Shadow Health

Shadow Health Faculty Debriefing Guide

Medical-Surgical DCE

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

Contents in Shadow Health Faculty Debriefing Guide: Medical-Surgical 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 Medical Surgical 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 Hourly Rounds: Endocrine System (Fatima Khan)

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 were the most significant assessment findings you identified during your hourly rounds with Fatima Khan? Describe how these findings relate to potential endocrine dysfunction.
2. Which open-ended questions were most effective in gathering information about the patient's endocrine-related symptoms? How did the patient's responses guide your subsequent assessment?
3. What specific risks does a patient with type 1 diabetes face during the perioperative period? (Consider hypoglycemia, hyperglycemia, ketosis, delayed wound healing, infection, and cardiovascular alterations)
4. How does surgical stress affect blood glucose levels in patients with diabetes? What physiological mechanisms are at play?
5. What vital sign changes would prompt you to notify the provider immediately? Explain the pathophysiology behind why these changes occur in endocrine disorders.
6. When would you use regular (short-acting) insulin versus the patient's usual insulin regimen? What's the rationale?
7. How did you assess the patient's ability to perform activities of daily living? What endocrine-related symptoms might impact functional status?
8. What did you do well in managing this patient's labile blood sugar? What would you do differently?
9. If you could repeat this hourly round, what would you do differently? What assessment data would you prioritize gathering first and why?
10. How did you prioritize your nursing interventions during the hourly round? What evidence-based rationale supported your decisions?

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 were the most significant assessment findings you identified during your hourly rounds, and how did these relate to potential endocrine dysfunction?
    - This question is essential because endocrine disorders often present with nonspecific symptoms like fatigue, weakness, and weight changes that are easy to overlook. It pushes students to connect their observations to underlying pathophysiology and recognize patterns in endocrine presentations.
2. What psychosocial concerns did you identify or anticipate for this patient, and how might endocrine changes affect their emotional well-being and self-image?
    - Endocrine problems significantly impact behaviors, personality, psychological responses, and self-image. Body features can change greatly, and patients may experience infertility, impotence, or other changes affecting sexuality. This question develops holistic, patient-centered thinking and helps students recognize that endocrine care extends beyond physical symptoms.
3. If you could repeat this hourly round, what would you do differently, and what assessment data would you prioritize gathering first?
    - This metacognitive question promotes clinical judgment development by having students critically evaluate their own performance. It encourages them to think about prioritization—a crucial skill for safe practice—and helps them identify gaps in their assessment approach.

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 start by gathering your thoughts about the case. Tell me what happened with Ms. Khan during your hourly rounds.
- Prompting questions if needed:
    - What did you notice about her blood glucose levels?
    - What assessment findings stood out to you?
    - What interventions did you perform?

Analysis

- Now let's analyze what happened. I'll ask some questions to help us think through your clinical decisions.
- What factors can affect blood glucose levels in older adults like Ms. Khan? (Explore: medications like diuretics, β-blockers, steroids; dietary intake; infection; stress)
- You assessed for hyperglycemia symptoms. How might these present differently in older adults? (Reinforce subtle presentation)
- Walk me through your skin assessment priorities. Why are certain areas more critical? (Feet for neuropathy/breakdown; perianal for fungal infections)

Clinical Reasoning

- What warning signs of hypoglycemia should Ms. Khan recognize? (Clammy, cold, sweaty, shaky, confused)
- How did you assess her ability to perform self-monitoring of blood glucose at home? (Vision, dexterity, arthritis, cognitive function)
- What barriers to diabetes self-management did you identify? (Physical limitations, social support, financial resources, Medicare coverage for education and supplies)

Summary

- Let's summarize the key learning points.
- Invite student to identify:
    - What are the most important assessments for hourly rounds with a diabetic patient?
    - What will you do differently or continue doing in future diabetes care?
- Faculty summary:
    - "Comprehensive diabetes assessment in older adults requires systematic evaluation of blood glucose, medications, nutrition, elimination, skin integrity, and self-management abilities. Age-related factors like arthritis, vision changes, and cognitive function significantly impact diabetes self-management. Medicare covers diabetes self-management education—10 hours initially and 2 hours annually—which is an important resource for patients like Ms. Khan.

Closing

- What questions remain for you about diabetes care in older adults?

Debrief Hourly Rounds: Perioperative Care (Sonia Best)

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 postoperative assessment findings did you prioritize during your hourly rounds with Sonia Best? How did these relate to potential surgical complications you were monitoring for?
2. How did you apply the "Ps" of hourly rounding (pain, potty, positioning, periphery, pump) during your assessment? Which of these was most critical for this postoperative patient and why?
3. What changes in vital signs or physical assessment would have prompted you to notify the surgeon or provider immediately? Explain the pathophysiology behind why these changes are concerning postoperatively.
4. What is the significance of peripheral artery disease (PAD) in this patient's amputation? How would you assess for PAD signs?
5. Why do wounds heal more slowly in patients with diabetes? (Decreased blood flow, oxygen, WBCs, nutrients; hyperglycemia as bacterial growth medium)
6. How did you assess and address the patient's pain during hourly rounds? What nonpharmacological interventions did you consider alongside medication administration?
7. What patient and family teaching did you or could you have provided or reinforced during your rounds? How did you evaluate the patient's understanding of postoperative care instructions? What foot care education is critical for the patient's remaining limb? How will you emphasize the importance of preventing recurrence?
8. How did you address the patient's psychological response to surgery? What concerns or anxieties did you identify, and how did you respond?
9. If you could repeat this hourly round, what would you do differently? What assessment data or interventions would you prioritize and why?
10. How did you use clinical reasoning to determine which findings required immediate intervention versus continued monitoring? Walk through your decision-making process for one specific situation.

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 postoperative assessment findings did you prioritize during your hourly rounds, and how did these relate to potential surgical complications you were monitoring for?
    - Assessment is the critical foundation of postoperative nursing care. The nurse spends the most time at the bedside gathering data about the patient and judging the clinical course. This question pushes students to demonstrate clinical reasoning by connecting their assessment findings to anticipated complications based on the type of surgery and the patient's baseline condition.
2. What changes in vital signs or physical assessment would have prompted you to notify the surgeon immediately, and what is your rationale?
    - Sound clinical judgment in perioperative care originates from knowledge of the surgical procedure, the patient's initial condition, and intended effects combined with clinical experience. This question develops students' ability to recognize patterns, distinguish normal postoperative changes from concerning complications, and understand when escalation is necessary—essential skills for patient safety.
3. How did you use communication and teamwork during your rounds to ensure patient safety?
    - Communication is fundamental to patient safety in perioperative settings. Successful surgery and recovery result from a common goal and the surgical team understanding and respecting the importance of each person's role. This question encourages students to reflect on their communication with the patient, family, and interprofessional

team members, reinforcing that perioperative nursing requires effective collaboration to prevent adverse events.

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 start by gathering your thoughts about Ms. Best's postoperative care. Tell me what happened during your hourly rounds.
- Prompting questions if needed:
    - What did you notice about her vital signs?
    - What assessment findings did you observe?
    - What interventions did you perform during rounds?

Analysis

- Now let's analyze your clinical decisions and connect them to evidence-based postoperative care.
    - What was your assessment schedule for vital signs? Why do we use the 'times 4' factor? (Every 15 minutes × 4, then every 30 minutes × 4, then hourly × 4, then every 4 hours)
    - You assessed Ms. Best's blood pressure and pulse. What combination of findings would concern you most?(Hypotension with rapid pulse and cold, clammy, pale skin suggests hypovolemic shock versus hypotension with normal pulse and warm, dry, pink skin suggests residual vasodilation from anesthesia)
- Purposeful Hourly Rounding:
    - Walk me through the 4 Ps you addressed during rounds. (Pain, Potty, Positioning, Periphery—ensuring call light, phone, and possessions within reach)
    - How did you assess Ms. Best's pain level and effectiveness of pain management?
- Safety & Neurological Status:
    - What safety measures did you implement based on her level of consciousness?" (Side rails up, call light within reach, positioning on side or head elevated 45 degrees until fully conscious, no pillow under head initially to prevent airway obstruction)
- Surgical Site & Drains:
    - Describe your assessment of the incision, dressing, and any drains. What findings would require immediate notification of the surgeon?

Summary

- Invite student to identify:
    - What are your top three assessment priorities during postoperative hourly rounds?
    - What will you carry forward into your clinical practice?
    - Faculty summary: Postoperative hourly rounds systematically address the 4 Ps while monitoring for complications. Frequent vital sign monitoring with comparison to baseline helps detect cardiovascular changes early. Understanding the difference between expected anesthesia effects and signs of shock is critical for patient safety.

Closing

- What questions do you have about postoperative monitoring or early mobility protocols?

Debrief Hourly Rounds: Respiratory System (Richard Trottier)

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 respiratory assessment findings did you prioritize during your hourly rounds with Richard Trottier? Describe how you evaluated airway patency, chest symmetry, and the depth, rate, and character of respirations.
2. Did you observe any signs of respiratory distress such as flaring nostrils, substernal or clavicular retractions, asymmetric chest wall expansion, or use of accessory muscles for breathing? What do these findings indicate about the patient's ventilatory status?
3. What breath sounds did you auscultate anteriorly, laterally, and posteriorly? If you detected decreased, absent breath sounds, crackles, or wheezes, what actions did you take and why?
4. What were the patient's oxygen saturation levels and vital signs during your assessment? How did you use pulse oximetry in conjunction with your respiratory assessment to recognize early signs of complications?
5. What signs of hypoxemia did you monitor for? Explain how rapid breathing, gasping, apprehension, restlessness, or a rapid or thready pulse relate to inadequate oxygenation.
6. If the patient had a cough, how did you assess whether it was productive or nonproductive? Describe the amount, color, and consistency of any sputum you observed and what this indicated about the patient's respiratory status.
7. How did you assess the patient's subjective experience of dyspnea or shortness of breath? What impact did respiratory symptoms have on the patient's functional status and quality of life?
8. What assessment findings would have required you to immediately notify the health care provider? Explain your clinical reasoning for escalating care.
9. How did you determine whether the patient's chest wall movement was symmetric? What technique did you use, and what would asymmetry indicate?
10. If you could repeat this hourly round, what would you do differently? What respiratory assessment techniques would you prioritize or perform more thoroughly?

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 respiratory assessment findings did you prioritize during your hourly rounds, and how did these relate to potential respiratory complications?
    - This targets clinical reasoning by connecting assessment data (breath sounds, respiratory rate, oxygen saturation, signs of distress) to underlying pathophysiology and anticipated complications based on the patient's condition.
2. What signs of hypoxemia or respiratory distress would have prompted you to notify the provider immediately, and what is your clinical rationale?
    - This develops critical judgment by requiring students to distinguish normal findings from concerning changes, understand escalation criteria, and recognize when immediate intervention is necessary for patient safety.
3. How did you assess the patient's subjective experience of dyspnea, and what impact did respiratory symptoms have on their functional status and quality of life?
    - This promotes holistic, patient-centered care by encouraging students to recognize that respiratory assessment extends beyond objective data to include the patient's lived experience and how symptoms affect daily functioning and well-being.

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 start by gathering your thoughts about Mr. Trottier's respiratory assessment. Tell me what happened during your hourly rounds.
- Allow student to describe the scenario without interruption
- Prompting questions if needed:
    - What did you notice about his breathing pattern?
    - What assessment findings stood out to you?
    - What interventions did you perform?

Analysis

- Now let's analyze your clinical decisions and connect them to evidence-based respiratory assessment.
- Airway & Breathing Pattern:
    - What specific components did you assess regarding Mr. Trottier's respiratory effort? (Rate, rhythm, symmetry, quality of ventilatory movements—normal is 12-20 breaths/min, effortless and regular)
    - You observed his breathing pattern. How would you differentiate between tachypnea and hyperventilation? (Tachypnea: increased rate with decreased depth; Hyperventilation: increased rate AND depth)
    - What signs of respiratory distress did you look for? (Flaring nostrils, substernal or clavicular retractions, asymmetric chest wall expansion, abdominal breathing, use of accessory muscles)
- Auscultation & Oxygenation:
    - Walk me through where you auscultated breath sounds and what you heard. (Anteriorly, laterally, posteriorly—decreased or absent sounds indicate diminished or obstructed airflow)
    - What does pulse oximetry tell you, and what are its limitations? (Early indicator of impaired ventilation alongside slowed breathing and reduced chest/abdominal movement)
- Cough & Sputum Assessment:
    - If Mr. Trottier had a cough, how would you document it comprehensively? (Onset, duration, frequency, type—wet or dry, severity, sputum characteristics: color, consistency, odor, amount)
- Hypoxemia Recognition:
    - What early manifestations of hypoxemia would prompt immediate intervention? (Tachypnea, gasping, anxiety, restlessness, confusion, rapid or thready pulse)

Summary

- Invite student to identify:
    - What are your top three respiratory assessment priorities during hourly rounds?
    - What will you do differently in future respiratory assessments?
- Faculty summary:
    - Thorough respiratory assessment includes airway patency, chest symmetry, depth, rate, and character of respirations. Early recognition of impaired ventilation—through decreasing pulse oximetry, slowed breathing, reduced chest movement, or accessory muscle use—allows prompt intervention before respiratory crisis develops.

Closing

- What questions remain about respiratory assessment or managing respiratory distress?

Debrief Hourly Rounds: Gastrointestinal System (Scott Becker)

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 gastrointestinal assessment findings did you prioritize during your hourly rounds with Scott Becker? How did you assess for abdominal pain, distention, nausea, vomiting, and bowel sounds in the four quadrants?
2. How did you use inspection, auscultation, percussion, and palpation during your abdominal assessment? Describe what you were looking for with each technique and what your findings indicated about GI function.
3. What specific symptoms of anemia did you identify in this patient? How do extreme fatigue and other manifestations relate to tissue hypoxia?
4. What cardiopulmonary manifestations did you assess for? (Tachycardia, palpitations, dyspnea, systolic murmurs, increased pulse pressure)
5. What questions did you ask about the patient's usual bowel elimination patterns? How did you determine whether the patient's current bowel function represented a change from their normal pattern?
6. What medications did you assess that could affect GI function? How did you inquire about the use of laxatives, antacids, NSAIDs, antibiotics, or other medications that may impact the gastrointestinal system?
7. Beyond fatigue, what other body systems might be affected by severe anemia?(Neurological, gastrointestinal, integumentary, musculoskeletal)
8. Is anemia a disease or a manifestation of an underlying pathological process? What does this mean for your assessment approach?
9. What safety measures are important for a patient with severe fatigue? (Fall prevention, assistance with ADLs and transfers)
10. If you could repeat this hourly round, what aspects of your GI assessment would you perform more thoroughly or differently? What assessment data would you prioritize gathering first?

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 are the three main etiological categories of anemia, and which seems most likely given this patient's presentation of abdominal pain?
    - Why this matters: This question assesses whether students understand that anemia is not a disease itself but a manifestation of an underlying pathological process. The three categories are:
        i. Blood loss (acute or chronic)
        ii. Impaired RBC production
        iii. ncreased RBC destruction
    - The presence of abdominal pain suggests potential GI bleeding, making blood loss a priority consideration. This question pushes students to connect clinical manifestations with underlying pathophysiology and guides appropriate diagnostic investigation.
2. How would you classify the severity of this patient's anemia based on hemoglobin level, and what compensatory mechanisms did you observe or should you assess for?
    - Why this matters: This evaluates students' ability to:
        i. Categorize anemia severity (mild: 100-120 g/L; moderate: 60-100 g/L; severe: <60 g/L)
        ii. Recognize that the body compensates through cardiovascular (increased heart rate, stroke volume), respiratory (increased rate and depth), and hematologic systems
        iii. Understand that extreme fatigue results from tissue hypoxia due to reduced oxygen-carrying capacity

- Students should identify signs like tachycardia, tachypnea, pallor, and understand that symptoms become more pronounced as compensation fails?

3. How did you prioritize this patient's competing needs—extreme fatigue versus abdominal pain—and what safety measures did you implement?
    - Why this matters: This question targets clinical judgment and priority-setting skills. Students must:
        i. Balance immediate safety concerns (fall risk from fatigue, potential ongoing bleeding)
        ii. Implement energy conservation strategies while investigating the cause of anemia
        iii. Recognize when to escalate concerns to the healthcare team
        iv. Demonstrate understanding that treating symptoms alone without addressing the underlying cause is insufficient
    - This reflection helps students articulate their decision-making process and identify gaps in their clinical reasoning.

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 this simulation. Let's take time to reflect on your clinical decisions and reasoning. This debriefing is a safe space—there are no wrong answers, only learning opportunities. Let's start with your initial impressions.
- How are you feeling about how that went? What stood out to you most during this assessment?

Reaction Phase

- Let's talk about what you observed and experienced.
    - What were the patient's primary complaints?
    - What initial concerns came to mind when you saw the low hemoglobin?
    - Did anything surprise you or catch you off guard?
    - Listen for: Recognition of fatigue, abdominal pain, and anemia connection

Analysis Phase

- Question 1: Anemia isn't a disease itself—it's a manifestation of an underlying problem. What are the three main causes of anemia, and which seems most likely here given the abdominal pain?
    - Look for: Blood loss, impaired RBC production, increased RBC destruction. Guide toward GI bleeding as likely cause.
- Question 2: How would you classify this patient's anemia severity based on hemoglobin level? What compensatory mechanisms should you assess for?
    - Look for: Understanding of mild (100-120 g/L), moderate (60-100 g/L), severe (<60 g/L) categories. Cardiopulmonary compensation—tachycardia, tachypnea, increased oxygen release from hemoglobin.
- Question 3: You had a patient with extreme fatigue AND abdominal pain. How did you prioritize these competing needs? What safety measures did you implement?
    - Look for: Fall risk awareness, energy conservation strategies, recognition that treating symptoms without addressing cause is insufficient, appropriate escalation.
- Probe deeper: What body systems are affected by tissue hypoxia? How does this explain the extreme fatigue?

Summary

- What are your key takeaways from this experience?
- Reinforce:
    - Anemia requires investigation of underlying cause
    - Severity guides symptom presentation and intervention urgency
    - Safety and energy conservation are essential nursing priorities
    - Abdominal pain + anemia = investigate GI bleeding
- What will you do differently in clinical practice based on today's learning?

Closing

- Excellent work thinking through this complex patient. Questions before we wrap up?

Debrief Hourly Rounds: Renal System (Arturo Perez)

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 key assessment findings did you identify during your hourly rounds with Arturo Perez? How did you prioritize which assessments to perform first?
2. Describe the intake and output measurements you documented. Why is accurate I&O monitoring critical for patients with renal conditions?
3. What elements of Arturo's health history (occupational exposure, lifestyle factors, or symptoms) might contribute to his current renal condition?
4. How did you assess for subtle signs of kidney dysfunction, such as fatigue, changes in appetite, fluid retention, or pruritus?
5. What potential complications did you monitor for during your assessment? Explain your rationale for each.
6. If Arturo showed signs of fluid overload or electrolyte imbalance, what would be your immediate nursing interventions?
7. How did you explain the purpose of hourly rounds and ongoing monitoring to Arturo? What concerns or questions did he express?
8. Renal conditions can significantly impact a patient's daily life, work, and relationships. What psychosocial concerns did you identify or anticipate for Arturo?
9. If Arturo was receiving diuretic therapy or other renal-related medications, how would you monitor effectiveness and potential adverse effects?
10. Reflect on one aspect of your assessment that went well and one area where you would like to improve. What specific strategies will you use to strengthen your renal assessment skills?

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 assessment findings indicated the patient's current fluid balance status, and what interventions would you prioritize?
    - This question encourages students to synthesize multiple data points. Students should identify:
        - Hourly urine output trends (oliguria is <0.5 mL/kg/h in adults)
        - Signs of fluid overload: dependent edema, crackles, ascites, neck vein distention, pericardial effusions, Hemodynamic parameters correlated with intake and output
        - Daily weight changes (>1 kg/day typically indicates fluid shifts, not nutritional changes)
    - Students should connect assessment findings to appropriate nursing actions, such as fluid restriction, diuretic administration, or preparing for dialysis.
2. How did you prioritize your assessments during hourly rounds, and what clinical reasoning guided your decisions?
    - This promotes reflection on systematic assessment approaches. Key priorities for renal patients include:
        - Vital signs and hemodynamic stability
        - Strict intake and output monitoring
        - Mental status changes (indicating uremia or electrolyte imbalances)
        - Cardiovascular assessment (S3 gallop, murmurs, pericardial friction rub, ECG dysrhythmias)
        - Respiratory assessment (crackles, decreased breath sounds indicating fluid overload)
        - Dialysis access site evaluation if applicable

    - Students should articulate why certain assessments take precedence based on the patient's acute kidney injury phase and current clinical status.
3. What changes in the patient's condition would require immediate notification of the healthcare provider?
    - This develops critical thinking about recognizing deterioration. Students should identify:
        - Significant changes in urine output (worsening oliguria or anuria)
        - Signs of severe fluid overload (pulmonary edema, respiratory distress)
        - Cardiac complications (new dysrhythmias, pericardial friction rub)
        - Neurological changes suggesting uremia or electrolyte imbalances
        - Abnormal laboratory values indicating worsening kidney function
    - These questions align with evidence-based renal nursing management and help students connect assessment data to clinical decision-making and patient safety priorities.

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 reflect on your clinical decisions and reasoning. This is a safe learning space where we can explore what worked well and what you might approach differently next time.
- How are you feeling about how that went? What was your immediate reaction when the blood pressure dropped during dialysis?

Reaction Phase

- Let's start by discussing what you observed.
    - What signs of fluid overload did you identify in this patient?
    - Walk me through what happened when the blood pressure dropped. What did you notice?
    - What was most challenging about managing this patient?
- Listen for: Recognition of edema, shortness of breath, crackles; concern about hypotension; understanding that dialysis causes fluid shifts

Analysis Phase

- Question 1: What clinical signs indicated fluid overload in this patient, and how does hemodialysis address this problem?
    - Look for: Dependent edema, shortness of breath, crackles/pulmonary edema, understanding that dialysis removes excess fluid through ultrafiltration
- Question 2: Why did the patient's blood pressure drop during dialysis? What nursing interventions should you implement when this happens?
    - Look for: Considerable fluid volume shifts affecting homeostasis, need for more frequent assessment, comparing vital signs to pretreatment values, signs of confusion/disorientation, dizziness, nausea, muscle cramps, when to notify the provider
    - Probe: How do you balance the need to remove excess fluid with preventing dangerous hypotension?
- Question 3: After dialysis ends, what assessments and safety precautions are essential for the next several hours?
    - Look for: Monitor access site for bleeding for 1 hour, assess for confusion/disorientation/headache/dizziness, continue vital sign monitoring, postpone invasive procedures for 4-6 hours due to heparin, assess access site patency and infection signs
- Additional probe: Why do we delay invasive procedures after dialysis?

- Look for: Heparin remains active 4-6 hours, extended clotting time, bleeding risk

Summary

- What are your key takeaways from this experience?
- Reinforce these concepts:
  - Fluid overload requires dialysis but creates hemodynamic instability risk
  - Patients need frequent assessment during and after dialysis due to fluid shifts
  - Hypotension during dialysis requires immediate intervention and vital sign comparison
  - Postdialysis anticoagulation creates bleeding risk requiring access site monitoring and procedure delays
  - Communication with the healthcare team ensures continuity when dialysis patients are hospitalized
  - What will you prioritize differently in your next dialysis patient encounter?

Closing

- Excellent work thinking through these complex physiological changes. Any final questions?

Debrief Complex Assessment: Generalized Weakness (Minerva Garcia)

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 were most significant in understanding Ms. Garcia's generalized weakness? How did you cluster these cues to identify patterns?
2. Which assessment findings were expected versus unexpected for a patient presenting with generalized weakness? What additional data did you gather to clarify unexpected findings?
3. Describe your systematic approach to the physical examination. How did your history findings guide which body systems you prioritized during the physical exam?
4. What were your top three differential diagnoses for Ms. Garcia's generalized weakness?Walk through your clinical reasoning for each possibility.
5. How did you distinguish between Activity Intolerance and Fatigue as potential nursing diagnoses? What specific assessment data helped you differentiate between these two diagnoses?
6. What related factors or contributing causes did you identify for Ms. Garcia's weakness?How would different related factors change your nursing interventions?
7. Reflect on a moment during the assessment when you needed to gather additional data to confirm a pattern. What prompted you to seek more information, and how did it influence your clinical judgment?
8. What intellectual standards (precision, specificity, relevance) did you apply during your assessment? Provide a specific example of how you ensured accuracy in your data collection.
9. Based on your assessment findings, what safety concerns or risk factors did you identify for Ms. Garcia? What immediate nursing interventions would you prioritize?
10. How would you communicate your assessment findings and nursing diagnoses to the healthcare team? What information is most critical to include in your handoff?

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 assessment findings helped you recognize sepsis in this older adult patient, and why is early detection critical?
    - Why this matters: Older adults are at higher risk for sepsis and may present atypically. Students should identify qSOFA criteria (altered mental status, systolic BP ≤100 mm Hg, respiratory rate ≥22/min) and understand that two or more of these with infection indicates sepsis. Generalized weakness may be the primary manifestation in older adults rather than fever. Early detection allows for early treatment and decreases mortality—this is a cornerstone of successful outcomes.
2. How does sepsis progress from infection to organ dysfunction, and what compensatory mechanisms did you assess for in this patient?
    - Why this matters: Students must understand the pathophysiology: infection escapes local control → widespread inflammation (SIRS) → hormonal, tissue, and vascular changes → impaired gas exchange and perfusion → organ dysfunction. Assessment should include temperature variations (low-grade fever, high fever, or hypothermia—especially in older adults), decreased urine output, increased respiratory rate, mild hypotension, and elevated WBC. Inappropriate clotting with microthrombi causes organ hypoxia. Recognizing these subtle changes allows intervention before irreversible organ damage occurs.
3. What infection prevention measures and evidence-based interventions are priorities for this septic patient?
    - Why this matters: Nursing management focuses on prevention, early recognition, and supportive care. Students should identify: handwashing and aseptic technique to prevent further infection, continual observation for progression (cool/clammy skin,

weak/thready pulses indicating shock), monitoring hourly urine output, assessing breath sounds for crackles, recognizing increased fatigue and anxiety, and implementing the sepsis resuscitation bundle when hypoperfusion is recognized. Immunosuppression is common as sepsis progresses, with opportunistic infections occurring 2+ weeks after initial diagnosis.

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 this sepsis simulation. Let's reflect together on your clinical decisions and reasoning. This is a safe learning space—let's start with your initial impressions.
- How are you feeling about how that scenario went? What stood out to you most about this patient?

Reaction Phase

- Let's talk about what you observed and experienced.
    - What were your first concerns when you assessed this 76-year-old with generalized weakness?
    - What assessment findings made you suspect sepsis rather than typical age-related weakness?"
    - Did anything about her presentation surprise you or catch you off guard?
- Listen for: Recognition that older adults present atypically, qSOFA criteria awareness, concern about rapid deterioration

Analysis Phase

- Question 1: What assessment findings helped you recognize sepsis in this older adult, and why is early detection so critical?
    - Look for: qSOFA criteria (altered mental status, systolic BP ≤100 mm Hg, respiratory rate ≥22/min), understanding that older adults may have hypothermia instead of fever, early detection significantly alters prognosis
- Question 2: "Walk me through how sepsis progresses from infection to organ dysfunction. What compensatory mechanisms and warning signs did you assess for?"
    - Look for: Infection escapes local control → widespread inflammation → vascular/tissue changes → impaired perfusion → organ dysfunction; temperature variations, decreased urine output, increased respiratory rate, mild hypotension, elevated WBC, microthrombi formation
    - Probe deeper: Why might this 76-year-old have hypothermia or only slightly elevated temperature instead of high fever?
- Question 3: What infection prevention measures and evidence-based interventions are priorities for this patient?
    - Look for: Handwashing/aseptic technique, continual observation for progression to septic shock (cool/clammy skin, weak/thready pulses), hourly urine output monitoring, breath sounds assessment for crackles, recognition of increased fatigue/anxiety/mental status changes, sepsis resuscitation bundle implementation
    - Additional probe: "What signs would indicate this patient is progressing to septic shock?

Summary Phase (3-5 minutes)

- What are your key takeaways from this experience?
- Reinforce:
    - Older adults are high-risk and present atypically with sepsis

- Subtle changes (weakness, slight temperature changes, decreased urine output) indicate progression
- Early recognition and treatment decrease mortality—astute nursing assessment is critical
- Prevention of further infection through aseptic technique is essential
- Vigilance for shock progression is ongoing
- What will you prioritize differently when caring for older adults with suspected infection?

Closing

- Excellent work thinking through this complex patient. Any questions before we wrap up?

Debrief Complex Assessment: Unresponsive (Taylor Herndon)

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. Describe your immediate actions upon discovering an unresponsive patient. What safety checks and rapid assessments did you prioritize in the first 30 seconds?
2. How did you assess Mr. Herndon's level of consciousness? Rather than using terms like "lethargic" or "stuporous," describe the specific stimuli you used and his exact responses.
3. What objective data did you collect to determine the severity of Mr. Herndon's condition? How did vital signs, respiratory pattern, and pupillary response inform your clinical judgment?
4. Walk through your systematic neurologic assessment. Which components were you able to complete given his unresponsiveness, and what did each finding tell you about his neurologic status?
5. What degree of stimulation was required to evoke any response from Mr. Herndon? How does this finding correlate with altered levels of consciousness (somnolence, stupor, semicoma, coma)?
6. What were your top three possible causes for Mr. Herndon's unresponsiveness? What assessment data supported or ruled out each possibility?
7. How did you differentiate between a neurologic emergency versus other causes of altered consciousness (e.g., drugs, metabolic, toxic, cardiovascular)? What specific cues guided your thinking?
8. What immediate interventions did you implement, and in what order? Explain your rationale for prioritization.
9. How would you communicate Mr. Herndon's status using SBAR or another structured format? What critical information must be included for the rapid response team or provider?
10. Reflect on a moment when you felt uncertain during this assessment. How did you manage that uncertainty while maintaining patient safety?

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. Describe your immediate actions upon discovering an unresponsive patient. What safety checks and rapid assessments did you prioritize in the first 30 seconds?
    - This evaluates emergency response prioritization and systematic thinking under pressure—critical for patient safety.
2. How did you assess Mr. Herndon's level of consciousness? Rather than using terms like "lethargic" or "stuporous," describe the specific stimuli you used and his exact responses.
    - This reinforces the textbook principle that level of consciousness is "the most accurate and reliable indicator of neurologic status" and that describing specific patient responses to specific stimuli is clearer than interpretive terms. This addresses a common pitfall in neurologic assessment.
3. What were your top three possible causes for Mr. Herndon's unresponsiveness? What assessment data supported or ruled out each possibility?
    - This assesses clinical reasoning and the ability to generate differential diagnoses while connecting assessment findings to potential etiologies.

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 start with your immediate thoughts. How are you feeling after that scenario?
- Invite students to describe what happened:

    - Walk me through what you observed when you first encountered the patient.
    - What were your initial priorities?
    - What actions did your team take?

Analysis

- Explore clinical reasoning around ABC priorities:
    - The priority of care in overdose is always the patient's ABCs—airway, breathing, and circulation. How did you assess and support respiratory status?
    - What signs of respiratory depression did you identify?
- Discuss medication management:
    - Tell me about your decision to administer naloxone. What were you thinking?
    - Naloxone has a shorter duration of action than most opioids. What monitoring did you plan after administration?
    - Were you prepared for the patient's response to naloxone? The rapid reversal can cause discomfort, fear, and panic when consciousness is restored."
- Address uncertainty:
    - In real practice, uncertainty often exists about which substances are involved. How did you handle not knowing definitively what the patient took?
    - If the patient doesn't respond to 10 mg total of naloxone, what might that tell you?
- Explore therapeutic communication:
    - Substance use requires a positive, nonjudgmental, supportive approach. Reflect on your communication with this patient.

Application

- Connect to future practice:
    - What will you do differently in your next overdose situation?
    - Once acute issues are resolved, what's the next step? (Brief intervention about consequences and behavior change; psychiatric evaluation if intentional)

Closing

- What questions remain?
- What resources do you need to feel more confident managing overdose situations?

Debrief Complex Assessment: Arrhythmia (Martin Francis)

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. Describe the specific cardiac rhythm you identified for Mr. Francis. What ECG characteristics (rate, P wave presence/morphology, PR interval, QRS duration, rhythm regularity) led you to this interpretation?
2. Walk through your systematic approach to analyzing the ECG. How did you measure intervals and calculate heart rate using the ECG paper's time and voltage measurements?
3. What is the difference between the terms "arrhythmia" and "dysrhythmia"? Which term is more clinically accurate, and what does this rhythm disturbance indicate about Mr. Francis's cardiac electrical activity?
4. How did you assess Mr. Francis's hemodynamic response to the dysrhythmia? What specific vital signs, symptoms, and physical findings indicated whether he was stable or unstable?
5. Why is assessing the patient's hemodynamic response essential before determining treatment? Provide a specific example of how the same rhythm might require different interventions based on patient response.
6. What potential causes did you identify for Mr. Francis's dysrhythmia? How did you systematically assess for underlying factors (electrolyte disturbances, fever, medications, cardiac pathology)?
7. How does this dysrhythmia potentially affect cardiac output? Explain the pathophysiologic mechanism connecting the rhythm disturbance to hemodynamic consequences.
8. What immediate nursing interventions did you prioritize for Mr. Francis? Explain your rationale for the sequence of your actions.
9. How would you communicate your assessment findings to the interprofessional team? What critical information about the rhythm, hemodynamic status, and patient response must be included?
10. Reflect on the relationship between accurate rhythm identification and patient safety. How does prompt recognition of dysrhythmias and assessment of patient response impact clinical outcomes?

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. Describe the specific cardiac rhythm you identified for Mr. Francis. What ECG characteristics (rate, P wave presence/morphology, PR interval, QRS duration, rhythm regularity) led you to this interpretation?
    - This assesses the foundational skill of accurate rhythm recognition using systematic ECG analysis—essential for safe cardiac nursing practice.
2. How did you assess Mr. Francis's hemodynamic response to the dysrhythmia? What specific vital signs, symptoms, and physical findings indicated whether he was stable or unstable?
    - This directly applies the critical textbook principle that "assessment of the patient's hemodynamic response to any change in rhythm is essential because this information guides the selection of therapeutic interventions." Students must connect rhythm identification to patient impact.
3. What potential causes did you identify for Mr. Francis's dysrhythmia? How did you systematically assess for underlying factors (electrolyte disturbances, fever, medications, cardiac pathology)?
    - This reinforces that "determination of the cause of dysrhythmias should be a priority" and develops clinical reasoning about treating underlying causes rather than just the rhythm itself.

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 (2-3 minutes)

- Let's reflect on your clinical decisions together. How are you feeling after managing this patient?
- Describe what you found during your initial assessment.
- What were your first priorities when the patient reported palpitations and dizziness?
- Walk me through the actions your team took.

Analysis

- Cardiovascular Assessment:
  - Palpitations and dizziness can indicate dysrhythmias. What vital signs did you obtain?
  - Tell me about your cardiac monitoring decisions. Why is a 12-lead ECG essential?
  - What rhythm did you identify? How did it correlate with the patient's symptoms?
- Recognizing Myocardial Ischemia:
  - Did you assess for chest discomfort? Remember, patients may describe angina as 'pressure' or 'heaviness' rather than pain.
  - What characteristics of discomfort did you document—onset, location, radiation, intensity, duration, precipitating and relieving factors?
  - On a 0-10 scale, how did the patient rate their discomfort? Pain assessment must be culturally sensitive.
  - A 12-lead ECG identifies areas of ischemic myocardium. What findings would concern you for pre-infarction angina?
- Recognizing Ischemic Stroke:
  - Cardiac dysrhythmias, especially atrial fibrillation, increase stroke risk due to thrombus formation. Did you perform a neurological assessment?
  - What stroke screening tool did you use? (FAST, BEFAST, NIH Stroke Scale)
  - Key stroke signs include: sudden facial drooping, arm weakness or drift, speech difficulties, visual changes, severe headache, loss of balance, or altered mental status.
  - Time is critical—'time is brain.' What is your facility's stroke protocol? When would you activate a stroke alert?"
- Safety Considerations:
  - The patient is dizzy. What fall precautions did you implement?
  - Did you consider syncope risk? What position is safest?

Application

- What would you do differently next time?
- How would you prioritize if this patient developed chest pain AND stroke symptoms simultaneously?
- What patient education would you provide about recognizing warning signs?

Closing

- What questions remain?
- What additional resources would help you feel confident managing similar presentations?

Debrief Complex Assessment: End Stage Heart Failure (Vandana Kumar)

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 findings indicated that Ms. Kumar has end-stage (NYHA Class IV/Stage D) heart failure? How did you differentiate these from earlier stages of the disease?
2. Describe Ms. Kumar's most distressing symptoms. How did you assess the severity of her dyspnea, pain, and fatigue using objective and subjective measures?
3. How did you perform a psychosocial assessment for Ms. Kumar? What specific questions or observations helped you identify anxiety, depression, or coping challenges related to her chronic, progressive illness?
4. At what point in the heart failure trajectory does palliative care become appropriate? How would you explain to Ms. Kumar and her family that palliative care focuses on symptom management and quality of life, not "giving up"?
5. What is the primary aim of palliative care for patients with advanced heart failure? How does optimizing cardiac medications fit within this approach?
6. How would you address Ms. Kumar's dyspnea using both pharmacologic and nonpharmacologic interventions? Explain the role of opioids like morphine in managing breathlessness near end of life.
7. What indicators suggest that Ms. Kumar and her family are coping effectively—or struggling—with her progressive disease? How did you assess for hope, social involvement, and daily functioning?
8. Ms. Kumar is at high risk for depression. What assessment findings would prompt you to notify the primary health care provider for further evaluation? What interprofessional team members might be involved?
9. How would you facilitate a conversation about advance care planning with Ms. Kumar?What topics should be addressed regarding cardiac devices (ICD, pacemaker), inotropes, and end-of-life preferences?
10. Reflect on the balance between disease management and comfort care in end-stage heart failure. How did your interventions prioritize relief of suffering while maintaining Ms. Kumar's dignity and quality of life?

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 assessment findings indicated that Ms. Kumar has end-stage (NYHA Class IV/Stage D) heart failure? How did you differentiate these from earlier stages of the disease?
    - This evaluates students' ability to recognize advanced heart failure characteristics and understand disease progression—critical for identifying when palliative care becomes appropriate.
2. How would you address Ms. Kumar's dyspnea using both pharmacologic and nonpharmacologic interventions? Explain the role of opioids like morphine in managing breathlessness near end of life.
    - This directly applies the evidence-based principle that opioids are the standard treatment for dyspnea near death, working by altering the perception of air hunger and reducing pulmonary congestion. Dyspnea is described as "terrifying" and often considered "the major cause of suffering at the end of life," making expert symptom management essential.
3. How did you facilitate a conversation about advance care planning with Ms. Kumar? What topics should be addressed regarding cardiac devices (ICD, pacemaker), inotropes, and end-of-life preferences?
    - This reinforces that "transparency and shared decision making with the patient and their significant others is essential" in palliative care, and that cardiac devices and

inotropes "are not incompatible with end-of-life treatments." Students must practice navigating these sensitive conversations about goals of 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

- Thank you for participating in this simulation. End-of-life conversations require compassion and skill. How are you feeling after this experience?
- Describe the patient's clinical presentation and what led to the hospice discussion.
- What was the family's initial reaction when the patient expressed her wishes? Walk me through how the conversation unfolded.

Analysis Phase

- Communication Skills:
  - Communication is the most common source of complaints in families and should be at the center of efforts to improve end-of-life care. How did you facilitate information exchange between the patient and family?
  - Did you use empathy and active listening? These are key components in end-of-life care.
  - Silence is frequently related to overwhelming feelings. How comfortable were you allowing silence?
- Assessing Readiness:
  - Sometimes families are not ready to receive the prognosis and engage in decision making. How did you evaluate the family's readiness?
  - Did you observe any cues from the family? Have you had any interations like this in your clinical practice?
- Supporting Decision Making:
  - The patient and family need to be involved in planning and coordinating end-of-life care. How did you support the patient's autonomy while addressing family concerns?
  - Shared decision making encompasses three key elements: information exchange, deliberation, and making a treatment decision. Did you address all three?
- Hospice Education:
  - What information did you provide about hospice philosophy and services?
  - Hospice provides expert medical care, pain management, and emotional and spiritual support tailored to the person's needs and wishes. Did you clarify misconceptions?"
- Interprofessional Collaboration:
  - End-of-life care should always be interprofessional. Who else should be involved in this family conference?

Application

- What would you do differently in future end-of-life conversations?
- How will you advocate for patients whose wishes differ from family preferences?
- What self-care strategies will you use after emotionally challenging conversations?

Closing

- What questions remain?
- What additional support do you need for facilitating difficult conversations?

Debrief Complex Assessment: Cardiac Intervention (James Morris)

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. How did you assess the patient's chest discomfort? What specific questions did you ask, and why is it important to use terms like "pressure" or "heaviness" rather than only "pain"?
2. What vital signs and physical assessment findings indicated deterioration? How did you document heart rate and rhythm, BP, respirations, skin color, peripheral pulses, and overall tissue perfusion?
3. What did the 12-lead ECG reveal? How did you use it to identify the area of ischemic myocardium and recognize pre-infarction angina?
4. What was your rationale for the medications you administered? How does aspirin reduce recurrent MI risk and improve mortality in unstable angina?
5. How did you provide prompt pain relief? Walk me through your use of sublingual or IV nitroglycerin and IV opioid analgesics.
6. What differentiated this presentation from stable angina? Why is the change from stable to unstable angina potentially life-threatening?
7. When did you recognize the patient was in cardiac arrest? How quickly did you initiate CPR, and what was the lethal rhythm you identified?
8. Describe your team's response during the code. Who led the resuscitation? How did team members communicate and coordinate roles?
9. What early warning signs might have predicted this patient's deterioration? Looking back, were there opportunities for earlier intervention to prevent the arrest?
10. If the patient had been transferred to the cardiac catheterization laboratory before arrest, what treatment might have prevented this outcome? What role do GP IIb/IIIa receptor blockers play when immediate catheterization isn't available?

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 did the 12-lead ECG reveal, and how did you use it to recognize pre-infarction angina?
    - This targets the critical assessment skill that should have triggered urgent intervention *before* arrest occurred.
2. When did you recognize the patient was deteriorating, and what early warning signs might have predicted the cardiac arrest?
    - This builds clinical reasoning about recognizing decompensation and the importance of escalating care proactively.
3. Walk me through your CPR performance and team communication during the code. What went well, and what could improve?
    - This addresses both technical competency and teamwork—essential for successful resuscitation outcomes.

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

- Cardiac arrest situations are stressful. How are you feeling?
- Describe what you observed when you first assessed this patient.
- Walk me through the events leading up to the cardiac arrest.
- What actions did your team take during the code?

Analysis

- Recognizing Myocardial Ischemia:
  - Complaints of chest discomfort must be evaluated quickly because angina indicates myocardial ischemia. How did you assess the chest pain?
  - Did you ask the patient to rate intensity on a 0-10 scale? Remember to assess with sensitivity to cultural differences in pain manifestation.
  - Patients may describe angina as 'pressure' or 'heaviness' rather than 'pain.' What descriptors did your patient use?
  - What characteristics did you document—heart rate and rhythm, BP, respirations, temperature, skin color, peripheral pulses, urine output, mentation, and overall tissue perfusion?"
- ECG Interpretation:
  - A 12-lead ECG identifies the area of ischemic myocardium. What did you find?
    - The major concern is that chest pain may represent pre-infarction angina. Early identification is essential for immediate treatment.
- Pharmacologic Management:
  - For unstable angina, what medications did you consider? Aspirin is the gold standard and the only agent proven to reduce recurrent MI risk and improve mortality.
  - Did you provide prompt pain relief with sublingual or IV nitroglycerin, followed by IV opioid analgesic if needed?
- CPR Performance:
  - When the patient arrested, how quickly did you initiate CPR? For successful treatment, CPR and AED use should begin within 3-5 minutes.
  - Walk me through your assessment of responsiveness and activation of the emergency response.
  - What was the rhythm? How did you manage it?"

Application

- Were there any early warning signs might have predicted deterioration?
- What will you do differently when managing unstable angina?
- How will you prepare for sudden decompensation in cardiac patients?

Closing

- What questions remain?
- What additional practice would build your confidence?