Care of a Patient with COPD Exacerbation
Simulation Scenario

Target AACN Domains, Competencies, and Sub-Competencies

Domain 1: Knowledge for Nursing Practice
1.3. Demonstrate clinical judgment founded on a broad knowledge base.
c. Incorporate knowledge from nursing and other disciplines to support clinical judgment.

Domain 2: Person-Centered Care
2.1. Engage with the individual in establishing a caring relationship.
a. Demonstrate qualities of empathy.
b. Demonstrate compassionate 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 6: Interprofessional Partnerships
6.1. Communicate in a manner that facilitates a partnership approach to quality care delivery.
b. Use various communication tools and techniques effectively.
e. Communicate individual information in a professional, accurate, and timely manner.

Domain 9: Professionalism
9.1 Demonstrate an ethical comportment in one's practice reflective of nursing's mission to society.
d. Change behavior based on self and situational awareness.
9.2. Employ participatory approach to nursing care.
g. Communicate in a professional manner.

AACN Concepts
Clinical Judgment
Communication
Compassionate Care

Scenario: Care of a patient experiencing COPD exacerbation **Level of Learner**: PRELICENSURE; JUNIOR (IDEAL FOR SIM ZONE 1)	**CONTEXT** **Spheres of Care:** Regenerative or Restorative care, Chronic Illness **Concept:** Clinical Judgement, Communication, Compassionate Care **Patient:** COPD exacerbation **AACN Domains:** 1, 2, 6, 9
Case Summary A 72-year-old male with a history of COPD, is admitted to the medical-surgical unit for worsening shortness of breath and increased productive cough. On arrival to the unit, his oxygen saturation is 87% on room air, respiratory rate is 28, and he is using accessory muscles. Learners will enter the room as primary/support nurses. They must initiate assessment, apply oxygen, and contact the provider with a clear SBAR. The student must remain accountable for all tasks, including documentation and patient safety, while working within their scope of practice.	**TARGET AACN COMPETENCIES** **1.3** — Demonstrate clinical judgment founded on a broad knowledge base. **2.1** — Engage with the individual in establishing a caring relationship. **2.3** — Integrate assessment skills in practice. **2.7** — Evaluate outcomes of care. **2.9** — Provide care coordination. **6.1** — Communicate in a manner that facilitates a partnership approach to quality care delivery. **9.1** — Demonstrate an ethical comportment in one's practice reflective of nursing's mission to society. **9.2** — Employ participatory approach to nursing care.
Scenario Objectives 1. **Recognize Cues** (clinically relevant data [⁻ O2 sats, RR & depth, cough)	**Sub-Competencies** • Incorporate knowledge from nursing and other disciplines to support clinical judgment (1.3c).

2. **Analyze Cues** (Correlates cues to history of COPD.) 3. **Prioritize Hypotheses and establishes priority of care** (COPD exacerbation; priority is airway/breathing) 4. **Generate Solutions** (Increase oxygen, continuously monitor oxygen saturation, call provider, respiratory therapy) 5. **Takes Action** (administer oxygen and medications) 6. **Evaluates Outcomes** (Identifies s/s of improvements and interventions)	• Demonstrate qualities of empathy (2.1a). • Demonstrate compassionate care (2.1b). • 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 various communication tools and techniques effectively (6.1b). • Communicate individual information in a professional, accurate, and timely manner (6.1e). • Change behavior based on self and situational awareness (9.1d). • Communicate in a professional manner (9.2g).

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

- The facilitator is fully familiar with the scenario content, objectives, and expected learner actions.

- Prebrief is designed based on learner level (prelicensure/junior nursing student), learning needs, and scenario objectives.

- Prebrief plan accounts for learners' prior experience and knowledge base.

Preparation Considerations

- Suggested pre-work to help learners meet objectives and succeed with activities provided prior to the simulation:

  o Assigned reading or audiovisual materials on COPD and therapeutic communication.

(Original template developed by Gilbert, M., Durham, C., Kardong-Edgren S., November 2023; COPD scenario developed by Alderman, J. & Price, C., August 2025.)

- - - Review of oxygen delivery devices and local clinical site policies (include mask vs. nasal cannula practice).
    - Pharmacology related to bronchodilators and corticosteroids
    - National patient safety guidelines related to medication administration
    - Include skills review: focused respiratory assessment, vital sign interpretation, SBAR communication.
- Confirm learners have completed pre-work (consider entry requirement if possible).
    - Possible entry-ticket: reflective journaling prompts: *Describe a time you felt uncomfortable in a clinical situation. How did you respond? What would you do differently now?*
    - Possible entry-ticket: low-stakes quiz related to respiratory assessment/COPD
- 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 and timing (20–40 min; consider 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
        - Method of contacting provider (phone, text, electronic health record)
        - Medication administration setup/supplies
    - Explain any recording devices in use.
    - Review manikin capabilities and embedded participant roles.

- Establish Safe Container
  - Share the *Basic Assumption™*: All participants are capable, want to improve, and will engage in good faith.
  - Reinforce respect, integrity, and trust in all interactions.
  - Normalize feelings of nervousness and emphasize the importance of curiosity over perfection.
  - Note that this is a safe space and mistakes are expected as part of learning.
  - 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 (consider respiratory therapist)).
  - Provide initial patient hand-off report verbally (per scenario script).
  - Emphasize available resources (call provider and/or respiratory therapy, access MAR).
  - Reinforce oxygen escalation protocol, specific to clinical sites.
  - Reinforce team communication and empathy.
  - Emphasize that shared learning builds professional identity.

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

S – Situation:
 This is a 72-year-old male admitted with COPD exacerbation. He is short of breath at rest, with O_2 sat 87% on room air. He is not sure, why is he is not feeling well. He thinks it may be the recent change in the weather.

B – Background:
History of COPD, hypertension, hyperlipidemia. Quit smoking 5 years ago. Productive cough with yellow sputum x 3 days.

A – Assessment:
RR 28, labored; HR 104; BP 152/88; T 99.1°F. Wheezing heard bilaterally, diminished breath sounds at bases. O$_2$ sat 87% RA.

R – Recommendation:
Request order to initiate oxygen therapy, continue nebulizer treatments, and consider IV steroids. No orders have been written for additional medications

Admission Orders include:
- Vital signs with pulse oximetry every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 4 hours.
- Intake and output: Every 4 hours for 24 hours.
- Diet: Low sodium
- Activity: Fall precautions
- RT: Continuous pulse oxygenation monitoring
- Incentive Spirometry Q 1 hour while awake

Lab Results:
- ABG pH 7.32, PaCO2 55, PaO2 68 (respiratory acidosis)
- Chest XR: Hyperinflated lungs consistent with COPD
- CBC: WBC 13.2, Hgb 14.1, (mild leukocytosis, possible infection)
- Sputum culture pending (could be collected during simulation if skill practice needed)

Notify Provider if:
- Oxygen saturation is less than 90%
- Labored breathing, confusion or sedation

*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 retention, simple face masks are not recommended 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.

COPD REFERENCE: GLOBAL INITIATIVE FOR CHRONIC OBSTRUCTIVE LUNG DISEASE. (2026). HTTPS://GOLDCOPD.ORG/2026-GOLD-REPORT-AND-POCKET-GUIDE/

Case Flow			
Initiation of Scenario (Admission to Med-Surg unit) Patient in bed – "hand-off" report at bedside VS: HR 104, BP 152/88, RR 28, SPO2 is 87% on room air, Temp 99.1F, dyspnea with conversation, use of accessory muscles to breathe, Bilaterally wheezing and diminished breath sounds prolonged expiratory phase	->	**First Frame (Time: 0005-0010) (LO #1)** Patient is responsive. 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, pt expresses increased shortness of breath; SPO2 remains less than 90%; manikin or standardized patient showing signs of fatigue, pt demonstrating a productive cough	->
Second Frame (0010-0015): (LO's #2, #3, #4) Learner recognizes change in patient condition. Learner checks orders and notes that O2 sat is	->	**Third Frame (0015-0020) (LO #5)** Learner administers ordered medications. Patient is coughing more frequently, SPO2 improves to 91% on 2 L NC and appears relieved with less use of accessory muscles and as, and appears relieved with less use of accessory muscles and asks, "is this normal?" "what happened?" Learner provides	->

less than parameter in orders; need to call provider for additional orders. Note: orders should be based on current evidence.The citation for GOLD guidelines is included above.		education on medications, and oxygen.	
Scenario End Point (LO #6) The orders are implemented correctly. Learner reassesses lung sounds and VS, patient is stable. The learner documents care and scenario ends when learner states they would continue to monitor the patient's status.	**-**	*Debrief and coaching toward competency*	

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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?
  - Okay, let's resume from ….*identify where you will pick the scenario up from*

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

1. Managing Anxiety as a New Nurse in a Potentially Deteriorating Situation *(First Frame)*

Pause if the learner is showing signs of anxiety or indecision in general.

- How are you feeling right now in the simulation?

- What do you know about the nursing process? Where would you start?

AACN Sub-Competency Link

- 9.1d – Change behavior based on self and situational awareness.

2. **Building Trust and Psychological Safety for the Patient** *(Frame 1/When First Assessing the Patient)*

Pause if the learner does not validate or acknowledge subjective data.

AACN Sub-Competency Link

- 2.1a – Demonstrate qualities of empathy.

- 2.1b – Demonstrate compassionate care.

3. **Early Recognition of Respiratory Difficultly** *(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 subjective data

- 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 given his history? (learner should recognize presentation of COPD exacerbation)

AACN Sub-Competency Link

- 1.3c – Incorporate knowledge from nursing and other disciplines to support clinical judgment.

- 2.3c – Perform holistic, relevant health assessment

- 2.3e – Distinguish normal vs. abnormal findings

4. **Accountability for Initiating Timely Interventions** *(Frame 2 – After Call to Provider)*

Pause if the learner does not initiate appropriate oxygen therapy escalation 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?

- Why is oxygen therapy prioritized before medication administration?

- What risks are associated with giving too much oxygen in COPD?

o What other medications may be indicated after the initial round of priority meds?

AACN Sub-Competency Link

- 2.9d – Recognize when additional expertise and knowledge is needed to manage the patient.
- 6.1b – Use various communication tools and techniques effectively.
- 6.1e – Communicate individual information in a professional, accurate, and timely manner.

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 provider.

o Can you walk me through your SBAR for this situation?

o What key points must be included to ensure an accurate report?

AACN Sub-Competency Link

- 9.2g – Communicate in a professional manner.

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

Pause if the learner does not reassess oxygenation, respiratory effort, patient's psychosocial affect.

o What changes do you expect to see after this intervention?

o What parameters will you monitor to evaluate the patient's response?

o What would you do if oxygen therapy did not improve saturation?

o How could interprofessional collaboration improve outcomes here?

AACN Sub-Competency Link

- 2.7a – Reassess the individual to evaluate health outcomes/goals

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.

o What signs tell you the patient is improving?

o 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. Reactions?

#1 Cue Recognition

- (Gather) What were the first assessment data/signs you noticed that made you think you needed to intervene?

  Potential follow-up questions

  o How was the patient handling the situation?

  o How did you decide which changes in the patient's condition were most urgent?

  o If you could rewind to the start of the exacerbation, would you have done anything differently?

  AACN Sub-Competency Link

    - 1.3c – Incorporate knowledge from nursing and other disciplines to support clinical judgment.
    - 2.1a – Demonstrate qualities of empathy.
    - 2.1b – Demonstrate compassionate care.
    - 9.1d – Change behavior based on self and situational awareness.

2. Holistic Assessment (#1 Cues)

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

  Potential follow question

  o Were there any assessments you wish you had completed earlier?

  o Why?

  AACN Sub-Competency Link

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

3. Identifying Normal vs. Abnormal Findings (#2 Analyze cues)

- Which findings were abnormal to you in this case?

  Potential follow-up questions

  o 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 & #6 Outcome Evaluation

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

  Potential follow-up questions

  o What trends or changes did you track over time to make decisions?

  o What might you monitor more closely if this patient continued in your care?

  AACN Sub-competency link

  - 2.7a – Reassess to evaluate outcomes.

5. Modifying Plan of Care #3 priority or #4 generate solutions

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

  Potential follow up question

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

  AACN Sub-competency link

  - 2.7b – Modify plan of care as needed.

6. Notifying the Provider #4 generate solutions (SBAR)

  o At what point did you decide additional orders were needed?

  Potential follow up question

  o What information did you use to justify calling the provider?

  o How might you approach escalation differently in future situations?

  AACN Sub-competency link

  - 2.9d – Recognize when additional expertise is needed

  - 6.1b – Use various communication tools and techniques effectively.

7. Professional Communication #4 generate solutions (SBAR)

  o Tell us about your SBAR call to the provider. How'd it go?

  Potential follow up question

	o What was the most challenging part of communicating during the scenario?	
	o What strategies will you use to keep your communication clear and concise under pressure?	
	AACN Sub-competency link	
	▪ 6.1e – Communicate individual information in a professional, accurate, and timely manner	
	▪ 9.2g – Communicate in a professional manner.	

Progression Indicators

Sub-competency	Developing	Developed
Incorporate knowledge from nursing and other disciplines to support clinical judgment (1.3c)	Describe how patient and environmental factors influence clinical decision-making.	Integrate patient and environmental factors into the decision-making process.
	Provide an evidence-based rationale for adjusting plan of care to reflect contextual challenges and opportunities.	Incorporate knowledge of cultural, ethical, and legal considerations into one's clinical reasoning to make informed clinical judgments.
Demonstrate qualities of empathy (2.1a)	Listen to patients using verbal and nonverbal cues to understand their needs and concerns.	Anticipate patients' needs based on non-verbal cues and the clinical context, responding with appropriate emotional and clinical support.
	Use simple, patient-centered language when explaining procedures or plans of care.	Leverage communication skills to elicit verbal and nonverbal information to inform the plan of care.
	Use open-ended questions to elicit patient values and preferences, documenting them accurately in the medical record.	Ensure patient preferences are consistently revisited and reflected in interdisciplinary team discussions.
Demonstrate compassionate care (2.1b)	Demonstrate presence through eye contact, active listening, and appropriate verbal/nonverbal actions.	Remain fully present even in high-stakes or emotionally charged situations.
	Identify individual preferences to begin incorporating them into actions and conversations.	Integrate individual patient preferences and emotional support into every interaction.
		Engage with healthcare team members to create a seamless, person-centered care experience, respecting holistic needs.

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Perform a clinically relevant, holistic health assessment (2.3c)	Identify and prioritize assessments addressing the patient's immediate needs and presenting symptoms.	Apply clinical judgment to determine assessment, sequencing and urgency.
	Collect subjective and objective data to support clinical decision-making.	Adjust assessment priorities in real-time based on clinical judgment and patient feedback.
		Prioritize assessments based on the patient's immediate needs and presenting symptoms.
Distinguish between normal and abnormal health findings (2.3e)	Recognize and analyze normal and abnormal health findings.	Identify patterns in abnormal findings and correlate them with potential underlying conditions.
	Consult clinical guidelines and evidence-based resources to verify deviations from normal findings.	Use abnormal findings to prioritize interventions and refine care plans.
	Differentiate between findings requiring urgent versus routine follow-up and communicate appropriately with healthcare team members.	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.	Integrate physical, emotional, social, and cultural factors into reassessments to comprehensively evaluate health outcomes.
	Compare current findings with baseline data to identify changes in the individual's condition.	Synthesize patterns and trends in reassessment data, linking them to the effectiveness of interventions.
	Share reassessment results with the healthcare team to facilitate coordinated evaluation and decision-making.	
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.	Collaborate with the interdisciplinary team to ensure care plan modifications are holistic and evidence based.
	Propose changes based on clinical guidelines and emerging patient needs.	Provide a clear, evidence-supported rationale when modifying the care plan in discussions with the team or patient.
	Engage the individual in discussions about plan of care	

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	adjustments to align with their preferences and values.	
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 various communication tools and techniques effectively. (6.1b)	Utilize standardized communication tools and techniques to convey patient information accurately and concisely during handoffs and team discussions.	Adapt communication tools to the context and audience.
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.
Change behavior based on self and situational awareness. (9.1d)	Recognize personal emotions, biases, or stress levels during clinical experiences and describe their potential impact on interactions with patients or team members.	Adapt real-time clinical practices and communication strategies to align with dynamic patient care needs, team dynamics, and environmental factors.
	Adjust communication style or approach when responding to feedback or observing changes in patient needs or care priorities.	Demonstrate proactive problem-solving and flexibility by modifying approaches to address challenges or unexpected changes in clinical settings.
	Seek input from peers or instructors to identify specific actions or behaviors that could improve performance in different situations.	Incorporate self-reflection and situational analysis into decision-making, consistently improving the quality of care and fostering positive professional relationships.
Communicate in a professional manner. (9.2g)	Use clear, concise, and respectful language in all communications with patients, families, and healthcare team members.	Modify communication strategies to engage diverse audiences effectively.
	Demonstrate active listening skills and ensure understanding in patient interactions.	Address misunderstandings or conflicts with a respectful and solutions-focused approach.
	Document patient care and interactions using appropriate medical terminology and formats.	Provide constructive and actionable feedback to peers while fostering a supportive team environment.

Progression-Based Simulation: Tailoring Scenarios for Developing vs. Developed levels (Scenario I vs Scenario II)

Demonstrate active listening skills and ensure understanding in patient interactions.

Element	Scenario I	Scenario II
Scenario Title	Recognizing and Responding to COPD Exacerbation	Respiratory Distress: Independent Response
Purpose	To develop clinical judgment, cue recognition, and appropriate actions through guided practice	To demonstrate clinical judgment in prioritizing and managing acute respiratory distress through cue recognition and timely action.
Setting	Medical-surgical unit (receives handoff, signs of respiratory distress, escalates care to call provider and prepares SBAR, which can be a prewritten template or provider interaction can be removed, and facilitator provides orders once learner asks)	Same setting and case—no interruptions or prompts, delivers SBAR and continues to care for patient after carrying out new orders; could add a standardized patient as a distressed family member, incorporate competing priorities such as a second patient calling or alarms going off Not responding to oxygen therapy; CPAP; consult respiratory therapist Home visit or nursing home to acute care—communicate with provider or EMT/more care coordination
Learner Level	Junior nursing students	Senior nursing students / new grad RNs
Patient Condition	Admitted for COPD exacerbation, responds quickly to interventions	Same patient, condition progresses similarly but more rapidly, rapid response team may need to be notified
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

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Assessment Focus	Formative practice of cue recognition, SBAR prep and implementation of interventions	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)

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
Incorporate knowledge from nursing and other disciplines to support clinical judgment. (1.3c)	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.
Demonstrate qualities of empathy. (2.1a)	Does not notice or validate patient's verbal or nonverbal cues.	Notices and responds to some of patient's verbal and nonverbal cues.	Leverages communication skills to elicit verbal and nonverbal information from the patient.
Demonstrate compassionate care. (2.1b)	Does not make eye contact or show active listening behaviors.	Makes some eye contact and displays some active listening behaviors.	Remains fully present in patient interaction and provides emotional support and connects with other health care team members for any needed follow up
Perform 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.

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Distinguish 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.
Reassess to evaluate outcomes (2.7a)	Fails to reassess or monitors ineffectively after intervention.	Reassess but inconsistently integrates data into decision-making.	Routinely reassesses and uses data to evaluate intervention effectiveness and next steps.
Modify 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.
Recognize 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.
Use various communication tools and techniques effectively. (6.1b)	Does not use a standardized communication tool when communicating with other health care team members.	Utilizes a communication tool and omits some patient information; some information may not be concise.	Uses SBAR or a similar tool and includes relevant, concise information for the health care team member receiving the information.
Communicate 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.
Change behavior based on self and situational awareness. (9.1d)	Does not recognize personal emotions or biases when providing care.	Recognizes personal emotions but does not recognize impact on care provided.	Able to recognize personal emotions and adapt or cope in an appropriate manner to maximize quality of care.

Communicate in a professional manner. (9.2g)	Does not use clear language with interacting with patients, families or members of the health care team.	Demonstrates active listening and communicates concisely in most interactions with patients, families, or members of the health care team.	Able to communicate concisely and use active listening strategies; tailoring communication style to the needs of the receiver of the communication.

Observation Tool for COPD Exacerbation 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 judgment, 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: observed or missing behaviors
Identifies abnormal vital signs and acknowledges concerns voiced by patient.		
Links clinical cues (e.g., respiratory rate, use of accessory muscles, SOB, sputum) to current condition.		
Performs focused respiratory assessment.		
Calls provider in a timely manner to obtain orders.		
Implements oxygen delivery appropriately based on patient's condition and provider orders.		
Prepares and delivers a complete SBAR report.		
Reassesses patient after intervention (oxygen and med admin).		
Recognizes patient improvement or ongoing deterioration.		

Collaborates with team members to coordinate care.		
Demonstrates clear communication, with pt, team members and HCP.		