When employed as a substitute for real clinical time, simulation scenarios have proven effective in bridging the gap between theory and practice. This acclaimed text for nursing faculty provides detailed, step-by-step guidance on all aspects of clinical simulation. Appropriate for all levels of nursing students, from pre-licensure to doctoral level, the book contains the authors’ own advice and experiences working in simulation around the globe.

For the third edition, 20 new scenarios have been added, and all scenarios have been updated to adhere to best-practice simulation standards for design, facilitator and participant criteria, interprofessional criteria, and debriefing processes. Scenarios are presented in a structured format that includes objectives, pre-scenario checklists, implementation plans, evaluation criteria, debriefing guidelines, and recommendations for further use. A template for creating scenarios spans the text and includes student preparation materials, forms to enhance the realness of the scenario, and checklists for practice assessment and evaluation.

This comprehensive resource covers geriatric, pediatric, trauma, obstetric, and community-based patient scenarios. This revised edition includes scenarios easily adaptable to an instructor’s own lab, an international perspective, and a section on graduate nursing education.

New to the Third Edition:
• 20 brand new scenarios in anesthesia, midwifery, pediatric, disaster, and other specialty-focused situations, plus five new chapters
• Updated to encompass new simulation pedagogy including best-practice standards
• New scenarios easily adapted to an instructor’s own lab
• Interprofessional and international scenarios focused on areas of global concern: obstetric hemorrhage, neonatal hypoglycemia, and deteriorating patients

Key Features:
• Includes information on how to integrate simulation into curricula
• Addresses conceptual and theoretical foundations of simulation in nursing education, including an expanded chapter on the Framework for Simulation Learning in Nursing Education
• Includes a wide variety of practical scenarios in ready-to-use format with instructions
• Provides a template for scenario development
• Delivers recommendations for integration of point-of-care decision-making tools
• Offers opportunities for enhancing complexity and incorporating interprofessional competencies
Simulation Scenarios for Nursing Educators
Suzanne Hetzel Campbell, PhD, RN, WHNP-BC, IBCLC, graduated with her BS and MS in nursing from the University of Connecticut, and her PhD in nursing from the University of Rhode Island. She obtained her post-master’s certificate as a women’s health nurse practitioner from Boston College. At the writing of the first edition of this book, she was associate professor, associate dean for academic programs, and project director for the Fairfield University School of Nursing Robin Kanarek Learning Resource Center. She taught at Fairfield University from 2000 to 2012. Her increasing interest in web-enhanced learning and simulation-based pedagogy has led to publications and workshops on these topics; she uses her own experience to empower nursing faculty. Dr. Campbell was a board member and faculty liaison for the School of Nursing Advisory Board at Fairfield from 2008 to 2011, and she oversaw a $1.06 million 5-year project, which included building renovation, classroom upgrades, faculty development, and integration of simulation throughout the nursing curriculum. In June 2011, Dr. Campbell became interim dean at Fairfield University School of Nursing for the academic year 2011 to 2012. In this role, she hired a new lab director, continued simulation research, and worked with the administration to support plans for an interdisciplinary health science building, incorporating arts and sciences, business, engineering, graduate education, and applied professions. As described by some of the authors in this book, these plans for an integrative health science building and an interdisciplinary focus at Fairfield University have been realized with the support of visionary leadership, a supportive advisory board, and hard-working faculty.

In July 2012, Dr. Campbell was appointed director of the School of Nursing at the University of British Columbia (UBC), Vancouver, British Columbia, Canada, where her vision for interprofessional education incorporating the use of simulation and a global approach to health care professional education is being realized. Her global outreach in the use of simulation has included work on a health communication instrument with colleagues from Fairfield and UBC, which was tested internationally and won the Best Research Paper Award in 2015 in the International Nursing Association for Clinical Simulation and Learning’s (INACSL) Clinical Simulation in Nursing journal. In British Columbia, she has been part of research teams looking at communication modules for safe patient handover curriculums and is presently testing a Global Interprofessional Therapeutic Communication Scale (GITCS®). In addition to U.S. and Canadian international presentations, Dr. Campbell has presented on simulation in Hong Kong, Brazil, Shanghai, and Chile, and is collaborating with colleagues in Australia and South Africa. She is excited to bring an international perspective to the third edition of this text, with colleagues from several countries representing the universal use of simulation for nursing and health professional education.

Karen M. Daley, PhD, RN, graduated from Villanova University with a BS in nursing, from Troy State University with an MS in nursing, and from Rutgers—the State University of New Jersey with a PhD in nursing. At Western Connecticut State University, Dr. Daley spearheaded the implementation of human patient simulation throughout the curriculum and is primarily responsible for the acquisition of SimMan technology, the expansion and development of the nursing labs and the Nursing Resource Center, and the upgrade of resources for the nursing labs. As the chair of the Learning Resources Committee, she acquired additional lab space for an additional SimMan lab, an assessment lab, a technology classroom, and a pediatrics/obstetrics area. A new intensive care unit lab opened in the fall of 2008, funded by a federal initiative.

In June 2011, Dr. Daley became the dean of the College of Health Professions at Davenport University in Grand Rapids, Michigan. She now oversees the Allied Health, Health Information Management, Occupational Therapy, and Nursing programs. Davenport’s simulation facilities are state of the art, with four simulation labs on four campuses. In May 2012, Dr. Daley realized her dream of having multidisciplinary health students embedded in a mass disaster drill simulation. Her primary focus is implementing simulation in interprofessional teams and the integration of telehealth simulations across all programs. In this work, she continues to work to integrate simulation throughout nursing and the health curriculum; to facilitate faculty training in simulation-focused learning experiences in their classes; and to encourage the use of simulation for education, training, and to enhance interprofessional education, communication, and teamwork.

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Simulation Scenarios for Nursing Educators
Making It Real

Third Edition

Suzanne Hetzel Campbell, PhD, RN, WHNP-BC, IBCLC
Karen M. Daley, PhD, RN
Editors

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This book is dedicated to all those who have helped along the way. To our husbands and families who never stop believing, supporting, and inspiring us: You are the wings upon which we soar. We also dedicate this book to all nursing faculty, without whom none of this would be possible, and to our colleagues and the administrators at our respective universities who have helped pave the way, moved mountains, and given full support to integrating simulation within the nursing curriculum. To nursing students at all levels: Excellence in nursing is not just a goal; it is a journey. Simulation can help take you there.
CONTENTS

Contributors xiii
Foreword Pamela R. Jeffries, PhD, RN, FAAN, ANEF xxii
Preface xxiv
Acknowledgments xxvi

Share Simulation Scenarios for Nursing Educators: Making It Real, Third Edition

PART I: SETTING THE FOUNDATION FOR SIMULATION

1. Simulation-Focused Pedagogy for Nursing Education
   Suzanne Hetzel Campbell and Karen M. Daley

2. Framework for Simulation Learning in Nursing Education
   Karen M. Daley and Suzanne Hetzel Campbell

3. Integrating Simulation-Focused Pedagogy Into Curriculum
   Karen M. Daley and Suzanne Hetzel Campbell

4. Teaching and Evaluating Therapeutic Communication in Simulated Scenarios
   Suzanne Hetzel Campbell, Natalia Del Angelo Aredes, and Ranjit K. Dhari

5. Innovative Approaches to Simulation-Based Faculty Development
   Suzanne Hetzel Campbell, Maura MacPhee, and Maureen M. Ryan

6. Building and Maintaining a Learning Resource Center
   Karen M. Daley, Suzanne Hetzel Campbell, Diana R. Mager, and Cathryn Jackson

7. Lights, Camera, Action! The Process of Evaluating, Acquiring, and Implementing an Audiovisual Capturing Solution to Enhance Learning
   Colleen H. Meakim and Leland J. Rockstraw

8. Integration of Disability in Nursing Education With Standardized Patients
   Suzanne C. Smeltzer, Bette Mariani, and Colleen H. Meakim

9. IV Simulation Curriculum Development
   Shannon Krolikowski

PART II: INNOVATIVE NURSING SCENARIOS IN DIVERSE SETTINGS FOR DIVERSE STUDENTS

A. Specialty Undergraduate Nursing: Medical–Surgical

10. Tune Into Simulation Through Physical Examination Using Your Five Senses
    Catherine Napoli Rice and Carolynn Spera Bruno

11. Postoperative Care Following Appendectomy
    Diana R. Mager and Jean W. Lange

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12. Medical–Surgical Skill-Based Scenarios  
Karen M. Daley

13. Acute Management of Respiratory Distress in the Adult Patient  
Monica P. Sousa and Linda H. Warren

14. Trauma Resuscitation  
Carolynn Spera Bruno and Catherine Napoli Rice

15. Advanced Cardiac Life Support  
Sek-ying Chair and Ka-ming Chow

16. The Use of Simulation in the Recognition and Response of the Rapidly Deteriorating Patient  
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17. Medication Administration  
Kellie Bryant and Beth Latimer

B. Specialty Undergraduate Nursing: Obstetrics and Pediatrics

18. Obstetric Emergency: Postpartum Hemorrhage  
Suzanne Hetzel Campbell and Wendy A. Hall

19. Perinatal Grief: Threatened Spontaneous Abortion  
Joan Esper Kuhnly and Meredith Dodge

20. High-Risk Infant of a Diabetic Mother: Hypoglycemia  
Suzanne Hetzel Campbell, Natalia Del Angelo Aredes, Luciana Mara Monti Fonseca, and Julie de Salaberry

21. Pediatric Nursing Care Clinical Simulation Scenarios for Prelicensure Students  
Mary Ann Cantrell, Colleen H. Meakim, and Kathryn M. Reynolds

22. Preparing Prelicensure Nursing Students for Clinical Practice in Pediatric Acute Care Settings and Interprofessional In Situ Simulation  
Maureen M. Ryan and Melissa Holland

23. Developmental Assessment and Communication With Pediatric Patients and Their Families  
Lee-Anne Stephen and Anne Kent

C. Specialty Undergraduate Nursing: Older Adults

24. Care of an Older Adult With Congestive Heart Failure  
Alison Kris

25. The Older Adult in an ICU With Acute Respiratory Failure: Critical Care Nursing Senior-Year Elective  
Sheila C. Grossman

26. Communication With an Elderly Client  
Lillian A. Rafeldt, Heather Jane Bader, and Suzanne Turner

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D. Specialty Undergraduate Nursing: Other Themes—Cultural Humility, QSEN, and Mental Health

27. Discharge Teaching for an Immigrant Woman With Congestive Heart Failure and Atrial Fibrillation 321
    Mary Ann Cordeau and Leonie Rose Bovino

28. End-of-Life Scenario With Limited-English-Proficiency Patients 335
    Desiree A. Díaz and Lynn Allchin

29. QSEN CAROUSEL for First-Year Nursing Students 343
    Lillian A. Rafeldt

30. Assessing a Patient With a Mood Disorder 353
    Audrey M. Beauvais and Joyce M. Shea

E. Advanced Practice Nurse Practitioners: FNP, CRNA, PsychMHNP, and DNP

31. Diabetes Management: Nurse Practitioners 363
    Kellie Bryant

32. Assessment and Differential Diagnosis of the Patient Presenting With Chest Pain 375
    Nancy A. Moriber

33. Abdominal Pain in a Woman of Childbearing Age: A Trauma-Informed Care Approach 387
    Suzanne Hetzel Campbell and Jenna A. LoGiudice

34. Primary Care Patients With Gastrointestinal Problems: Graduate Program Advanced Physiology and Pathophysiology 399
    Sheila C. Grossman

35. Using Simulation to Enhance Emotional Intelligence in Nurse Anesthesia Students 409
    Nancy A. Moriber and Audrey M. Beauvais

36. Critical Care/Adult Gerontology Acute Care Nurse Practitioner: Aortic Emergencies 419
    Joshua Squiers and Rose Milano

PART III: INTERDISCIPLINARY AND INTERPROFESSIONAL SCENARIOS

37. Placental Abruption After Motor Vehicle Accident: An Interprofessional Simulation 433
    Jenna A. LoGiudice and Anka Roberto

38. Interprofessional End-of-Life Care of a Teenager 445
    Mary Ann Cordeau, Darlene Rogers, Dennis J. Brown, Barbara Glynn, Margaret B. Gray, Tania Grgurich, Jennifer L. Herbst, Christine Kasinskas, Meghan A. Lewis, Laura Mutrie, Karen M. Myrick, and Tracy Van Oss

39. Interdisciplinary Education in Simulation: Bridging the Gap Between Academic and Career Competencies 457
    Maureen M. Ryan, Anna Macdonald, Brian Farrell, and Darin Abbey

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40. Cardiovascular Resuscitation: Code Simulation for Health Care Students 469
   Gloria Brummer

41. Multiple Patient Medical–Surgical Scenario 479
   Kathleen A. Gordon and Mary S. Cook

42. SIMCamp: Trauma Simulation, Rapid-Cycle Deliberate Practice Team Training 495
   Kimberly Bilskey and Leslie Catron

43. Teaching Quality, Safety, and Process Improvement Through Root Cause Analysis Simulation 513
   Jared M. Kutzin

44. Student-Generated Scenarios for Senior Simulation Day 531
   Karen M. Daley and Robin S. Goodrich

45. Assessing for Elder Abuse: The Importance of Interprofessional Collaboration 545
   Lee-Anne Stephen, Dawna Williams, and Pamela Causton

46. Post-Concussion Syndrome 553
   Doris French, Andrew Booth, Michael J. Shoemaker, Jeanine Beasley, Geraldine Jacobus Terry, Margaret Devoest, Samantha Scanlon, and Philip Van Lente

47. Integrating Telehealth in a Simulated Multidisciplinary Rural Health Simulation 563
   Rebecca J. Ventura

48. Interprofessional Team Simulation: Pediatric Rapid Sequence Intubation in Respiratory Failure Due to Severe Bronchiolitis 571
   Jeff Bishop, Maureen M. Ryan, Melissa Holland, and Emma Carrick

49. Prevention and Management of Operating Room Fires 585
   Nancy A. Moriber

50. Teaching and Learning Experiences on Safe Patient Transfers by Occupational Therapy and Nursing Students 597
   Sharon R. Flinn and Julie L. Polanic

51. Professional Integrity in Interdisciplinary Simulation: Creating Workforce Relationships in Occupational Therapy and Nursing 605
   Theresa L. Leto

52. Interprofessional Disaster Simulation 615
   Doris French, Andrew Booth, Michael J. Shoemaker, Margaret Devoest, Jeanine Beasley, and Julie A. Bulson

PART IV: THE SIMULATION JOURNEY CONTINUES

53. Learning to Write Like a Nurse in Clinical Simulations 627
   Lillian Campbell

54. How to Assess Our Own Expertise: Certification and Accreditation 635
   Leland J. Rockstraw, Rita M. Coggins, Carol R. Sando, and Jared M. Kutzin
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We have come a long way in the 4 years since the previous edition of the book. Over the past few years, in the world of clinical simulations, the pedagogy, adoption, and the science have escalated. We have a lot more to do, but we are on the right path. This book, *Simulation Scenarios for Nursing Educators: Making It Real*, is a must-buy book, particularly if you are getting started in creating and integrating clinical simulations in your nursing program. Living up to the goals and outcomes of the first and second editions, the authors have continued to develop and refine more step-by-step guidelines for nursing faculty. These guidelines enable faculty to design, develop, and implement clinical simulation scenarios in diverse settings, with diverse patients, and for different levels of students, from the novice in a fundamentals course to the student in a senior-level critical care or capstone course, to a nurse practitioner in a graduate program.

The authors have done a wonderful job of providing clinical scenarios on major health disruption topics that any nursing student would need to experience from prelicensure to graduate to doctorate. Each chapter that focuses on the clinical simulation scenario contains essential elements such as the scenario objectives, prescenario checklists, an implementation plan, evaluation criteria, debriefing guidelines, and considerations for running the scenario in the future. What more would educators want?

The organization of the book is in four main categories: (a) setting the foundation, (b) innovative nursing scenarios in diverse settings for diverse students, (c) interdisciplinary and interprofessional scenarios, and (d) simulation journey. These continue to provide information to all levels of nurse educators, from novices to those experienced in the simulation world. The authors set the stage with the first section of the book by outlining foundational points, including the groundwork around simulation theories and frameworks to help guide the educator in this area of pedagogy.

Unique to this book, and what sets it apart from other books on simulations and clinical scenarios, are the personal experiences, local and global, that the authors bring to the chapters. The authors’ passion, enthusiasm, and inspiration are truly reflected and demonstrated in each chapter. Authors talk about lessons learned, teaching strategies, and in-depth research and exploration of their topics. This book is an excellent guide for nursing faculty just getting started with simulations and is a validation for faculty who are already using this pedagogy.

Whether you are beginning on the simulation journey or just want to refine and add more to the area of clinical simulations in your own nursing program or school, you will find ideas to foster your own teaching practices that can enhance students’ learning. The authors have included their experiences on how to develop a simulation center and approaches to developing faculty for simulations to debriefing and evaluation, as well as final words of wisdom on the future of simulations. The book is comprehensive, resourceful, and a gift for nurse educators embarking on the development and implementation of clinical simulations.

Key highlights in the book include the practice application of how to develop, implement, and evaluate clinical simulations in a nursing program. The authors make understanding simulation pedagogy an easy and exciting journey; one that educators will want to try to embrace even when there is hesitation and uncertainty. Other key topics include the richness of providing knowledge, strategies, and recommendations on how to implement simulations in different types of course or clinical settings. For example, if you are in doubt about how simulations can be incorporated in a primary care setting, one chapter provides ideas, scenario objectives, and examples of how the simulation pedagogy can be used in this type of environment. The entire spectrum of courses, from fundamentals, health assessment, and medical–surgical nursing courses, to more complex levels, such as trauma resuscitation, are discussed, with authors providing specific examples, simulation scenarios that include patient information, simulation objectives, preparation lists, and other information on all necessary components to develop and implement the...
simulation successfully. Various chapters address the diverse patient population, including geriatric, pediatric, trauma, obstetric, and community-based patients, in terms of simulations that can be designed and implemented in those contexts. Finally, Chapter 55 offers a scholarly perspective on how to publish your own work in this area of pedagogy and scholarship.

Experiential learning, such as we demonstrate through clinical simulations, is the future for preparing nurses to transition into the health care arena to provide safe, competent care. As the National Council of State Boards of Nursing’s (NCSBN) large, multisite, national simulation study demonstrated (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014), the evidence is there. When student learning occurred through clinical simulations, used as a substitute for real clinical time, overall, there was a positive impact on helping students bridge the gap from theory to practice as evidenced by the research. We no longer need to ask whether simulations work, but rather to ask how we can best implement and immerse our learners in realistic clinical scenarios in safe, nonthreatening environments that prepare them to provide quality, safe patient care. As nursing leaders embrace the future of nursing education recommendations as outlined by the Institute of Medicine (2011), this book provides educators the knowledge, skills, and tools to prepare for educational reform to manage the shortage of clinical learning experiences, the lack of clinical sites, shortage of nurse educators, and the need to better prepare students for clinical decision making in a complex health care environment. This book provides practical solutions to transform clinical education. The creativity and innovation demonstrated by the authors in this third edition provide a wonderful continued journey to meeting these challenges.

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REFERENCES


PREFACE

Nursing education is situated in a unique moment in time. In what has been called the perfect storm (Hinshaw, 2008), a faculty shortage has collided with a nursing shortage, and the two have resulted in challenges for nursing educators. In addition, new generations of tech-savvy nursing students are before us in our classrooms. In the face of this challenge, nursing educators have the opportunity to create a new paradigm for teaching that reflects students’ need for interactive technology. Throughout history, nurses have always responded to crises with creativity and innovation, and the same is true today. By complementing our traditional teaching with simulation, we, as educators, are addressing our need to do more with less. In making simulation real, we can deliver our teaching in an engaging yet effective manner, thereby transforming nursing education through a simulation-based pedagogy.

It has been fascinating to observe the breadth and depth of interest in the first two editions of our text. With one editor living internationally and having contact with people from around the globe, the distinction of this third edition is the incorporation of an international perspective, a stronger section on interprofessional simulation, and authors from other disciplines outside nursing. These additions can be found in shared scenarios from Hong Kong (Chapter 15); chapters revised to include a Canadian and Brazilian context (Chapters 4, 5, 6, and 20); examples from several Canadian schools of nursing; and interdisciplinary authors from medicine, occupational therapy, physio/physical therapy, social work, allied health, and English.

This book is divided into four parts. Part I provides an introduction to simulation-focused pedagogy with an explanation and updates on the Framework for Simulation Learning in Nursing Education©. Following that is an overview of the integration of simulation into nursing curricula; an examination of teaching and assessing health communication in a simulated environment; options for building a learning resource center, including audiovisual capabilities; and the description of innovative approaches to simulation-based faculty development. New to the section, a chapter on integrating disability into nursing education with standardized patients and the use of IV simulations has been added.

Part II presents a collection of 27 exemplars, including 10 brand-new simulation scenarios for this edition and significant revisions to the others, such as addition of the INACSL Best Practice Standards: SimulationSM (International Nursing Association for Clinical Simulation in Learning [INACSL], 2016) and updated evidence-based practice guidelines. These chapters contain increasingly complex scenarios in multiple clinical areas and testimonies of practicing faculty in a variety of settings at different levels of nursing education. Part II is divided into five key areas of specialty undergraduate nursing: (a) medical–surgical; (b) obstetric and pediatric; (c) older adult; (d) thematic scenarios on cultural humility, Quality and Safety Education in Nursing, and mental health; and (e) advanced practice nurses.

The following template has been used for the chapters in Part II:

A. Discussion of implementation of simulation-based pedagogy in each contributor’s individualized teaching
B. Description of educational materials available in your teaching area and relative to your specialty
C. Specific objectives for simulation utilization within a specific course and the overall program
D. Introduction of scenario to include setting the scene, technology used, objectives, and description of participants [setting the scene and technology used; objectives; description of participants]
E. Description of the running of the scenario
F. Presentation of completed template [title; focus area; scenario description; pre-scenario set-up checklist; patient data form; evaluative criteria].

G. Debriefing guidelines.

H. Suggestions/key features to replicate or improve.

I. Recommendations for further use.

J. Discussion of simulation-based pedagogy and how this new technology has contributed to improved student outcomes.

K. Expert recommendations and words of wisdom.

L. Evaluation of best practice standards and use of credentialed simulation faculty.

References

Further Readings

In this edition, because of the increased use of simulation for interdisciplinary and interprofessional education, we have dedicated Part III to 16 scenarios with this focus; 10 are brand new. These scenarios capture many of the key themes in nursing, including ethics, spirituality, palliative care, communication, and cultural humility. They are meant to show nursing faculty that simulation development and incorporation into the curriculum are both feasible and fun. The book provides concrete information about the use of simulation in a variety of programs, courses, and schools with flexible simulator uses, including static and live actors, and low-, medium-, and high-fidelity human patient simulators (HPSs). These practical applications are for individuals who are interested in taking first steps toward incorporating simulation or for those who have begun but want to expand beyond a typical medical–surgical, intensive care, and trauma focus. INACSL’s Standards of Practice: Simulation Glossary (2016) describes skill development and clinical judgment that fits with this book’s goal to encourage the development of critical thinking, clinical reasoning, and clinical judgment, as well as to develop caring, competent, and safe practitioners who demonstrate psychomotor skills and problem-solving capabilities that lead to safe, excellent, reflective practice. Hints for suspending disbelief and “making it real” for students and faculty are incorporated throughout the book.

Part IV explores the continuing simulation journey in nursing education. Given the continued work of the coeditors with the chapter authors and faculty in their own institutions, the framework of simulation learning was updated and placed in Chapter 2 of this book to provide better context for our readers. For this new edition, the role of certification in simulation for nursing education has been updated to incorporate the changing landscape. In addition, a model for “writing across the curriculum” that focuses on how to write like a nurse in clinical simulation environments has been added by an English professor well versed in nursing simulation. Support for publishing your simulation work is provided by the editor of Clinical Simulation in Nursing, Suzan Kardong-Edgren. Lastly, Chapter 56 details the evolution of simulation and its integration in nursing curriculum and practice since the publication of the first edition of this book.

A template for creating scenarios is provided throughout the book, including the following:

- Student preparation materials, such as suggested readings, skills necessary for scenario enactment, and websites with more information, based on INACSL Best Practice Standards: Simulation (INACSL, 2016)
- Forms to enhance the reality of the scenario, such as patient data forms, patient medication forms, and assessment tools (or websites, where they can be acquired) and table exemplars for setting the scene and scenario implementation
- Checklists, such as health communication checklists to use in the creation of scenarios, evaluation criteria checklists for assessing student performance in scenarios, and debriefing guidelines

The intent is to provide faculty with a strong foundation to be able to run multiple scenarios in a variety of clinical specialties geared at different learning levels and with different learning
objectives, providing opportunities to match the scenario to essential documents (American Association of Colleges of Nursing [AACN], 2008, 2011) and competencies [e.g., NCLEX-RN® test plan (NCSBN, 2015)].

It seems only fitting that the second edition was released after the 101st birthday of “Mrs. Chase”—the soft, lightweight doll that had hand-painted, raised facial features and included stitched jointed hips, knees, elbows, and shoulders, who was both flexible and durable (Herrmann, 2008). In 1911, this first manikin arrived at the Hartford Hospital Training School for Nurses at the request of “Miss A. Lauder Sutherland, an 1891 graduate of Toronto General Hospital who was then the superintendent of nurses and the principal of the Hartford (CT) Hospital Training School for Nurses (1905–1918)” (Herrmann, 2008, p. 53).

Today, upon the release of this third edition, nurse educators mature in their use of simulation, transition from flexible/durable manikins to wireless environments, virtual simulations, and virtual reality, while evaluating the impact of simulation on patient care, safety, and quality of care as well as the return on investment. We’ve come a long way in 100 years!

This long-awaited book provides real life stories of faculty in the trenches providing the light at the end of the tunnel to the sometimes challenging, but always worthwhile, journey of simulation integration!

Suzanne Hetzel Campbell
Karen M. Daley

REFERENCES


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Thanks to the nursing faculty of Davenport University, who have realized the dream of state-of-the-art simulation facilities as a standard, not just a remote goal; and to our visionary president, Dr. Pappas, and the provost, Dr. Rinker, who led the way. This vision has allowed us to grow and spread our wings with state-of-the-art simulation facilities for all programs. Most important, thanks is expressed to the amazing faculty, staff, and students of Davenport’s College of Health Professions, who inspire us every day to be our best.

Sincere appreciation to the University of British Columbia in providing support and the colleagues in the School of Nursing and other health disciplines who share their passion for simulation and innovative teaching pedagogy. Gratitude as well to the many colleagues in the province of British Columbia and throughout Canada who have continued to share their knowledge and expertise. Finally, thanks to colleagues internationally who inspire us to continue reaching and dreaming for new ways of educating the next generation.

Suzanne is grateful for the opportunity to be on the global stage, which has convinced her of the utility of simulation, regardless of language and cultural differences, to teach the foundational “art of nursing.”

The names have changed over the years but we express our help and gratitude to the unnamed influencers of our careers, our passion for nursing, and the use of simulation in education.

Specifically for this third edition, we would like to acknowledge the work of student Paramdeep Nahal, who assisted two very busy administrators in staying on task and coordinating 56 chapters and more than 100 authors. Without her dedicated and precise work, we would not have been able to complete this edition in a timely manner with the level of attention to detail and flow that we have accomplished.

So many have helped us, wiped our weary brows, and made sure we were able to march on. We cannot possibly name them all.
PART I

Setting the Foundation for Simulation
Simulation-Focused Pedagogy for Nursing Education

Suzanne Hetzel Campbell and Karen M. Daley

THE CHALLENGE OF TEACHING IN THE 21ST CENTURY

This book is written on the basis of our personal experiences with audiences of nursing faculty regionally, nationally, and internationally who have expressed frustration, consternation, anxiety, and bewilderment about “where to start” with simulation, especially with human patient simulators (HPSs). We have been privileged to be present at the start of simulation, with the inherent frustration of explaining to administration and fellow faculty the potential and vision that this innovative learning experience can provide for nursing students.

It is our hope that the simulation scenarios and other valuable information included in this text provide nurse educators with a place to start—a template for the creation of their own broad and relevant experiences in the classroom and in clinical settings. It is paramount that we share our passion for the process and our strong belief that all faculty can contribute, at whatever level of simulation, to this process. Yes, there are gaps and challenges expressed in the literature; yes, faculty struggles to meet the new demands of this technology within the realm of faculty shortages and workload. Yet, the potential benefits to faculty and students are clear, especially by enhancing critical thinking beyond protocol and critical pathways. Often, it is an astute, expert nurse who, in noting subtle changes in a patient, enacts the kind of care that saves the patient’s life. Nurses are the front-line providers of care.

Simulation is presented by allowing for reflection on all aspects of care. The built-in debriefing period, which encourages reflection on thoughts, actions, and outcomes, also leads to better transfer of knowledge to practice and more versatile thinking processes for future application individually, in groups, and across interprofessional teams with a focus on patient-centered care. In addition, the faculty role of mentor and facilitator in this process combines faculty expertise with student innovation. It is a learning process for all, which improves methods of teaching and learning overall.

ROLE OF SIMULATION IN NURSING EDUCATION

So many changes have occurred since the first edition of this book. The scenarios and information have been shared globally and Dr. Campbell’s Academia.edu website, which contains some of the text has been viewed 4,558 times and downloaded 302 times since 2012. One of the biggest changes for simulation in nursing is that the International Nursing Association for Clinical Simulation and Learning (INACSL) has taken the lead in defining best practices, referenced as INACSL Standards of Best Practice: SimulationSM (INACSL, 2013/2016) and which includes: Standard I: Terminology
were well documented by the National League for Nursing (NLN)/Laerdal simulation study on the education of health professionals. Early in this research trajectory, the benefits of simulation for new meta-analyses and reviews of the literature continue to support the use of simulation for performance (Cook et al., 2013). Research on simulation in nursing is ongoing, and has matured to the stage where was based on past experience, tradition, and resources rather than evidence (Wellard, Woolf, & Gleeson, 2007). Research on the use of clinical laboratories in Victoria, Australia (with site visits, interviews, and curricula review), researchers found that use of the laboratories is based on past experience, tradition, and resources rather than evidence (Wellard, Woolf, & Gleeson, 2007). Research on simulation in nursing is ongoing, and has matured to the stage where new meta-analyses and reviews of the literature continue to support the use of simulation for the education of health professionals. Early in this research trajectory, the benefits of simulation were well documented by the National League for Nursing (NLN)/Laerdal simulation study.
(Jeffries & Rizolo, 2006), and current evidence has suggested that substituting simulation for clinical practice results in similar outcomes to traditional education for prelicensure nursing students (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014).

On a broader level, an administration’s procurement of the money for providing the necessary resources (faculty development, equipment purchase, building renovations, faculty time, etc.) does not transfer immediately into less faculty workload. In contrast, it often requires more investment of time and resources up front to get to the “work smarter, not harder” phase. One strategy has been to assign already overburdened lab directors with the “task” of incorporating simulation for faculty. Whether in static modules as testing before entering clinical, skill-based task training, or endpoint competency testing, the actual development and running of the scenarios is parceled out to lab staff, information technology personnel, and others. As this process may not directly involve faculty, their valuable educational and clinical expertise is more often overlooked. Another strategy allows for individual faculty to initiate simulation within their own teaching load in single courses. Faculty find this process time-consuming and complex when starting without the help or guidance of those more experienced in simulation (Nehring & Lashley, 2004). Currently, to meet this faculty knowledge gap, simulation training and/or certification has become more commonplace, for example, through the Society for Simulation in Health Care (ssih.org/certification). In addition, multiple workshops are available through conferences (www.inacsl.org), and nursing programs are including courses and certificates in advanced innovative educational methodologies, including simulation. See Chapter 54 for more information about simulation certification and accreditation.

We feel that simulation offers an innovative approach that complements and easily integrates into the existing nursing curricula, addressing the needs of a new generation of nurses and a society with increasingly complex health care needs. In order to fully appreciate the incorporation of simulation and the driving forces behind this movement, one needs to recognize that the challenges include understanding issues facing nursing education, the influence of technology on theoretical and conceptual aspects of nursing education, learning in the digital culture, and the challenge of suspending disbelief to make simulations real. In order for a transfer of knowledge to occur, the student’s role in the simulation needs to be as authentic as possible.

Some of the issues facing nursing education include the increased acuity level of patients, the nursing faculty and staff shortages, limited clinical sites, and the shifting role of the nurse. Quality and safety of patient care have become a major societal focus driving the increased accountability of nursing faculty and students to provide safe, effective, knowledgeable nurses who can function in a highly complex health care environment. Nurses are expected to demonstrate leadership skills in the coordination of patient care and safety, and even in the role of overseeing interprofessional teams that provide multifaceted care. Increasingly, nurses are expected to use their knowledge to transform health care delivery. Simulation provides an environment for the teaching and learning of interprofessional collaboration through scenarios embedded with communication, safety, delegation, critical thinking, and other important nursing program outcomes where novice nursing students can practice in a safe environment (Berndt, 2014; Fisher & King, 2013; Haskvitz & Koop, 2004; Jeffries, 2005; Jose & Dufrene, 2014; Keers et al., 2014; Radhakrishnan, Roche, & Cunningham, 2007; Zhang, Thompson, & Miller, 2011). Finally, the challenge of assessment and evaluation of student performance can go beyond skill-based assessment to include nontechnical skills, such as communication and conflict resolution, as well as more summative processes such as student growth over time, development of critical thinking, and socialization into professional nursing practice.

THEORETICAL AND CONCEPTUAL ISSUES IN NURSING EDUCATION

When viewed as a learning tool, simulation aligns well with the theoretical and conceptual foundations of nursing education. Models and frameworks have been proposed and used to help
conceptualize the role of simulation in nursing education. One such model describes a simulation protocol that was formulated by the University of Maryland School of Nursing (Larew, Lessans, Spunt, Foster, & Covington, 2006). This protocol, based on the work of Benner (1984), uses a cue-based system with escalating prompts to move students through recognition to assessment to intervention to problem resolution. Recommendations to highlight one problem at a time, allowing the scenarios to be student directed with time for processing in the pacing of the scenario, laid the foundation for further development of simulation frameworks. Jeffries and Rodgers (2007) proposed a theoretical framework for simulation from “insights gained from theoretical and empirical literature” (p. 22) on simulation in nursing and related disciplines. This eclectic approach to formulating simulation frameworks provides the basis for a holistic, flexible, and multifaceted method of integrating simulation into nursing education.

In addition to those seminal works cited earlier (Jeffries & Rodgers, 2007; Larew et al., 2006), we have considered the work of Tanner (2006) in our conceptualization of simulation. Tanner’s model of clinical judgment is relevant in simulation because a large part of it involves clinical judgment and decision making. His description of aspects of the process includes noticing, interpreting, responding, and reflecting. This model emphasizes expectations of the situation that may be implicit or explicit. A particular emphasis on reflection finds support in the recent literature, which highlights reflection as an essential element in the improvement of clinical reasoning (Tanner, 2006). In simulation, an equivalent concept is debriefing, which should include Tanner’s reflection-on-action as a synthesis of experiential knowledge resulting in the formulation of best practices. In a clinical situation, nursing students often observe and are unable to enact interventions independently. In simulation, reflection on interventions can result in a second try in a safe environment, where improved outcomes are immediately evident.

Fink (2003), another driving force in our simulation-focused pedagogy, discussed the creation of significant learning experiences. On the basis of education research, he has compiled six major dimensions to “formulate significant learning goals” (p. 75). In considering these learning goals, we have identified areas that demonstrate how simulation complements nursing education to meet program goals and outcomes. For example, the goals include (a) foundational knowledge (nursing content), (b) application (enactment of the scenario allows for use of knowledge and skills in a safe environment), (c) integration (synthesizing the science of nursing with knowledge from all disciplines—in conjunction with critical thinking, this dimension incorporates decision making and priority setting), (d) human dimension (interacting with themselves and others to form a view of who they are as nursing professionals, including opportunities for collaboration), (e) caring (the art of nursing), and (f) learning how to learn (empowering students for professional lifelong learning). The debriefing component of simulation pedagogy allows for an integration of all six major dimensions of Fink’s learning goals.

Of interest in simulation is social ecological theory (Stokols, 1996). This framework examines individual experiences and culture brought to social situations and how they impact behavioral outcomes. The social determinants of health (Wilkinson & Marmot, 2003), developed by the World Health Organization’s European division in the 1990s, incorporate social ecological theory and continue to be imbedded as a foundation for Healthy People 2020 (U.S. Department of Health and Human Services, 2000). These theoretical cores should be directly linked to simulations as they are being developed.

For example, a common challenge for nurses working in inpatient environments is the decontextualization of the patient. By this, we mean that care is being provided without an understanding of the social and physical environment or the behavioral motivators related to health of the individual patient. The result can be that patient teaching and other nursing activities done in the institution do not match the reality of the patient’s home environment. In home health care, nurses often need to reteach the patient and/or caregiver to fit the care plan to the resources available.

In simulation, not only is the context of the patient important, but educators must consider the cultural predispositions that students bring into the learning environment, which may affect behavior and the outcome of the scenario. The same is almost true within the culture of a nursing floor or unit. Clinical judgments made may be influenced by these multiple factors and need
to be considered in the culturally sensitive care of real patients. In addition, simulations can be manipulated such that the patients being cared for have a variety of cultural backgrounds, needs (including special needs of patients with disabilities or chronic and/or terminal diseases), experiences, and diverse social and environmental support systems. Including these factors enhances the simulation and learning experience for students and increases the “realness” of the scenario.

Related nursing concepts in simulation are vigilance and failure to rescue. As nursing educators, vigilance is one of the most important yet difficult concepts to teach to nursing students (Almerud, Alapack, Fridlund, & Ekebergh, 2007; Jacobs, Apatov, & Glei, 2007; Meyer & Lavin, 2005). Although introduced early in assessment courses, the evolution of vigilance as an essential function of a nurse is amenable to practice and refinement during simulation. Once taught in this setting, students become aware of the value of maintaining vigilance in actual health care settings. A consequence of failed vigilance is failure to rescue. Although unethical to practice in the clinical setting, a student who experiences failure to rescue in a simulation can follow through with reflective debriefing, reformulate a plan, carry out the new plan, and then successfully maintain vigilance. Students have reported, “never forgetting” the opportunity to “redo.” Once again, this experience adds to the development of the student’s vision of the impact of maintaining excellence in nursing care.

From the student’s perspective, there have been reports that conceptualizing the scenario through the lens of the nursing process while in the midst of a simulation is extremely helpful in producing positive outcomes. It has been frequently observed in our teaching that students, in the excitement of enacting a scenario, jump past focused assessments and begin performing interventions without data to support their decisions. Gentle coaching and reminders by the instructors alleviate this tendency.

In theorizing about technology in simulation, one may want to consider that, beyond technological fidelity, there are actually three levels of fidelity: environmental, equipment, and psychological (Fritz et al., 2007).

- **Environmental fidelity:** “The realism of the environment in which the simulation takes place” (Fritz et al., 2007, p. 2).
- **Equipment fidelity:** “Hardware and/or software realism of the simulator” (Fritz et al., 2007, p. 2).
- **Psychological fidelity:** “The degree to which the trainee perceives the simulation to be a believable representation of the reality it is duplicating” (Fritz et al., 2007, p. 2).

In nursing, we have incorporated these fidelities by making simulation as real as possible—a suspension of disbelief—so that the student interacts and participates more fully. The way space is structured to look and feel like a clinical unit, with necessary equipment, sets the scene for the simulation. In addition, events need to flow smoothly (e.g., responses from “patients” and “families”) so that the student acknowledges his or her role in meeting patient needs.

There are three goals or levels of enacting a reality-based simulation:

1. **For students:** The simulation must be believable. They must take on the role of the “nurse” and feel the responsibility for the care, assessment, and delegation necessary to meet the needs of this “real” patient. If the patient takes a turn for the worse, can students believe that their actions (or inactions) may lead to an adverse outcome for the patient (maybe even death)? In reality, we would not want them to have a life-threatening experience with a real patient in clinical; however, simulation provides a safe environment to learn skills necessary for the prevention of adverse outcomes. It is necessary to “suspend reality” and allow the students to embrace their role and act confidently with the necessary clinical reasoning to accomplish their objectives. The debriefing component of the simulation is much richer if the students self-reflect from a perspective that their actions and decisions really made a difference in the outcome of care.

2. **For faculty:** Simulation must also be believable for faculty in the sense that they can accomplish this and meet their educational goals via simulation; it is feasible, possible, and fun.
From learning theory and brain theory, faculty are encouraging the use of the right and left brain, which has been demonstrated to better embed the experience, and make the substance of what is learned more accessible or easily retrieved for use in future, varied, patient encounters (Seigel, 2007). Faculty need to feel supported in their integration and use of simulation in their courses and they need to receive the resources necessary (time, equipment, information technology [IT] support) to effectively accomplish their goals.

3. **Translation into practice**: Tapping into an emotional or psychological component for the students when learning has been demonstrated to improve memory and allow for better information retrieval. Knowledge stored is more accessible and easily tapped for use in practice in a variety of situations. Students use a synthesis of past experiences to pool best practices into actual practice.

**LEARNING IN THE DIGITAL CULTURE**

Technology in nursing education is here to stay. Today’s students learn and study in the digital culture into which they were born. Multitasking is not an issue and, in fact, seems to be the way student brains are wired. Teaching to this group, whose attention span may be less than 10 to 15 minutes, requires new and innovative approaches other than the didactic. Repetition and visual, auditory, and kinesthetic stimulation in an environment in which students can move and interact while learning provide the variety of stimuli needed.

Of course, simulation also is one method to supplement didactic teaching. As such, educator expertise is essential when incorporating simulation. It requires background knowledge of the curriculum and the ability to assess where students should be, what they are capable of, and how nursing graduates from the program function in the workforce. To provide optimal student learning experiences, changes in educational practices need to be incorporated with pedagogical principles, which in turn guide the development and implementation of simulation activities and the integration of technology (Jeffries, 2005). Simulation provides another avenue for achieving these outcome objectives. The importance of the integration of, exposure to, and mastery of technology has been confirmed and included in the revision of *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing [AACN], 2008). For its part, the NLN (2003) challenges nursing to “reconceptualize reform in nursing education” by encouraging innovative teaching practices (p. 3). For this third edition, a global perspective of nursing education competencies has been considered and is noted where available.

Simulated patients allow for standardized learning experiences. Scenarios designed by nursing educators provide for focused learning with prescribed outcomes. Student performance can be measured and documented across groups at specific points of time in important focus areas of the curriculum. Results of these measurements can be used for assessment and evaluation of progress toward curricular goals and program outcomes.

Murray, Grant, Howarth, and Leigh (2008) discussed the use of simulation for teaching and learning to support practice learning and stated that, “simulation is a strategy to enhance clinical competence” (pp. 5–6). It is used as a supplement to clinical preparation or for clinical remediation, and provides opportunities for students to practice clinical skills and interactions outside the actual patient setting. Kuiper, Heinrich, Matthias, Graham, and Kotwall (2008) concurred, stating that the results of their study show that evidence “supports the use of simulation as a source of remediation for students with clinical challenges and for an enhancement of didactic content” (p. 12). Simulation has also been shown to increase the confidence of students in a low-anxiety setting before clinical experiences (Murray et al., 2008). A recent integrative review from 17 studies reported a similar positive effect of simulation on student confidence (Boling & Hardin-Pierce, 2016), whereas Kardong-Edgren (2013) warns about how the concept of self-efficacy is used and measured in simulation education.
Simulation contributes to the development of a reflective practitioner who demonstrates better decision-making skills and superior problem-solving skills by using more creative thinking (Carter, Creedy, & Sidebotham, 2016; Edwards, Hawker, Carrier, & Rees, 2015; Eppich & Cheng, 2015; Murray et al., 2008; Rauen, 2004). Unique to simulation exercises is the debriefing period, which allows for reflection on the effectiveness of interventions and processing of alternate theories for improving outcomes. Debriefing allows for reintegration of theory, evaluation of best practice, and an opportunity to learn about error management (Rudolph, Simon, Dufresne, & Raemer, 2006). This area has been well researched since the last edition and a best practice standard has been developed (Decker et al., 2013; Dreifuerst, 2012).

We are situated in a unique time period in which the ability to use simulation fits with the issues of growing nursing faculty shortages and limited resources for student admission to programs, as well as those related to clinical or agency use. In addition, safety and quality-of-care issues increase the importance of student education in situations in which they can feel safe in providing care and transform an observational experience into a hands-on simulated learning experience.

As aptly put by Starkweather and Kardong-Edgren (2008), “The best outcomes with simulation occur when it is integrated across a curriculum, creating a challenge for academic nursing administrators, curriculum committees and faculty members who are struggling with how to incorporate simulation into, rather than on top of, already crowded curricular agendas” (p. 2). However, one must start at the beginning, and simulation often begins with one faculty member in one course. Part I of this book explores the integration of simulation within a curriculum, outlining a framework of simulation learning created by the coeditors of this book; a review of health communication; innovative approaches to faculty development, including interprofessional facilitation; building a learning resource center; the use of audiovisual solutions; patients with unique needs; and specific skills. In order to meet the needs of nurse educators who are looking for help with designing and implementing simulation, we have written and collected scenarios currently in use by seasoned faculty. It is our hope that the exemplars in Part II fuel and encourage those who are enthusiastic about integrating simulation within their nursing programs. Given the focus on interprofessional education, Part III of this third edition focuses on interdisciplinary and interprofessional scenarios with rich diversity to meet the needs of today’s nursing programs. Finally, Part IV of this book explores future directions for simulation in nursing education, including information on how to write in clinical simulations and publish your work, as well as differentiating certification and accreditation for the evaluation of your professional development needs.

CONCLUSION

Although we initially believed that the “perfect storm” was near and the survival of the profession of nursing and the outcome of health care were at risk, we recognize that it has now arrived. We are weathering through this perfect storm, but the storm persists. What is encouraging to us is that much of what was outlined in this chapter in the first edition has been strengthened by empirical data, supporting theories, and tested interventions. One such theoretical framework that was outlined in our first edition is expanded in the next chapter. In addition, best practice standards now support how we have developed, outlined, and structured this book for sharing the knowledge and expertise we have gained over the years. We strongly believe that simulation-focused pedagogy holds many rewards, but working through the challenges and the need for extra resources to incorporate it awaits us. Infusing our passion for the process and our love of teaching and learning is the goal of this book. If we can help even one faculty member enhance teaching to incorporate these ideas for interactive learning that engages and excites students, then our mission is complete.
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Teaching and Evaluating Therapeutic Communication in Simulated Scenarios

Suzanne Hetzel Campbell, Natalia Del Angelo Aredes, and Ranjit K. Dhari

Communication is the foundation for all interpersonal relationships and involves an authentic presence and facilitative style that indicates one’s interest in and care for another. In health care, an interaction between health care professionals and patients is called therapeutic communication and is operationally defined as “aims to enhance the patient’s comfort, safety, trust, or health and well-being” (“Therapeutic communication,” 2017). When therapeutic communication is done well, patients are comforted, feel safe, and develop a sense of trust in health care professionals. This contributes to improved health or sense of well-being and a safe environment with improved quality of care. Communication is necessary to build trustworthy and therapeutic relationships.

In looking for frameworks that resonate with the importance of communication, the language within the American Academy Colleges of Nursing BSN and MSN Essentials refers to communication within leadership, advocacy, telehealth, and interprofessional areas (American Association of Colleges of Nursing [AACN], 2008, 2011) and there is an acknowledgment of the importance of communication as a critical skill to be practiced and learned as part of professional nursing. However, the Canadian Code of Ethics for Registered Nurses holds references to communication in both ethical responsibilities 2 and 3 under A. Providing Safe, Compassionate, Competent, and Ethical Care:

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others’ health-care needs.
3. Nurses build trustworthy relationships as the foundation of meaningful communication, recognizing that building these relationships involves a conscious effort. Such relationships are critical to understanding people’s needs and concerns. (CNA, 2008, p. 8)

One of the main competencies health professionals are expected to master is therapeutic communication; regulators look for it in ethical codes of conduct and accrediting bodies evaluate curriculum and education looking for evidence of students’ mastery of communication, both with patients and interprofessionally. Competency in communication is an expectation of all health professionals.

Studies have suggested that communication may have direct and/or indirect effects on patients’ health, such that when patients receive clinicians’ support and clear explanations about treatment, they establish trust and better understand the next steps. This open communication facilitates the follow-up process and positively affects the health outcomes. Through effective communication, health teams work together with the patient to recognize patients’ needs and devise a suitable plan to meet those needs (Leonard, Graham, & Bonacum, 2004). Misconceptions can be identified and clarified, accommodating patients’ varying health literacy needs, leading to
Health care providers are in direct contact with patients and their families and communicate in als: physicians, nurses, nutritionists, physiotherapists, psychologists, social workers, and so on. Communication is a core competency for all nursing disciplines as well as all health professionals in their ongoing development of therapeutic communication or relationship technologies (O'Shea et al., 2013; Pagano & Greiner, 2013). This new chapter provides an overview of methods to assess and evaluate therapeutic communication by health care professionals with patients. The focus of this chapter is on the education, assessment, and evaluation of health communication skills to improve health outcomes (Bhui et al., 2015) through patient-centered care (Epstein & Street, 2007) with the use of simulation. It provides a brief introduction of the development of a new Global Interprofessional Therapeutic Communication Scale (GITCS©) and subsequent development of train-the-trainer videos for health professions educators. Many researchers and health professions educators have invested their time and resources into enhancing therapeutic communication through the use of innovative teaching and learning models, such as simulation. Their goal is to prepare health professionals in their ongoing development of therapeutic communication or relationship techniques that will create a high-quality and safe health care system that truly serves the populations in need. Ultimately, these techniques can improve patients’ experiences within the health care system—increasing patients’ understanding to maintain well-being, providing a more satisfactory interaction so patients are partners in determining their treatment and plan of care, and removing accessibility barriers, such as cultural and health literacy factors, that may create a less-than-optimal experience.

Communication skills are widely recognized as a desirable “nontechnical” skill for nurses (Lai, 2016). Mental health nurses have provided leadership in studying therapeutic communication with standardized patients (SPs; Doolen, Giddings, Johnson, de Nathan, & Badia, 2014), yet communication is a core competency for all nursing disciplines as well as all health professionals: physicians, nurses, nutritionists, physiotherapists, psychologists, social workers, and so on. Health care providers are in direct contact with patients and their families and communicate in

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team-based situations continuously, such that communication in the health care context is a main issue reflecting on quality and safety, especially in areas such as the emergency room or operating room (Shapiro et al., 2004; Theilen et al., 2013; Weaver et al., 2010). Therefore, enhancing our ability to educate prelicensure and practicing clinicians by developing methods, education tools, and evaluation or assessment capabilities is crucial.

**REVIEW OF LITERATURE: INSTRUMENTS TO SUPPORT TEACHING AND EVALUATION OF HEALTH PROFESSIONAL STUDENTS’ HEALTH COMMUNICATION**

In order to provide effective education in communication skills for health care professionals, it is necessary to move beyond conceptualization to feasible methods of implementation and measurement. Table 4.1 provides a review of the literature representing instruments that have been developed and validated to support teaching or evaluation in health communication. This recognizes the scarce resources presently available, similar to findings from a previous study (Caron et al., 2013). In addition, the International Nursing Association for Clinical Simulation and Learning (INACSL) has identified the gap in reliable and valid instruments or scales for testing, research, and evaluation in simulation, and has created a Repository of Instruments Used in Simulation Research (INACSL, 2015; Kardong-Edgren, Adamson, & Fitzgerald, 2010).

These instruments have been used to teach and evaluate therapeutic communication skills in health professionals, mostly physicians and nurses. The instruments identify important elements of therapeutic communication and include both positive and negative behaviors that influence the interaction, as well as concepts related to relationship building. Each instrument examined is attempting to systematize and measure the concept of therapeutic communication and in so doing brings to the forefront consistent themes and behaviors. These instruments all have strengths for the context in which they were used, but a global scale, adapted for different cultural contexts and translated into different languages specific to health care professional and patient communication, does not yet exist.

When considering something as simple as introductions, differences among cultures abound. For example, in certain cultures, patients may not make direct eye contact while communicating with a health care provider, which can sometimes be perceived as the patient being disinterested or disengaged; however, the patient may be quietly reflecting or might not be comfortable holding the gaze of someone of another gender. In the health care setting, a smile with eye contact is the most common and socially acceptable greeting during an introduction between health care professionals and patients. In North America, a handshake is perceived, for the majority, as a respectful and appropriate introductory greeting. Individuals from South Asian cultures would perceive a nod with no touching at all to be more respectful. In Brazil, although a handshake may be an appropriate greeting, it is perceived to be very formal and generally associated with a business environment. Apart from introductions, the health care planning process also presents a plethora of cultural differences. For example, in some cultures, it is the family who helps to devise the plan especially if the patient is living in an extended family household or the patient relies on family members to help interpret and navigate the health care system. Simulation provides a risk-free opportunity for students to learn about therapeutic communication in a culturally safe manner.

Because of globalization, nurses find themselves caring for diverse people from a variety of countries with social, cultural, and religious differences and whose interaction and expectation of health care professionals may vary widely as well. Navigating care requires advanced communication skills and a solid foundation in health care professional curriculum with an opportunity to practice, receive feedback, and reflect on best practices. Simulation is well suited for this type of experiential learning.

Therefore, after an attempt to translate one of the instruments in Table 4.1, a decision was made to start from scratch with an international team and create an instrument that would be
### Table 4.1 Instruments Used to Measure Health-Professional Students’ Health Communication

<table>
<thead>
<tr>
<th>Instrument/Authors</th>
<th>Purpose</th>
<th>Communication Elements</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCCAP (Siminoff Communication Content and Affect Program; Siminoff et al., 2011)</td>
<td>Codify situations of communication in health</td>
<td>Positive behavior: reassurance, clarification, and offer of service</td>
<td>Therapeutic communication is composed of purpose, care logistics, disease and treatment, medical history, psychosocial aspects, and prognosis</td>
</tr>
<tr>
<td>OSCAR (Objective, Structured Communication Assessment of Residents; Caron et al., 2013)</td>
<td>Teach communication skills among residents and medical students</td>
<td>These 13 items include a nonjudgmental attitude with patients, explanation of jargon, consulting the patient to guide decision making and an emphasis on organization and time management</td>
<td>Categories: relationship development, case goals, and overall organization and time management. The teacher or instructor can score the resident as unsatisfactory, proficient, advanced, and outstanding in each category, except for introduction, which is either yes/no</td>
</tr>
<tr>
<td>T-Com-Skill Scale (Baumann, Baumann, Le Bihan, &amp; Chau, 2008)</td>
<td>Measure patients’ perception of medical doctors’ therapeutic communication skills</td>
<td>This 15-item list includes: completeness of information given, attention to patient’s difficulties during treatment, adequate use of words according to patient’s health literacy and more</td>
<td>This 9-item Likert scale (from 0—never to 9—always) strongly emphasizes the medical consultation and weakly includes aspects regarding empathy, power sharing, and holistic approach</td>
</tr>
<tr>
<td>HCAT (Health Communication Assessment Tool; Pagano et al., 2015)</td>
<td>Teach communication skills to nursing students in U.S. context (application in simulation strategy)</td>
<td>This has 22 items encompassing both verbal and nonverbal communication, introductions, respectful behaviors during interaction, and holistic approach beyond biological factors. Constructs included: Empathetic, Introduction; Trust Building; Patient/Family Education; and Power-sharing behaviors.</td>
<td>The instructor rates on a 5-point Likert scale (ranging from 1—strongly disagree to 5—strongly agree, with 3—unsure); through observation of a communication scene. Five factors explained 57% of the variance, Cronbach’s α = 0.89</td>
</tr>
<tr>
<td>Competency Assessment Tool for Therapeutic Communication (National Education Framework Cancer Nursing; Aranda &amp; Yates, 2009)</td>
<td>Measure communication skills of specialist cancer nurses</td>
<td>Includes learning aspect of therapeutic communication, concern with patient privacy and input, verbal and nonverbal skills, empathy, and multidisciplinary perspective</td>
<td>Focuses on domains of professional practice, critical thinking and analysis, provision and coordination of care, and collaborative therapeutic practice. Items scored from 0 to 2, resulting in ranges of performance levels: competent (established as nurse specialist), competent (beginning as nurse specialist), and not yet competent</td>
</tr>
</tbody>
</table>

*As this chapter focuses on student–patient interactions, patient handover instruments, such as those mentioned earlier, SBAR, iDRAW, and Team STEPPSTM are purposefully not covered in this table.*
globally adaptable, reflective of a broad range of interprofessional health care professionals, and useful in academic and clinical environments. For this reason, the GITCS was developed (Campbell & Aredes, 2017).

**GITCS DEVELOPMENT**

Attempting to use one of the other communication scales proved to be very ineffective because of poor interrater reliability and difficulty translating the scales in an international environment. This led to the authors going back to examine theory and skills from mental health on “therapeutic communication.” Based on empirical knowledge from years of practicing and teaching nursing and with input from interprofessional and international colleagues from many disciplines, a 45-item scale was developed and was used in a pilot study with nine nursing faculty from seven schools in a province in Canada to evaluate student nurse communication during a simulated scenario with either a human patient simulator (HPS) or an SP. Two expert panels reviewed the items and identified constructs for each of these items (Campbell & Aredes, 2017).

This scale developed items categorized according to active listening, empathy, empowerment, verbal and nonverbal communication, rapport and trust building, barriers, and cultural boundaries, among others. The goal was to create an instrument capable of supporting faculty, students, and health professionals in learning and assessing appropriate actions to establish and maintain therapeutic communication in an international environment. The hope is that the use of GITCS will allow teachers and facilitators to identify individuals’ strengths and weaknesses easily during active learning experiences, such as simulations or interactions with patients in clinical practicums (students) or work activities (health professionals).

A recent study (Lum, Dowedoff, & Englander, 2016) stated the importance of training immigrant nurses in therapeutic communication, considering the differences in the process of nursing education and work in practice amid various countries, in addition to changes in the cultural context and, sometimes, language. Although the study arose in Canada, we believe that, given globalization, this discussion is relevant in many countries and the researchers’ findings for a need to strengthen therapeutic communication in nursing courses and strengthen self-assessment among nurses about their knowledge in communication resonates with what we have experienced.

GITCS was developed and is being validated in Canada. Validity and reliability will be tested using an international and interprofessional sample of health care professional educators who use simulation for education. A multicenter research project in a province in Canada will also test its reliability and validity across sites, level of students, and varied simulation and clinical experiences. In addition, it will be translated into French, Portuguese, Spanish, Mandarin, and Punjabi, in collaboration with colleagues in Quebec, Brazil, Chile, Hong Kong, and India, respectively. Other validation in countries where English is the main language will be possible, including the United Kingdom, Ireland, Australia, United States, and other areas with interested participants. The scale will be appropriate for use in simulated and clinical environments, with prelicensure or seasoned clinicians.

**LIGHTS, CAMERA, AND ACTION**

To set up a train-the-trainer opportunity for health care professions faculty and in order to validate the GITCS, videos were developed demonstrating interactions between an RN and a patient during a home care visit. Therefore, it was possible to test the items’ application over the same interaction presented in three different ways: overall therapeutic communication with good behaviors, overall nontherapeutic communication with poor behaviors, and mixed communication combining both good and poor behaviors.
Because of the complexity of clinical settings, we chose to film the videos in a structured environment using a trained actor and public health nurse faculty with decades of experience. The scenario involved a visit by a public health RN to an older adult at her home and was roughly scripted based on Chapter 24 in the second edition of this text (Mager, 2012).

The videos provided a level of consistency for train-the-trainer education and validation of the instruments’ reliability. In addition, the videos match teaching needs by allowing for pausing, rewinding, forwarding, and replaying anytime depending on the students’ needs. Other studies have shown positive results using videos of simulation for teaching and evaluating therapeutic communication in health care (Hammer, Fox, & Hampton, 2014).

FILMING: THE CHALLENGES OF PRODUCING AN EDUCATIONAL VIDEO

In preparation for the production of videos for train-the-trainer education, the authors used a scenario from the second edition of this text (Mager, 2012), home care of a patient with elevated blood sugars, to create a script with three modules that became three separate videos. As mentioned previously, the goal was to create modules demonstrating good, bad, and mixed therapeutic communication. The intention in creating the videos was to be able to portray sufficiently different interactions that would demonstrate good and poor therapeutic communication behaviors.

Lessons learned in creating these videos included that it would have been helpful for more of a rehearsal process before filming the videos. Scheduling conflicts meant that the faculty member was unable to meet the crew or the actress before the filming process began. In hindsight, it is important to have time allotted for the actors to meet and practice with the director’s guidance. A suggestion would be to consider including the actors in the development of the script, the production meetings, allowing ample time for discussion and questions so that they have a clear understanding of the video and its purpose. This would enhance the development of such tools and create a more beneficial learning process for all involved. When the faculty member and actress finally met, they became comfortable with each other and briefly practiced the scenarios before the filming began.

As a faculty member acting the RN role, the scenario of overall therapeutic communication with good behavior was easy to memorize and act out during production. However, it was challenging and difficult to act out the patient scenario with overall nontherapeutic communication with bad behaviors. It had become second nature to always conduct communication with patients using excellent therapeutic communication skills so that when prompted to act out scenes with bad behavior, it was challenging to speak. This made it difficult to follow the script, which was incumbent to demonstrating bad communication and meeting the goal of the video. In future, recognizing that a seasoned and expert nurse may face more challenges with the poor behavior video, we would have scheduled more time for filming that portion. We also recommend that it would have been better to film this more difficult scenario first.

These videos provided nurse educators concrete examples of good and poor behaviors and allowed for an opportunity to reflect on therapeutic communication. This opportunity for reflection allowed discussion of strategies for improved communication and methods to develop trust and rapport while being respectful and actively listening to the client’s needs. Finally, videotaped examples allowed for moving at the individual’s own pace of learning and helped to connect effective communication techniques to actual clinical practice, which can encourage students to think of examples of when communication with a patient went particularly well or particularly poorly.

In the area of instrument development, video recording can also be used as a strategy to educate faculty about the instrument’s features and uses, and can allow for beginning interrater reliability testing and enhancement.
EVALUATING THERAPEUTIC COMMUNICATION THROUGH SIMULATION

Creative and experimental strategies for learning and the adoption of more participative learning theories, in the student’s point of view, have increased alongside technology and innovation (Hammer et al., 2014). The use of simulation in teaching therapeutic health communication is successful when students are able to project themselves into a “real situation,” experiment with different approaches, debrief with a group, and know they are in a controlled environment that allows for error without life-threatening adverse events. Many studies have reported simulation use as a strategy to teach communication in the health arena and have identified favorable results (Caron et al., 2013; Fay-Hillier et al., 2012; Fejzic & Barker, 2015; Kameg, Howard, Clochesy, Mitchell, & Suresky, 2010; Strada, Vegni, & Lamiani, 2016); and as such, simulation is a valuable ally of health communication skills improvement.

When running a simulation, faculty are encouraged to observe the dynamic interaction critically by using a tool to assess various areas of therapeutic communication and positive or negative interactions. After the scenario is complete there is time to use debriefing questions to discuss with students their perception of their performance and identify what they felt good about and areas where they believe they can do better.

Learning about health communication is an important activity even for experienced professionals. One research study used simulation to train health professionals from diverse backgrounds to communicate with their patients around the topic of sexuality. Even with a mean of 11 years of experience in the clinical practice field, the participants, physicians, nurses, and psychosocial professionals consistently reported acquiring new strategies of communication to not only approach the sexuality subject, but also to explore patients’ health concerns related to sexuality. The researchers emphasized the importance of communication and relational skills, and appreciated the interactivity allowed through simulation as a pedagogical approach (Strada et al., 2016).

Simulation promotes engaging experiences of learning for adults (students, health professionals, and even professors, in the perspective of continuous learning). It naturally arouses curiosity and inquiry, providing a rich environment to develop critical thinking, clinical reasoning, and self-reflection (Hammer et al., 2014). Faculty and students observe that they like this form of “hands-on” activity and found, even if they were the observer and member of the debriefing group, they felt they had better knowledge about the team and experienced greater satisfaction in the method of learning (Fay-Hillier et al., 2012; Fejzic & Barker, 2015; Strada et al., 2016).

Studies that combined health communication skills training and simulation did have differences in preference related to the use of actors—SPs over HPSs, even with high-fidelity HPSs. Researchers stated that sometimes it is hard to interact properly with an HPS because it does not manifest nonverbal signs (Kameg, Mitchell, Clochesy, Howard, & Suresky, 2009), which are considered important in communication. In this regard, it is important to consider what is being accomplished and how you will teach and evaluate health communication skills through simulation whether the “patient” is an HPS or an SP.

Debriefing is the core of simulation as it is the moment for reflection, concept rebuilding based on simulated actions, and exchange of information with colleagues and teachers or facilitators (Decker et al., 2013). After the simulation scenario, it is crucial to discuss the effectiveness of communication with students identifying what went well and what might be improved to enhance the relationship between the health professional and the patient and their families to provide patient-centered care. Considering that most clinical experiences do not allow for clinical faculty to observe every interaction or provide feedback for students about their communication skills, simulation provides a feasible venue to build skills to mastering therapeutic communication.
FUTURE OF THERAPEUTIC COMMUNICATION

Based on our academic and clinical practice in Canada, the United States of America, and Brazil, we conclude that checklists or instruments support the debriefing process to provide useful feedback to students or health professionals, to identify completed performance, and facilitate the follow-up of skills improvement throughout the course. However, we are still lacking a robust, valid, and reliable tool to measure outcomes in health communication between professionals and patients and families, in both global and interprofessional scenarios. The researchers who used simulation to teach communication did not have this type of instrument, because they usually developed their own to conduct research or approached self-efficacy techniques to present data. Still, all of them stated that this lack of a standard measurement tool is a limitation and suggested one should be developed for future research and that it would be best to use validated instruments (Fay-Hillier et al., 2012; Fejzic & Barker, 2015; Hammer et al., 2014; Kameg et al., 2010; Kawamura, Mylopoulos, Orsino, Jimenez, & McNaughton, 2016).

Given the complexity of a faculty’s role, it is important to establish a way to evaluate health communication globally. Faculty members are responsible for complex evaluations during a simulation, including clinical reasoning, critical thinking, as well as cognitive and procedural knowledge. Therefore, a valid, reliable, and simple instrument to measure student performance would be a valuable asset.

Broadly, the flexibility simulation provided is an incentive for teachers to offer engaging learning in therapeutic communication skills training that is aligned with learning objectives and patient-centered care. This chapter describes some of the instruments and scales available today as well as an innovative new method for validating an instrument that will also be used in a train-the-trainer fashion globally.

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