American Association of Colleges of Nursing
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Care of a Decompensating Patient Simulation Scenario

Target AACN Domains, Competencies, and Sub-Competencies

Domain 1: Knowledge for Nursing Practice
1.3. Demonstrate clinical judgement founded on a broad knowledge base.
a. Demonstrates clinical reasoning.

Domain 2: Person-Centered Care
2.3. Integrate assessment skills in practice.
c. Perform a clinically relevant, holistic health assessment.
e. Distinguish between normal and abnormal health findings.

2.7 Evaluate outcomes of care.
a. Reassess the individual to evaluate health outcomes/goals.
b. Modify plan of care as needed.

2.9 Provide care coordination.
d. Recognize when additional expertise and knowledge is needed to manage the patient.

Domain 5: Quality and Safety
5.2. Contributes to a culture of patient safety.
f. Uses national patient safety resources, initiatives, and regulations at the point of care.

Domain 6: Interprofessional Partnerships
6.1 Communicate in a manner that facilitates a partnership approach to quality care delivery.
e. Communicate individual information in a professional, accurate, and timely manner.

AACN Concepts
Clinical Judgement
Communication
Compassionate Care

Scenario: Care of a decompensating patient (Post Operative Pain Management) **Level of Learner**: Senior Nursing Student/New Graduate RN	**CONTEXT** **Spheres of Care:** Regenerative or Restorative care **Concept:** Clinical Judgement, Communication, Compassionate Care **Patient:** Post-operative respiratory depression **AACN Domains:** 1, 2, 5, 6
Case Summary A 68-year-old patient just transferred from PACU to medical-surgical unit in stable condition following a right total knee replacement. After x3 doses of Morphine (in the PACU) and approx. 5 minutes following transfer to the surgical floor vital signs begin to change (trend over 5 minutes) ↓O2 sats 86%, ↓ RR 8, & shallow, ↓ LOC, groans with stimuli, ↓HR 64, ↓BP 100/60. Learners are expected to recognize deterioration, intervene with appropriate actions, escalate care by calling a Rapid Response Team, provide SBAR and work collaboratively with the RRT.	**TARGET AACN COMPETENCIES** **1.3** Demonstrate clinical judgement founded on a broad knowledge base. **2.3** Integrate assessment skills in practice. **2.7** Evaluate outcomes of care. **2.9** Provide care coordination. **5.2** Contribute to a culture of patient safety. **6.1** Communicate in a manner that facilitates a partnership approach to quality care delivery.
Scenario Objectives 1. **Recognize Cues** (clinically relevant data [↓ O2 sats, ↓ RR & depth, ↓ LOC) 2. **Analyze Cues** (Correlates cues to recent surgery and morphine doses in PACU.) 3. **Prioritize Hypotheses and establishes priority of care** (respiratory depression due to multiple doses of Morphine) **4. Generate Solutions** (Increase oxygen, continuously monitor oxygen saturation, ensure working IV, call RRT) 5. **Takes Action** (Applies face mask*, connects to continuous pulse oximetry, q 5 VS, checks IV site, calls Rapid Response Team (RRT), provide effective SBAR report to the RRT) 6. **Evaluates Outcomes** (Identifies s/s of improvements and s/s of continued deterioration and interventions)	**Sub-Competencies** • Demonstrates clinical reasoning (1.3a) • Perform a clinically relevant, holistic health assessment (2.3c) • Distinguish between normal and abnormal health findings (2.3e) • Reassess the individual to evaluate health outcomes/goals (2.7a) • Modify plan of care as needed (2.7b) • Recognize when additional expertise and knowledge is needed to manage the patient (2.9d) • Use national patient safety resources, initiatives, and regulations at the point of care (5.2f) • Communicate individual information in a professional, accurate, and timely manner (6.1e)

Prebriefing: Preparation and briefing considerations

Follow best practice outlined in Persico, L., Ramakrishnan, S., Wilson-Keates, B., Catena, R., Charnetski, M., Fogg, N., ... & Wilk, A. (2025). Healthcare Simulation Standard of Best Practice® Prebriefing: Preparation and briefing. Clinical Simulation in Nursing, 105.

Universal Considerations

- Facilitator is fully familiar with the scenario content, objectives, and expected learner actions.
- Prebrief is designed based on learner level (senior nursing student/new grad RN), learning needs, and scenario objectives.
- Prebrief plan accounts for learners' prior experience and knowledge base.

Preparation Considerations

- Suggested Prework to help learners meet objectives and succeed with activities provided prior to the simulation:
    - Assigned reading or audiovisual materials on post-op respiratory depression and opioid safety.
    - Review of oxygen delivery devices and local clinical site policies (include mask vs. NC practice).
    - Morphine pharmacology, side effects, and reversal agents (Naloxone).
    - National patient safety guidelines related to medication administration and rapid response activation.
    - Include skills review: focused respiratory assessment, vital sign interpretation, SBAR communication.
- Confirm learners have completed pre-work (consider entry requirement if possible).
- Provide time for Q&A or clarification of preparatory material before scenario starts.

Briefing Considerations

- Set the tone with expectations, logistics, and roles
    - Review scenario objectives
    - Set performance expectations (formative vs. summative emphasis).
    - Share session logistics:
        - Scenario length (~15 – 20 min)
        - Debrief process (micro-debrief vs end of scenario debrief)
        - Location of restrooms, break schedule if needed
    - Discuss confidentiality and "fiction contract" (suspension of disbelief, safe space for learning).
- Orient to Environment & Equipment
    - Introduce simulation environment (patient room, monitor, chart access).

- Orient to equipment:
    - Oxygen devices (NC, simple mask, non-rebreather)
    - IV pump & supplies
    - Rapid Response activation phone or button
    - Narcan administration setup
  - Explain any recording devices in use.
  - Review manikin capabilities and embedded participant roles.
- Establish Psychological Safety
  - Share the *Basic Assumption*™: All participants are intelligent, capable, cares about doing their best and wants to improve.
  - Reinforce respect, integrity, and trust in all interactions.
  - Encourage learners to ask questions during scenario setup.
  - Facilitator remains approachable and supportive.
- Scenario-Specific Briefing Notes
  - Clarify role assignments (primary nurse, support nurse, recorder, observer, other).
  - Provide initial patient hand-off report verbally (per scenario script).
  - Emphasize available resources (call RRT, escalate to provider, access MAR).
  - Reinforce oxygen escalation protocol and thresholds for calling RRT, specific to clinical sites

Self-Check Ready-to-Run Confirmation for Facilitator

- Preparatory materials distributed and reviewed.
- All equipment and environment set up as per case flow.
- Learners oriented and comfortable with environment.
- All confidentiality and safety agreements confirmed.
- Scenario timing and debrief plan finalized.

Initial Hand Off Report

Situation
It is 11am, and you are the RN on the Surgical floor who has just accepted a patient from the PACU.

Background
The patient is a 68-year-old female who has a right total knee replacement. No complications noted from OR.

Assessment

- The patient has no known allergies and is “full code” status. Wt. 65kg Ht. 5’ 5’’
- VS: Heart Rate: 72 sinus rhythm (Pre-op - 82 Sinus Rhythm). BP 120/75 (Pre-op – 140/80), SPO2 97% in 2L O2 via NC, Temperature 98°F

- Respiratory Rate 12, no sign of distress. Patient has a cough reflex.
- Level of consciousness: the patient is drowsy but responds to verbal commands.
- Perfusion: Warm extremities CRT < 2 seconds, 2+ pulses
- Urine output: 50 ml/hr. during surgery (Foley catheter insitu)
- Wound assessment & drainage: 6-inch incision to right knee, clear dressing no oozing, drainage 50 mls during surgery. Hemovac drain insitu minimal drainage observed.
- Pain 2/10 **4mg dose given at 10:45am** (*Of note, but <u>not</u> included in report - Morphine administered x3 in PACU (Doses given: 2mg IV at 9:50am, 4mg IV given at 10:15am, Patient still in pain so 4mg dose repeated at 10:45am)*

Other medications administered in PACU.

- Cefazolin IVPB 1 gm every 8 hours x2 doses (the first does has been given in PACU @ 10:30am)
- Ondansetron 4mg IV every 6 hours as needed for nausea/vomiting (first dose given 10:45am)

Post Operative Orders include:

- Post operative vital signs with pulse oximetry every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 4 hours.
- Neurovascular checks every hour for 4 hours, then every 4 hours for 24 hours.
- *Oxygen via nasal canula (2-6L/m) or simple face mask (5-8L/m) to maintain oxygen saturations greater than 92%
- Intake and output: Every 4 hours for 24 hours.
- IV Normal Saline 0.9% 125ml/hr. for 4 hours.
- Diet: Clear liquid initially, advance as tolerated
- Observe dressing for bleeding/drainage.
- Medication: Morphine 2-4 mg IVP as needed (Max dose 8mg every 2 hours): Cefazolin IVPB 1 gm every 8 hours x2 doses (the first does has been given in PACU): Ondansetron 4mg IV every 6 hours as needed for nausea/vomiting: Deep Vein Thrombosis Prophylaxis (Pharmacy to dose)
- Active flexion of foot every 1 hour while awake: Continuous passive motion (CPM) devise: Early ambulation with knee immobilizer.

Notify Physician if:

- SBP greater than 180 or less than 90
- DBP greater than 100 or less than 60
- If Urine output less than 30ml/hr.
- If wound drainage is greater than 200-400/first 24 hours

Recommendation

- Meet the patient and provide post operative management.

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*Clinical sites have differing policies and procedures regarding the use of simple face masks. In some clinical sites simple face masks are not recommended or stocked due to if applied with less than 6L, the risk of CO2 build up and procedures require that if Oxygen saturations do not improve with NC at 4L then move to a non-rebreather mask. Review Oxygen delivery devices in pre-work and/or pre-brief specific to clinical sites in the region.

Case Flow			
Initiation of Scenario (11am – Surgical Floor) Patient in bed – "hand-off" report at bedside VS: HR 72, BP 120/75, RR 12, SPO2 is 97% in 2LO2 via NC, no signs of distress, drowsy but responds to commands, Temp 98F, arm to touch, CRT <2 secs x4. Reported pain level "2/10" after 3 doses of IV Morphine (*Note this information was not given in report and is in the medication administration record: Doses given: 2mg IV @ 9:50am, 4mg IV given at 10:15am, Patient still in pain so 4mg dose repeated @ 10:45am))*. IV infusion at 125 ml/hr.	→→	**First Frame** Patient is responsive at first. The learner introduces self and co-workers, performs hand hygiene, identifies the pt with 2 forms of ID, checks for allergy band here and begins assessment. 5 minutes into the scenario vital signs begin a decompensation trend over 5 minutes: ↓ O2 sats 86%, ↓ RR 8 & shallow, ↓ LOC, groans with stimuli, ↓HR 64, ↓BP 100/60. Snoring respirations start.	→→
Second Frame: Learner recognizes change in patient condition. Learner checks orders: Changes O2 from NC to mask*, ↑O2 flow rate Learner reassesses patient (decompensation tend continues until ↓ O2 sats 86%, ↓ RR 8 & shallow, ↓ LOC, groans with stimuli, ↓HR 64, ↓BP 100/60) Pupils are pinpoint. Learner Calls for help (Rapid Response Team RRT), Learner gives SBAR to RRT	→→	**Third Frame** Naloxone (Narcan) 0.4 mg IV push per provider order with flush administered. Following Narcan the patient becomes increasingly agitated. Improvement trend over 2-3 minutes ↑O2 sats 96%, ↑RR 16, ↑HR 84, ↑BP 125/78 The learner reassesses the patient after Narcan administration, and assesses pain level	→→
Scenario End Point Learner reassesses and patient is stable.	→→	***Debrief and coaching toward competency***	

Debriefing Considerations

Follow best practice outlined Decker, S., Sapp, A., Bibin, L., Chidume, T., Crawford, S. B., Fayyaz, J., ... & Szydlowski, J. (2025). Healthcare Simulation Standards of Best Practice®: The Debriefing Process. Clinical Simulation in Nursing, 105.

Adjust your debrief strategies in this scenario based on the learner's stage of competency development. For learners in the early stages of developing specific competencies featured in the scenario, consider using a structured micro-debrief with a coaching tool and replaying key sections for practice. For learners who have already had multiple opportunities to develop those competencies, a full debrief at the end of the scenario may be more appropriate.

Micro-debrief considerations (For learners in the early stages of developing specific competencies)

Micro-debriefing provides a great opportunity for competency formation. Short debriefing inside the simulation focuses on immediate feedback and reflection on specific aspects of the scenario or performance and allows for quick course corrections and adjustments.

- Pause when you notice any of the following:
    - A learner misses or misinterprets important data.
    - A key decision point arises (e.g., whether to escalate care, administer medication, or re-assess).
    - A communication breakdown occurs (unclear SBAR, missed handoff detail, miscommunication with team).
    - There's a clear opportunity for coaching to support an early-stage competency (as identified in prebrief).

Prompt questions/statements to ask/state when the scenario is paused

- Let's pause here for a quick reflection
- Tell me what's happening right now with your patient.
- What other assessments could give you more information here?
- What are your next steps?

After the pause resume with "Okay, let's resume from …. *identify where you will pick the scenario up from"* (or a similar statement)

Possible Pause Cues with focus prompt questions (Aligned with specific sub competencies)

1. Early Deterioration Recognition *(End of Frame 1 / Beginning of Frame 2)*

Pause if the learner does not identify the patient's declining oxygen saturation, respiratory rate/effort, or change in level of consciousness as abnormal for the situation.

- What do you notice about the patient's oxygen saturation and breathing?

- How do these findings compare to what you would expect for this patient at this stage?

  AACN Sub-Competency Link

  - 2.3c – Perform holistic, relevant health assessment
  - 2.3e – Distinguish normal vs. abnormal findings

2. Linking Cues to Clinical Context *(Frame 2 – After Vital Signs Decline)*

Pause if the learner does not connect changes in vital signs and level of consciousness to recent opioid administration and post-operative status.

- What possible causes could explain these changes in vital signs and LOC?
- How might the patient's recent medications be influencing their condition?

AACN Sub-Competency Link

- 1.3a – Apply clinical reasoning
- 2.3e – Recognize abnormal findings in context

3. Oxygen Escalation Decision *(Frame 2 – After Deterioration Recognition)*

Pause if the learner does not initiate appropriate oxygen therapy escalation (e.g., from nasal cannula to mask/non-rebreather) in response to worsening respiratory status.

- What options do you have for increasing oxygen delivery?
- What would be the safest choice for this patient right now, and why?

AACN Sub-Competency Link

- 2.7b – Modify plan of care
- 5.2f – Apply patient safety regulations

4. Rapid Response Activation *(Frame 2 – Ongoing Deterioration)*

Pause if the learner delays or omits calling the Rapid Response Team when the patient's condition fails to improve or continues to decline.

- What criteria would trigger a Rapid Response Team call in this situation?
- How could involving additional expertise benefit the patient right now?

AACN Sub-Competency Link

- 2.9d – Recognize when additional expertise is needed
- 5.2f – Use patient safety resources

5. SBAR Communication *(Transition to Frame 3)*

Pause if the learner cannot clearly organize or communicate the patient's current condition, background, assessment, and recommendation to the RRT.

- Can you walk me through your SBAR for this situation?
- What key points must be included to ensure accurate handover?

AACN Sub-Competency Link

- 6.1e – Communicate individual information professionally and accurately

6. Post-Intervention Reassessment *(Frame 3 – After Naloxone Administration)*

Pause if the learner does not reassess oxygenation, respiratory effort, mental status, and pain level following intervention.

- What changes do you expect to see after this intervention?
- What parameters will you monitor to evaluate the patient's response?

AACN Sub-Competency Link

- 2.7a – Reassess to evaluate outcomes
- 1.3a – Apply reasoning to determine next steps

7. Recognizing Improvement or Ongoing Risk *(End of Frame 3)*

Pause if the learner does not identify signs of improvement or fails to recognize lingering risks that require ongoing monitoring.

- What signs tell you the patient is improving?
- What risks remain, and how will you address them?

AACN Sub-Competency Link

- 2.7a – Evaluate outcomes of care
- 2.7b – Modify plan of care

Full debrief at the end of the scenario considerations (For learners who have already had multiple opportunities to develop specific competencies)

The following questions are suggestions for questions that could be used in the ***analysis*** phase of the debrief and are linked to specific sub-competencies in the scenario. It is designed to promote learner reflection, reinforce competency development, and support facilitator consistency.

1. Clinical Reasoning & Cue Recognition

- What were the first signs you noticed that made you think something was wrong?"

  Potential follow up questions

  - How did you decide which changes in the patient's condition were most urgent?
  - If you could rewind to the start of the deterioration, would you have done anything differently?

  AACN Sub-Competency Link

  - 1.3a – Demonstrates clinical reasoning

2. Holistic Assessment

- What assessment findings were most helpful in forming your plan of care?

  Potential follow question

- Were there any assessments you wish you had completed earlier?
- Why?

AACN Sub-Competency Link

- 2.3c – Performs a clinically relevant, holistic health assessment)

3. Identifying Normal vs. Abnormal Findings

- Which findings were abnormal to you in this case?

Potential follow up questions

- Were there any findings you initially thought were normal but later realized were concerning?

AACN Sub-Competency link

- 2.3e – Distinguish between normal and abnormal health findings.

4. Reassessment & Outcome Evaluation

- After interventions, how did you know whether the patient was improving?

Potential follow up questions

- What trends or changes did you track over time to make decisions?
- What might you monitor more closely if this patient continued in your care?

AACN Sub-Competency link

- 2.7a – Reassesses to evaluate outcomes

5. Modifying Plan of Care (2.7b)

- Did you change your plan of care during the scenario?

Potential follow up question

- What information or feedback guided you to modify your approach?

AACN Sub-Competency link

- 2.7b – Modify plan of care as needed.

6. Escalating Care

- At what point did you decide additional help was needed?

Potential follow up question

- What information did you use to justify calling the Rapid Response Team?
- How might you approach escalation differently in future situations?

AACN Sub-Competency link

- 2.9d – Recognizes when additional expertise is needed

7. Patient Safety Practices

- What safety measures did you consciously apply during this case?

Potential follow up question

- Were there any safety protocols you could have used but didn't?

  AACN Sub-Competency link

  - 5.2f – Uses national patient safety resources, initiatives, and regulations at the point of care

8. Professional Communication

- How confident did you feel in your SBAR handoff?

  Potential follow up question

  - What was the most challenging part of communicating during the scenario?
  - What strategies will you use to keep your communication clear and concise under pressure?

    AACN Sub-Competency link

    - 6.1e – Communicates individual information in a professional, accurate, and timely manner

Progression indicators

Sub-competency	Developing	Developed
Demonstrate clinical reasoning (1.3a)	Identify key patient problems and articulate the nursing knowledge and logical steps for clinical decisions. Recognize gaps in knowledge that affect clinical decisions and use appropriate resources to support sound clinical judgements during clinical rotations or simulations.	Re-prioritize patient problems based on changes in the patient's condition and severity, initiating appropriate interventions promptly to prevent complications and improve outcomes during clinical practice. Develop and revise a comprehensive patient plan of care, incorporating a critical analysis of changes in the patient's condition, integrating new clinical information, and adjusting interventions to optimize patient outcomes.
Perform a clinically relevant, holistic health assessment (2.3c)	Identify and prioritize assessments addressing the patient's immediate needs and presenting symptoms. Collect subjective and objective data to support clinical decision-making.	Apply clinical judgement to determine assessment sequencing and urgency. Adjust assessment priorities in real-time based on clinical judgement and patient feedback. Prioritize assessments based on the patient's immediate needs and presenting symptoms.
Distinguish between	Recognize and analyze normal	Identify patterns in abnormal

normal and abnormal health findings (2.3e)	and abnormal health findings. Consult clinical guidelines and evidence-based resources to verify deviations from normal findings. Differentiate between findings requiring urgent versus routine follow-up and communicate appropriately with healthcare team members.	findings and correlate them with potential underlying conditions. Use abnormal findings to prioritize interventions and refine care plans. Synthesize normal and abnormal findings in relation to the patient's disease process.
Reassess the individual to evaluate health outcomes/goals (2.7a)	Conduct routine reassessments to evaluate progress toward health goals. Compare current findings with baseline data to identify changes in the individual's condition. Share reassessment results with the healthcare team to facilitate coordinated evaluation and decision-making.	Integrate physical, emotional, social, and cultural factors into reassessments to comprehensively evaluate health outcomes. Synthesize patterns and trends in reassessment data, linking them to the effectiveness of interventions.
Modify plan of care as needed (2.7b)	Identify necessary adjustments to the plan of care based on feedback from the patient and team members. Propose changes based on clinical guidelines and emerging patient needs. Engage the individual in discussions about plan of care adjustments to align with their preferences and values.	Collaborate with the interdisciplinary team to ensure care plan modifications are holistic and evidence-based. Provide a clear, evidence-supported rationale when modifying the care plan in discussions with the team or patient.
Recognize when additional expertise and knowledge is needed to manage the patient (2.9d)	Acknowledge when additional expertise is required and seek assistance as needed.	Utilize available resources and services to access the necessary expertise.
Use national patient safety resources, initiatives, and regulations at the point of care (5.2f)	Reference relevant national patient safety guidelines and resources in clinical discussions. Apply knowledge of patient safety	Utilize current evidence-based patient safety guidelines and regulations. Integrate national patient safety resources into daily clinical

	regulations to clinical practice.	practice.
Communicate individual information in a professional, accurate, and timely manner (6.1e)	Document and share information using standardized communication tools concisely and respectfully within required timeframes.	Contribute concise, accurate information in a professional manner to facilitate timely decision-making and continuity of care.

Progression-Based Simulation: Tailoring Scenarios for Developing vs. Developed levels (Scenario I vs Scenario II)		
Element	Scenario I	Scenario II
Scenario Title	Recognizing and Responding to Respiratory Deterioration	Post-Op Respiratory Distress: Independent Response
Purpose	To develop clinical judgement, cue recognition, and appropriate actions through guided practice	To demonstrate clinical judgement in prioritizing and managing acute deterioration through cue recognition and timely action.
Setting	Medical-surgical unit (receives handoff, signs of decompensation, escalates care to call RRT and prepares SBAR)	Same setting and case—no interruptions or prompts, delivers SBAR and continues to care for patient when RRT arrives
Learner Level	Senior nursing students / new grad RNs	Senior nursing students / new grad RNs
Patient Condition	Post-op TKR, recent morphine use, vitals trending down	Same patient, condition progresses similarly but more rapidly
Cue Changes	Slow vitals change (RR ↓, O2 sat ↓, LOC ↓), with prompts	Same cue set, but no faculty guidance unless safety is compromised
Facilitator Role	Active coaching, pause-and-reflect, micro-debriefs	Observer only—no coaching; evaluates independently
Assessment Focus	Formative practice of cue recognition, SBAR prep, escalation steps	Independent execution of assessment, interventions, SBAR, outcome evaluation
Debriefing Approach	Structured micro-debrief using coaching tool, full debrief after scenario. Repeats sections identified as opportunities for improvement	Full debrief after scenario ends
Evaluation Tool	Coaching Rubric (Developing Level)	Coaching Rubric (Developed Level)

Coaching Rubric

Faculty Quick Guide: Coaching Rubric

This coaching rubric is a formative; developmental tool used during simulation with senior nursing students and new graduate RNs. It is not punitive or summative. The rubric supports coaching, reflection, and progressive skill development aligned with the learner's stage of competence.

Performance levels reflect a continuum of development (*Developing → Developed*). Learners are not expected to demonstrate developed-level performance across all competencies in a single scenario. Variation in performance is expected and valued as part of learning.

Faculty use the rubric to:

- Identify strengths and growth areas
- Guide coaching or micro-debriefing
- Support reflective discussion during debrief
- Track progression across repeated simulations

Learner Transparency (Faculty Reminder)

Learners should be introduced to the rubric ***prior*** to the simulation. Sharing the rubric:

- Clarifies expectations
- Supports self-assessment
- Frames simulation as developmental, not evaluative

Suggested language:

"*This rubric is not a grade or pass/fail tool. It helps guide reflection, feedback and support your development*."
"*You're not expected to be 'developed' in every area—progress happens over time*."

Framing the Levels

- *Developing*: Learning in progress; guidance expected
- *Developed*: More consistent, independent performance

"Where you land today guides coaching—not your capability as a nurse."

Using the Rubric in Debrief

- Invite self-reflection first
- Anchor feedback to observable behaviors
- Focus on next steps and progression

Coaching Rubric			
Competency	Not Demonstrated	Developing	Developed
Demonstrates clinical reasoning (1.3a)	Does not identify relevant clinical cues or link them to the patient's condition.	Recognizes some relevant cues; may need guidance to prioritize or take appropriate actions.	Accurately identifies key problems, prioritizes effectively, and initiates appropriate clinical decisions with rationale.
Performs a clinically relevant, holistic health assessment (2.3c)	Incomplete or delayed assessment; misses key systems or fails to reassess.	Conducts basic assessment; may miss subtleties or lack timely prioritization.	Performs thorough, prioritized assessment tailored to patient's needs and context.
Distinguishes between normal and abnormal findings (2.3e)	Fails to differentiate abnormal from expected findings.	Identifies some abnormal findings but may need help interpreting clinical relevance.	Clearly distinguishes abnormal findings and correlates with potential causes.
Modifies plan of care as needed (2.7b)	Does not recognize the need to change care plan or delays adjustments.	Proposes basic changes; may require guidance to align with clinical evidence.	Initiates appropriate changes based on evolving patient condition and best practices.
Reassesses the individual to evaluate outcomes (2.7a)	Fails to reassess or monitors ineffectively after intervention.	Reassesses but inconsistently integrates data into decision-making.	Routinely reassesses and uses data to evaluate intervention effectiveness and next steps.
Recognizes need for additional expertise (2.9d)	Does not call for help or delays escalation of care.	Recognizes deteriorating condition but may delay escalation.	Promptly seeks additional support (e.g., calls RRT) when condition worsens.
Communicates effectively (6.1e)	Provides incomplete, disorganized, or inaccurate information.	Communicates essential information but may miss key details or need structure.	Uses SBAR or equivalent to deliver clear, concise, timely communication.

Observation Tool for Decompensating Patient Simulation

This observation tool is designed to actively engage observers during the simulation and to support meaningful discussion during debrief. It may be used by faculty as an alternative to the coaching rubric and by students in observer roles to guide focused observation of clinically relevant behaviors. By directing attention to cue recognition, clinical judgement, communication, and escalation of care, the tool promotes deeper learning and more intentional participation in debrief. ***This tool is formative and developmental and is not intended for evaluation or grading.***

Observed Behavior	Observed (✓)	Comments
Identifies abnormal vital signs and changes in LOC promptly.		
Links clinical cues (e.g., morphine use, surgery) to current condition.		
Performs focused post-op respiratory assessment.		
Adjusts oxygen delivery appropriately based on patient's condition.		
Calls Rapid Response Team in a timely manner.		
Prepares and delivers a complete SBAR report.		
Reassesses patient after intervention (e.g., Narcan administration).		
Recognizes patient improvement or ongoing deterioration.		
Collaborates with team members to coordinate care.		
Demonstrates confidence and clarity during communication.		

(Original Scenario developed by Gilbert, M., Durham, C., Kardong-Edgren S., November 2023)