provider using SBAR • Obtain sterile urine sample for culture • Administer IV antibiotics • Recognize increased fall risk • Implement fall risk prevention measures • Provide patient education and support • Access and document care in the EMR	Older adult with polypharmacy-related dehydration and urinary retention is admitted for monitoring, rehydration, and IV antibiotics. Patient experiences acute confusion related to a urinary tract infection. **Primary diagnosis:** Dehydration **Secondary diagnosis:** Urinary retention	Learner assesses and implements care for an older adult patient experiencing acute confusion related to a urinary tract infection.
Fundamentals 3 	**Samuel Green** 75 years Male **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts** • Assessment • Older adult • End-of-life care • Older adult • Communication • Culture and ethnicity • Documentation and informatics	• Assess patient • Recognize cessation of cardiovascular and respiratory function • Notify provider of patient's death using SBAR • Follow postmortem care policy and procedure • Utilize therapeutic communication with the family • Elicit the patient and family's preferences related to death rituals and postmortem care • Respect the patient and family's spiritual beliefs and cultural values throughout the dying process • Access and document care in the EMR	Patient with inoperable pulmonary adenocarcinoma and a documented code status of do not resuscitate (DNR) is admitted for palliative care. **Primary diagnosis:** Adenocarcinoma bilateral lungs **Secondary diagnosis:** Bone and lymph metastasis	Learner provides end-of-life and postmortem care while supporting a grieving family in a manner consistent with the patient and family's spiritual beliefs and cultural values.

Scenario	Patient Data Scenario Time* Debriefing Time*	Scenario Concepts	Scenario Skills	Simulation Presentation Patient Diagnoses	Primary Challenge
Fundamentals 4 	**Jesus Garcia** 28 years Male **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts:** • Assessment • Stress and coping • Sexuality • Bowel elimination • Skin integrity and wound care • Patient education • Documentation and informatics	• Assess patient • Recognize leaking colostomy bag • Recognize knowledge deficit regarding colostomy care • Recognize ineffective coping, disturbed body image, and low sexual self-esteem • Utilize therapeutic communication • Ensure patient privacy • Assist patient with colostomy care and hygiene • Provide patient education and support • Access and document care in the EMR	Patient with history of ulcerative colitis and transverse colostomy is admitted with dehydration. **Primary diagnosis:** Dehydration **Secondary diagnosis:** Ulcerative colitis; status postpartial colectomy with transverse colostomy	Learner assesses and manages colostomy care while addressing a patient's issues with body image and sexuality.
Fundamentals 5 	**Lisa Rae** 78 years Female **Scenario Time:** 20-30 minutes **Debriefing: Time:** 20-30 minutes	**Concepts:** • Vital signs • Assessment • Communication • Older adult • Patient safety • Skin integrity • Patient education • Documentation and informatics	• Assess patient • Utilize therapeutic communication • Assess fall risk using Morse Fall Scale • Asses pressure ulcer risk using Braden Scale • Implement fall prevention measures • Implement pressure ulcer prevention measures • Provide patient education and support • Access and document care in the EMR	Patient with a history of falls is admitted with dizziness and a mechanical fall. Patient is incontinent of urine and has limited mobility. **Primary diagnosis:** Hypotension **Secondary diagnosis:** Mechanical fall	Learner assesses and implements nursing care for a patient at high risk for falls and pressure ulcer development.
Fundamentals 6 	**Nancy Gilbert** 65 years Female **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts** • Vital signs • Assessment • Infection control • Oxygenation • Skin integrity and wound care • Communication • Patient education • Documentation and informatics	• Assess patient • Recognize moderate respiratory distress • Conduct sterile tracheostomy suctioning and dressing care • Maintain contact isolation precautions • Utilize therapeutic communication • Provide patient and family education • Access and document care in the EMR	Patient with a history of laryngeal cancer, a permanent tracheostomy, and continuous supplemental oxygen is admitted with pneumonia. Patient is in contact isolation for MRSA in her sputum. **Primary diagnosis:** Pneumonia **Secondary diagnosis:** Laryngeal cancer, tracheostomy	Learner assesses a patient with moderate respiratory distress and conducts sterile tracheostomy suctioning while maintaining contact isolation precautions.
Fundamentals 7 	**Carl Rogers** 67 years Male **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts** • Assessment • Skin and wound care • Diabetes management • Medication administration (SQ) • Patient education • Documentation and informatics	• Receive report including current blood glucose level • Assess patient • Administer SQ insulin according to scheduled dose plus correction scale order • Conduct wound care per order • Provide patient education and support • Access and document care in the EMR	Patient with a history of type I diabetes mellitus and a stage II non-healing foot ulcer is admitted for diabetic management and wound care. **Primary diagnosis:** Stage II non-healing ulcer on right heel **Secondary diagnosis:** Diabetes mellitus type I	Learner assesses, prioritizes, and manages care for a diabetic patient with a non-healing foot ulcer and elevated blood glucose level.

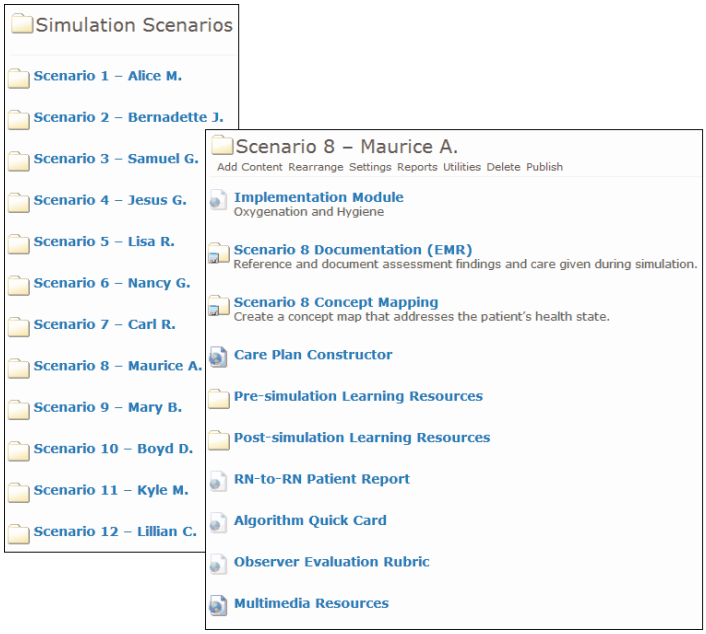
Scenario	Patient Data Scenario Time* Debriefing Time*	Scenario Concepts	Scenario Skills	Simulation Presentation Patient Diagnoses	Primary Challenge
Fundamentals 8 	**Maurice Arviso** 60 years Male **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts:** • Vital signs • Assessment • Prioritization • Oxygenation • Communication • Hygiene • Patient education • Documentation and informatics	• Assess patient • Recognize dyspnea • Recognize patient's frustration related to loss of independence • Prioritize respiratory interventions • Administer oxygen therapy • Utilize therapeutic communication • Maintain privacy and promote dignity • Assist with personal hygiene • Provide patient education and support • Access and document care in the EMR	Patient is admitted with community acquired pneumonia. Patient struggles to maintain independence in daily cares and refuses assistance despite dyspnea upon exertion. Just before scenario begins, patient spills urinal and nasal cannula falls out of reach. Patient becomes dyspneic. **Primary diagnosis:** Pnuemococcal pneumonia	Learner assesses, prioritizes, and implements nursing care for a patient experiencing dyspnea and loss of independence.
Fundamentals 9 	**Mary Bailey** 30 years Female **Scenario Time:** 25-30 minutes **Debriefing: Time:** 25-30 minutes	**Concepts:** • Vital signs • Assessment • Fluid, electrolyte, and acid-base balance • Medication administration (IV) • Patient education • Documentation and informatics	• Assess patient and lab results • Recognize nausea and vomiting • Administer IV antiemetic per PRN order • Recognize abnormal lab values including low serum potassium • Change IV fluids per standing order • Monitor intake and output • Provide patient education and support • Access and document care in the EMR	Pregnant female patient at 16 weeks gestation is admitted with hyperemesis and dehydration. **Primary diagnosis:** Hyperemesis gravidarum **Secondary diagnosis:** Dehydration	Learner assesses and implements nursing interventions for a pregnant patient experiencing persistent vomiting, dehydration, and fluid and electrolyte imbalance.
Fundamentals 10 	**Boyd Dubois** 58 years Male **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts** • Vital signs • Postoperative assessment • Pain management • Medictaion administration (IV and SQ) • Postoperative care • Documentation and informatics	• Conduct postoperative assessment • Assess and recognize pain • Recognize bibasilar crackles in lungs • Recognize elevated temperature • Recognize impaired mobility • Administer IV pain medication per order • Administer SQ anticoagulant per order • Assist patient with postoperative exercises • Provide patient education and support • Access and document care in the EMR	Patient with a history of osteoarthritis is admitted to the orthopaedic unit following a right total hip replacement. **Primary diagnosis:** Osteoarthritis **Secondary diagnosis:** Total hip replacement	Learner assesses and implements nursing interventions for a postoperative patient with pain, mild post-operative atelectasis, and impaired physical mobility.

Scenario	Patient Data Scenario Time* Debriefing Time*	Scenario Concepts	Scenario Skills	Simulation Presentation Patient Diagnoses	Primary Challenge
Fundamentals 11 	**Kyle Miller** 41 years Male **Scenario Time:** 15-20 minutes **Debriefing: Time:** 15-20 minutes	**Concepts** • Vital signs • Assessment • Skin integrity and wound care • Communication • Delegation • Documentation and informatics	• Assess patient • Recognize physical assessment findings within normal parameters • Notify provider using SBAR • Manage unit distractions (calls, interruptions) • Delegate tasks appropriately • Maintain patient's privacy in compliance with HIPAA regulations • Utilize therapeutic communication • Provide patient and family education • Access and document care in the EMR	Patient with cellulitis of the forearm is admitted for antibiotic therapy and monitoring. Patient is stable and ready for discharge after learner conducts an assessment and notifies provider of stable status. **Primary diagnosis:** Cellulitis	Learner conducts nursing assessment and care while managing and prioritizing multiple common unit distractions.
Fundamentals 12 	**Lillian Chambers** 40 years Female **Scenario Time:** 20-25 minutes **Debriefing: Time:** 20-25 minutes	**Concepts:** • Vital signs • Postoperative assessment • Communication • Skin integrity and wound care • Patient education • Documentation and informatics	• Receive report from PACU • Conduct postoperative assessment • Recognize moderate surgical site bleeding • Notify provider using SBAR • Reinforce surgical dressing per provider order • Utilize therapeutic communication • Provide patient and family education and support • Access and document care in the EMR	Patient with a ruptured appendix undergoes an urgent appendectomy. The patient is discharged from post-anesthesia care unit (PACU) to the medical-surgical unit for routine postoperative care. **Primary diagnosis:** Acute appendicitis with rupture	Learner receives a report from the PACU and assesses and implements nursing interventions for a postoperative patient with moderate surgical site bleeding.

* Scenario and debriefing times are estimated based on field testing results.

The actual simulation scenarios may be accessed through the folder labeled ***Simulation Scenarios***. From there, select the scenario you wish to open.

PATHWAY TO THE SCENARIO



SLS Implementation Module

The SLS is set up identically for each scenario. Once you become familiar with how the materials are organized for one scenario, you'll easily be able to navigate through the rest. The following sections detail the SLS resources available within each scenario ***Implementation Module***.

IMPLEMENTATION MODULE OVERVIEW

Each scenario ***Implementation Module*** is organized into four main tabs that house the preparation, scenario, debriefing, and supplemental resources for the scenario. Within these tabs you will find all of the instructions, details, and resources necessary for implementing the scenario.

1. **Preparation** resources are for pre-simulation planning and preparation.

2. **Scenario** resources assist during simulation implementation.

3. **Debriefing** resources facilitate discussion and evaluation post-simulation.

4. **Resources** are additional items to facilitate student understanding.

In addition to these four main tabs, five quick-access icons are displayed in the scenario header of the ***Implementation Module***. These icons offer easy access to frequently used resources.

A. The ***Facilitator's Packet*** is a convenient printable PDF that includes resources needed for preparation and implementation of the scenario. The resources in the ***Facilitator's Packet*** are located in various places within the ***Implementation Module*** and compiled here for easy reference. A link to the ***Facilitator's Packet*** is also found under the *Preparing Yourself* screen of the **Preparation** tab.

B. The ***Electronic Medical Record (EMR)*** is a fully interactive medical record that the learner will use to reference and document patient data before, during, and after the scenario. This quick-access icon is the main faculty access point for the ***EMR***.

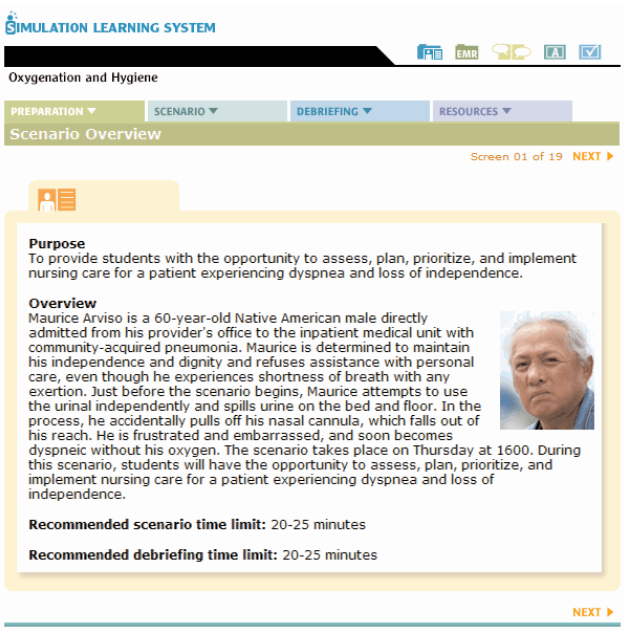
C. The **RN-to-RN Patient Report** summarizes the patient's condition immediately before the scenario begins. This report is used to initiate the simulation experience. A link to the **RN-to-RN Patient Report** is also found on the *Initiating the Simulation Experience* screen of the **Scenario** tab.

D. The **Algorithm Quick Card** provides the facilitator with a visual progression of the scenario. A link to the **Algorithm Quick Card** is also found on the *Scenario Phase I: Introduction* screen of the **Scenario** tab.

E. The **Performance Checklist** may be used for evaluation of student actions during the scenario. A link to the **Performance Checklist** is also found on the *Scenario Phase I: Introduction* screen of the **Scenario** tab.

1. PREPARATION

Scenario Overview



Title. The scenario title, located just to the left of the quick-access links, reflects the patient's medical condition. For students, scenarios are referred to by number and patient name only, so as not to reveal too much about the simulation experience.

Purpose. The scenario purpose reflects the nursing actions that the student will perform during the scenario. This purpose closely mirrors the nursing process in that the student must assess, plan, intervene, and evaluate the effect of the nursing interventions.

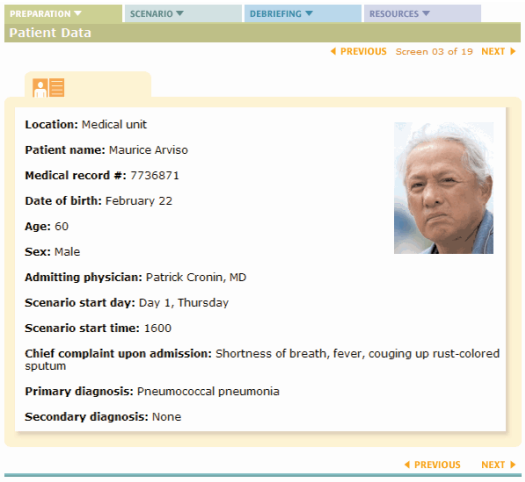
Overview. The scenario overview offers a brief sketch of the patient and the events occurring before the scenario start time. A description of the patient upon initial contact is also provided, along with the nursing actions to be performed.

Recommended Scenario and Debriefing Time Limit. Recommended scenario and debriefing time limits are identified on the first screen, with suggested times based on the number of performance objectives for each simulation scenario and the scenario phases. The facilitator must remain flexible, however, because student performance during the simulation scenario is not always predictable. The struggling student may take longer to achieve the performance objectives of a given simulation scenario, whereas the more experienced or confident student may progress more quickly. Therefore, it may be helpful to allow extra time when scheduling. These times are estimated based on SLS field testing.

Performance Objectives

The **Performance Objectives** consist of identifiable actions that the student should perform during the scenario or after in the debriefing discussion. These objectives are based on the nursing process and are organized according to the Quality and Safety Education for Nurses (QSEN) quality and safety competencies. Specific nursing actions are listed in the **Performance Objectives** section to guide the facilitator in choosing the most appropriate simulation scenario for the student's skill level. The **Performance Objectives** correlate closely with the objectives in the **Performance Checklist** (see page 27). However, the checklist has been organized chronologically for trouble-free student evaluation.

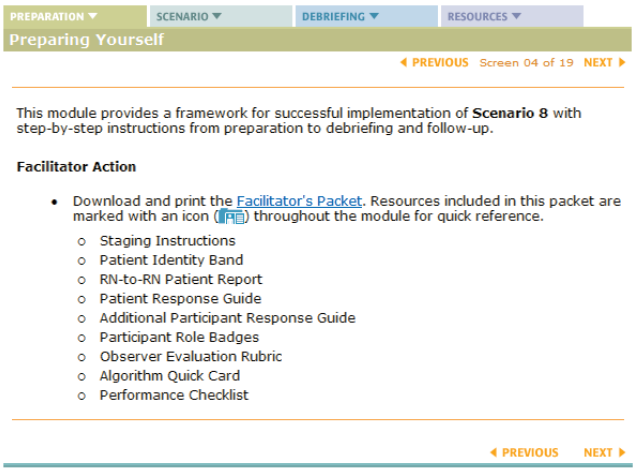
Patient Data



The patient's name, medical record number, date of birth, gender, admitting health care provider, chief complaint upon admission to the health care facility, and primary and secondary diagnoses are listed here, closely mirroring the medical record in the real-world clinical environment.

Scenario Start Day and Time. The scenario start day and time reflect the exact time that the student encounters the patient during the simulation scenario. The corresponding ***EMR*** reflects patient data collected up to the start time of the scenario, again recreating the real-life clinical environment. Students have the opportunity to document in the ***EMR*** the events that occur during the scenario, beginning with the start day and time.

Preparing Yourself



Preparation is the key to success in clinical simulation and ensures that the simulation scenario runs smoothly for you and your students. Before running an SLS scenario with students, you should review the complete ***Implementation Module*** of each scenario so that you are familiar with all aspects of the simulation scenario and its related resources. In addition, try to schedule some time with colleagues or a small group of students to do a "practice run" of the scenario before implementation with a large group of students. Familiarization with the essential elements of each scenario will assist in the successful implementation of clinical simulation throughout the curriculum.

Following the review of materials and practice session, determine how the simulation scenario will be scheduled and managed with all students. For example, you may choose to run each scenario with small groups of 4 to 5 students with assigned roles, or you may prefer to run a simulation scenario with a few students while projecting the real-time simulation to a classroom using audio-visual equipment. Some facilitators may choose to run the simulation scenario with their designated clinical groups. However you choose to implement the simulation scenarios, this should be determined and communicated to students before initiating the simulation.

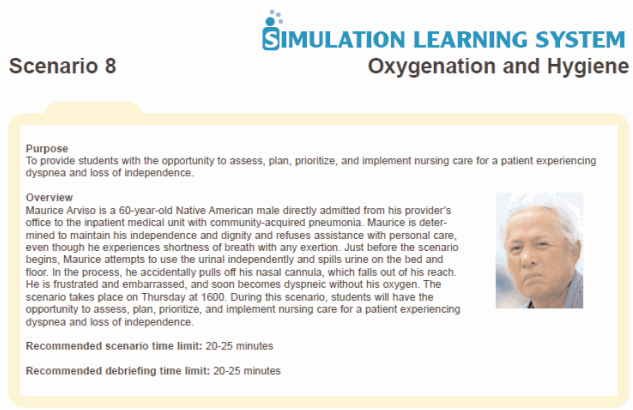
The ***Facilitator's Packet*** is a printable PDF file designed to assist facilitators before and during clinical simulation and includes information needed to prepare the setting, communicate important information to students, and evaluate student performance. The ***Facilitator's Packet*** can be downloaded and printed from the *Preparing Yourself* screen or accessed by clicking on the quick-access icon in the upper right hand corner of the ***Implementation Module*** screen. The icon appears throughout the ***Implementation Module*** next to any specific resources that can be found within the ***Facilitator's Packet***.

FACILITATOR'S PACKET

The ***Facilitator's Packet*** contains the **Scenario Overview**, **Staging Instructions**, **Identity Bands**, **RN-to-RN Patient Report**, **Patient Response Guide**, **Additional Participant Response Guide(s)**, **Participant Role Badges**, **Observer Evaluation Rubric**, **Algorithm Quick Card**, and **Performance Checklist**.

The Scenario

The scenario purpose, overview, and time limit is the same as that found on the *Scenario Overview* screen under the **Preparation** tab.


SIMULATION LEARNING SYSTEM

Scenario 8

Oxygenation and Hygiene

Purpose
To provide students with the opportunity to assess, plan, prioritize, and implement nursing care for a patient experiencing dyspnea and loss of independence.

Overview
Maurice Arviso is a 60-year-old Native American male directly admitted from his provider's office to the inpatient medical unit with community-acquired pneumonia. Maurice is determined to maintain his independence and dignity and refuses assistance with personal care, even though he experiences shortness of breath with any exertion. Just before the scenario begins, Maurice attempts to use the urinal independently and spills urine on the bed and floor. In the process, he accidentally pulls off his nasal cannula, which falls out of his reach. He is frustrated and embarrassed, and soon becomes dyspneic without his oxygen. The scenario takes place on Thursday at 1600. During this scenario, students will have the opportunity to assess, plan, prioritize, and implement nursing care for a patient experiencing dyspnea and loss of independence.

Recommended scenario time limit: 20-25 minutes

Recommended debriefing time limit: 20-25 minutes

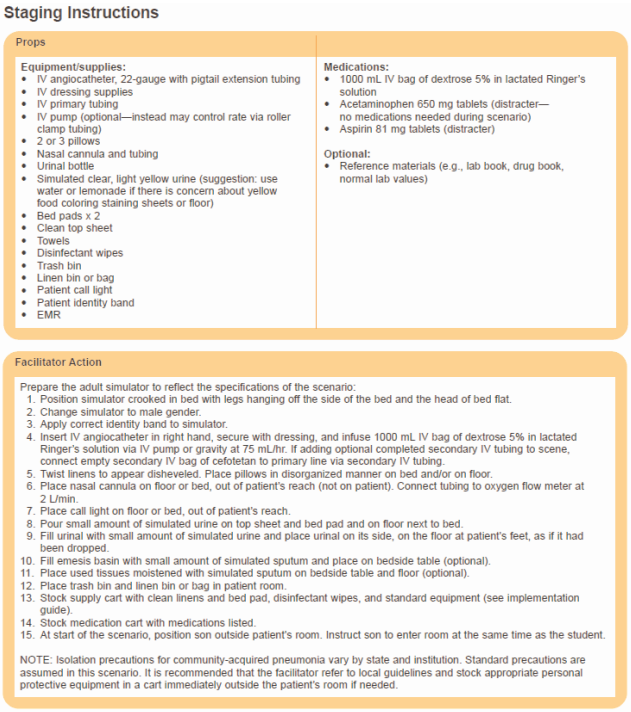
Staging Instructions

The physical simulation environment must be conducive to learning. One primary purpose of simulation is to engage students in a challenging, realistic situation, and to allow them to interact with the physical environment, as well as the patient, when managing the situation. Maintaining an organized and well-equipped physical environment will facilitate learning and enhance knowledge transfer to the clinical setting. The SLS Home Page provides a link to ***Simulation Center Resources***, which include many resources that may help you in planning and preparing the physical simulation environment.

Simulation labs may be equipped with human patient simulators created by different manufacturers with varying functionalities. Facilitators should make every effort to orient themselves to the particular human patient simulator used in their own simulation laboratory and gain mastery of its functionalities and technical operations. It can be especially helpful for your nursing program to enlist one or more "champions" of clinical simulation as experts in the implementation of simulation and to coordinate clinical simulation activities with other facilitators.

The **Staging Instructions** provide detailed information regarding the scenario-specific props-including equipment, supplies, and medications-necessary for scenario implementation. Instructions regarding the use and placement of these props for scenario staging are included.

In some scenarios, paper resources or forms will be required as props. Any required resources or forms are included within the ***Facilitator's Packet*** and appear as links in the *Preparing the Setting* screen of the ***Implementation Module***. Simply click on the link and print the required materials.



Staging Instructions

Props

Equipment/supplies:
- IV angiocatheter, 22-gauge with pigtail extension tubing
- IV dressing supplies
- IV primary tubing
- IV pump (optional—instead may control rate via roller clamp tubing)
- 2 or 3 pillows
- Nasal cannula and tubing
- Urinal bottle
- Simulated clear, light yellow urine (suggestion: use water or lemonade if there is concern about yellow food coloring staining sheets or floor)
- Bed pads x 2
- Clean top sheet
- Towels
- Disinfectant wipes
- Trash bin
- Linen bin or bag
- Patient call light
- Patient identity band
- EMR

Medications:
- 1000 mL IV bag of dextrose 5% in lactated Ringer's solution
- Acetaminophen 650 mg tablets (distracter—no medications needed during scenario)
- Aspirin 81 mg tablets (distracter)

Optional:
- Reference materials (e.g., lab book, drug book, normal lab values)

Facilitator Action

Prepare the adult simulator to reflect the specifications of the scenario:
1. Position simulator crooked in bed with legs hanging off the side of the bed and the head of bed flat.
2. Change simulator to male gender.
3. Apply correct identity band to simulator.
4. Insert IV angiocatheter in right hand, secure with dressing, and infuse 1000 mL IV bag of dextrose 5% in lactated Ringer's solution via IV pump or gravity at 75 mL/hr. If adding optional completed secondary IV tubing to scene, connect empty secondary IV bag of cefotetan to primary line via secondary IV tubing.
5. Twist linens to appear disheveled. Place pillows in disorganized manner on bed and/or on floor.
6. Place nasal cannula on floor or bed, out of patient's reach (not on patient). Connect tubing to oxygen flow meter at 2 L/min.
7. Place call light on floor or bed, out of patient's reach.
8. Pour small amount of simulated urine on top sheet and bed pad and on floor next to bed.
9. Fill urinal with small amount of simulated urine and place urinal on its side, on the floor at patient's feet, as if it had been dropped.
10. Fill emesis basin with small amount of simulated sputum and place on bedside table (optional).
11. Place used tissues moistened with simulated sputum on bedside table and floor (optional).
12. Place trash bin and linen bin or bag in patient room.
13. Stock supply cart with clean linens and bed pad, disinfectant wipes, and standard equipment (see implementation guide).
14. Stock medication cart with medications listed.
15. At start of the scenario, position son outside patient's room. Instruct son to enter room at the same time as the student.

NOTE: Isolation precautions for community-acquired pneumonia vary by state and institution. Standard precautions are assumed in this scenario. It is recommended that the facilitator refer to local guidelines and stock appropriate personal protective equipment in a cart immediately outside the patient's room if needed.

In addition to scenario-specific props, the simulation area should be stocked with standard props. These standard props include items commonly found in a patient care setting. Since standard props are not usually listed on the scenario-specific **Staging Instructions**, take time to be sure that all standard props are in place when staging each scenario. It may be helpful to print a copy of the standard props list included here to use as a checklist for each scenario.

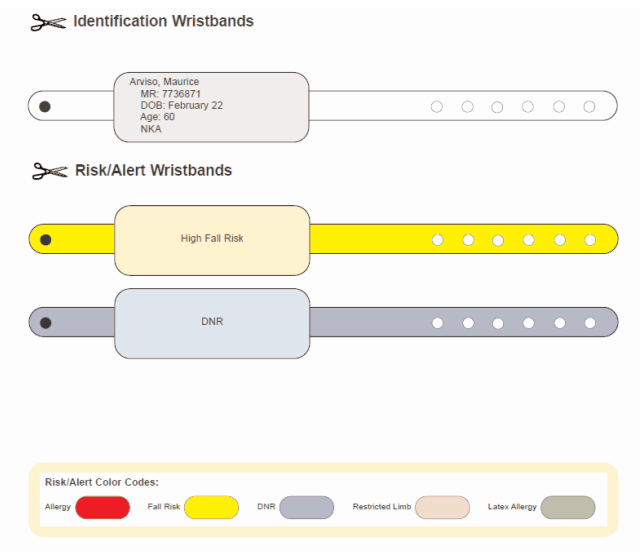
Standard Props and Equipment for All Scenarios		
Supplies: • Hand sanitizer or hand washing station • Universal precaution supplies: clean gloves (all sizes), gowns, masks, face shields, or goggles • Saline flush syringes (for IV flushes) • Alcohol wipes • Cotton balls • Clean gauze squares • Bandages • Tape • Scissors • Box of tissues • Peripads • Bed pads • Sterile gloves in all sizes • Supply cart (optional, for organization of supplies) • Medication cart with simulated medications (see each scenario list for specific medications)	**Patient care equipment:** • Functioning bed • Extra pillows • Sphygmomanometer • Stethoscope (or student to provide) • Thermometer • Pulse oximeter • Cardiac monitor • Oxygen source (wall mount or tank) • Oxygen flow meter • Nasal cannula and tubing • Oxygen face mask • Bag-valve mask • Suction equipment (wall mount or portable)	**Additional equipment in or near patient room:** • Telephone (for provider or interprofessional calls) • Regular garbage bin • Biohazard garbage bin • Linen bag or bin • Sharps container • Writing surface • Pen and note paper • Calculator • Chair for visitor • Laptop or desktop computer with internet connection (for the ***Electronic Medical Record***)

Depending on the type of human patient simulator being used and the type of equipment available in your simulation setting, creative moulage may be necessary. The ***Staging Instructions*** may specify a particular patient presentation, such as type of wound or bloody discharge. When these specifications cannot be met with standard simulator settings, it may be necessary to improvise in order to create the best possible simulation environment. Suggestions for alternative moulage or equipment work-arounds have been supplied when available. Following the guidelines where possible - and using creativity when the guidelines cannot be followed - will ensure a quality simulation learning environment for your students.

Because the ***EMR*** is an essential component of patient care, it is necessary to provide internet access for student access to the ***EMR*** during the scenario. Access to the ***EMR*** will allow students to review patient data or reference orders during the scenario, as well as to practice documentation during or immediately following the scenario.

Identity Bands

In order to closely mimic the real-life clinical environment, the ***Facilitator's Packet*** provides **Identity Bands** appropriate to the scenario. Provided bands include *Patient Identity*, *Allergy*, and other *Risks/Alerts*. Correct identification of a patient reduces the risk for errors in the clinical setting. Utilizing these bands during simulation allows students to practice this skill with each scenario in order to promote patient safety. The bands are designed to be cut out and used during the simulation. Facilitators may find it useful to laminate the bands and store them with scenario-specific documents and materials for future use.



Patient Band	**White**	Name Medical record number Date of birth Age
Risk/Alert: Allergy	**Red**	Band indicates that patient has allergy identified
Risk/Alert: Fall Risk	**Yellow**	Band indicates that paitient has determined fall risk
Risk/Alert: DNR	**Purple**	Band indicates that paitient has a do not resuscitate order
Risk/Alert: Restricted Limb	**Pink**	Band indicates that limb to which band is placed has restricted access
Risk/Alert: Latex Allergy	**Green**	Band indicates that patient has a latex allergy

RN-to-RN Patient Report

Clear communication of patient information during hand-off or at the change of shift is essential to error prevention in the clinical setting. The **RN-to-RN Patient Report** offers detailed information, in SBAR format, regarding the patient's situation, background, and assessment findings, as well as recommendations for care.

The **RN-to-RN Patient Report** may be accessed from three locations:

- From the icon on the scenario header bar
- From the link on the *Implementing the Simulation Experience* screen
- From the scenario-specific ***Facilitator's Packet***

The **RN-to-RN Patient Report** provides students with a current patient status update and sets the stage for the scenario. Facilitators may choose to present the report to their students themselves, or to have a student play the role of the nurse providing the report. The report may be reviewed in written form, read aloud as if in a report room, or communicated at the patient's bedside. Regardless of the delivery method, this report must be provided to students before the start of the scenario. This simulates an actual RN-to-RN report given when one nurse accepts patient care from another and leads the learner into the simulation scenario.

RN-to-RN Patient Report

SBAR Hand-Off	Current day and time:	1600 Thursday											
Situation	Name:	Maurice Arviso											
	Age:	60	Sex:	Male	Ethnicity:	Native American	Religion:	Christian					
	Provider:	Patrick Cronin, MD											
	Admission diagnosis:	Pneumococcal pneumonia											
Background	Pertinent medical history:	Mild arthritis											
	Pertinent social history:	Widowed with one living son											
	Allergies:	No known allergies											
	Code status:	Full code											
	Vital signs (most recent):	Time:	1430	T:	102.4 F (39.1 C)	BP:	130/72	P:	96	RR:	24	O_2 Sat:	92%
	Oxygen therapy:	Mode:	Nasal cannula	LPM:	2								
	Pain:	Rating:	0 (at 1530)	Most recent pain medication:	650 mg acetaminophen			Time:	1430				
	Other recent medication:	Cefotetan 1 g administered IV at 1530 Azithromycin 500 mg administered PO at 1530											
	IVs:	Site:	Right hand	Type:	22-gauge, peripheral	Assessment:	Patent, intact	Fluid:	Dextrose 5% in lactated Ringer's solution at 75 mL/hr				
	Drains and tubes:	Site:	None	Type:	Not applicable	Assessment:	Not applicable						
	Wounds:	Site:	None	Type:	Not applicable	Assessment:	Not applicable						
	ADLs:	Diet:	Regular			Activity:	As tolerated						
	Restrictions:	Isolation:	Standard precautions			Fall risk:	Low						
	Assessments:	Neurologic:	Alert and oriented x 4										
		Cardiac:	Heart rate regular; pulses 2+ radial and pedal; no peripheral edema.										
		Respiratory:	Productive cough; thick rust-colored sputum. Dyspnea upon exertion.										
		GI/GU:	Bowel movement 1 day ago. Urine clear—using urinal at bedside.										
		Integumentary:	Skin intact										
		Ortho/Mobility:	Patient independent, but becomes short of breath with activity.										
		Psychosocial:	Frustrated about being in hospital; son supportive. Wife died 1 year ago.										
		Other:	None										
	Labs and diagnostics:	White blood cell count suggests infection. Antibiotics started.											
Assessment	Nurse's assessment:	Patient comfortable when resting. Very independent gentleman.											
Recommendation	Plan of care:	Monitor respiratory function. Administer antibiotics and oxygen therapy.											
	Tests/results pending:	Chest x-ray just done. Specimen for sputum culture collected and sent at 1450. Results are pending.											
	Orders pending completion:	None											
	Other:	Son (Jonathan) is waiting outside the room while his father uses the urinal. He can walk back in with you now.											

Patient Response Guide

The **Patient Response Guide** offers questions, comments, and responses that the patient might make during the scenario. Some responses are intended to provide the student with information, such as clinical findings or data, while other responses, such as questions about interventions, are intended to challenge or cue the student to interact with the patient. Responses are organized into categories so that the facilitator can quickly locate the appropriate response.

The **Patient Response Guide** has been scripted to reflect the patient's clinical condition and anticipated issues. These general responses are provided as a framework, with the understanding that student questions and actions are often unpredictable. The facilitator is encouraged to improvise and add appropriate impromptu responses on behalf of the patient when necessary.

Patient Response Guide

Maurice Arviso

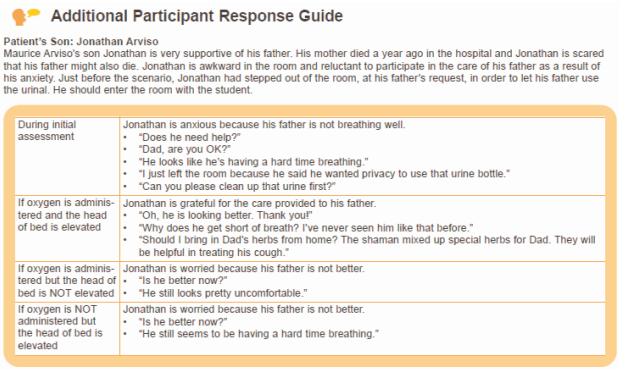
Maurice Arviso is a 60-year-old Native American male admitted to the hospital with pneumonia. He is a kind-hearted, soft-spoken man. He does not want to be a "burden" to anyone and tries to do everything independently. He is used to a full and busy life as a retired craftsman and loves to make wooden toys for his grandchildren. Both Maurice's wife and his father passed away while in a hospital. His wife died one year ago and his father passed away "at age 55 after developing a cough." Maurice is anxious about his current illness and is troubled by the idea of dying in a hospital like his loved ones. Just before the scenario started, Maurice asked his son Jonathan to step out so that he could use the urinal. When Maurice finished, he accidentally spilled urine on the bed and floor. While dealing with the urinal spill, his nasal cannula fell off and he has since become short of breath. During the scenario, Maurice is quiet and cooperative, but also frustrated and embarrassed about his loss of dignity and independence. He is only able to speak in short, four- to five-word phrases until his oxygen saturation improves and dyspnea resolves.

General	• "My birthday is February 22." • "I don't have any allergies."
During initial assessment	• Maurice is dyspneic and can only communicate in four- to five-word phrases. • "I used the urinal (deep breath); tried to hang it on bedrail (deep breath); spilled it on bed and floor (deep breath); I feel badly for making this mess (deep breath); my oxygen came off (deep breath) as I reached for the urinal (deep breath)." • "I'm sorry about the mess (deep breath); I'm so embarrassed (deep breath); feel so weak (deep breath)."
If oxygen is administered and the head of bed is elevated	Maurice's shortness of breath will resolve if oxygen is titrated to 4 L/min or greater and the head of bed is elevated. Oxygen 2 L/min via nasal cannula: O2 Sat = 89% • "I feel a little better (deep breath), but I still can't catch my breath (deep breath)." • "My wife died in the hospital (deep breath). Am I going to die here too (deep breath)?" Oxygen 3 L/min via nasal cannula: O2 Sat = 91% • "I feel a little better (deep breath), but I still can't catch my breath (deep breath)." Oxygen 4 L/min via nasal cannula: O2 Sat = 94% • "I can breathe much better now." • "I am so sorry about the mess I made, but I want to be able to use the urinal myself." • "I don't want to be a burden to anyone." • "Do you think I will be able to go home? I am afraid that I will have to go to a nursing home." • "I want to be able to take care of myself." • "I haven't been able to spend time with my grandchildren because of this cough. Can they catch it?"
If oxygen is administered but the head of bed is NOT elevated	Maurice's shortness of breath will improve with increases in the oxygen flow rate. However, oxygen saturation will not rise above 91% unless the head of bed is elevated. Oxygen 2 L/min via nasal cannula: O2 Sat = 88% • "I feel a little better with the oxygen on (deep breath), but it's still so hard to breathe (deep breath)." Oxygen 3 L/min via nasal cannula: O2 Sat = 90% • "That oxygen is helping some (deep breath), but it's still so hard to breathe (deep breath)." Oxygen 4 L/min via nasal cannula: O2 Sat = 91% • "I feel better, but I still can't really catch my breath (deep breath). Is there anything else you can do to help me breathe easier (deep breath)?"
If oxygen is NOT administered but the head of bed is elevated	Maurice will have increased shortness of breath until oxygen is titrated to 4 L/min or greater. • "At least (deep breath) I'm not lying flat (deep breath), but I still can't breathe (deep breath)."
If oxygen is NOT administered and the head of bed is NOT elevated	Maurice will have increased shortness of breath. He will only be able to talk in two- to three-word phrases. • "Help (deep breath); breathing worse (deep breath); call doctor (deep breath)."
If dignity and privacy are maintained during care	Maurice will express his gratitude. • "Thank you for helping me. I am usually very independent. This is difficult for me."
If dignity and privacy are NOT maintained during care	Maurice will express further frustration and embarrassment. • "This is so hard. I don't want to be a burden to anyone." • "I might as well just die if I can't do things on my own."

Additional Participant Response Guide

Additional participant(s) may be family members, friends, a physician, or another person who is present either physically or by telephone during the simulation. The **Additional Participant Response Guide** provides a script for the person assigned to the particular role. Print out or copy the **Additional Participant Response Guides** and provide them to participants at the time of the scenario.

Family Member or Friend. Student participants, faculty or staff members, or volunteers may be assigned the role of family member or friend of the patient. The person playing this role should be given adequate time to review the **Additional Participant Response Guide** and prepare to use the guide to provide appropriate responses and comments during the scenario. Playing the role of a family member may provide the student insight into the feelings of a visitor in a health care environment. The thoughts and emotions of the visitor should be discussed during the debriefing session, and discussions of the importance of therapeutic communication with both the patient and family member or friend should be encouraged.



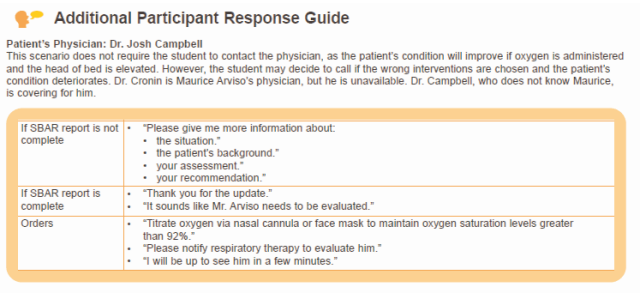
Additional Participant Response Guide

Patient's Son: Jonathan Arviso
Maurice Arviso's son Jonathan is very supportive of his father. His mother died a year ago in the hospital and Jonathan is scared that his father might also die. Jonathan is awkward in the room and reluctant to participate in the care of his father as a result of his anxiety. Just before the scenario, Jonathan had stepped out of the room, at his father's request, in order to let his father use the urinal. He should enter the room with the student.

During initial assessment	Jonathan is anxious because his father is not breathing well. • "Does he need help?" • "Dad, are you OK?" • "He looks like he's having a hard time breathing." • "I just left the room because he said he wanted privacy to use that urine bottle." • "Can you please clean up that urine first?"
If oxygen is administered and the head of bed is elevated	Jonathan is grateful for the care provided to his father. • "Oh, he is looking better. Thank you!" • "Why does he get short of breath? I've never seen him like that before." • "Should I bring in Dad's herbs from home? The shaman mixed up special herbs for Dad. They will be helpful in treating his cough."
If oxygen is administered but the head of bed is NOT elevated	Jonathan is worried because his father is not better. • "Is he better now?" • "He still looks pretty uncomfortable."
If oxygen is NOT administered but the head of bed is elevated	Jonathan is worried because his father is not better. • "Is he better now?" • "He still seems to be having a hard time breathing."

Ancillary Personnel. Student participants in ancillary personnel roles, such as the secondary nurse or nursing assistant, should be instructed to provide care within that provider's scope of practice. If indicated in the response guide, or to guide the direction of the scenario, the facilitator should prompt the secondary nurse and assistive personnel to enter the room or conduct a certain action depending on the events occurring in the scenario. In most scenarios, no response guide is provided for ancillary personnel unless a specific action is required of that person during the scenario. Students in ancillary personnel roles are expected to take direction from the primary nurse and complete tasks appropriately. It may be challenging for some students to maintain an ancillary role during a scenario when they are accustomed to acting as a nurse; students should be reminded during orientation to limit their interventions to the scope of practice of the ancillary care provider during the simulation. Issues that arise during simulation related to an individual's scope of practice and responsibilities during patient care may make for rich discussion during the debriefing session.

Physician or other Health Care Provider. Students should be informed during orientation that they may need to contact the patient's physician or other health care provider to provide a status update or to obtain verbal orders during the course of the scenario. Communication may be obtained through a telephone line, paging system, in-person communication, or two-way walkie-talkies, depending on the scenario and your simulation facility's design and resources.



Additional Participant Response Guide

Patient's Physician: Dr. Josh Campbell
This scenario does not require the student to contact the physician, as the patient's condition will improve if oxygen is administered and the head of bed is elevated. However, the student may decide to call if the wrong interventions are chosen and the patient's condition deteriorates. Dr. Cronin is Maurice Arviso's physician, but he is unavailable. Dr. Campbell, who does not know Maurice, is covering for him.

If SBAR report is not complete	• "Please give me more information about:
	  • the situation."
	  • the patient's background."
	  • your assessment."
	  • your recommendation."

If SBAR report is complete	• "Thank you for the update." • "It sounds like Mr. Arviso needs to be evaluated."
Orders	• "Titrate oxygen via nasal cannula or face mask to maintain oxygen saturation levels greater than 92%." • "Please notify respiratory therapy to evaluate him." • "I will be up to see him in a few minutes."

The role of the health care provider should be played by a facilitator or faculty member using the **Additional Participant Response Guide** for reference. Advance practice nursing students, medical students, or other similarly prepared students may also play this role; in general, it is not advisable to have nursing students play this role as it is beyond their scope of practice.

SBAR Communication. During communication with the physician or health care provider, students should be instructed to provide clear and concise communication regarding the patient condition in the format of **situation**, **background**, **assessment**, and **recommendation (SBAR)** SBAR provides a framework for effectively communicating relevant patient information in an effort to minimize errors in the health care setting and optimize patient safety. When reporting about the **situation**, students should identify themselves

and the environment and provide clear information regarding the events occurring at the present time. **Background** information includes the events leading up to the current situation, including the patient's diagnosis, medications, brief summary of hospitalization, recent vital signs, and other relevant clinical information. **Assessment** includes the student's analysis of the patient situation. Finally, students should give their **recommendation**, or what they feel can be done to improve the patient situation (for example, requesting an order for diagnostic tests or medications or demanding the patient be seen immediately).

The following is an example of nurse-to-provider communication in the SBAR format:

Situation: "Hello, Dr. Rebecca. I am Sarah Matthews, a nurse on unit 6G at Local Hospital. I'm caring for Ms. Ann Howard, who is experiencing a sudden onset of shortness of breath."

Background: "Ms. Howard is a 67-year-old female who was admitted from the emergency department for an exacerbation of her COPD last evening. She also has a history of hypertension. Following lab tests and a chest x-ray, she was placed on 2 liters of oxygen via nasal cannula and IV steroids. An antibiotic was started for treatment of possible bronchitis."

Assessment: "During my 7 AM assessment, I noted the following vital signs: temperature of 99.3˚ F, pulse of 114 bpm, shallow respirations of 26, and blood pressure of 148/86. Her pulse oximeter is reading 92%. She is moderately anxious and speaking in 2- to 3-word sentences. Bilateral breath sounds reveal wheezes throughout all lung fields. I have increased her oxygen flow rate to 4 liters via nasal cannula and am continuously monitoring her oxygen saturation."

Recommendation: "Since there is no order for bronchodilators on her chart, I am requesting an order to administer a fast-acting bronchodilator STAT. I will notify you with an update on her condition following the respiratory treatment."

Participant Role Badges

Role badges are provided for each scenario for participants, including primary nurse, secondary nurse, nursing assistant, health care provider, visitors, friends, and/or family members. Badges may be cut out and provided as identification props for the scenario. Like the armbands, facilitators may find it useful to laminate the role badges(s) and store them with scenario-specific documents and materials for future use.

Observer Evaluation Rubric

Created for the students who are observing the simulation, the **Observer Evaluation Rubric** helps student observers evaluate how well the primary nurse, secondary nurse, and other participant(s) meet or exceed expectations related to the core nursing competency areas. These areas include:

- Management of Care
- Safety and Infection Control
- Health Promotion and Maintenance
- Psychosocial Integrity
- Basic Care and Comfort
- Pharmacological and Parenteral Therapies
- Reduction of Risk Potential
- Physiological Adaptation

SLS Observer Evaluation Rubric

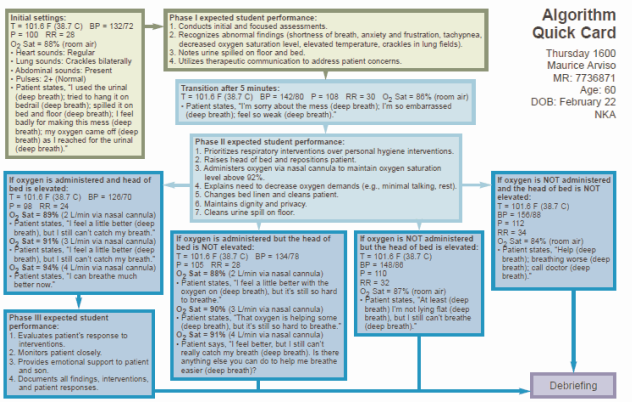
Observe the simulation scenario and assess the participants' management of the situation. Note areas in which participants performed well and areas in which they need improvement. Use these observations to provide feedback and participate in discussion during debriefing.

NCLEX® Client Needs Category	Exemplars observed during scenario:	Opportunities for improvement:
1. SAFE AND EFFECTIVE CARE ENVIRONMENT: MANAGEMENT OF CARE		
2. SAFE AND EFFECTIVE CARE ENVIRONMENT: SAFETY AND INFECTION CONTROL		
3. HEALTH PROMOTION AND MAINTENANCE		
4. PSYCHOSOCIAL INTEGRITY		

For each of these areas, evaluation criteria and expected activities are detailed. Information regarding the related QSEN competencies and national patient safety goals is also included. For ease of use, the **Observer Evaluation Rubric** should be printed out and provided to the student to write on during the scenario. If desired, each student may be assigned only one or two competency areas in order to help narrow the focus of their observation. The facilitator should encourage observers to share the results of their observations during the debriefing session.

Algorithm Quick Card

The **Algorithm Quick Card** is a one-page visual depiction of the three phases of the scenario designed as an easy reference for the simulation facilitator. The **Algorithm Quick Card** summarizes the patient progression, the student's expected actions, and the main possible scenario outcomes in a succinct, graphic representation. The facilitator should keep the card readily available as the scenario progresses and use it as a guide for transitioning the scenario from one phase to the next.



The **Algorithm Quick Card** may be accessed from several locations:

- The ***Facilitator's Packet*** for the scenario
- The *Scenario Phase I: Introduction* screen
- The **Algorithm Quick Card** quick-access icon  on the scenario header bar to the right of the scenario title

The **Algorithm Quick Card** is color-coded to provide a quick visual cue to the current simulation phase. Take a look at the example above:

PHASE I is the assessment stage. Phase I lists the initial patient settings and the expected student performance.

PHASE II is the intervention stage. Any changes in the patient's state from Phase I are noted here, along with the expected student performance for this phase. The student's interventions during Phase II will affect which route the patient will take going into Phase III.

PHASE III offers two or more patient outcomes depending on which interventions occurred during Phase II. Expected student performance statements are provided for when the student performs the appropriate interventions. If the student proceeds down the wrong route, the scenario can proceed directly to the debriefing stage.

The number of branches for any given scenario depends on:

- The complexity of the situation
- The number of appropriate interventions, and
- The number of possible outcomes

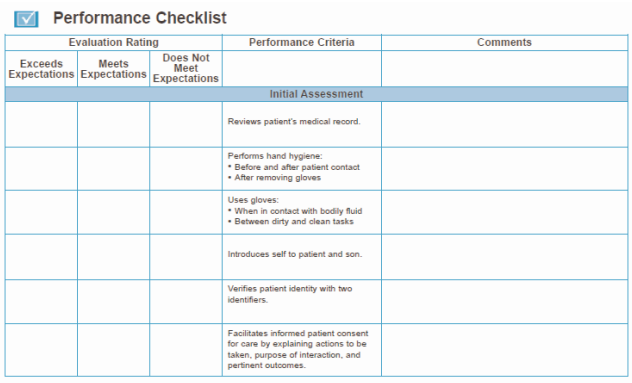
Vital sign data and patient presentation details are provided for all three phases of the scenario, although it is not expected that students necessarily assess this data during all three phases. Vital signs and patient details are provided so that the facilitator is able to program the manikin(s) and provide students with patient presentation details at any time the student chooses to assess the patient during the course of the scenario. Expected frequency of vital sign assessment will be dependent upon the individual scenario.

Although the quick card anticipates the most logical student response during the scenario, it is important that the facilitator remain alert to unanticipated student actions and adjust the simulator as necessary. At any point, the facilitator should be ready to manually change the parameters on the simulator to reflect the consequences of a student's action. In addition, if the facilitator notes that students are struggling and the scenario progression is compromised, the facilitator may wish to prompt students using verbal clues from the patient. For example, if students have not identified postoperative bleeding after a basic assessment, the patient may hint at the problem by saying, "Oh, I am so light-headed and I feel like my bed is all wet. Can you check to see if I wet the bed?" In many cases, these clues will be enough to redirect the scenario. If students remain at a total impasse, an alternative is to call a "time out," in which the facilitator pauses the scenario and talks with students about their perception of the situation and their plan of care. Following the time out, the facilitator may choose to begin the scenario from the beginning or continue with the scenario from the pause point.

The **Algorithm Quick Card** can be used as a guide to run a simulation scenario with or without using preprogrammed files. Any scenario can be run entirely *on-the-fly* (without preprogrammed files) using the **Algorithm Quick Card** as a reference, or scenarios may be run using preprogrammed files or "frames" corresponding to the initial settings, transition, and various possible outcomes. You can choose the method that works best for you. To create preprogrammed files for use in your simulation center, open the file programming feature in your particular simulator software and enter the data provided in the initial settings, transition, and outcomes boxes on the **Algorithm Quick Card**. Name the files accordingly and save them in a preprogrammed folder for use during the scenario.

Performance Checklist

Designed for the facilitator, the **Performance Checklist** details the expected student performance objectives specific to the scenario. The **Performance Checklist** is used for summative student evaluation following the simulation scenario. As the student progresses through the scenario, the facilitator can easily place a checkmark in the appropriate column—Exceeds Expectations, Meets Expectations, or Does Not Meet Expectations—and make comments.



Performance Checklist

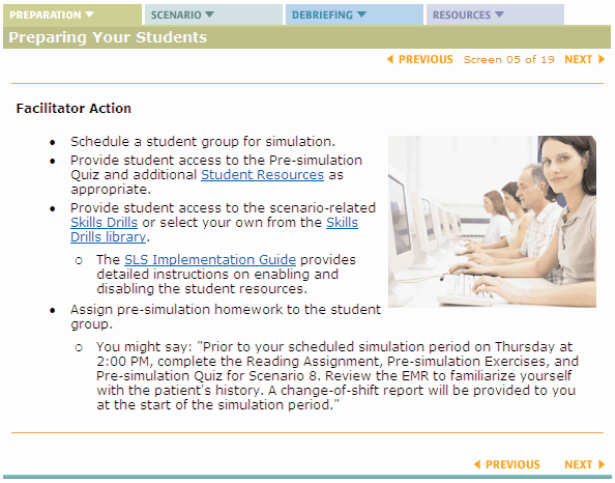
Evaluation Rating			Performance Criteria	Comments
Exceeds Expectations	Meets Expectations	Does Not Meet Expectations		
Initial Assessment				
			Reviews patient's medical record.	
			Performs hand hygiene: • Before and after patient contact • After removing gloves	
			Uses gloves: • When in contact with bodily fluid • Between dirty and clean tasks	
			Introduces self to patient and son.	
			Verifies patient identity with two identifiers.	
			Facilitates informed patient consent for care by explaining actions to be taken, purpose of interaction, and pertinent outcomes.	

The **Performance Checklist** is provided in the ***Facilitator's Packet*** and can be referenced in list format from anywhere within the ***Implementation Module*** by clicking on the icon  on the scenario header bar to the right of the scenario title.

The **Performance Checklist** should be shared with students during or after the debriefing session in order to facilitate student reflection and maximize learning. If the facilitator chooses, each performance behavior can be assigned a point value, and the checklist can easily be converted into a grading tool. For example, the student may earn a "2" if the performance exceeds expectations and a "1" if it meets expectations. The decision to use these scenarios as a grading tool or for competency testing should be made before the start of the scenario and identified in the course syllabus. Students should be informed of this during the clinical simulation orientation period.

Preparing Your Students

An important part of the student simulation experience is preparation. You can help your students maximize their time in simulation by assigning pre-simulation and post-simulation homework using the available scenario-specific resources. The Resources section of the ***Implementation Module*** lists all of the pre- and post-simulation learning resources that can be assigned. In addition to the scenario-specific assignments, the EMR User Guide should be assigned as reading before the first simulation scenario event, and should be continue to be accessible by students as a reference document throughout their simulation training.



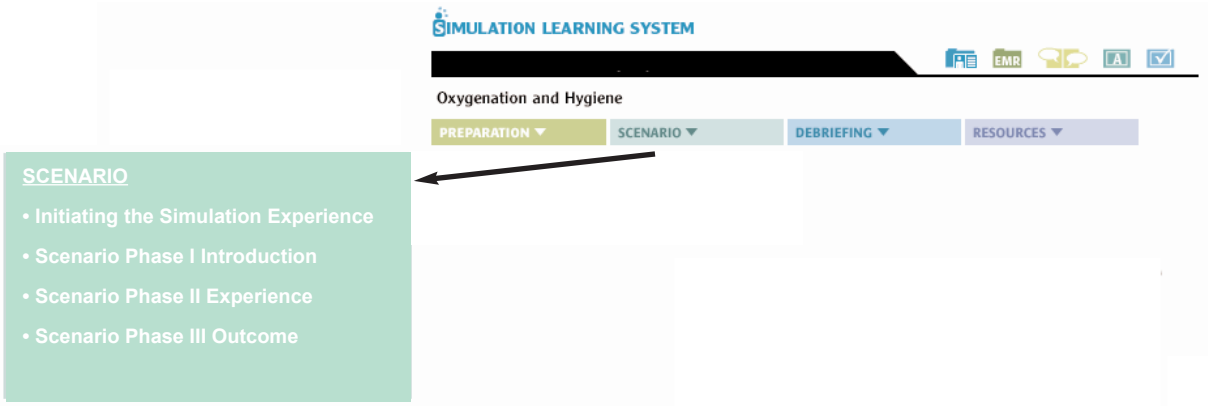
To activate assignments, return to the main scenario folder and open the **Pre-simulation Learning Resources** and **Post-simulation Learning Resources** folders for the desired scenario. For detailed instructions on activating these resources, see the *Using Student, Faculty, and Evolve Resources* section of this guide, page 46.

You may elect to assign the student to review the patient's ***EMR*** prior to arriving at the simulation event. In this case, assign student access to the patient's ***EMR*** prior to simulation through the Post-simulation Learning Resources folder (see page 47). The student would review the ***EMR*** before patient care, just as might be done during an actual clinical assignment. The ***EMR*** contains data leading up to the scenario start time, but, like the pre-simulation activities, the ***EMR*** does not reveal any information about the patient's condition during the scenario, so reviewing the EMR would not "give away" the scenario.

Preparing the Setting

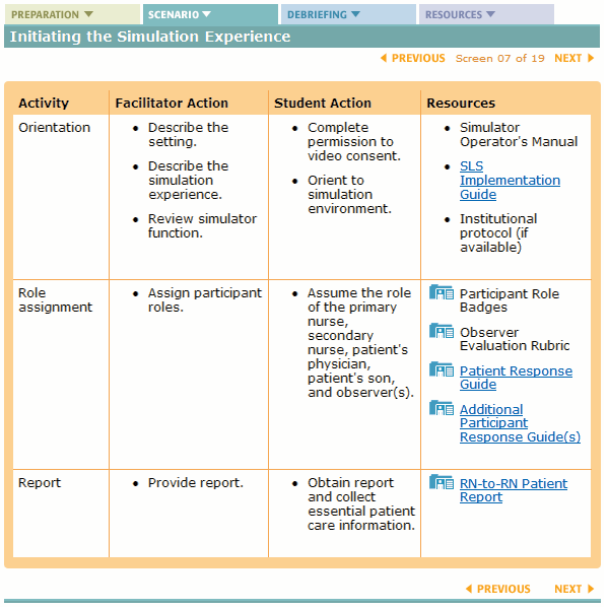
The **Preparing the Setting** section contains a reference copy of the scenario-specific Staging Instructions including equipment, props, medications, and facilitator's set-up actions. Please see detailed information about Staging Instructions in the ***Facilitator's Packet*** section of this guide on page 19.

2. SCENARIO



Initiating the Simulation Experience

Orientation. When students arrive on the first clinical simulation day, it is important to provide them with an orientation to the human patient simulator and its functionality, the equipment available in the room, and the surrounding environment. This should be individualized based on your setting and your students' familiarity with the simulation environment-students who are new to the simulator will need more time for orientation than more experienced students. Students should be given a clear idea of the general activities they will perform during any simulation. For example, they should be prepared to assume a role, receive report, review the ***EMR***, and begin to provide care to the patient while following the steps of the nursing process.



Certain ground rules should be established with students before beginning the clinical simulation experience. The facilitator should reinforce that the simulation environment is a safe and positive environment for students to practice their skills. It is essential to make students feel comfortable in simulation and acknowledge the possibility that they may make mistakes. Remind students that it is better to make a mistake in simulation and learn from the experience than to make a mistake with a real patient with the potential of causing harm. Take time to promote an environment that fosters constructive criticism and mature, respectful behavior. To establish an environment conducive to learning, make it clear that students must be respectful to their peers during and after the simulation experience and that there should be no ridiculing or demeaning of a peer who may have made an error. Students should understand that a debriefing session will be conducted following the scenario in which all participants will be given the opportunity to critically reflect on both the strengths and weaknesses of their performance as well as areas in which they can improve.

If written permission to film student performance is required in your simulation lab, permissions should be obtained during orientation.

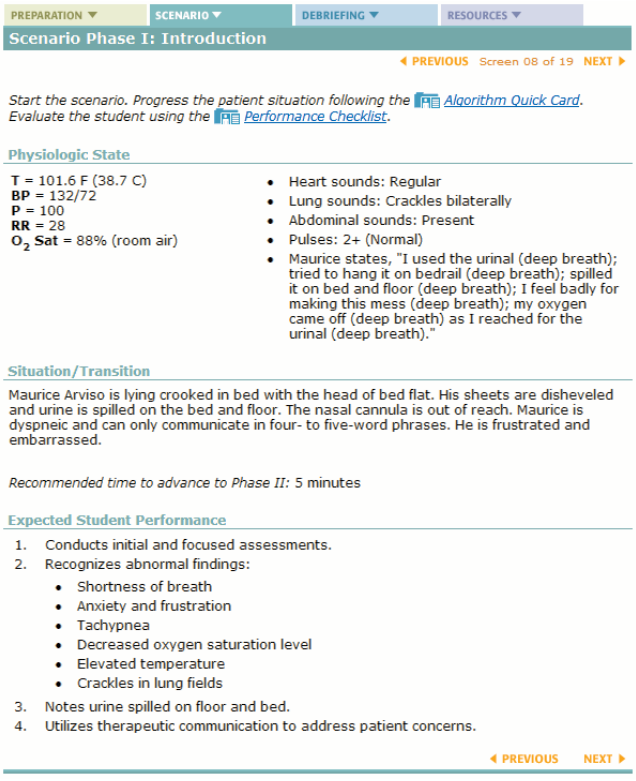
Role Assignment. Following orientation, students should be assigned specific roles to be played during the simulation scenario. The facilitator may choose to assign student roles or allow students to randomly choose badges to determine their role. Each scenario includes the role of the primary nurse and secondary nurse, with some scenarios including additional participants such as a nursing assistant or a patient's family member or friend. In general, it is recommended that the role of the health care provider should be played by a facilitator or faculty member, as it is beyond a nursing student's scope of practice. As facilitator, you can include additional participants at your discretion, such as charge nurse, unlicensed assistive personnel, or lab technician. The inclusion of any assistive personnel allows the primary and secondary nurses to practice delegating tasks, while the delegate is given the opportunity to perform appropriate tasks and experience an ancillary role. The inclusion of students in roles such as friends or family members allows them to experience a health care setting from their unique perspective. Be sure to give participants in scripted roles the **Additional Participant Response Guide** for their role, available in the ***Facilitator's Packet***.

The primary nurse is expected to act as the team leader during the scenario, with the secondary nurse assisting as needed within the nursing scope of practice. Participants in both nursing roles (primary and secondary) should be encouraged to talk and think out loud as they practice their clinical decision-making skills, while also being cognizant of their communication techniques.

To ensure that all roles are clearly identified during the scenario, have each student participant wear a badge. Printable **Participant Role Badges** are available in the ***Facilitator's Packet***. You may also wish to provide costumes including wigs, hats, clothing, or other props for particular roles to enhance realism.

Report. To begin the simulation scenario, provide report using the **RN-to-RN Patient Report**. Detailed information about using the **RN-to-RN Patient Report** is found in the ***Facilitator's Packet*** section of this guide on page 23.

Scenario Phase I (Introduction)


PREPARATION | SCENARIO | DEBRIEFING | RESOURCES

Scenario Phase I: Introduction

◀ PREVIOUS Screen 08 of 19 NEXT ▶

Start the scenario. Progress the patient situation following the Algorithm Quick Card. Evaluate the student using the Performance Checklist.

Physiologic State

T = 101.6 F (38.7 C)
BP = 132/72
P = 100
RR = 28
O_2 Sat = 88% (room air)

- Heart sounds: Regular
- Lung sounds: Crackles bilaterally
- Abdominal sounds: Present
- Pulses: 2+ (Normal)
- Maurice states, "I used the urinal (deep breath); tried to hang it on bedrail (deep breath); spilled it on bed and floor (deep breath); I feel badly for making this mess (deep breath); my oxygen came off (deep breath) as I reached for the urinal (deep breath)."

Situation/Transition

Maurice Arviso is lying crooked in bed with the head of bed flat. His sheets are disheveled and urine is spilled on the bed and floor. The nasal cannula is out of reach. Maurice is dyspneic and can only communicate in four- to five-word phrases. He is frustrated and embarrassed.

Recommended time to advance to Phase II: 5 minutes

Expected Student Performance

1. Conducts initial and focused assessments.
2. Recognizes abnormal findings:
   - Shortness of breath
   - Anxiety and frustration
   - Tachypnea
   - Decreased oxygen saturation level
   - Elevated temperature
   - Crackles in lung fields
3. Notes urine spilled on floor and bed.
4. Utilizes therapeutic communication to address patient concerns.

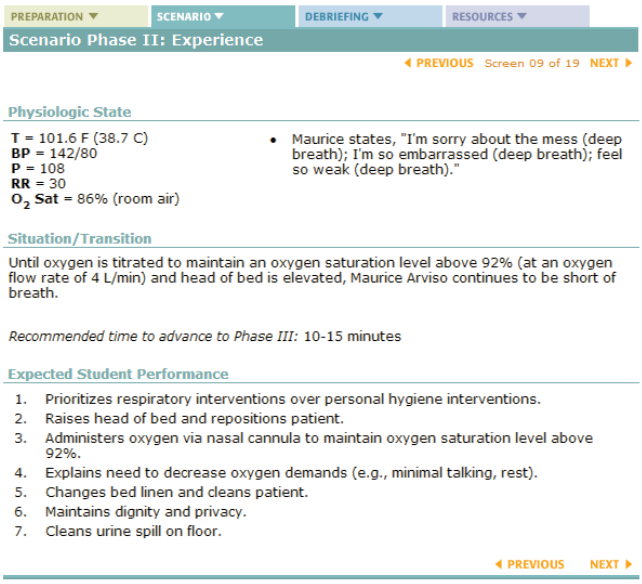
◀ PREVIOUS NEXT ▶

The Scenario Phase I, II, and III screens provide detailed information about the scenario. This information is most useful if reviewed ahead of time by the simulation facilitator in order to understand the pathways of the scenario. It can be referenced as needed during the actual scenario. These documents provide a high level of detail in contrast to the **Algorithm Quick Card** which provides a visual overview of the scenario. If the facilitator is both controlling and speaking for the manikin, it is recommended that the **Patient Response Guide** and **Algorithm Quick Card** be printed for use at the control station, and that the Scenario Phase I, II, and III screens be kept close for occasional reference if needed.

Phase I represents the initial contact between student and patient. During this phase, the primary nurse enters the room, identifies the patient, and conducts a focused assessment. With each scenario, the additional events in Phase I are tailored to the specific scenario. The initial **Physiologic State** indicates the specific physiologic parameters that should be programmed into the simulator. The **Situation/Transition** provides a description of the patient environment to be encountered by the student, along with a **Recommended Time to Advance** to

the next phase. The time required to advance may vary based on actual student performance. The **Expected Student Performance** lists actions to be accomplished during the first phase of the scenario. These expected performance statements correspond with the **Performance Checklist**.

Scenario Phase II (Experience)



During Phase II, the student must use the data collected during the assessment process and begin to plan and intervene with the patient. Vital signs are included in each phase in the event that the student assesses vital signs at that time, not implying that students must assess vital signs during each phase. Depending on the assessment findings, the student may need to conduct interventions such as calling the appropriate health care provider and obtaining orders for treatments, administering medications, or performing other nursing interventions. Students will have the opportunity to implement nursing interventions and perform psychomotor skills, including—but not limited to—patient assessment, medication administration, intravenous fluid administration, oxygen initiation and monitoring, catheterization, and blood product administration, depending on the specific scenario. As in Phase I, the **Physiologic State**, **Situation/Transition**, **Recommended Time to Advance**, and **Expected Student Performance** are provided.

Scenario Phase III (Outcome)

During Phase III, the simulator responds to the interventions (or lack thereof), in a positive or negative manner, resulting in the ultimate patient outcome. The student has the opportunity to reassess the patient and evaluate the effectiveness of the interventions. The **Physiologic State** and **Situation/Transition** are also provided as in previous phases. **Expected Student Performance** during Phase III involves evaluation of the interventions and documentation of the events in the ***EMR***. Once the student completes all performance behaviors, or if the student appears to be following an incorrect pathway and the patient situation deteriorates, the facilitator may choose to state "The scenario is over" and proceed to the debriefing portion of the SLS.

PREPARATION | SCENARIO | DEBRIEFING | RESOURCES

Scenario Phase III: Outcome

◀ PREVIOUS Screen 10 of 19 NEXT ▶

Physiologic State

If oxygen is administered and head of bed is elevated:

T = 101.6 F (38.7 C)
BP = 126/70
P = 98
RR = 24

O_2 Sat = 89% (2 L/min via nasal cannula)	• Maurice states, "I feel a little better (deep breath), but I still can't catch my breath."
O_2 Sat = 91% (3 L/min via nasal cannula)	• Maurice states, "I feel a little better (deep breath), but I still can't catch my breath."
O_2 Sat = 94% (4 L/min via nasal cannula)	• Maurice states, "I can breathe much better now."

If oxygen is administered but the head of bed is NOT elevated:

T = 101.6 F (38.7 C)
BP = 134/78
P = 105
RR = 28

O_2 Sat = 88% (2 L/min via nasal cannula)	• Maurice states, "I feel a little better with the oxygen on (deep breath), but it's still so hard to breathe."
O_2 Sat = 90% (3 L/min via nasal cannula)	• Maurice states, "That oxygen is helping some (deep breath), but it's still so hard to breathe."
O_2 Sat = 91% (4 L/min via nasal cannula)	• Maurice says, "I feel better, but I still can't really catch my breath (deep breath). Is there anything else you can do to help me breathe easier (deep breath)?"

If oxygen is NOT administered but the head of bed is elevated:

T = 101.6 F (38.7 C)
BP = 148/86
P = 110
RR = 32
O_2 Sat = 87% (room air)

• Maurice states, "At least (deep breath) I'm not lying flat (deep breath), but I still can't breathe (deep breath)."

If oxygen is NOT administered and the head of bed is NOT elevated:

T = 101.6 F (38.7 C)
BP = 156/88
P = 112
RR = 34
O_2 Sat = 84% (room air)

• Maurice states, "Help (deep breath); breathing worse (deep breath); call doctor (deep breath)."

Situation/Transition

If oxygen is administered and the head of bed is elevated, Maurice Arviso's oxygen saturation level will increase and his dyspnea will decrease in correlation with the oxygen flow rate. Vital signs will return to baseline when the oxygen saturation level rises above 92% (at an oxygen flow rate of 4 L/min).

If oxygen is administered but the head of bed is not elevated, Maurice's oxygen saturation level will increase and his dyspnea will decrease in correlation with the oxygen flow rate. However, dyspnea will not resolve until the head of bed is elevated. Vital signs will reflect mild hypoxia.

If oxygen is not administered but the head of bed is elevated, Maurice will experience only a slight improvement in his dyspnea. He will communicate in short phrases only. Vital signs will reflect hypoxia.

If oxygen is not administered and the head of bed is not elevated, Maurice will experience worsening dyspnea. He will communicate in two- to three-word phrases only. Vital signs will reflect hypoxia.

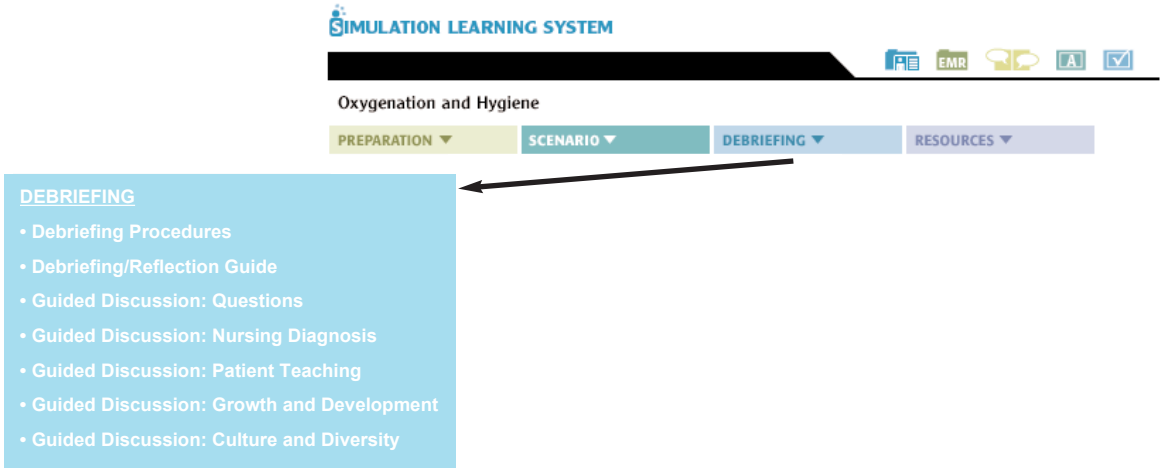
Expected Student Performance

1. Evaluates patient's response to interventions.
2. Monitors patient closely.
3. Provides emotional support to patient and son.
4. Documents all findings, interventions, and patient responses.

End the scenario.

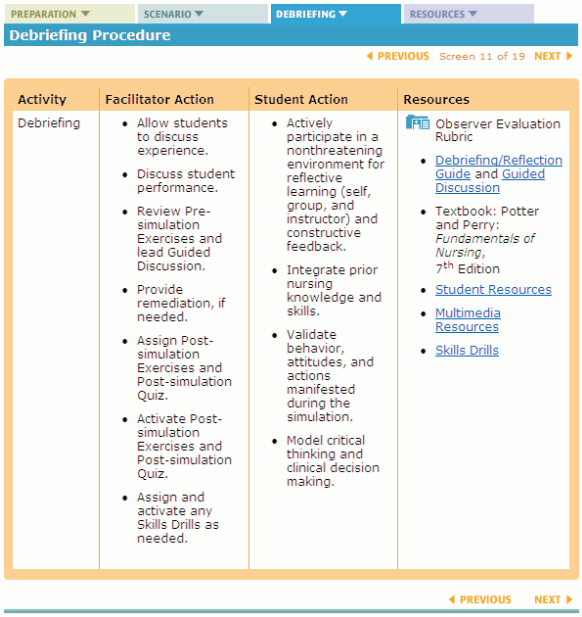
◀ PREVIOUS NEXT ▶

3. DEBRIEFING



Debriefing Procedure

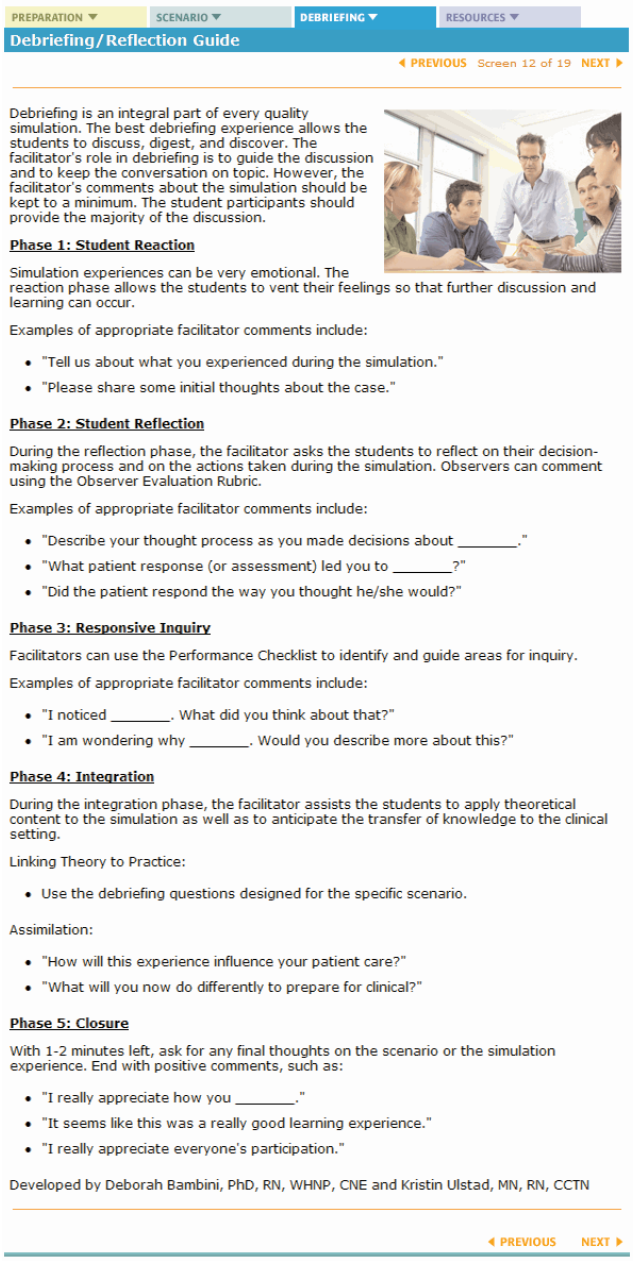
A well-conducted debriefing session is integral to the simulation learning experience. The best debriefing experience allows participants to openly reflect on the scenario in a non-threatening and non-judgmental environment. The debriefing session should immediately follow completion of the scenario and should be conducted in a comfortable area with all scenario participants present. The facilitator's role in debriefing is to provide structure to the discussion as students actively review and discuss details and outcomes of the scenario. Facilitator's comments and reactions to student performance during the simulation should be kept to a minimum, and student participants should be encouraged to lead the discussion as much as possible. Reinforce the importance of the debriefing session and emphasize how this critical reflective process correlates with enhanced learning outcomes. The debriefing should last as long or longer than the scenario itself.



Debriefing/Reflection Guide

The **Debriefing/Reflection Guide** is organized into 5 phases to help you provide structure to the debriefing process. The phases include:

1. Student Reaction
2. Student Reflection
3. Responsive Inquiry
4. Integration
5. Closure


PREPARATION SCENARIO DEBRIEFING RESOURCES

Debriefing/Reflection Guide

PREVIOUS Screen 12 of 19 NEXT

Debriefing is an integral part of every quality simulation. The best debriefing experience allows the students to discuss, digest, and discover. The facilitator's role in debriefing is to guide the discussion and to keep the conversation on topic. However, the facilitator's comments about the simulation should be kept to a minimum. The student participants should provide the majority of the discussion.

Phase 1: Student Reaction

Simulation experiences can be very emotional. The reaction phase allows the students to vent their feelings so that further discussion and learning can occur.

Examples of appropriate facilitator comments include:

- "Tell us about what you experienced during the simulation."
- "Please share some initial thoughts about the case."

Phase 2: Student Reflection

During the reflection phase, the facilitator asks the students to reflect on their decision-making process and on the actions taken during the simulation. Observers can comment using the Observer Evaluation Rubric.

Examples of appropriate facilitator comments include:

- "Describe your thought process as you made decisions about _____."
- "What patient response (or assessment) led you to _____?"
- "Did the patient respond the way you thought he/she would?"

Phase 3: Responsive Inquiry

Facilitators can use the Performance Checklist to identify and guide areas for inquiry.

Examples of appropriate facilitator comments include:

- "I noticed _____. What did you think about that?"
- "I am wondering why _____. Would you describe more about this?"

Phase 4: Integration

During the integration phase, the facilitator assists the students to apply theoretical content to the simulation as well as to anticipate the transfer of knowledge to the clinical setting.

Linking Theory to Practice:

- Use the debriefing questions designed for the specific scenario.

Assimilation:

- "How will this experience influence your patient care?"
- "What will you now do differently to prepare for clinical?"

Phase 5: Closure

With 1-2 minutes left, ask for any final thoughts on the scenario or the simulation experience. End with positive comments, such as:

- "I really appreciate how you _____."
- "It seems like this was a really good learning experience."
- "I really appreciate everyone's participation."

Developed by Deborah Bambini, PhD, RN, WHNP, CNE and Kristin Ulstad, MN, RN, CCTN

PREVIOUS NEXT

The **Student Reaction** phase allows students to vent their feelings immediately after the scenario. During this phase, the facilitator invites students to share initial thoughts about the case. Students may experience intense emotional responses, especially if the patient suffered a negative outcome.

During the **Student Reflection** phase, students are encouraged to reflect on their decision making process and on interventions conducted during the scenario. During this phase, all participants should be encouraged to participate in the discussion. Observers should be encouraged to provide feedback using the **Observer Evaluation Rubric**.

During the **Responsive Inquiry** phase, the facilitator has several options for stimulating critical thinking and modeling clinical decision making for students. The **Performance Checklist** could be reviewed, including both positive feedback and honest evaluation of events that occurred during the scenario. If your simulation center has the capacity for recording the scenario, the recording can be reviewed with students at this time, allowing the facilitator to pause and ask critical thinking questions at pivotal points during the scenario.

During the **Integration** phase, discussion is guided to link theory to practice and facilitate transfer of knowledge to the clinical setting and next patient encounter. The Integration phase is also an optimal time to review any pre-simulation learning exercises that students completed before the simulation experience.

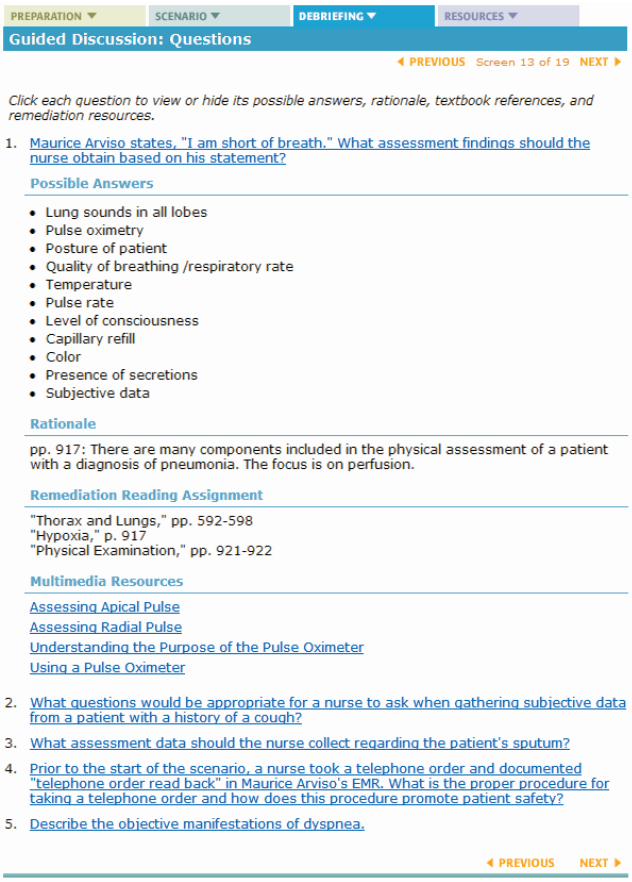
Other important clinical skills and concepts can be discussed during the **Responsive Inquiry** and **Integration** phases. The **Guided Discussion** section of the SLS (described below) provides suggestions for questions specific to the scenario. Other valuable debriefing topics common to all scenarios include therapeutic communication, professional communication, teamwork, patient safety, quality of care considerations, and documentation.

The **Closure** phase concludes the debriefing with the students' final thoughts on the scenario and positive, honest comments from the facilitator. If the scenario was particularly challenging for the students, the facilitator should be cautious not to offer false praise such as by saying, "Good job." Instead, the facilitator should offer an honest appraisal such as, "This was a difficult scenario and I appreciate your participation. It seems like this was a good learning experience."

Guided Discussion: Questions

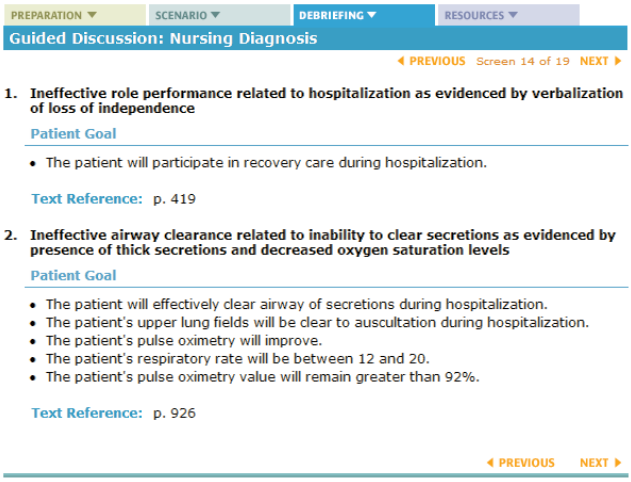
The SLS provides questions that directly relate to the scenario content for guided discussion during the Responsive Inquiry and Integration phases of debriefing. These questions cover topics such as pathophysiology, treatment options, expected patient responses to interventions, quality and safety indicators, and protocols. Suggested answers, rationales from the textbook, reading assignments, and multimedia resources are provided to assist facilitators in leading discussion and initiating remediation. Encourage students to openly share their responses to these questions during the debriefing session. If students are challenged by a question, encourage them to think out loud and collaborate with their peers to problem-solve and arrive at the best answer.

Alternatively, if debriefing time is limited, the guided discussion questions may be utilized as a large group discussion in a lecture class shortly after the simulation event, or assigned as homework immediately following simulation.



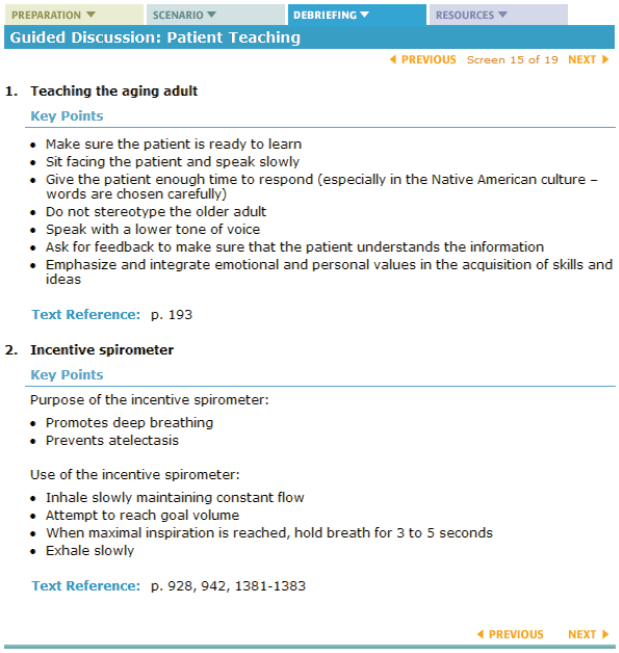
Guided Discussion: Nursing Diagnosis

Corresponding North American Nursing Diagnosis Association (NANDA) International-approved nursing diagnoses and patient goals from your specific nursing textbook are provided for each scenario, with page references included. The facilitator may use these diagnoses as a guide when asking students to identify appropriate scenario-specific nursing diagnoses and to develop related patient goals. Suggested answers are provided to the facilitator to assist in leading the discussion.



Guided Discussion: Patient Teaching

Patient teaching points related to each scenario are included with corresponding textbook references. The facilitator can refer students to these textbook references for remediation and guidance if needed.


PREPARATION SCENARIO DEBRIEFING RESOURCES

Guided Discussion: Patient Teaching

PREVIOUS Screen 15 of 19 NEXT

1. **Teaching the aging adult**

Key Points

- Make sure the patient is ready to learn
- Sit facing the patient and speak slowly
- Give the patient enough time to respond (especially in the Native American culture – words are chosen carefully)
- Do not stereotype the older adult
- Speak with a lower tone of voice
- Ask for feedback to make sure that the patient understands the information
- Emphasize and integrate emotional and personal values in the acquisition of skills and ideas

Text Reference: p. 193

2. **Incentive spirometer**

Key Points

Purpose of the incentive spirometer:

- Promotes deep breathing
- Prevents atelectasis

Use of the incentive spirometer:

- Inhale slowly maintaining constant flow
- Attempt to reach goal volume
- When maximal inspiration is reached, hold breath for 3 to 5 seconds
- Exhale slowly

Text Reference: p. 928, 942, 1381-1383

PREVIOUS NEXT

Guided Discussion: Growth and Development

Students are encouraged to consider how the patient's condition may impact social interactions, family dynamics, and role performance. In this section, growth and development considerations, including Erikson's stages specific to each patient, are presented with corresponding textbook references.


PREPARATION SCENARIO DEBRIEFING RESOURCES

Guided Discussion: Growth and Development

PREVIOUS Screen 16 of 19 NEXT

1. **Developmental Stage**

Middle adulthood (age 36-65)
Erikson psychosocial development stage: Generativity versus self-absorption and stagnation

Key Points

- Some adults suffer the loss of status and function
- May suffer loss of significant people in their lives
- Maintaining independence is important to one's self-esteem

Maurice Arviso is having difficulty adjusting to his current health problems and lack of physical strength. He has not accepted his dependence on others for personal care. He will need to find ways to maintain his quality of life while recovering from this illness.

Text Reference: p. 139

2. **Gerontologic Considerations**

Aging and the cardiopulmonary system

Key Points

- Decreased respiratory muscle mass and chest wall compliance
- Decreased alveolar surface area
- Decreased responsiveness of central and peripheral chemoreceptors to hypoxemia and hypercapnia
- Decreased number of cilia
- Decreased IgA production and humoral and cellular immunity

Text Reference: p. 922

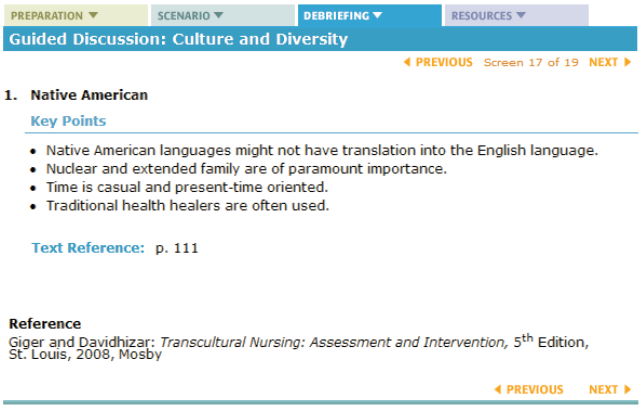
Reference

Edelman and Mandle: *Health Promotion Throughout the Life Span*, 7th Edition, St. Louis, 2010, Mosby

PREVIOUS NEXT

Guided Discussion: Culture and Diversity

Culture and diversity considerations are presented for each scenario with textbook references.


PREPARATION SCENARIO DEBRIEFING RESOURCES

Guided Discussion: Culture and Diversity

PREVIOUS Screen 17 of 19 NEXT

1. **Native American**

Key Points

- Native American languages might not have translation into the English language.
- Nuclear and extended family are of paramount importance.
- Time is casual and present-time oriented.
- Traditional health healers are often used.

Text Reference: p. 111

Reference

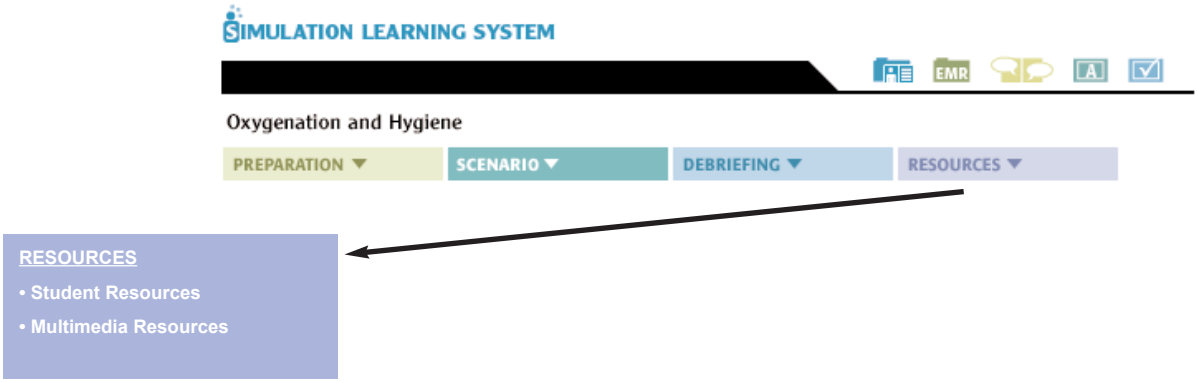
Giger and Davidhizar: *Transcultural Nursing: Assessment and Intervention*, 5th Edition, St. Louis, 2008, Mosby

PREVIOUS NEXT

Debriefing—Final Notes

Students should be reminded that the details of the particular simulation scenario should not be shared with other nursing students-this ensures that all students are given equal opportunity to experience clinical simulation and that no student will have an unfair advantage. In addition, if your institution records the simulation scenarios for student review during the debriefing session, students should sign a permission form indicating that the recording will be used only for educational purposes, will not be shared with individuals who have not been directly involved with the simulation scenario, and will be destroyed following review. You may wish to include specific institutional policies and procedures that guide the process of data recording, management, and storage.

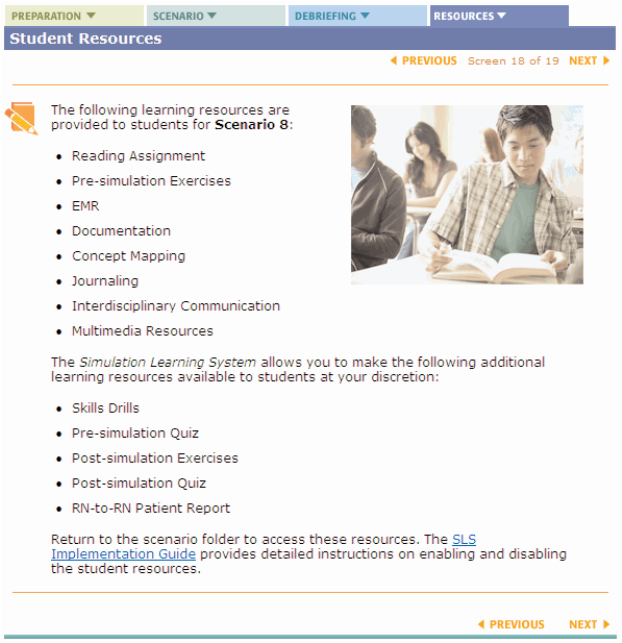
4. RESOURCES



Student Resources

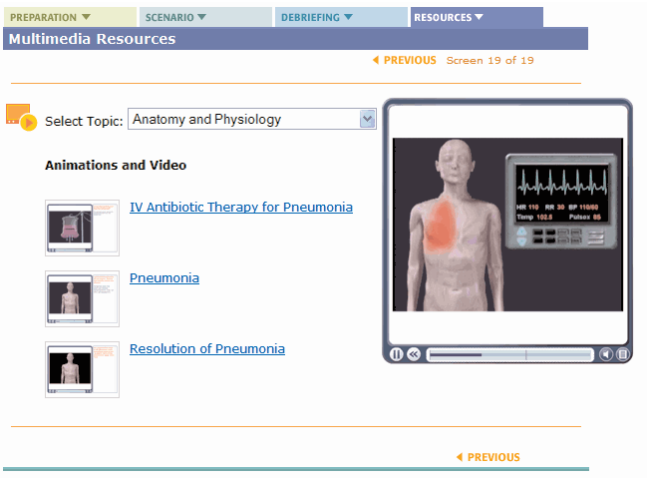
Numerous scenario-specific resources are available for student learning and evaluation before and after simulation. The *Student Resources* screen summarizes these resources for each scenario.

For detailed instructions on activating these resources, see the *Using Student, Faculty, and Evolve Resources* section of this guide, page 46.



Multimedia Resources

The SLS is embedded with numerous multimedia resources that correlate to the scenario or to the type of patient represented to further enhance understanding of the nursing concepts. Animations, skills videos, and audio clips offer review of physiologic processes and nursing procedures and are available to students for reference and review before or following simulation, although access can be restricted at your discretion.



Electronic Medical Record

The nurse's effective use of an ***EMR*** is directly related to improved patient outcomes in the health care setting. Nursing students must be able to access, retrieve, and interpret health-related information effectively in order to provide safe, optimal care to their patients. When reviewing a patient's record, nursing students must gather and interpret the pertinent data while sorting through the voluminous amount of information provided.

The SLS provides an opportunity for students to learn these skills through the use of a fully functional ***EMR*** for each simulation scenario. The ***EMR*** allows students to reference important patient data and document assessment findings and care given during simulation using forms and methods similar to those they will use in both the clinical setting and in practice. The ***EMR*** should be accessible in or near the patient's room during simulation.

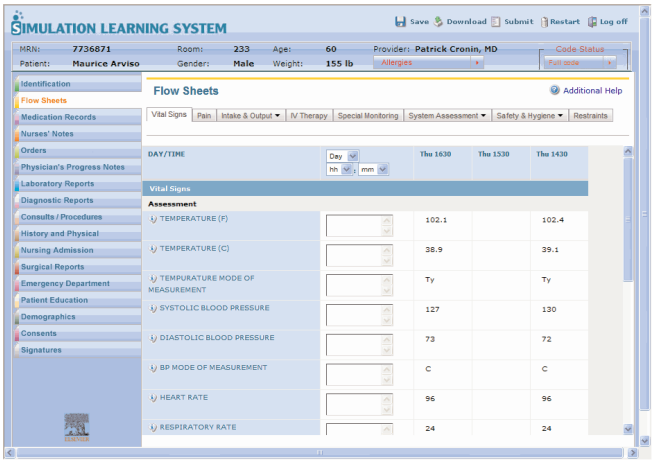
To launch the ***EMR***, the student logs into their own *Evolve* account. Any modifications made to the ***EMR*** under a student's login will be saved only to that student's account. Student ***EMR*** documentation during the scenario can be saved and retrieved later by the student for further charting and electronic submission to the instructor, or documentation can be submitted immediately after the scenario for evaluation. Students should reference the *EMR User Guide* in their SLS *Evolve* account for specific instructions about how to use the ***EMR***, how to submit documentation to their instructor, and how to access ***EMR*** support if needed.

Although particular aspects of the ***EMR*** may or may not be relevant to the scenario, all sections of a basic patient chart are included for each scenario to closely mirror a real patient chart. The facilitator can use any parts of the ***EMR*** to reinforce other pertinent clinical concepts in debriefing or individually with students as time allows. As in the real clinical setting, portions of the ***EMR*** may have data omissions, giving the student the opportunity to discover the missing data and interpret the consequences of the omissions. Each section of the ***EMR*** is described in detail below.

IDENTIFICATION

The **Identification** page appears first in the ***EMR***. The patient's medical record number, name, room number, gender, age, provider's name, primary diagnosis, secondary diagnosis, allergies, height, weight, and code status are listed next to a photograph of the patient. These data cannot be modified by the student. Using this information, students should correctly identify the patient and validate the presented information with the simulated patient, especially related to patient allergies.

NURSING FLOW SHEETS



The interactive **Nursing Flow Sheets** section of the ***EMR*** contains nursing assessment and intervention data beginning at the time of the patient's admission to the inpatient unit. The flow sheets are organized according to the following subcategories: *Vital Signs*, *Pain*, *Intake & Output*, *IV Therapy*, *Special Monitoring*, *System Assessment*, *Safety & Hygiene*, and *Restraints*. Students can document assessments they have conducted during the scenario, gaining practice that will lead to improved documentation skills transferrable to the clinical setting. Codes for abbreviations are listed under the information icon to the left of each assessment item. Each subcategory within the **Nursing Flow Sheet** section is described in detail below.

Vital Signs. This interactive page contains information regarding the patient's temperature, blood pressure, pulse, respirations, oxygen saturation, blood glucose, height, and weight, as well as other vital measurements. These fields will be populated up to the time of the scenario start according to the patient's hospital stay. Students should reference this page to determine the patient's baseline vital signs, detect trends in the values, and document findings noted as part of the care administered during the simulation scenario.

Pain. This interactive page contains information regarding the patient's report of pain according to the pain rating scale, the location, characteristics, and relieving factors. Students should use the appropriate pain scale to evaluate the patient's pain and to determine trends related to pain management. In addition, students can enter their own assessment findings in this section.

Intake & Output. This interactive page represents the patient's fluid intake and output since admission. Depending on the course of the simulation scenario, the student can enter the specific fluid intake (either by IV or by mouth) and output (such as urine, blood, emesis, nasogastric tube secretion, or liquid stool) obtained while caring for the simulated patient. Additional learning activities using this record may include determining a trend related to intake and output values since the patient was admitted and using these data to determine the patient's fluid balance status.

Intravenous Therapy. Information about intravenous therapy is recorded on this page. The IV fluids and rates of administration can be documented by students.

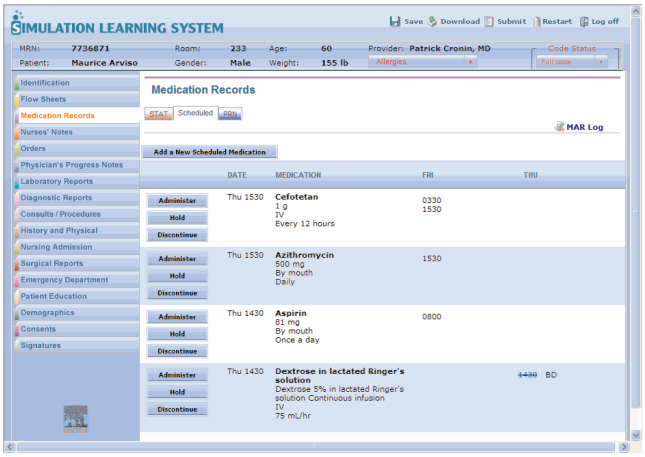
Special Monitoring. Information related to PCA Pump Monitoring can be found within this tab.

System Assessment. This tab is organized according to biological and psychosocial systems: Respiratory, Cardiovascular, Neurologic, Gastrointestinal, Genitourinary/Reproductive, Musculoskeletal, Integumentary, and Psychosocial. Any assessments completed during simulation should be documented in this section by the student. Student learning activities using assessment data include identifying abnormal findings or trends in assessments.

Safety & Hygiene. Patient safety is paramount in any clinical setting. Students must document the fall risk and basic safety measures implemented. This interactive page also details interventions related to patient hygiene and comfort.

Restraints. For simulated patients who have restraints ordered, students should use this interactive flow sheet to document the restrained patient's care. Students should ensure that the patient has the restraints removed at appropriate intervals and has been offered nutrition and toileting; that alternative clinical activities have been offered; and that the neurovascular status of the restrained area has been documented. Rules and regulations regarding the use of restraints in the clinical setting and the impact of restraints on patient's rights are continually changing; the ***EMR*** reflects the current practice recommendations at time of publication. Suggested learning activities include asking students the rationale for these changing regulations and how proper documentation can ensure that the rights of restrained patients are protected.

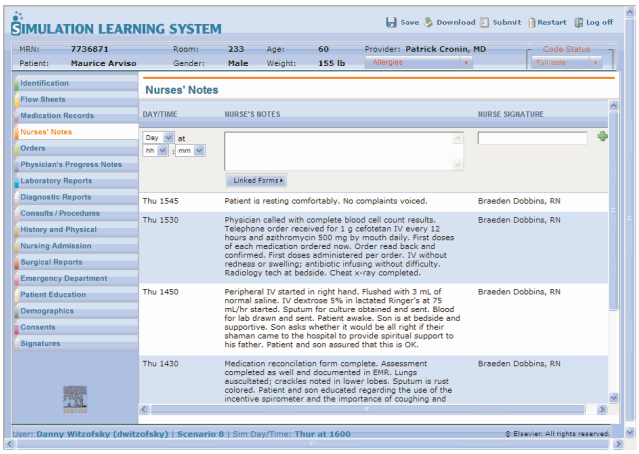
MEDICATION RECORDS



In this interactive portion of the EMR, students can review medications administered since the patient's admission and document all medications administered during the simulation scenario. Medication administration errors are among the most common preventable medical errors. The Medication Records allow students to practice the skill of proper medication administration, which will enhance patient safety in the clinical setting. The student can carefully reference medication orders, check for medication allergies, and practice implementing the six rights of safe medication administration in the simulated clinical setting. Practicing in the simulation lab will enhance student performance of these important skills.

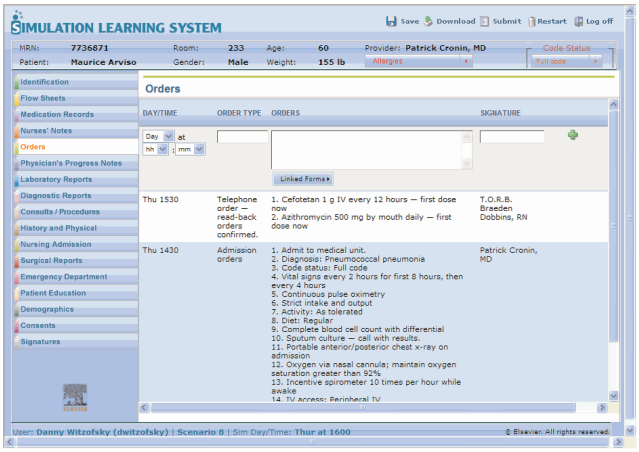
Only medications ordered and administered before the start of the scenario will be included in the Medication Records. During the course of the scenario, if a new medication is ordered or administered, students can enter the medication order in the Orders and the Medication Records section and document that the medication was administered. Once the medication is administered, the time appears as a strikethrough in the record. The facilitator can use the Medication Records list to facilitate discussion of the classification, mechanism of action, and nursing considerations related to the medications, in addition to asking the student to provide the rationale for the medication order.

NURSES' NOTES



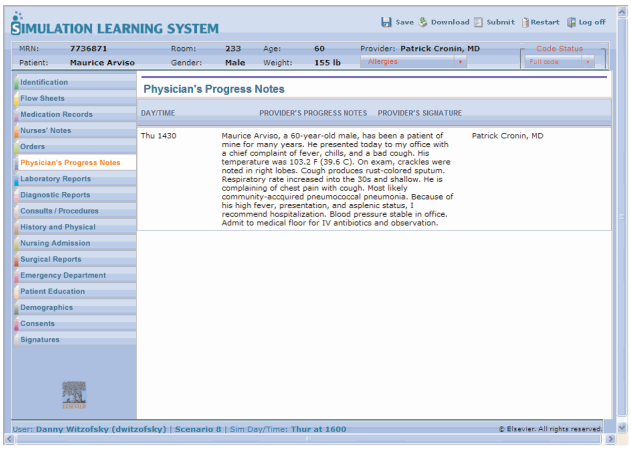
This portion of the ***EMR*** contains the narrative nursing notes, which begin at the time of patient admission. Any information that cannot be adequately described in the nursing flow sheet should be documented in narrative format in the **Nurses' Notes** to supplement the flow sheets. Students can add their narrative documentation of the events that occurred during the simulation scenario, such as detailed assessments, patient interventions, and the patient response to the particular intervention. The facilitator should instruct students to write detailed nursing notes regarding the simulated patient experience. Thorough documentation of clinical events is essential to the safe care of patients in the clinical environment—a skill that can be practiced in the ***EMR*** during clinical simulation.

ORDERS



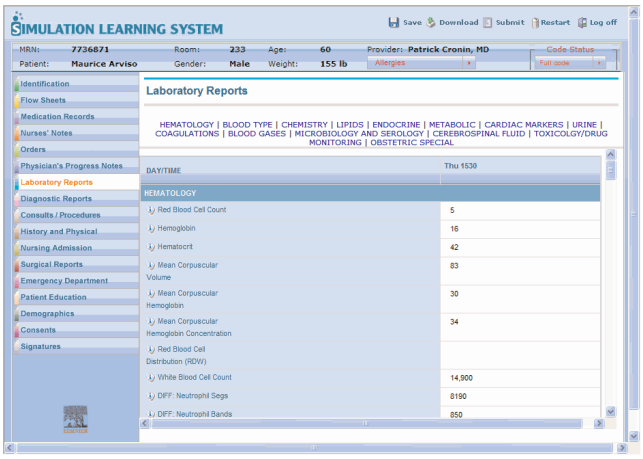
The primary health care provider's written orders are documented in the **Orders** section. These orders begin at the time of admission and progress until the scenario begins. Checking and interpreting orders correctly is a valuable nursing skill that ensures patient safety. The facilitator should make sure that students access this information when checking medication orders in the **Medication Records** and when implementing any nursing or medical interventions. If the student obtains any verbal orders during the course of the simulation scenario, these orders can be documented on this interactive page.

PHYSICIAN'S PROGRESS NOTES



Physician notes or primary health care providers' notes are displayed under the **Physician's Progress Notes** tab. These narrative notes include the primary health care provider's description of the patient assessment along with the rationales for interventions. This information cannot be modified by the student. Suggested learning activities include the analysis of this information when determining the rationale for various orders, such as medication changes, treatment additions, or the ordering of diagnostic tests.

LABORATORY REPORTS

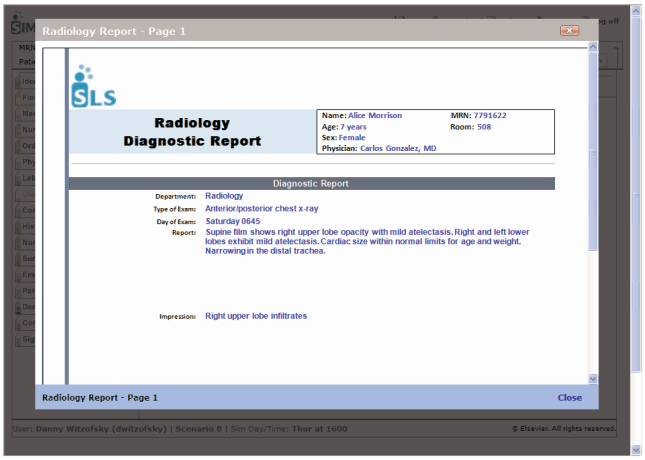


Results of blood, urine, wounds, fluids, or any other lab results from the time of the patient's admission will be found in the **Laboratory Reports** section of the ***EMR***. By scrolling over the information icon to the left of the term, a pop-up box will reveal expected reference values.

Laboratory reports and studies requested during the simulation scenario will not be found in the **Laboratory Reports** section because the ***EMR*** only reflects the time leading up to the clinical simulation experience. Laboratory results which are reported during the simulation scenario can be communicated by the facilitator verbally via a telephone call to the primary nurse, or in a printed or projected laboratory result format.

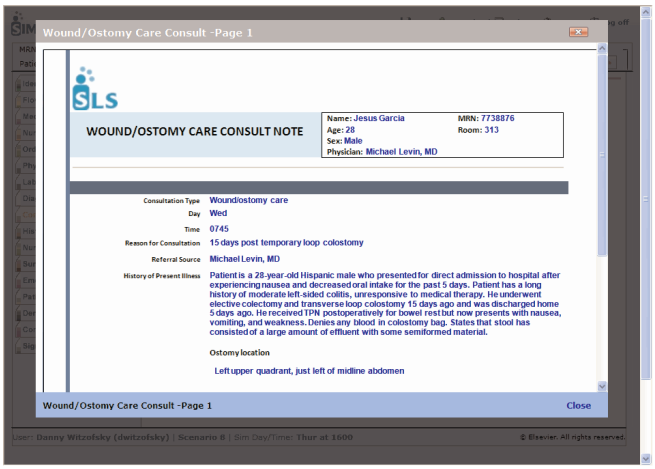
The facilitator can reinforce the interpretation of patient laboratory report data before, during, or after the simulation scenario to enhance student understanding of how results relate to the care of the patient. The facilitator may ask students to report normal ranges for laboratory values and give suggested rationales for abnormal findings.

DIAGNOSTIC REPORTS



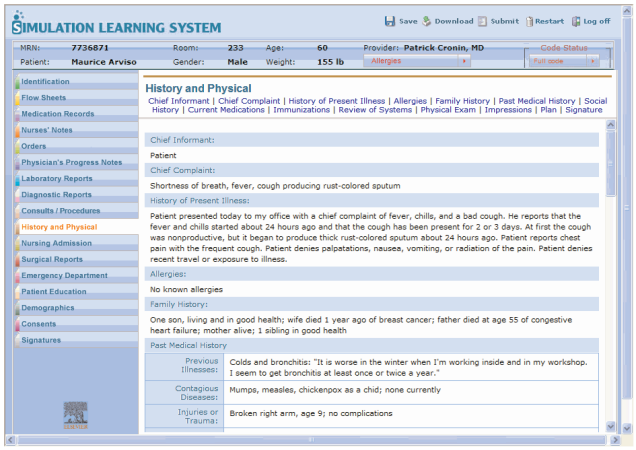
Results of radiologic tests and other special diagnostic studies can be found under the **Diagnostic Reports** tab. Types of studies include chest x-rays, magnetic resonance imaging, and computerized tomography scans. Diagnostic reports cannot be modified by the student. Diagnostic reports requested during the clinical simulation experience will not be found here because the ***EMR*** only reflects the time leading up to the clinical simulation experience. If, for instance, a stat ultrasound is requested during the course of the simulation scenario, the facilitator should report the results verbally via telephone to the primary nurse, or present the primary nurse with a printed or projected ultrasound results report. The facilitator may wish to use the contents of the **Diagnostic Reports** section as a tool to review with students the nursing care of the patient before and after a procedure. The **Diagnostic Reports** also allow the facilitator the opportunity to discuss actual test results related to the patient's diagnosis, and explore implications for patient care with the students.

CONSULTS/PROCEDURES



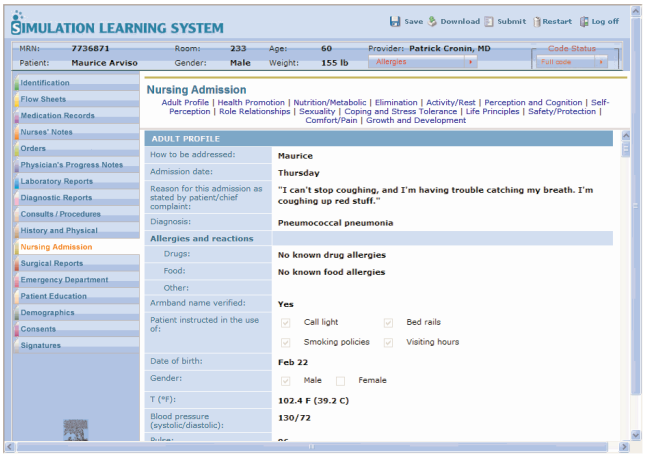
If the simulated patient was assessed by a specialist, such as a cardiologist, nutritionist, or social worker, a report of the visit is located in the **Consults/Procedures** tab. This section cannot be modified by the student. The facilitator may use this information to discuss with students the potential patient implications and nursing interventions related to the specific consult.

HISTORY AND PHYSICAL



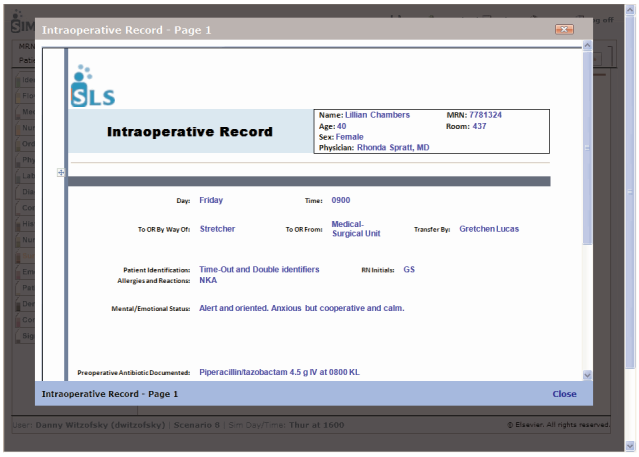
The **History and Physical** tab contains the initial history and physical (H&P) report. Subsections of this comprehensive form include the following: *Chief Informant*, *Chief Complaint*, *History of Present Illness*, *Allergies*, *Family History*, *Past Medical History*, *Social History*, *Current Medications*, *Immunizations*, *Review of Systems*, *Physical Exam*, *Impressions*, and *Plan*. The history and physical is completed by the primary health care provider when the patient is admitted; therefore, this information cannot be modified by the student. With the history and physical data serving as the foundation for admission orders, the facilitator can ask the student to provide a rationale for the admitting orders based on the H&P. The facilitator may also ask the student to identify any abnormal findings in the report and relate these to the diagnosis and care of the simulated patient.

NURSING ADMISSION



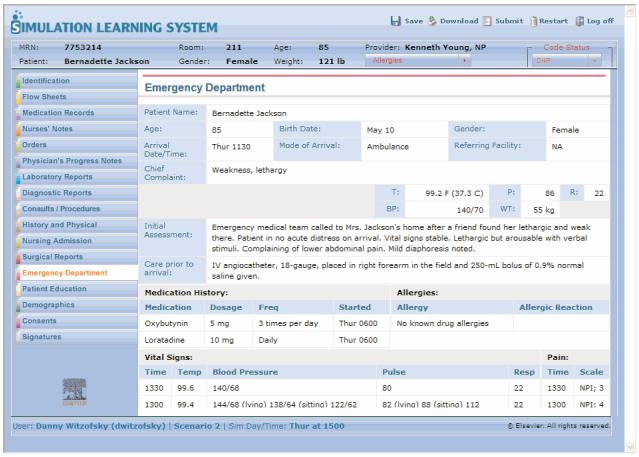
The **Nursing Admission** section is completed by the nurse at the time of the patient's admission to the inpatient unit. Whether or not students will complete this section themselves depends on when the simulation is scheduled to occur during the course of the hospitalization. That is, if completion of the admission assessment section is a stated performance objective for the clinical simulation scenario, students will be able to enter data. However, if the patient was admitted before the designated simulation scenario start time, the section will have been previously completed and students will not be able to modify the existing data. Subsections of this comprehensive nursing form include the following: *Patient Profile*, *Health Promotion*, *Nutrition/Metabolic*, *Elimination*, *Activity/Rest*, *Perception and Cognition*, *Self-Perception*, *Role Relationships*, *Sexuality*, *Coping and Stress Tolerance*, *Life Principles*, *Safety/Protection*, *Comfort/Pain*, and *Growth and Development*. These categories provide data necessary for students to provide holistic care to the simulated patient. Students can use this information to create pertinent nursing diagnoses and a comprehensive plan of care for their patients.

SURGICAL REPORTS



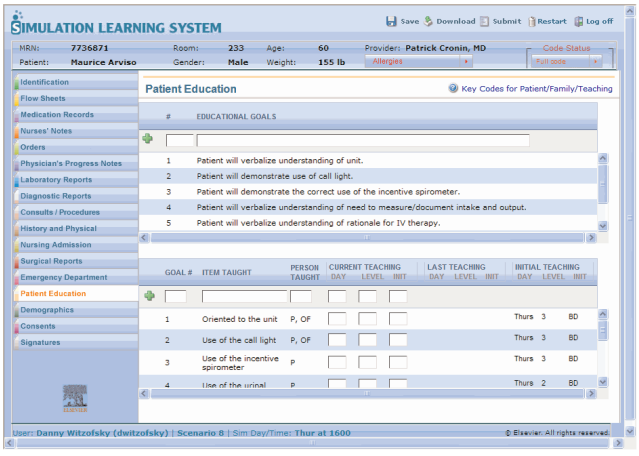
Surgical Reports are included in the ***EMR*** if the simulated patient underwent a surgical procedure. Reports include the following: *Anesthesia Questionnaire*, *Operative Report*, *PACU Discharge*, *Preoperative Checklist*, *Preoperative Patient Instruction*, and *Surgery Unit Admission Form*. This portion of the ***EMR*** cannot be modified by the student. The facilitator can use this information to reinforce operative content such as the preoperative assessment, consent for treatment, preoperative checklist, and important legal implications related to operative consents.

EMERGENCY DEPARTMENT



Data will be found in the **Emergency Department** record if the simulated patient experienced an emergency department (ED) visit during the current admission. This multidisciplinary documentation form contains the following subsections: *Patient Demographics*, *Chief Complaint*, *Initial Assessment*, *Systems Review*, *Medication Record*, *Laboratory Record*, *Radiology Record*, *Nurse's Notes*, and *Provider's Progress Notes*. If the simulation scenario takes place in the emergency department, the student will be able to enter data in this form to reflect care administered. The facilitator can discuss how this ED record differs from documentation used on the clinical unit and why these differences exist. For example, by accessing this form, students will be able to see how the care of the patient in the emergency department is focused on quickly diagnosing and stabilizing the patient and then preparing for transfer to the appropriate clinical area.

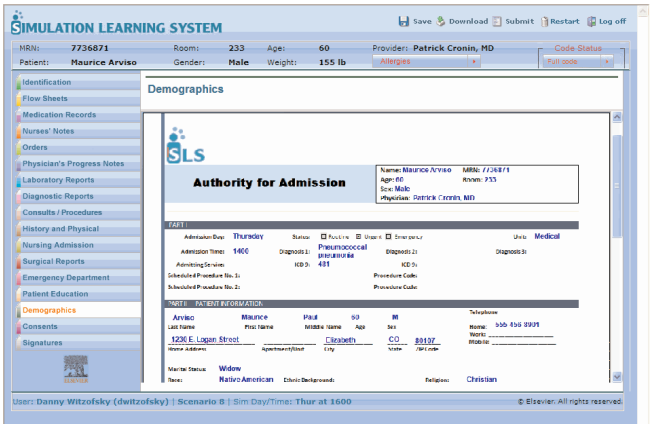
PATIENT EDUCATION



Patient education is a priority of nursing care in the clinical setting. The **Patient Education** tab includes patient goals and a form outlining a systematic process for documenting educational interventions and progress toward meeting the goals. A concise method of coding is used to assist with the documentation on the form. As students provide patient teaching, the interventions can be documented and modified in the **Patient Education** section. As with all other sections where students enter documentation data, the facilitator can review and offer constructive feedback to students regarding patient education. In addition, patient teaching topics are covered in the debriefing guide following the scenario. The facilitator may ask the student to provide a rationale for certain patient education topics or create a sample teaching plan including methods of delivery and expected patient outcomes.

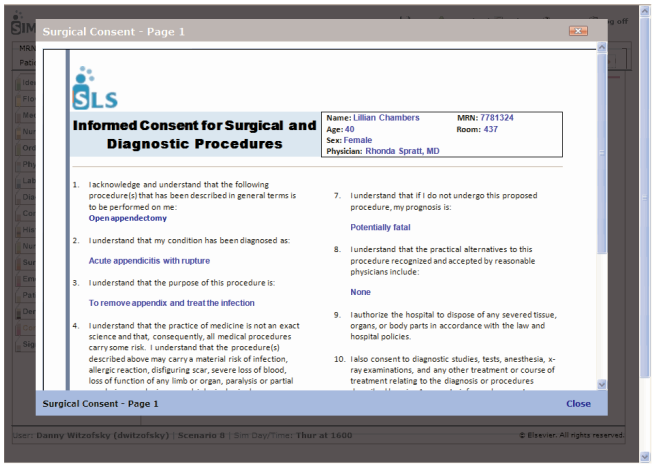
DEMOGRAPHICS

The **Demographics** section contains admission information including admitting diagnoses, patient address and telephone number, emergency contact, insurance details, admission consent, and information about whether or not the patient has an advanced directive. This information cannot be modified by the student. Suggested learning activities may include asking the student to review the patient's insurance information to anticipate any limitations or challenges for patient care access after discharge.



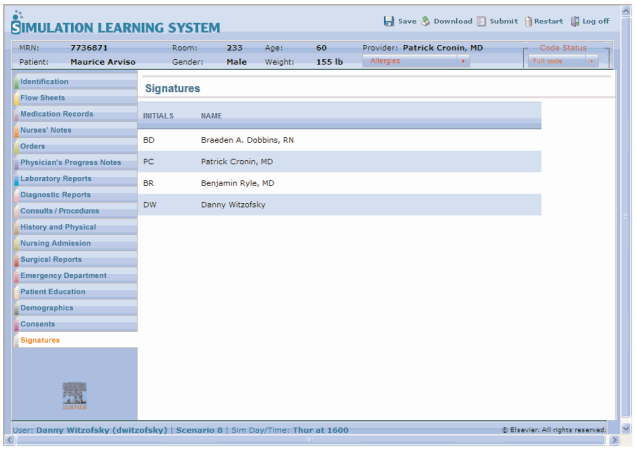
CONSENTS

Consent forms for blood transfusions and other diagnostic or surgical procedures are provided in the **Consents** tab. Consents cannot be modified by the student in this section, but some scenarios require a blank consent form to be printed out by the facilitator and provided as a prop during the scenario; in these cases, the form is available from the Preparing the Setting screen, or within the ***Facilitator's Packet***. Learning activities related to consents may include discussions related to the legal implications of obtaining consents.



SIGNATURES

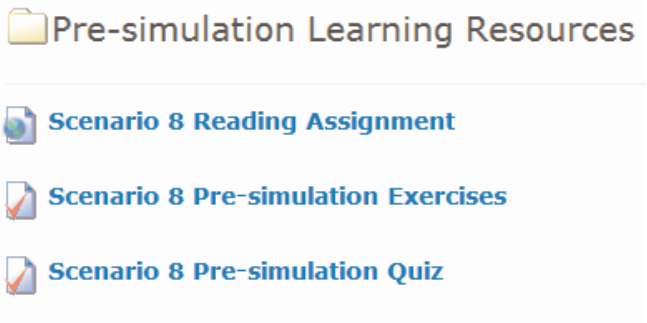
This page is simply the electronic signature page for health care providers who have previously recorded data on the medical record.



Using Student, Faculty, and *Evolve* Resources

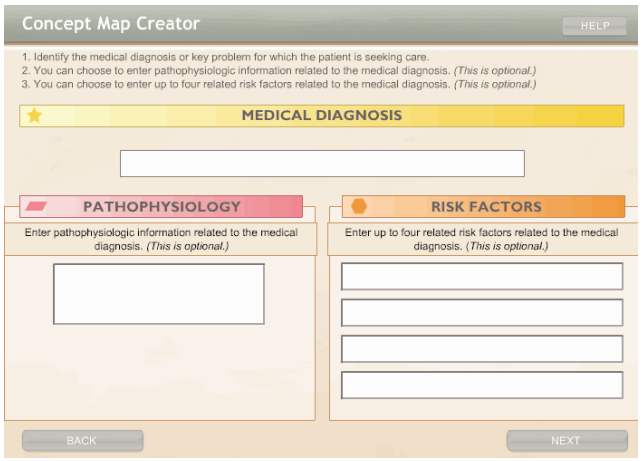
PRE-SIMULATION LEARNING RESOURCES

While you are preparing the scenario and the environment, students also need preparation in order to maximize their time in simulation. You may elect to have students do all, some, or none of the pre- simulation assignments. Students who complete these assignments independently can submit their responses electronically to the facilitator.



Reading Assignments offer relevant content in your obstetric nursing text that will help students prepare for the scenario. These textbook readings correlate specifically with the learning outcomes for each simulation scenario. Before the simulation experience, the facilitator may assign general readings so that students can prepare adequately for the events that may occur in the simulation scenario, without revealing the specific storyline of the scenario. Students who are adequately prepared for the simulation scenarios can use this foundational knowledge and build on it during the scenario, thus honing their critical thinking abilities. The reading assignment may also serve as a guide for students as they complete the pre- and post-simulation exercises and quizzes.

Concept Mapping. Using the **Concept Map Creator** designed to accompany the specific nursing textbook, students can create a concept map linking the patient's medical diagnoses, clinical manifestations, collaborative problems, pathophysiology, risk factors, nursing diagnoses, interventions, and expected outcomes. The concept map can be saved as a final draft, saved for future modification, or printed.



Pre-simulation Exercises are meant to encourage higher level thinking in the nursing student and should be completed before the simulation experience. The exercises reinforce concepts related to the nursing process, pathophysiology, patient education, and other issues that may be pertinent to the elements of the scenario, without revealing the specifics related to the scenario. These exercises can be performed independently or in a group setting led by a facilitator. Once completed, the student can submit the answers to the facilitator. These pre-simulation exercises should be discussed during the debriefing session following the simulation.

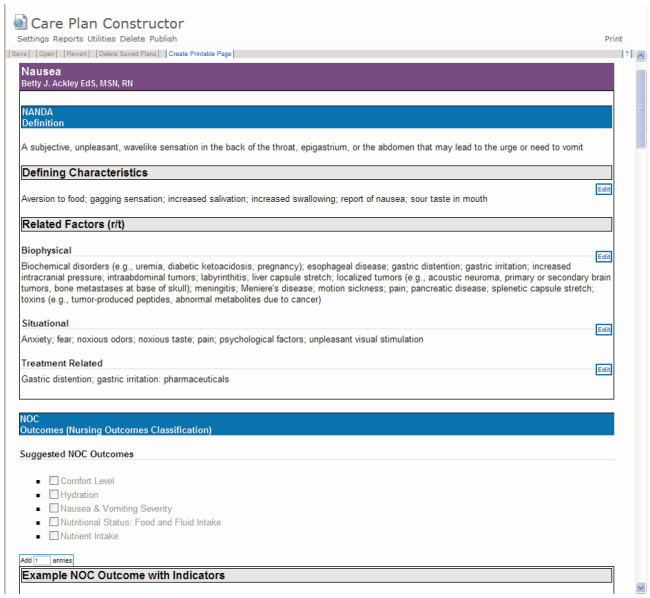
The ***Pre-simulation Quiz*** contains 6 to 10 multiple choice questions that allow students to evaluate their knowledge and understanding of the reading assignment prior to simulation. Once students submit their answers, the quiz is automatically graded and rationales are provided for the correct and incorrect answers, along with textbook page references. The quiz grades can be automatically entered into the instructor's gradebook.

POST-SIMULATION LEARNING RESOURCES

Following the debriefing session, the facilitator may wish to assign post-simulation activities. These activities are designed to summarize the important elements of each scenario, reinforce relevant concepts, promote student self-reflection, and encourage retention and understanding of the nursing care related to the scenario. Post-simulation assignments can be performed independently or in a group setting led by a facilitator. Students who complete these assignments online can submit their responses electronically to the facilitator for grading and feedback.

Documentation (EMR). Documenting patient care is a fundamental nursing skill. Before, during, and after the simulation event, the student can practice referencing and documenting care in the ***EMR***. When students document in the ***EMR*** under their specific login, the data is saved only to that particular student account. When logged into the ***EMR***, students have the option to save data and return to the patient chart to complete documentation at a later time, or to submit the chart electronically to the facilitator for review.

A ***Care Plan Constructor*** guides the student in the creation of a care plan that they can customize for the patient. The ***Care Plan Constructor*** allows the student to identify nursing diagnoses using NANDA, NOC, or NIC format, and outline evidence-based nursing interventions appropriate for the patient. The student may then save or print out the customized care plan.



Journaling. After the simulation event, students can be encouraged to practice self-reflection by completing a journaling assignment. If desired, the journal question can be modified by the facilitator to reflect a particular style, such as the journal format used during student clinical rotations. After the student completes the journal entry, it can be submitted electronically to the facilitator for evaluation or grading.

Interdisciplinary Communication. SBAR (situation, background, assessment, and recommendation) communication should be expected in all verbal reports during simulation. The SBAR post-simulation ***Interdisciplinary Communication*** activity gives students the opportunity to practice SBAR in a written format. In this activity, students are instructed to provide an SBAR change-of-shift report for the nurse assuming care for the simulated patient after the scenario is over. The SBAR report can be submitted electronically to the facilitator for evaluation or grading.

Post-simulation Exercises activities extend the simulation experience beyond the lab, promoting further critical thinking and clinical judgment related to events encountered during the scenario. As with the pre-simulation exercises, answers are provided, but because the exercises are short answer, they are not self-grading. Once completed, the student can submit the answers electronically to the facilitator for grading.

The ***Post-simulation Quiz*** focuses on key scenario events and can assist the facilitator in identifying students' areas of understanding and areas needing additional review and practice. The quiz is self-grading and provides immediate feedback to students with rationales and page references to their nursing textbook.

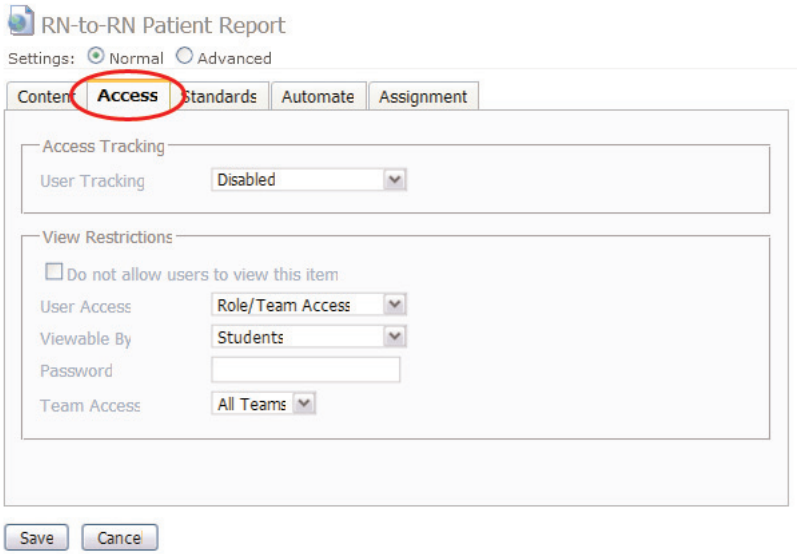
ACTIVATING AND DEACTIVATING STUDENT RESOURCES

The SLS pre-simulation and post-simulation student resources described above are designed to enhance understanding and have a positive impact on learning outcomes. All of these resources can be made available or unavailable to students at your discretion. You should review and activate or deactivate the appropriate resources depending on your students' knowledge base and level of experience with simulation:

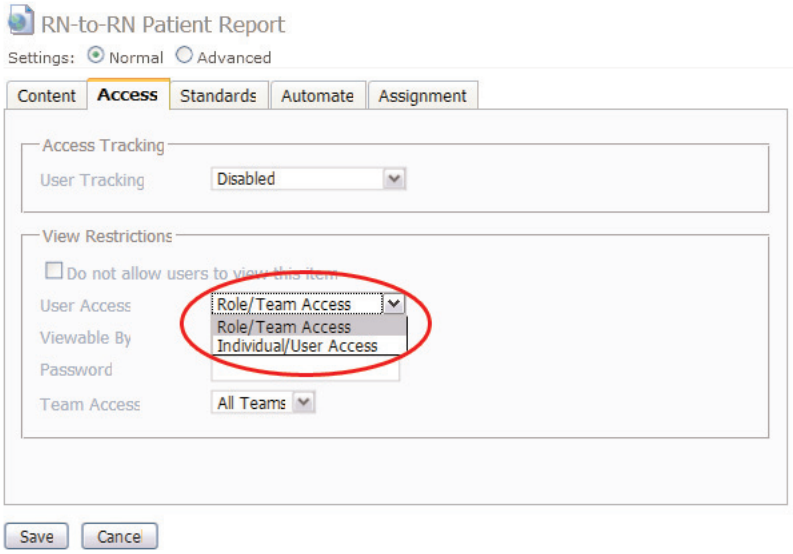
1. Navigate to the course folder containing the resource you wish to make available.

2. Select **Settings** from the menu that appears under the resource title.

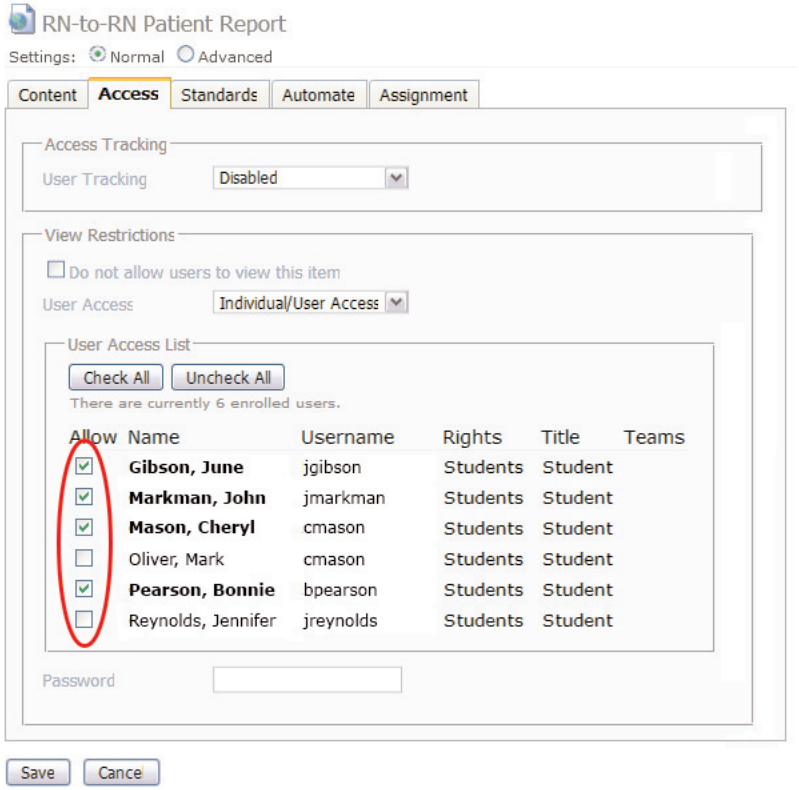
3. Select the **Access** tab. From this section, the *Evolve Learning System* allows you to restrict access by individual student.



4. Under View Restrictions, select **Individual/User Access** from the User Access drop-down menu. (If you wish to restrict access by using teams, leave this selection as **Role/Team Access**.)



5. A list of currently enrolled students will appear in the User Access List. Check the box next to each student's name to make that resource available. Un-check the box to deny access.

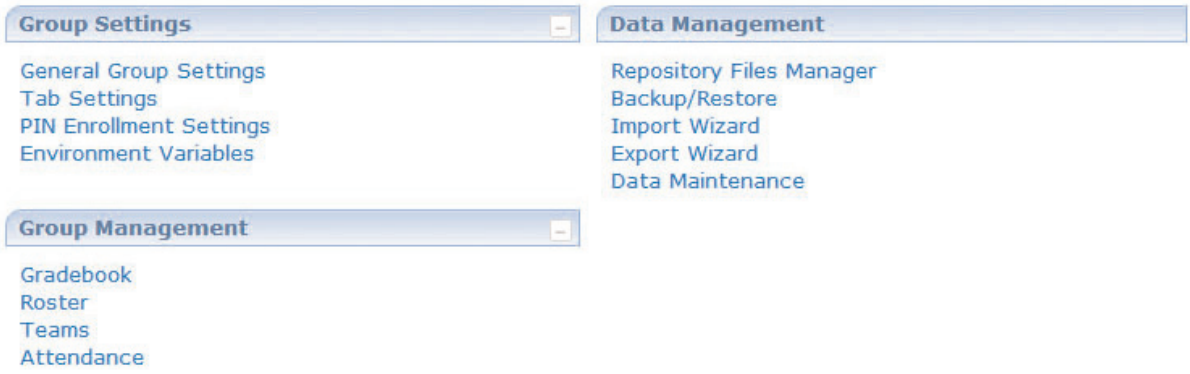


6. Additionally, you may restrict access to a resource by assigning a password in the Access settings. Be sure to communicate this password to students so that they will be able to access the resource.

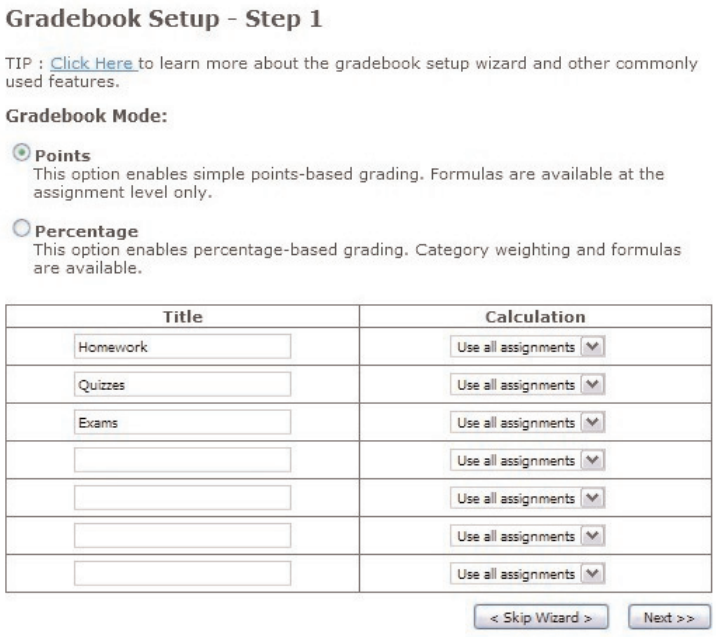
7. Click **Save**.

GRADEBOOK

Evaluation of students' work throughout the SLS is managed using the gradebook of the *Evolve Learning Management System*. You may access the gradebook using the Tools menu under the Group Management section of the Course Toolbox:



You will be presented with the Evolve gradebook setup wizard when you first access your gradebook. You may use this tool to customize the assignments and gradebook to suit your needs. Detailed instructions for configuring your gradebook are included in the Manage tab of the *Evolve Learning System* User's Manual, which is also contained within the Tools menu.

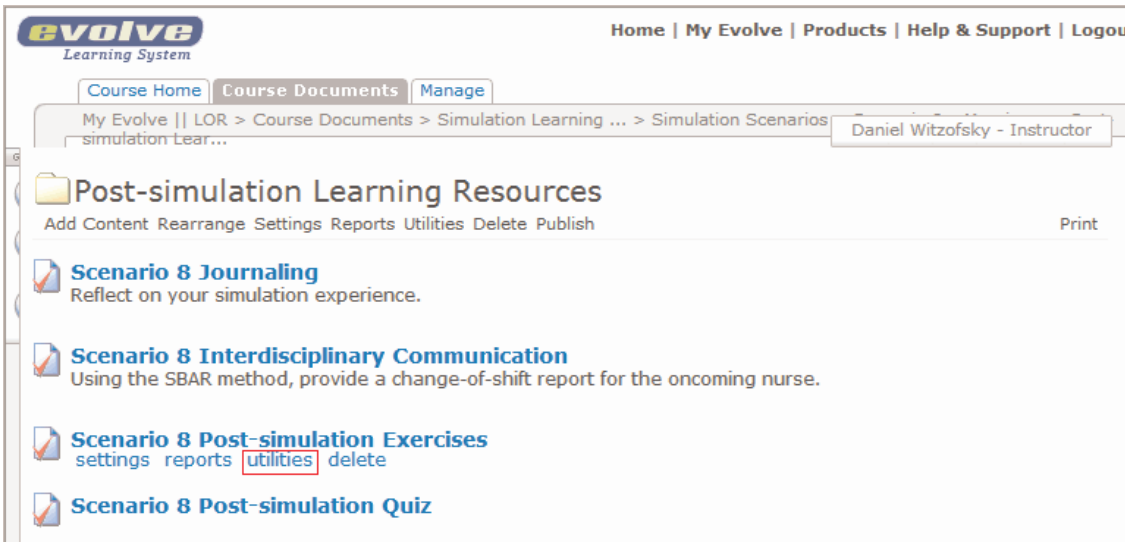


GRADING ASSIGNMENTS

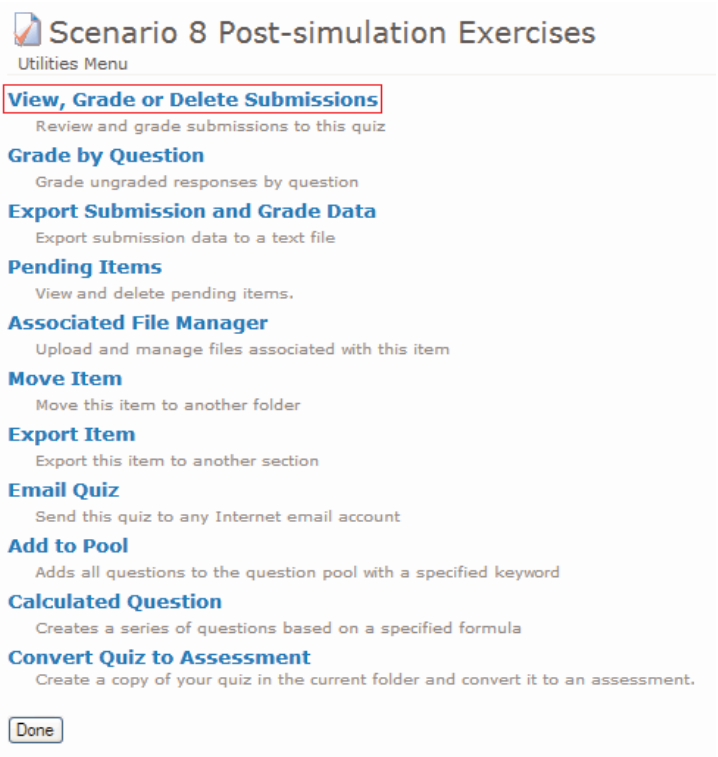
The SLS pre- and post-simulation quizzes are graded automatically by the *Evolve Learning Management System*. All remaining assignments (e.g., exercises, essay questions, concept mapping, EMR documentation) must be manually evaluated and graded by you:

1. View the activity you wish to grade within the Simulation Scenarios directory.

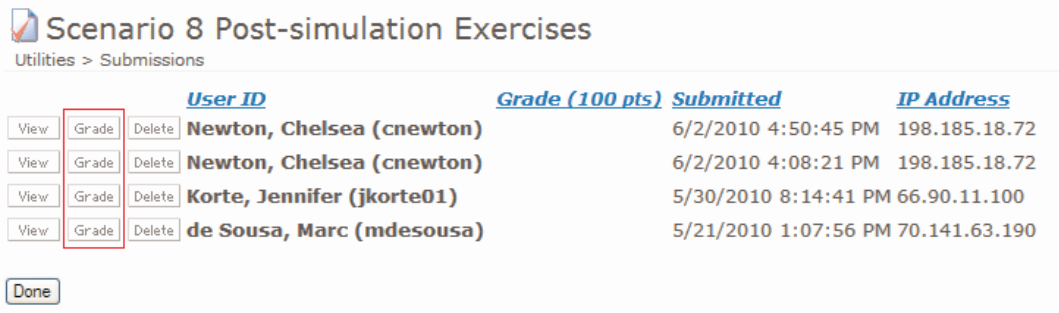
2. Select 'Utilities' from the menu beneath the title of the activity.



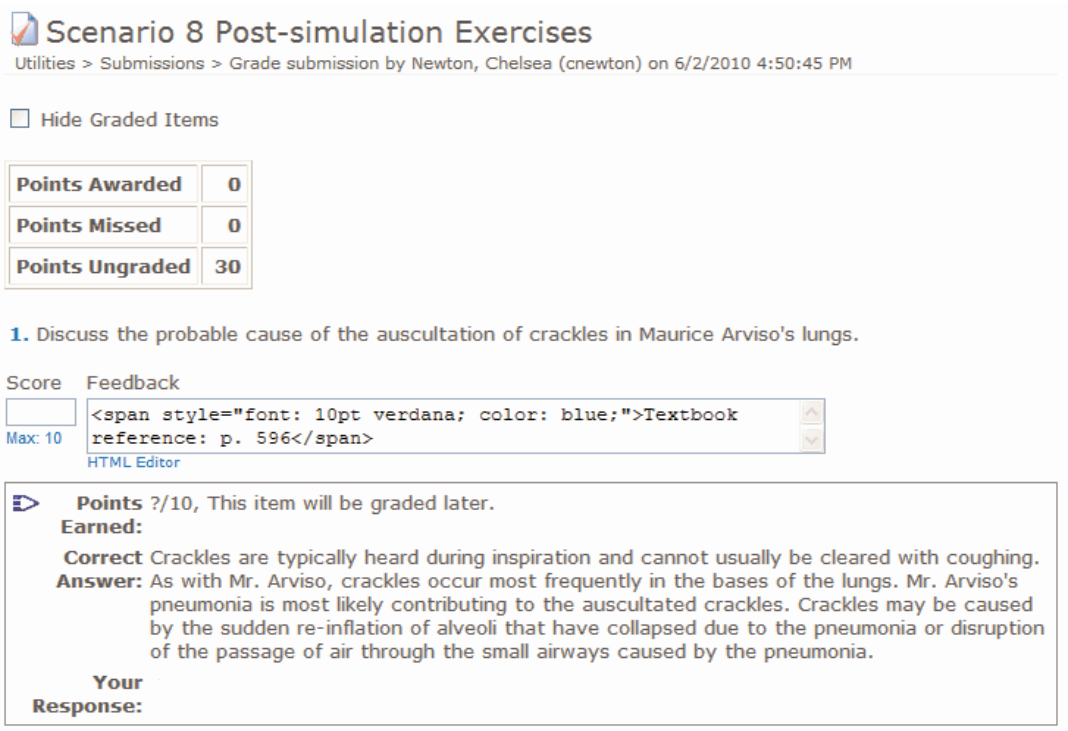
3. Select 'View, Grade, or Delete Submissions' from the list of utilities.



4. You will be presented with a list of submissions from all students. Click 'Grade' next to the student's User ID to view and submit a score for that student's response.



5. After reviewing the response, enter the points you wish to award in the Score field.



6. Click **OK** after you have graded all responses. You may return to an activity and assign or revise grades at any time.

7. Return to the Assignment window to continue grading other assignments. Click **Done** when finished. You may also grade individual assignments within the Pre- and Post-simulation Learning Resources folder of each scenario. Simply select Utilities from the menu beneath each activity.

GRADING STUDENT DOCUMENTATION IN THE EMR

The process for grading EMR submissions is the same as grading other activity submissions. However, if a student has submitted a scenario's EMR more than once, remember to grade only the most recent submission.

SLS Observer Evaluation Rubric

Observe the simulation scenario and assess the participants' management of the situation. Note areas in which participants performed well and areas in which they need improvement. Use these observations to provide feedback and participate in discussion during debriefing.

NCLEX® Client Needs Category	Exemplars observed during scenario:	Opportunities for improvement:
1. SAFE AND EFFECTIVE CARE ENVIRONMENT: MANAGEMENT OF CARE		
2. SAFE AND EFFECTIVE CARE ENVIRONMENT: SAFETY AND INFECTION CONTROL		
3. HEALTH PROMOTION AND MAINTENANCE		
4. PSYCHOSOCIAL INTEGRITY		

Observer Evaluation Rubric—cont'd

NCLEX® Client Needs Category	Exemplars observed during scenario:	Opportunities for improvement:
5. PHYSIOLOGICAL INTEGRITY: BASIC CARE AND COMFORT		
6. PHYSIOLOGICAL INTEGRITY: PHARMACOLOGICAL AND PARENTERAL THERAPIES		
7. PHYSIOLOGICAL INTEGRITY: REDUCTION OF RISK POTENTIAL		
8. PHYSIOLOGICAL INTEGRITY: PHYSIOLOGICAL ADAPTATION		

Observer Evaluation Rubric—cont'd

1. **SAFE AND EFFECTIVE CARE ENVIRONMENT: MANAGEMENT OF CARE**

   - **NCLEX® CATEGORY: SAFE AND EFFECTIVE CARE ENVIRONMENT**—The nurse promotes the achievement of patient outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect patients, family/significant others, and health care personnel.
   - **NCLEX® SUBCATEGORY: MANAGEMENT OF CARE**—Providing and directing nursing care that enhances the care delivery setting to protect patients, family/significant others, and health care personnel.

   Related content includes but is not limited to:

   - Advance Directives
   - Delegation
   - Advocacy
   - Establishing Priorities
   - Case Management
   - Ethical Practice
   - Patient Rights
   - Informed Consent
   - Collaboration with Interdisciplinary Team
   - Information Technology
   - Concepts of Management
   - Legal Rights and Responsibilities
   - Confidentiality/Information Security
   - Performance Improvement (Quality Improvement)
   - Consultation
   - Referrals
   - Continuity of Care
   - Supervision

   Related QSEN Competencies:

   - **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
   - **Teamwork and Collaboration:** Function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.
   - **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.
   - **Quality Improvement:** Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.
   - **Informatics:** Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

   Related 2010 National Patient Safety Goals:

   - **Goal 2:** Improve the effectiveness of communication among caregivers.
   - **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.

Observer Evaluation Rubric—cont'd

2. **SAFE AND EFFECTIVE CARE ENVIRONMENT: SAFETY AND INFECTION CONTROL**

- **NCLEX® CATEGORY: SAFE AND EFFECTIVE CARE ENVIRONMENT**—The nurse promotes the achievement of patient outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect patients, family/significant others, and health care personnel.
- **NCLEX® SUBCATEGORY: SAFETY AND INFECTION CONTROL**—Protecting patients, family/significant others, and health care personnel from health and environmental hazards.

Related content includes but is not limited to:

- Accident/Injury Prevention
- Emergency Response Plan
- Reporting of Incident/Event/Irregular Occurrence/Variance
- Ergonomic Principles
- Safe Use of Equipment
- Error Prevention
- Security Plan
- Handling Hazardous and Infectious Materials
- Standard Precautions/Transmission-Based Precautions/Surgical Asepsis
- Home Safety
- Use of Restraints/Safety Devices

Related QSEN Competencies:

- **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.
- **Quality Improvement:** Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.

Related 2010 National Patient Safety Goals:

- **Goal 1:** Improve the accuracy of patient identification.
- **Goal 3:** Improve the safety of using medications.
- **Goal 7:** Reduce the risk of health care associated infections.
- **Goal 9:** Reduce the risk of patient harm resulting from falls.
- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 15:** Identify safety risk inherent in patient population.

Observer Evaluation Rubric—cont'd

3. HEALTH PROMOTION AND MAINTENANCE

- **NCLEX® CATEGORY: HEALTH PROMOTION AND MAINTENANCE**—The nurse provides and directs nursing care of the patient and family/significant others that incorporates the knowledge of expected growth and development principles; prevention and/or early detection of health problems, and strategies to achieve optimal health.

Related content includes but is not limited to:

- Aging Process
- High Risk Behaviors
- Ante/Intra/Postpartum and Newborn Care
- Lifestyle Choices
- Developmental Stages and Transitions
- Principles of Teaching/Learning
- Health and Wellness
- Self-Care
- Health Promotion/Disease Prevention
- Techniques of Physical Assessment
- Health Screening

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 10:** Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.

Observer Evaluation Rubric—cont'd

4. PSYCHOSOCIAL INTEGRITY

- **NCLEX® CATEGORY: PSYCHOSOCIAL INTEGRITY**—The nurse provides and directs nursing care that promotes and supports the emotional, mental, and social wellbeing of the patient and family/significant others experiencing stressful events, as well as patients with acute or chronic mental illness.

Related content includes but is not limited to:

- Abuse/Neglect
- Grief and Loss
- Behavioral Interventions
- Mental Health Concepts
- Chemical and Other Dependencies
- Religious and Spiritual Influences on Health
- Coping Mechanisms
- Sensory/Perceptual Alterations
- Crisis Intervention
- Stress Management
- Cultural Diversity
- Support Systems
- End-of-Life Care
- Therapeutic Communication
- Family Dynamics
- Therapeutic Environment

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 15:** Identify safety risk inherent in patient population.

Observer Evaluation Rubric—cont'd

5. **PHYSIOLOGICAL INTEGRITY: BASIC CARE AND COMFORT**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: BASIC CARE AND COMFORT**—Providing comfort and assistance in the performance of activities of daily living.

Related content includes but is not limited to:

- Assistive Devices
- Nutrition and Oral Hydration
- Elimination
- Personal Hygiene
- Mobility/Immobility
- Rest and Sleep
- Non-Pharmacological Comfort Interventions

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 9:** Reduce the risk of patient harm resulting from falls.
- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 14:** Prevent health care associated pressure ulcers.

Observer Evaluation Rubric—cont'd

6. **PHYSIOLOGICAL INTEGRITY: PHARMACOLOGICAL AND PARENTERAL THERAPIES**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: PHARMACOLOGICAL AND PARENTERAL THERAPIES**—Providing care related to the administration of medications and parenteral therapies.

Related content includes but is not limited to:

- Adverse Effects/Contraindications/Side Effects/Interactions
- Expected Actions/Outcomes
- Medication Administration
- Blood and Blood Products
- Parenteral/Intravenous Therapies
- Central Venous Access Devices
- Pharmacological Pain Management
- Dosage Calculation
- Total Parenteral Nutrition

Related QSEN Competencies:

- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.
- **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.

Related 2010 National Patient Safety Goals:

- **Goal 1:** Improve the accuracy of patient identification.
- **Goal 3:** Improve the safety of using medications.
- **Goal 8:** Accurately and completely reconcile medications across the continuum of care.

Observer Evaluation Rubric—cont'd

7. **PHYSIOLOGICAL INTEGRITY: REDUCTION OF RISK POTENTIAL**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: REDUCTION OF RISK POTENTIAL**—Reducing the likelihood that patients will develop complications or health problems related to existing conditions, treatments, or procedures.

Related content includes but is not limited to:

- Changes/Abnormalities in Vital Signs
- Diagnostic Tests
- Potential for Complications from Surgical Procedures and Health Alterations
- Laboratory Values
- System Specific Assessments
- Potential for Alterations in Body Systems
- Therapeutic Procedures
- Potential for Complications of Diagnostic Tests/Treatments/Procedures

Related QSEN Competencies:

- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.
- **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.

Related 2010 National Patient Safety Goals:

- **Goal 7:** Reduce the risk of health care associated infections.
- **Goal 9:** Reduce the risk of patient harm resulting from falls.
- **Goal 10:** Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- **Goal 11:** Reduce the risk of surgical fires.
- **Goal 15:** Identify safety risk inherent in patient population.
- **Goal 16:** Improve recognition and response to changes in a patient's condition.

Observer Evaluation Rubric—cont'd

8. **PHYSIOLOGICAL INTEGRITY: PHYSIOLOGICAL ADAPTATION**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: PHYSIOLOGICAL ADAPTATION**—Managing and providing care for patients with acute, chronic, or life threatening physical health conditions.

Related content includes but is not limited to:

- Alterations in Body Systems
- Medical Emergencies
- Fluid and Electrolyte Imbalances
- Pathophysiology
- Hemodynamics
- Unexpected Response to Therapies
- Illness Management

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 16:** Improve recognition and response to changes in a patient's condition.

References

The Joint Commission. (2010). *National Patient Safety Goals*. Retrieved June 28, 2010, from http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/

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