Shadow Health

Shadow Health Faculty Debriefing Guide

Gerontology DCE

This guide will provide comprehensive faculty debriefing resources for the Shadow Health Gerontology DCE patient encounters. Debriefing resources will include key takeaways, customizable questions, and scripted prompts to facilitate discussion.

Contents in Shadow Health Faculty Debriefing Guide: Gerontology DCE

Introduction and Utilization

Debriefing after a patient encounter is a crucial component of nursing education, offering students a structured opportunity to reflect on their clinical experiences. It allows them to process what occurred, analyze their clinical decision-making, and gain insight into their strengths and areas for improvement. The same is true after nursing students go through a Shadow Health patient encounter. Through guided discussion, students can connect theory to practice, reinforce clinical skills, and deepen their understanding of patient-centered care. Debriefing also fosters critical thinking, emotional intelligence, and professional development by encouraging open dialogue about challenges, ethical dilemmas, and interpersonal communication. Ultimately, it enhances learning outcomes and prepares nursing students for real-world practice by transforming experience into meaningful growth.

This document will go through each of the Gerontology DCEs, and give you some ideas on how to debrief with your students in a meaningful way. Pick and choose from a list of questions to customize the discussion for your students or follow our script to help create a meaningful discussion and learning opportunities for your students.

Debrief Focused Exam: Pain (Edward Carter)

10 Minutes or Less

If you have 10 minutes or less, choose a few key questions from this list to focus your debrief and highlight the most important takeaways for your students:

1. What specific questions did you ask to elicit Mr. Carter's pain experience, and why are direct questions particularly important when assessing pain in older adults?
2. Mr. Carter may have used words like "ache" or "discomfort" rather than "pain." How did you adapt your language during the assessment, and why is this flexibility important in gerontological nursing?
3. Walk through how you assessed the P-Q-R-S-T-U components of Mr. Carter's pain. Which elements were most challenging to obtain and why?
4. What factors did you explore regarding pain intensity, frequency, quality, location, and aggravating/alleviating factors? How might chronic conditions complicate pain assessment in older adults?
5. How did you assess Mr. Carter's medication history, including prescribed medications, over-the-counter drugs, and supplements? Why is this comprehensive medication review essential?
6. What nonverbal cues or behavioral changes did you observe that might indicate pain or discomfort? How do these observations complement self-report data?
7. If Mr. Carter had cognitive impairment, what alternative assessment approaches would you have used? Consider tools like PACSLAC or PAINAD.
8. Older adults may present with atypical pain presentations, such as "silent" myocardial infarctions. How did you differentiate between acute and chronic pain in your assessment?
9. What barriers to effective pain assessment did you encounter or anticipate with Mr. Carter? How might factors like reluctance to report pain or fear of medication affect your assessment?
10. Based on your assessment findings, what would be your next steps in developing a pain management plan? How would you involve Mr. Carter in shared decision-making about his comfort needs?

If you're really short on time, we can suggest the following 3 questions as some of the most important takeaways from this scenario:

1. What specific questions did you ask to elicit Mr. Carter's pain experience, and why are direct questions particularly important when assessing pain in older adults?
    - This is foundational because older adults often won't report pain unless directly asked. Students need to understand that questions like "Do you have pain now?," "Where is your pain?," and "Does pain keep you from sleeping at night?" are essential. They should also recognize that using alternate words like "ache," "hurt," or "discomfort" may be necessary, as older adults may not use the word "pain" to describe their experience.
2. What nonverbal cues or behavioral changes did you observe that might indicate pain or discomfort? How do these observations complement self-report data?
    - This question addresses a critical skill in gerontological nursing. Students must learn to recognize nonverbal indicators such as grimacing, wincing, restlessness, guarding, changes in sleep patterns, or withdrawal from usual activities. This is particularly important because many older adults underreport pain, and those with cognitive or communication impairments may be unable to verbalize their discomfort. Understanding that observation complements self-report helps students provide comprehensive assessments.
3. Based on your assessment findings, what would be your next steps in developing a pain management plan? How would you involve Mr. Carter in shared decision-making about his comfort needs?
    - This question bridges assessment to action and emphasizes patient-centered care. Students must demonstrate clinical judgment by synthesizing their assessment data into appropriate interventions while respecting the patient's preferences and goals. It

reinforces that pain assessment isn't just data collection—it's the foundation for improving quality of life and functional outcomes in older adults.

30 Minutes or More

If you have 30 minutes or more to debrief with students, we recommend following our debriefing script to support a thoughtful and comprehensive reflection.

Opening

- Thank you for completing the Shadow Health pain assessment with Mr. Carter. This debriefing will help you reflect on your clinical reasoning and connect your virtual experience to evidence-based gerontological nursing practice. There are no wrong answers here—this is about learning from the experience.

Core Discussion Questions

- Direct Assessment Approach
  - Let's start with your assessment technique. What specific questions did you ask to elicit Mr. Carter's pain experience?
  - Older adults often won't volunteer that they're uncomfortable unless directly asked. Did you use questions like 'Do you have pain now?' or 'Does pain keep you from sleeping at night?' Did you need to use alternate words like 'ache,' 'hurt,' or 'discomfort'? Why might this language flexibility matter?
- Teaching Point: Self-report is the most reliable indicator of pain. Pain is whatever the person says it is. Direct, specific questions using the patient's preferred language are essential.

Observational Skills

- What nonverbal cues did you observe that might indicate pain or discomfort?
  - Listen for: facial expressions, grimacing, wincing, guarding, restlessness, changes in activity
  - How do these observations complement what Mr. Carter told you verbally? What if he had cognitive impairment and couldn't communicate verbally—what would change in your approach?
- Teaching Point: Behavioral observation is critical, especially for those with communication limitations. Tools like PACSLAC assess facial expressions, vocalizations, body movements, changes in interactions, activity patterns, and mental status.

Clinical Judgment and Next Steps

- Based on your findings, what are your next steps for Mr. Carter's pain management plan? How would you involve him in decision-making about his comfort?
- Guide discussion toward:
  - Both pharmacological and nonpharmacological interventions
  - Timing medications before activities or sleep
  - Balancing activity with rest
- Teaching Point: Effective pain management requires multiple actions—positioning, pacing activities, anticipatory medication before painful procedures, and treating pain before sleep to optimize next-day functioning. Encourage active patient participation in their pain management.

Closing

- Excellent reflection. Remember: comprehensive pain assessment in older adults requires direct questioning, careful observation, adequate time for responses, and patient-centered planning. These skills transfer directly to clinical practice.

Debrief Focused Exam: Mobility (Robert Hall)

10 Minutes or Less

If you have 10 minutes or less, choose a few key questions from this list to focus your debrief and highlight the most important takeaways for your students:

1. What specific components of gait did you assess during Mr. Hall's examination? How did you evaluate step length, step height, step symmetry, and path deviation?
2. Walk through your balance assessment. What did you observe regarding Mr. Hall's sitting balance, standing balance, ability to turn, and stability when transitioning from sitting to standing?
3. If you used the Timed Up and Go (TUG) test, what was Mr. Hall's time? If not, what do you think his time might be? Why is 12 seconds considered the threshold for fall risk, and what would you do if he exceeded this time?
4. What age-related changes, chronic diseases, or medications did you identify that could contribute to Mr. Hall's mobility impairment? How do these intrinsic factors interact to affect his functional status?
5. Gait velocity has been called the "sixth vital sign" in older adults. What does Mr. Hall's walking speed tell you about his overall health status and functional independence?
6. How did you assess the impact of mobility limitations on Mr. Hall's activities of daily living (ADLs) and instrumental activities of daily living (IADLs)? Did his self-report align with your performance-based observations?
7. What nonverbal cues or compensatory strategies did you observe while Mr. Hall was moving? Did he use furniture for support, demonstrate hesitancy, or show signs of pain or fatigue?
8. Based on your mobility assessment, what is Mr. Hall's fall risk level? What specific findings led you to this conclusion?
9. Before recommending assistive devices or physical therapy, what treatable causes of gait and balance abnormalities should be ruled out through medical workup?
10. What evidence-based interventions would you recommend to maintain or improve Mr. Hall's mobility? Consider both immediate safety needs and long-term strategies like strength training, walking programs, or balance exercises. How would you involve Mr. Hall in setting realistic mobility goals?

If you're really short on time, we can suggest the following 3 questions as some of the most important takeaways from this scenario:

1. What specific components of gait did you assess during Mr. Hall's examination, and how did you evaluate step length, step height, step symmetry, and path deviation?
    - This is foundational because systematic gait assessment is the cornerstone of mobility evaluation in older adults. Students must learn to observe and describe specific, measurable parameters rather than vague impressions. This skill directly transfers to clinical practice.
2. What age-related changes, chronic diseases, or medications did you identify that could contribute to Mr. Hall's mobility impairment? How do these intrinsic factors interact to affect his functional status?
    - This question develops clinical reasoning by connecting assessment findings to underlying causes. Older adults often have multiple interacting factors affecting mobility—understanding these relationships helps students move beyond surface-level observation to deeper analysis and appropriate intervention planning.
3. Based on your mobility assessment, what is Mr. Hall's fall risk level, and what evidence-based interventions would you recommend to maintain or improve his mobility while involving him in goal-setting?
    - This bridges assessment to action and emphasizes patient-centered care. Students must synthesize findings into practical, realistic interventions while recognizing that mobility preservation directly impacts independence, quality of life, and fall prevention in older adults.

30 Minutes or More

If you have 30 minutes or more to debrief with students, we recommend following our debriefing script to support a thoughtful and comprehensive reflection.

Opening

- Thank you for completing the mobility assessment with Mr. Hall. This debriefing will help you reflect on your systematic assessment approach and connect your findings to fall risk and functional independence. Let's explore what you observed and what it means for Mr. Hall's care.

Core Discussion Questions

- Systematic Gait Assessment
    - What specific components of gait did you assess during Mr. Hall's examination?
    - Did you observe step length, step height, step symmetry, and path? What did you notice about each component? Were his steps short or shuffling? Did he lift his feet adequately? Were his steps even on both sides?
    - Teaching Point: Gait assessment requires systematic observation of measurable parameters. Tools like the Tinetti Gait and Balance Test quantitatively score these components. Marked gait disorders aren't normal aging—they indicate underlying pathological conditions requiring medical workup.
- Intrinsic Risk Factors
    - What age-related changes, chronic diseases, or medications did you identify that could affect Mr. Hall's mobility?
        - Listen for: arthritis, Parkinson's disease, stroke history, diabetes, medications causing dizziness or weakness
        - How do these factors interact? For example, if Mr. Hall has arthritis in his knee, how might ligamentous weakness affect his stability?
    - Teaching Point: Intrinsic risk refers to the combined effect of age-related changes, concurrent disease, and adverse drug effects. Mobility impairment is an early predictor of physical disability and associated with falls, loss of independence, depression, and institutionalization.
- Fall Risk and Intervention Planning
    - Based on your assessment, what is Mr. Hall's fall risk level, and what interventions would you recommend?
    - Guide discussion toward:
        - TUG test results (>12 seconds = fall risk)
        - Treatable causes requiring medical evaluation
        - Evidence-based interventions: structured exercise, progressive resistance strength training, walking programs
        - Patient involvement in goal-setting
    - Teaching Point: Maintenance of mobility is essential in preventing falls and loss of independence. Walking 30 minutes daily, strength training, and balance exercises improve functional capacity even in adults in their 90s. Interdisciplinary approaches are most effective.

Closing

- Excellent work. Remember: mobility assessment connects directly to fall prevention, functional independence, and quality of life. Your systematic observations guide evidence-based interventions that help older adults maintain their autonomy.

Debrief Focused Exam: Infection (Patricia Young)

10 Minutes or Less

If you have 10 minutes or less, choose a few key questions from this list to focus your debrief and highlight the most important takeaways for your students:

1. What subjective and objective data did you collect that indicated Patricia Young might have an infection? Describe specific cues such as patient complaints, vital signs, and physical findings.
2. Which assessment findings were most significant in recognizing the presence of infection? Explain why you prioritized certain cues over others during your examination.
3. What additional questions could you have asked to gather a more complete infection history? Consider travel history, recent exposures, immunosuppression factors, or recent procedures.
4. How did you cluster your assessment findings to identify patterns suggesting infection? Describe the relationship between the patient's symptoms and the body system affected.
5. What risk factors did Patricia Young have that increased her susceptibility to infection? Consider factors like recent surgery, medications, chronic conditions, or compromised immune status.
6. If you suspected infection, what diagnostic tests would you anticipate the primary care provider ordering, and why? Think about cultures, laboratory studies (CBC, urinalysis), or imaging.
7. Based on your assessment, what nursing diagnosis would be most appropriate for this patient? Explain whether you identified an actual infection or "Risk for Infection" and your rationale.
8. What expected outcomes would you establish for this patient related to infection prevention or management? Consider measurable, realistic outcomes aligned with the patient's condition.
9. What transmission-based precautions, if any, would be necessary for this patient? Justify your decision based on the type of infection suspected or confirmed.
10. Reflecting on your performance, what would you do differently in your next patient encounter involving suspected infection? Consider communication, assessment technique, clinical reasoning, or time management.

If you're really short on time, we can suggest the following 3 questions as some of the most important takeaways from this scenario:

1. What subjective and objective data did you collect that indicated Patricia Young might have an infection, and how did you cluster these findings to identify patterns?
    - This question integrates assessment and clinical reasoning. Students should identify specific cues like fever, pain, changes in vital signs, or laboratory values (elevated WBC), and explain how they recognized patterns suggesting infection in a particular body system. This reflects the nursing process emphasis on data interpretation and pattern recognition.
2. What risk factors did Patricia Young have that increased her susceptibility to infection, and how did these influence your assessment priorities?
    - This prompts students to think critically about the patient's vulnerability to infection—considering factors like recent procedures, medications (immunosuppressants, steroids), compromised immune status, or recent travel. Understanding risk factors is essential for both recognizing infection and planning appropriate interventions.
3. Based on your assessment findings, what nursing diagnosis would be most appropriate, and what infection control measures would you implement?
    - This question bridges diagnosis with action. Students must justify whether they identified an actual infection or "Risk for Infection," then apply evidence-based infection prevention and control principles, including appropriate transmission-based precautions. This demonstrates their ability to move from assessment through planning to safe, competent care.

30 Minutes or More

If you have 30 minutes or more to debrief with students, we recommend following our debriefing script to support a thoughtful and comprehensive reflection.

Opening

- Welcome everyone. Let's debrief your Shadow Health infection assessment with Patricia Young. We'll use the GAS method today—Gather, Analyze, and Summarize. First, let's gather what happened during your encounter.
- Guiding Questions:
    - What did you observe and discover?
    - What were Patricia's chief complaints or presenting symptoms?
    - What subjective data did she share about her symptoms—onset, duration, severity?
    - What objective findings did you collect? (vital signs, physical assessment findings)
    - Did you notice any signs of localized infection—redness, warmth, swelling, drainage?
    - Were there systemic symptoms like fever, fatigue, nausea, or malaise?
- Let's also gather context. What did you learn about Patricia's risk factors?
    - Recent procedures or hospitalizations?
    - Medications (steroids, immunosuppressants)?
    - Chronic conditions (diabetes, compromised immune system)?
    - Recent travel or exposures?

Analysis

- Now let's analyze. How did you make sense of what you gathered?
- Clinical Reasoning Questions, Pattern Recognition:
    - How did you cluster your assessment findings? What patterns emerged?
    - Which cues were most significant in recognizing infection?
    - Did you identify localized or systemic infection—or both? What led you to that conclusion?
- Risk Analysis:
    - How did Patricia's risk factors influence your assessment priorities?
    - What made her particularly vulnerable to infection?
- Diagnostic Thinking:
    - What nursing diagnosis did you formulate—actual infection or Risk for Infection?
    - What was your related factor, and how did it guide your interventions?
    - What diagnostic tests would you anticipate? Blood cultures? Urinalysis? Why?
- Infection Control:
    - What transmission-based precautions would be appropriate?
    - What infection prevention measures would you implement?"
- Tip: Encourage evidence-based discussion. Reference assessment principles: inspect for inflammation signs, assess wounds each shift, monitor temperature and lab values.

Summary

- Let's summarize our key takeaways
- Guided Reflection:
    - What are the 2-3 most important assessment findings that indicate infection?
    - What's one thing you'd do differently in your next infection-focused assessment?
    - How does understanding risk factors change your approach to patient care?

Closing

- Excellent work today. Remember: thorough baseline assessment, recognizing cue patterns, and implementing evidence-based infection control are essential to safe patient care.

Debrief Focused Exam: Cognition (Esther Park)

10 Minutes or Less

If you have 10 minutes or less, choose a few key questions from this list to focus your debrief and highlight the most important takeaways for your students:

1. What baseline cognitive assessment data did you collect from Esther Park? Describe specific findings related to orientation, memory, attention, language, and executive function.
2. Which assessment techniques or tools did you use to evaluate Esther's cognitive status? Consider screening tools like the Mini-Cog, Montreal Cognitive Assessment (MoCA), or Mini-Mental State Exam (MMSE), and explain why these are appropriate.
3. What subjective information from Esther or her family members helped you understand changes in her cognitive function? Knowing the patient's baseline cognitive functioning is essential for accurate assessment.
4. Based on your assessment findings, did you identify characteristics of delirium, dementia, or depression? Explain which features led you to your conclusion. Remember: delirium predominantly affects attention and is typically reversible; dementia predominantly affects memory and is irreversible.
5. If you suspected delirium, what were the key features you identified using the Confusion Assessment Method (CAM) criteria? Delirium is diagnosed if features 1 (acute onset and fluctuating course) and 2 (inattention) are present, plus either 3 (disorganized thinking) or 4 (altered level of consciousness).
6. What risk factors did Esther have that could contribute to cognitive changes? Consider medications, recent illness, infections, metabolic disturbances, or environmental factors.
7. What nursing diagnosis would be most appropriate based on your cognitive assessment findings? Justify whether you identified acute confusion (delirium), chronic confusion (dementia), or another diagnosis.
8. What interventions would you implement to support Esther's cognitive function and safety? Consider environmental modifications, reorientation strategies, medication review, or further diagnostic workup.
9. How did you document your cognitive assessment findings? Reflect on the importance of documenting specific objective indicators rather than using nonspecific terms like "confusion."
10. What would you do differently in your next cognitive assessment? Consider your communication approach, use of validated tools, collaboration with family members, or time management.

If you're really short on time, we can suggest the following 3 questions as some of the most important takeaways from this scenario:

1. Based on your assessment findings, did you identify characteristics of delirium, dementia, or depression—and what specific features led you to your conclusion?
    - This question requires students to differentiate between the "three Ds" using evidence-based criteria. Delirium predominantly affects attention with acute onset and fluctuating course, and is typically reversible. Dementia is a global, sustained deterioration affecting memory with deficits in learning, language, and executive function, and is irreversible. Students must demonstrate pattern recognition and clinical reasoning by identifying which cognitive syndrome matches their assessment data.
2. If you suspected delirium, what features did you identify using the Confusion Assessment Method (CAM)?
    - The CAM is a validated, evidence-based tool for quickly and accurately identifying delirium. Students should recognize that delirium is diagnosed when features 1 (acute onset and fluctuating course) and 2 (inattention) are present, plus either 3 (disorganized thinking) or 4 (altered level of consciousness). This question assesses whether students can apply a standardized assessment tool and understand that sudden changes in cognitive function often result from illness, not aging.

3. What risk factors did Esther have that could contribute to cognitive changes, and how did understanding her baseline cognitive status influence your assessment and interventions?
    - This integrates risk assessment with intervention planning. Students should consider multivariate causes including medications, recent illness, infections, metabolic disturbances, or environmental factors. Knowing the patient's baseline mental status is essential to avoid overlooking serious illness manifesting as delirium. Students must also articulate specific interventions—environmental modifications, reorientation strategies, medication review, or recommendations for further diagnostic workup—demonstrating their ability to move from assessment to action.

30 Minutes or More

If you have 30 minutes or more to debrief with students, we recommend following our debriefing script to support a thoughtful and comprehensive reflection.

Opening

- Welcome everyone. Let's debrief your cognitive assessment with Esther Park using the GAS method. First, let's gather what happened during your encounter.
- Guiding Questions:
    - *What did you observe during your assessment?*
    - What cognitive assessment data did you collect? (orientation, memory, attention, language)
    - What were Esther's responses during your cognitive screening?
    - What subjective information did you gather from Esther or family about baseline cognitive function?
    - What objective findings did you document? (vital signs, behavior observations)
- Instructor Prompt: What assessment tools did you use?
    - Did you use Mini-Cog, MMSE, MoCA, or CAM?
    - How did you assess for acute changes versus chronic changes?
- What additional information helped you understand Esther's situation?
    - Recent illnesses, infections, or hospitalizations?
    - Current medications?
    - Environmental changes or stressors?

Analysis

- Now let's analyze your findings and clinical reasoning.
- Differential Diagnosis:
    - Based on your assessment, did you identify characteristics of delirium, dementia, or depression?
    - What specific features led you to your conclusion?
    - Remember: delirium predominantly affects attention with acute onset and is typically reversible; dementia predominantly affects memory and is irreversible.
- Application
    - If you suspected delirium, walk me through the CAM criteria you identified.
    - Did you find: (1) acute onset and fluctuating course, (2) inattention, (3) disorganized thinking, or (4) altered level of consciousness?
    - Delirium requires features 1 AND 2, plus either 3 OR 4."
- Risk Factor Analysis:
    - What risk factors did Esther have that could contribute to cognitive changes?
    - How did knowing her baseline cognitive status influence your assessment?
- Intervention Planning:
    - What nursing diagnosis did you formulate?
    - What interventions would you implement for safety and cognitive support?

Summary

- Let's summarize our key learning points.
- Guided Reflection:
    - What's the most important difference between delirium and dementia?
    - Why is the CAM tool valuable in clinical practice?
    - What's one thing you'll do differently in your next cognitive assessment?

Closing

- Excellent work. Remember: any sudden change in mental status requires urgent assessment. Use validated tools like the CAM, know the patient's baseline, and differentiate between the three Ds to provide safe, evidence-based care.

Debrief Focused Exam: End of Life (Regina Walker)

10 Minutes or Less

If you have 10 minutes or less, choose a few key questions from this list to focus your debrief and highlight the most important takeaways for your students:

1. What assessment data did you collect about Regina's pain, and how would you ensure adequate pain control at end of life? Consider pain location, intensity, response to medication, and the importance of regularly scheduled medications augmented with PRN doses. There is no risk of addiction when narcotics are increased in response to pain for dying patients.
2. What other symptoms of distress did you identify beyond pain, and what comfort measures would you implement? Dying patients may experience multiple symptoms requiring anticipation and prevention.
3. What fears or concerns did Regina express about dying, and how did you respond therapeutically? Patients commonly fear pain, loneliness, abandonment, the unknown, loss of dignity, and loss of control.
4. How did you assess Regina's psychological, spiritual, and emotional needs? Patients with life-limiting illnesses suffer not only physically but also psychologically, spiritually, and emotionally.
5. What unfinished business or end-of-life concerns did Regina identify, and how would you support her in addressing these? Unfinished business often occupies dying patients' thoughts.
6. Reflect on your therapeutic communication during this encounter. What went well, and what would you do differently? Therapeutic communication is crucial for high-quality end-of-life nursing care. Consider how you responded to difficult questions and whether you allowed Regina to discuss her feelings and needs.
7. How did you balance honesty with compassion when discussing Regina's prognosis and goals of care? Patients are sensitive to how caregivers react to uncomfortable subjects.
8. What is the primary goal of palliative care for Regina, and how does this differ from curative care? The goal is to improve quality of life, alleviate suffering, and improve the end-of-life experience—not to cure.
9. How would you involve Regina's family in her care planning, and what support would they need? Family members are integral to palliative care planning and require support to meet their needs.
10. How comfortable were you discussing death and dying with Regina? What personal beliefs or values influenced your approach? Begin by becoming comfortable with your own beliefs, values, and attitudes about death and dying to master this essential nursing skill.

If you're really short on time, we can suggest the following 3 questions as some of the most important takeaways from this scenario:

1. What fears or concerns did Regina express about dying, and how did you use therapeutic communication to respond?
    - This question addresses the core of end-of-life nursing care. Patients commonly fear pain, loneliness, abandonment, the unknown, loss of dignity, and loss of control. Students must demonstrate therapeutic communication skills including empathy, active listening (paying attention to what is said and observing nonverbal cues without interrupting), and comfort with silence. Silence is frequently related to overwhelming feelings experienced at end of life and can allow time to gather thoughts. Listening to silence sends a message of acceptance and comfort. Students should reflect on whether they allowed Regina to express her feelings and thoughts, and whether they remained open to difficult questions that permit patients to discuss their needs.
2. What assessment data did you collect about Regina's pain and other symptoms, and how would you ensure comprehensive comfort care?
    - Comfort care focuses on identifying symptoms that cause distress and adequately treating those symptoms. Students should articulate specific pain assessment findings (location, intensity, quality, response to medication) and recognize that prevention of

many symptoms is possible by anticipating their likelihood. They must understand that regularly scheduled pain medications augmented with PRN doses are appropriate, and there is no risk of addiction when narcotics are increased in response to pain for dying patients. This question assesses whether students can identify existing and anticipated needs of dying patients.

3. How did you assess Regina's psychological, spiritual, and emotional needs, including any unfinished business or desire for life review?
    - Patients with life-limiting illnesses suffer not only physically but also psychologically, spiritually, and emotionally. Fear of meaninglessness leads people to review their lives, examining actions and expressing regrets. Students should identify whether Regina wished to leave a legacy, address unfinished business, or engage in life review. Practical approaches include looking at photo albums or important mementos while sharing thoughts and feelings. This question integrates holistic assessment with person-centered care planning.

30 Minutes or More

If you have 30 minutes or more to debrief with students, we recommend following our debriefing script to support a thoughtful and comprehensive reflection:

Opening

- Let's debrief your end-of-life encounter with Regina Walker. We'll use the GAS method, starting by gathering what happened during your assessment.
- Guiding Questions:
    - What did you observe and hear from Regina?
    - What fears or concerns did Regina express about dying?
    - What symptoms of distress did you identify? (pain, dyspnea, anxiety, other)
    - What was Regina's pain assessment? (location, intensity, quality, response to medication)
    - Did Regina discuss any unfinished business or desire for life review?
- How did Regina and her family respond to you?
    - What nonverbal cues did you observe?
    - How did family members express their concerns or needs?
    - Were there moments of silence? How did you handle them?

Analysis

- Now let's analyze your clinical reasoning and therapeutic responses.
- Therapeutic Communication:
    - How did you respond when Regina expressed fears about dying?
    - Patients commonly fear pain, loneliness, abandonment, the unknown, loss of dignity, and loss of control. Which did Regina express?
    - Did you allow Regina time to express her feelings without interrupting? Silence can allow time to gather thoughts and sends a message of acceptance.
- Comfort Care & Symptom Management:
    - How would you ensure Regina's pain is adequately controlled?
    - Remember: regularly scheduled pain medications augmented with PRN doses are appropriate. There is no risk of addiction when narcotics are increased in response to pain for dying patients.
    - What other comfort measures would you implement beyond pain medication?
- Holistic Assessment:
    - How did you assess Regina's psychological, spiritual, and emotional needs?
    - Did Regina wish to engage in life review? Practical approaches include looking at photo albums or important mementos while sharing thoughts and feelings.

- What support does Regina's family need?

Summary

- Guided Reflection:
  - What's the primary goal of palliative care for Regina?
  - What's one therapeutic communication skill you'll strengthen for future end-of-life encounters?
  - How comfortable were you discussing death and dying? What influenced your approach?

Closing

- Excellent reflection. End-of-life nursing requires therapeutic presence, empathy, active listening, and comprehensive symptom management. Simply being present offers support and comfort.