Shadow Health

Shadow Health Faculty Debriefing Guide

Health Assessment DCE

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

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Introduction and Utilization

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

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

Debrief: Health History (Tina Jones)

10 Minutes or Less

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

- What interview techniques helped you gather the most comprehensive information? Which ones felt awkward or didn't work as expected?
- How did you balance using open-ended versus closed questions? When did you find each type most effective?
- What specific strategies did you use to establish rapport and trust with your patient? How did you know if you were successful?
- Describe a moment when you felt you truly understood the patient's perspective. What communication approach helped you get there?
- What subjective data surprised you or seemed most significant? How will you validate this information with objective assessment?
- Identify one assumption or bias you noticed in yourself during the interview. How might this affect your clinical judgment in real practice?
- What was most challenging about organizing and documenting the health history information? How did you decide what to prioritize?
- Integration & Application:
- Compare your Shadow Health experience to therapeutic communication principles from your textbook. What worked differently in the virtual environment versus what you anticipate in real clinical settings?
- If you could redo one part of your interview, what would you change and why? What did this teach you about the interview process?
- What is one specific communication skill you want to strengthen before your first clinical experience? What's your plan to develop it?

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

1. What assumption or bias did you notice in yourself during the interview, and how might this affect your clinical judgment?
    - Hits critical thinking, self-awareness, and clinical reasoning in one question
2. If you could redo one part of your interview, what would you change and why?
    - Captures communication skills, therapeutic relationship, and reflection on real-world application
3. What is one specific communication skill you want to strengthen before your first clinical experience?
    - Bridges all focus areas while promoting actionable learning and accountability

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these 3 questions:

- **Gather:** Walk us through the subjective data you collected. What key information did you elicit, and what open-ended questions were most effective in getting the patient to share their story?
- **Analyze:** Now that you've gathered this information, what patterns or concerns stand out to you? How does this subjective data connect to potential health risks or clinical priorities?
- **Summarize:** Based on what you gathered and analyzed, how would you summarize this patient's overall health status and main health concerns? What would you communicate back to the patient to confirm your understanding.
- **Facilitation tip:** Ask these sequentially to guide students through clinical reasoning progression. This scaffolds their thinking from data collection → interpretation → synthesis—mirroring real assessment practice.

30 Minutes or More

Introduction

- Great work completing your Shadow Health Health History! Let's debrief on your interview experience. We'll focus on communication skills, clinical reasoning, and what you'll carry into real clinical practice.

Communication & Interviewing

- What interview techniques helped you gather the most information? Which open-ended or closed questions were most effective? What felt awkward or didn't work as expected?
- Teaching point: Intentional questioning builds rapport and uncovers patient priorities.

Critical Thinking & Self-Awareness

- What assumption or bias did you notice in yourself during the interview? How might this affect your judgment in real practice? What subjective findings surprised you?
- Teaching point: Recognizing bias strengthens clinical reasoning and patient-centered care.

Application & Growth

- If you could redo one part of your interview, what would you change and why? What's one communication skill you want to strengthen before clinical?
- Teaching point: Reflection drives intentional skill development.

Closing

- Share one key takeaway with your group.

Debrief Single System Assessment: HEENT (Kellan Clarke)

10 Minutes or Less

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

- What assessment techniques did you use during the head and neck exam, and in what order? Why is sequence important? (Reinforces inspection, palpation, auscultation)
- How did you palpate the lymph nodes and carotid arteries? What safety considerations are important when assessing carotid pulses? (Addresses proper technique—palpate one carotid at a time, gently)
- What normal findings did you expect versus what you actually documented? Were there any surprises? (Builds pattern recognition)
- If you detected jugular venous distention, what would that indicate about the patient's cardiovascular status? (Connects findings to right-sided heart function and volume status)
- What would a bruit sound like, and what does it suggest about the underlying vessel?(Reinforces abnormal findings—"swishing" sound indicating narrowed/occluded artery)
- How did you explain what you were doing to the patient during the exam? What could you improve to enhance patient comfort? (Develops communication skills)
- What cues from the patient's facial expression or appearance gave you insight into their emotional state?(Emphasizes holistic observation)
- What was most challenging about this assessment? What would you do differently next time? (Encourages self-reflection and identifies learning gaps)
- Did you remember to assess range of motion of the head and neck? Why might this be clinically significant?(Addresses commonly missed components)
- How would your HEENT findings influence your overall patient assessment and care planning? (Promotes systematic thinking and connection to the nursing process)

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

1. What assessment techniques did you use during the head and neck exam, and in what order? Why is sequence important?
    - Anchors proper technique and clinical reasoning in the first 2-3 minutes
2. What was most challenging about this assessment? What would you do differently next time
    - Surfaces learning gaps and misconceptions quickly; builds self-awareness
3. How would your HEENT findings influence your overall patient assessment and care planning?
    - Closes the loop by connecting findings to clinical application and the nursing process

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these 3 questions:

- **Gather:** Walk me through what you observed during Kellen's HEENT exam. What findings did you document? What did the patient tell you about any symptoms or concerns
- **Analyze:** What assessment techniques did you use, and in what order? Why? What was most challenging about this assessment? How do your findings connect to Kellen's overall health status?
- **Summarize:** What's one key takeaway from this exam you'll carry forward? How would these HEENT findings influence your care planning? What will you do differently on your next health assessment?

30 Minutes or More

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

Opening

- Welcome! You've all completed the Shadow Health HEENT exam with Kellen Clarke. Today, you're leading this debrief—I'm here to guide the conversation. We'll connect what you learned in simulation to your upcoming clinical rotations.
- **Turn-and-talk:** Pair up with someone next to you. Share one thing that went well and one thing that surprised you during the exam.
- **Quick share-out:** Call on 2-3 pairs to share highlights with the group.

Peer-Led Observation Round

- Let's build a collective picture of Kellen's assessment.
- Popcorn style—students call on each other: Who wants to start? Describe one assessment technique you used and why you chose that sequence."
- After each response: "Thanks, [Name]. Who can add a different technique or build on that?"
- Rotate through 6-8 students.
- You facilitate by:
    - Acknowledging contributions
    - Asking follow-ups: "What made that challenging?" or "What were you thinking when...?"
    - Redirecting: "Does anyone have a different approach?"

Small Group Problem-Solving

- Break into pairs or trios. Each group gets a clinical scenario card.
- Scenarios (assign 3-4 groups different prompts):
    - Your clinical patient has the same lymph node findings as Kellen. What questions do you ask? What do you document?
    - A patient becomes anxious during your head/neck exam. How do you respond and still complete your assessment?
    - You notice asymmetry during a facial assessment. Walk through your next steps and who you'd communicate with.
- Group work: Students discuss and prepare brief responses.
- Report-out: Each group shares their reasoning. Encourage peer questions: "What would you add to their plan?"

Peer Teaching Moment

- Pick one finding from Kellen's exam you want to explain to a peer as if they've never done this assessment.
- Volunteer 2 students to do 1-minute mini-teachings. Class provides feedback: "What was clear? What would strengthen the explanation?"

Closing Reflection

- On a notecard or in the chat: Write one specific skill from today you'll use in clinical this week and how you'll apply it.
- Collect or have 2-3 students share aloud.

Facilitator Notes

Your role is to listen, redirect, and connect dots—not lecture. Use the textbook principle that groups of six or fewer maximize participation, so breaking your 10 students into smaller units keeps everyone engaged and confident.

Debrief Single System Assessment: Respiratory (Yuki Morimoto)

10 Minutes or Less

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

- What assessment cues did you prioritize when first approaching Yuki, and how did you determine which data were most critical to collect immediately?
- How did you use the ABCDE approach or systematic assessment framework to organize your respiratory evaluation? What would you do differently next time?
- Describe the relationship between the respiratory rate, pattern, depth, and lung sounds you observed. How did these findings cluster together to inform your clinical judgment?
- When auscultating Yuki's lung sounds anteriorly, laterally, and posteriorly, what specific abnormalities did you identify? How did you differentiate between crackles, wheezes, or diminished breath sounds?
- How did you assess chest symmetry and use of accessory muscles? What do these findings indicate about Yuki's work of breathing and ventilation status?
- Based on your assessment findings—including respiratory rate, SpO_2, breath sounds, and patient symptoms—what nursing diagnosis would be most appropriate? Consider diagnoses such as Impaired Gas Exchange or Ineffective Breathing Pattern.
- What related factors or underlying causes might explain Yuki's respiratory symptoms? How would you distinguish between ventilation, diffusion, and perfusion problems?
- How did you assess Yuki's subjective experience of dyspnea? What questions helped you understand the functional impact on daily activities and quality of life?
- What patient education would you provide to Yuki based on your assessment findings? How would you explain the significance of the respiratory changes you observed?
- What assessment findings would prompt you to immediately notify the healthcare provider? At what point would Yuki's respiratory status require escalation of care?

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

1. Describe the relationship between the respiratory rate, pattern, depth, and lung sounds you observed. How did these findings cluster together to inform your clinical judgment?
    - This drives critical thinking by connecting objective data into a coherent clinical picture.
2. Based on your assessment findings—including respiratory rate, SpO_2, breath sounds, and patient symptoms—what nursing diagnosis would be most appropriate?
    - This bridges assessment to clinical reasoning and helps students move from data collection to actionable nursing care.
3. What assessment findings would prompt you to immediately notify the healthcare provider? At what point would Yuki's respiratory status require escalation of care?
    - This emphasizes safety and clinical judgment—essential for recognizing when a patient needs urgent intervention.

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these questions:

- **Gather**:
    - Walk me through your assessment of Yuki. What did you observe first?
    - What objective data did you collect—respiratory rate, pattern, depth, SpO_2, lung sounds?
    - What subjective information did Yuki share about their breathing?
    - **Goal:** Students describe their assessment findings without judgment. Focus on collecting facts about vital signs, breath sounds (anteriorly, laterally, posteriorly), chest symmetry, use of accessory muscles, and patient-reported symptoms.
- **Analyze**:

- How did you interpret the cluster of findings—respiratory rate, SpO_2, breath sounds, and Yuki's symptoms? What patterns did you notice?
  - What nursing diagnosis best fits this clinical picture? Consider *Impaired Gas Exchange* or *Ineffective Breathing Pattern*. What related factors support your choice?
  - How did you differentiate between ventilation, diffusion, and perfusion issues based on your assessment?
  - What subtle cues indicated Yuki's respiratory status—restlessness, skin color, anxiety? How did these influence your clinical judgment?
  - **Goal:** Students connect assessment data to underlying pathophysiology and formulate appropriate nursing diagnoses. Encourage recognition of early signs of hypoxemia (tachypnea, restlessness, borderline vital signs).
- **Summarize**:
  - What assessment findings would require immediate notification of the healthcare provider or escalation of care?
  - What would you do differently in your next respiratory assessment to be more thorough or efficient?
  - How will you apply systematic assessment techniques (ABCDE, head-to-toe) in future clinical encounters?
  - What patient education would you provide to Yuki based on your findings?
  - **Goal:** Students identify actionable takeaways, safety priorities, and strategies for improvement. Reinforce the importance of recognizing when respiratory status requires urgent intervention and reflecting on clinical experiences to strengthen future judgment.

30 Minutes or More

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

Opening

- You've completed Yuki Morimoto's respiratory assessment. Today you're driving this debrief. We'll connect your simulation experience to real patients you'll encounter in clinical.
- Turn-and-talk: Partner up. Share one assessment finding you documented and one technique you want to improve.
- Quick share-out: 2-3 pairs share key takeaways.

Peer-Led Observation Round

- Let's reconstruct Yuki's respiratory exam together.
- **Popcorn style—students call on each other:**
  - Who'll start? Describe your inspection findings and what you compared side-to-side.
  - After responses: Who used palpation? What were you assessing for—chest expansion, fremitus, or both?
  - What breath sounds did you hear? Where specifically?
  - Probe deeper: What does decreased fremitus tell you?
  - Redirect: Did anyone find something different?
  - Connect concepts: How does that relate to Yuki's history?

Small Group Problem-Solving

- Break into pairs or trios. Each group tackles a clinical scenario.
- **Scenarios (rotate among 3-4 groups):**
  - Your patient has unilateral decreased chest expansion like Yuki. What's your differential? What do you assess next and document?
  - You hear crackles in the bases bilaterally. Are they fine or coarse? What questions do you ask? When do you notify the provider?

    - A patient has increased tactile fremitus in the right lower lobe. What underlying condition might this indicate? What other assessment findings would you expect?
    - You're assessing diaphragmatic excursion and measure 2 cm. Is this normal? What conditions affect this finding?
- **Group work:** Students discuss clinical reasoning and next steps.
- **Report-out:** Each group presents. Encourage peer feedback: What would you add? What's missing?

Peer Teaching Moment

- Choose one adventitious breath sound. Explain to a peer: what it sounds like, what causes it, and what it means clinically
- 2 volunteers give 1-minute explanations. Class provides constructive feedback on clarity and accuracy.

Closing Reflection (2 Minutes)

- Write down: One respiratory assessment skill you'll prioritize in clinical this week and how you'll practice it with real patients.
- 2-3 students share aloud or collect responses.

Facilitator Tip

- Reference the textbook principle of systematic assessment—apex to base, side-to-side comparison. When students struggle, redirect to the four techniques: inspection, palpation, percussion, auscultation.

Debrief Single System Assessment: Cardiovascular (Rochelle Joseph)

10 Minutes or Less

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

- What cardiovascular assessment cues did you prioritize when first approaching Rochelle, and how did you determine which data were most critical to collect immediately?
- How did you use a systematic approach to organize your cardiovascular evaluation? Walk through your assessment sequence from inspection to auscultation.
- Describe the relationship between heart rate, rhythm, blood pressure, and any abnormal heart sounds you identified. How did these findings cluster together to inform your clinical judgment?
- When auscultating Rochelle's heart sounds, what did you hear at each valve location (aortic, pulmonic, tricuspid, mitral)? How did you differentiate between S_1 and S_2, and did you identify any extra heart sounds (S_3, S_4) or murmurs?
- How did you assess peripheral circulation—including peripheral pulses, capillary refill, skin color and temperature, and edema? What do these findings indicate about Rochelle's cardiovascular perfusion?
- Did you assess for jugular vein distention? What position did you place Rochelle in, and what would this finding suggest about cardiac function?
- Based on your assessment findings—including vital signs, heart sounds, peripheral perfusion, and patient symptoms—what nursing diagnosis would be most appropriate? Consider diagnoses such as Decreased Cardiac Output or Ineffective Tissue Perfusion.
- What related factors or underlying cardiovascular conditions might explain Rochelle's symptoms? How would you distinguish between left-sided versus right-sided heart failure findings?
- How did you assess Rochelle's subjective experience of cardiovascular symptoms (chest discomfort, palpitations, dyspnea, fatigue)? What questions helped you understand the onset, duration, and impact on daily activities?
- What assessment findings would prompt you to immediately notify the healthcare provider? At what point would Rochelle's cardiovascular status require escalation of care or continuous cardiac monitoring?

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

1. Describe the relationship between heart rate, rhythm, blood pressure, and any abnormal heart sounds you identified. How did these findings cluster together to inform your clinical judgment?
    - This drives critical thinking by connecting objective cardiac data into a coherent clinical picture.
2. Based on your assessment findings—including vital signs, heart sounds, peripheral perfusion, and patient symptoms—what nursing diagnosis would be most appropriate?
    - This bridges assessment to clinical reasoning and helps students move from data collection to actionable nursing care.
3. What assessment findings would prompt you to immediately notify the healthcare provider? At what point would Rochelle's cardiovascular status require escalation of care?
    - This emphasizes safety and clinical judgment—essential for recognizing when a patient needs urgent intervention.

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these 3 questions:

- **Gather**:
    1. Walk me through your cardiovascular assessment of Rochelle. What did you observe and measure first?
    2. What vital signs did you obtain—heart rate, blood pressure, respiratory rate?

3. Describe the heart sounds you heard at each auscultation site. Did you identify S_1 and S_2? Any extra sounds or murmurs?
4. What did you find when assessing peripheral circulation—pulses, capillary refill, skin color and temperature, edema?
5. What subjective symptoms did Rochelle report?

- **Analyze**:
  1. How did you interpret the cluster of findings—heart rate, rhythm, blood pressure, heart sounds, and peripheral perfusion? What patterns emerged?
  2. What nursing diagnosis best fits Rochelle's clinical picture? Consider *Decreased Cardiac Output* or *Ineffective Tissue Perfusion*. What assessment data support your choice?
  3. If you noted hypotension with tachycardia and cold, clammy, pale skin—what would this indicate? How does this differ from hypotension with warm, dry, pink skin?
  4. How did you differentiate between adequate and impaired peripheral perfusion? What would absent or weak peripheral pulses suggest?"
  5. If you assessed jugular vein distention, what would elevated right atrial pressure indicate about cardiac function?
- **Summarize**:
  1. What cardiovascular findings would require immediate notification of the healthcare provider or Rapid Response Team?
  2. What would you do differently in your next cardiovascular assessment to be more systematic or thorough?
  3. How will you apply these assessment techniques in future clinical practice, especially for patients with cardiac history or post-operative monitoring?
  4. What patient education would you provide to Rochelle based on your findings?

30 Minutes or More

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

Opening

Welcome back, everyone. Let's debrief your cardiovascular assessment of Rochelle Joseph. This is a safe space to reflect on what went well and what we can learn. I'll be asking questions to help you think through your clinical reasoning—there are no wrong answers here, only learning opportunities.

Gather Phase

- Let's start by gathering what happened. I'd like to hear from a few of you.
- Who can walk me through the vital signs you obtained? Heart rate, blood pressure, respiratory rate?
- What did you hear when auscultating heart sounds? Let's go location by location—aortic, pulmonic, tricuspid, mitral. Did you identify S_1 and S_2 clearly?
- Did anyone hear extra heart sounds—S_3 or S_4—or murmurs? Describe what you heard.
- How did you assess peripheral circulation? Tell me about peripheral pulses, capillary refill, skin color and temperature.
- Did anyone check for edema or jugular vein distention? What did you find?
- What subjective symptoms did Rochelle report?
- **Facilitator Notes:** Allow multiple students to share. Normalize variations in findings. Clarify any confusion about technique (e.g., proper stethoscope placement, comparing apical-radial pulses).

Analyze Phase

- Now let's analyze what these findings mean.

- Looking at your cluster of data—heart rate, rhythm, blood pressure, heart sounds, peripheral perfusion—what patterns did you notice?
- Based on these findings, what nursing diagnosis fits best? Think about *Decreased Cardiac Output* or *Ineffective Tissue Perfusion*. What evidence supports your choice?
- Pause for responses. Probe deeper:
    - If you found hypotension with tachycardia and cold, clammy, pale skin—what would that suggest? How is that different from hypotension with warm, dry, pink skin?
    - What would weak or absent peripheral pulses indicate about perfusion?
    - If you noted jugular vein distention, what does elevated venous pressure tell us about cardiac function?
    - How do heart sounds like S_3 or S_4 relate to heart failure?
- Teaching moment: Reinforce that hypotension + tachycardia + cold/clammy skin suggests impending shock, while hypotension + normal pulse + warm skin may indicate residual vasodilation.

Summarize Phase

- Let's summarize what you'll take forward.
- What cardiovascular findings would require you to immediately notify the provider or call a Rapid Response?
- What will you do differently next time to be more systematic or thorough?
- How will you apply these skills in future clinical practice?

Closing (2 minutes)

- Excellent reflection today. Cardiovascular assessment is complex—you're building critical skills. Keep practicing heart sound auscultation and peripheral perfusion checks.

Debrief Single System Assessment: Abdominal (Martin Francis)

10 Minutes or Less

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

- What systematic approach did you use to assess Martin's abdomen, and why is the sequence of inspection, auscultation, percussion, and palpation important in abdominal examination?
- Describe the bowel sounds you auscultated in each quadrant. Were they normoactive (5-35 per minute), hyperactive, hypoactive, or absent? How long did you listen in each area, and what do your findings indicate?
- When performing light palpation, what were you assessing for? Did you detect any tenderness, masses, muscular resistance, or guarding? How did you differentiate between voluntary and involuntary guarding?
- Walk through your percussion findings. What sounds did you hear—tympany or dullness—and in which quadrants? What do these sounds indicate about underlying structures?
- If you palpated the liver, describe your technique. What position were your hands in, and did you ask Martin to take a deep breath? What would you expect to feel if the liver were normal versus enlarged?
- How did you assess Martin's facial expressions and nonverbal cues during palpation? What would grimacing or guarding indicate about his comfort level or potential peritoneal inflammation?
- Did you encounter any findings that would require you to stop the examination immediately—such as a pulsating abdominal mass? What would this indicate, and what would be your next action?
- Based on your assessment findings—including bowel sounds, abdominal contour, tenderness, and any masses—what nursing diagnosis would be most appropriate? Consider diagnoses such as *Acute Pain*, *Constipation*, or *Risk for Deficient Fluid Volume*.
- How did you integrate Martin's subjective complaints (pain location, character, onset, associated symptoms) with your objective findings to form a complete clinical picture?
- What assessment findings would prompt immediate notification of the healthcare provider? At what point would Martin's abdominal status require urgent intervention or further diagnostic imaging?

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

1. Walk through your percussion and palpation findings in each quadrant. What sounds and sensations did you detect, and how did they help you identify potential abdominal pathology?
    - This drives systematic assessment and connects physical exam techniques to clinical interpretation.
2. Based on your assessment findings—bowel sounds, abdominal contour, tenderness, and any masses—what nursing diagnosis best fits Martin's presentation? What objective data support your choice?
    - This bridges assessment to clinical reasoning and actionable nursing care.
3. What abdominal findings would require you to immediately notify the healthcare provider or escalate care? For example, what would a pulsating mass or acute peritoneal signs indicate?
    - This emphasizes safety and recognition of urgent conditions requiring intervention.

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these 3 questions:

1. **Gather - What happened during your assessment?**
    - Walk me through your sequence—inspection, auscultation, percussion, palpation.
    - What bowel sounds did you hear? Frequency? Character?
    - What did percussion reveal—tympany or dullness? Where?

    - Describe your palpation findings—tenderness, masses, guarding?
    - What did Martin report as his chief complaint?

2. **Analyze - What do these findings mean?**
    - Why is the assessment sequence critical? What happens if you palpate before auscultating?
    - Hyperactive bowel sounds with rushes suggest what?
    - Absent bowel sounds—how long did you listen? What does absence indicate?
    - Involuntary guarding or rebound tenderness indicates what pathology?
    - What nursing diagnosis fits—*Acute Pain*, *Constipation*, *Nausea*?
    - **Key point:** Tympany is normal (air in intestines). Dullness suggests fluid or masses. Rebound tenderness = peritoneal inflammation.

3. **Summarize - What are your takeaways?**
    - What findings require immediate provider notification? *(pulsating mass, acute peritoneal signs, absent bowel sounds)*
    - What will you do differently next time?
    - How will you apply systematic abdominal assessment in practice?

30 Minutes or More

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

Opening & Context Setting

Welcome back, everyone. Let's talk about your abdominal assessment of Martin Francis. I want to hear about your techniques, findings, and clinical thinking. This is a learning conversation—share what you observed and any challenges you encountered.

Assessment Sequence & Technique

- Let's start with your assessment approach.
- Who can tell me the order you used for abdominal assessment? Why must we auscultate *before* percussion and palpation?
- What did you observe during inspection—contour, symmetry, visible masses, or pulsations
- Describe your auscultation technique. Which quadrant did you start in? How long did you listen in each area?
- What bowel sounds did you hear—clicks, gurgles, rushes? How frequent were they?
- During percussion, what sounds did you hear? Where did you find tympany versus dullness?
- For palpation, did you start with light or deep? What depth did you use for light palpation—about 1 cm?
- **Key teaching point:** Reinforce that palpation alters bowel sounds, so auscultation must come first. Light palpation detects tenderness and masses; deep palpation is an advanced skill.

Clinical Findings & Interpretation

- Now let's connect your findings to clinical meaning.
- What would hyperactive, high-pitched bowel sounds with tinkling indicate?
- If you heard no bowel sounds, how long should you listen before documenting them as absent? What does absence suggest?
- What does tympany tell you? What about dullness in the flanks?
- If you felt involuntary guarding or Martin grimaced during palpation, what might this indicate?
- Did anyone assess for rebound tenderness? What does pain on withdrawal suggest?
- If you encountered a pulsating abdominal mass, what would be your immediate action?

- **Key teaching point:** Absent bowel sounds require 2-5 minutes of listening per quadrant. Rebound tenderness indicates peritoneal inflammation. Never palpate a pulsating mass—it may signal an abdominal aortic aneurysm.

Safety & Clinical Judgment

- What findings would require immediate escalation?
- Which assessment findings need urgent provider notification?
- What nursing diagnosis best fits Martin's presentation based on your data?
- How did Martin's subjective complaints align with your objective findings?

Closing & Application

- What will you take into your next clinical experience? What techniques need more practice
- Great work today. Abdominal assessment is complex—keep practicing systematic sequencing.

Debrief Single System Assessment: Musculoskeletal (Ezra Levy)

10 Minutes or Less

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

- What specific cues did you recognize during your inspection that indicated a musculoskeletal problem? (Consider gait, posture, symmetry, use of assistive devices, facial expressions during movement)
- How did you differentiate between pain originating from bone, muscle, or joint structures during your assessment? What questions or techniques helped you determine this?
- Describe your approach to palpation. How did you ensure your technique was effective in identifying tenderness, swelling, or temperature changes?
- What impact did the patient's musculoskeletal condition have on their ability to perform ADLs? How would you incorporate this into your care plan?
- If you identified mobility limitations, what assistive devices might be appropriate, and how would you assess whether the patient could use them safely?
- How did you assess the patient's pain using the appropriate scale, quality descriptors (dull, burning, aching, stabbing), location, and radiation patterns? What challenges did you encounter?
- Did you identify whether the pain was acute or chronic, and how might this distinction influence your nursing interventions?
- What neurovascular assessments were important for this patient, and what specific findings would concern you? (Consider circulation, sensation, movement)
- Beyond the physical findings, what psychosocial factors did you consider? How might chronic musculoskeletal conditions affect body image, employment, or coping mechanisms?
- Reflecting on your assessment, what findings would require immediate intervention or collaboration with other healthcare team members? What would be your priority nursing actions?

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

1. What specific cues did you recognize during your inspection that indicated a musculoskeletal problem?
    - This anchors students in *observation skills* and helps them connect physical findings to clinical significance.
2. How did you assess the patient's pain using the appropriate scale, quality descriptors, location, and radiation patterns?
    - Pain assessment is foundational to musculoskeletal care and directly impacts treatment decisions—this question ensures students understand *why* thorough pain evaluation matters.
3. Reflecting on your assessment, what findings would require immediate intervention or collaboration with other healthcare team members?
    - This pushes students toward *clinical judgment and safety awareness*—the ability to recognize red flags and escalate appropriately is essential for safe practice.

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these 3 questions:

1. **Gather (What happened?)**
    - Let's start by reviewing what you observed and assessed during the Ezra Levy simulation:
        - What were your key findings during inspection? (gait, posture, symmetry, assistive devices)

- What did you discover through palpation? (tenderness, swelling, temperature, crepitation)
- How did the patient describe their pain? (location, quality, intensity, radiation)
- What functional limitations did you identify related to ADLs?

  - *Take 2-3 minutes for students to share their observations.*

2. **Analyze (What does it mean?)**
   - Now let's connect your findings to clinical reasoning:
     - Which assessment findings were most significant? Why did they stand out?
     - How did you differentiate between bone, joint, or muscle involvement?
     - What risk factors did you identify? (Consider age-related changes like decreased bone density, muscle mass, balance issues, or fall risk)
     - How did the musculoskeletal problem impact the patient's mobility and independence?
     - Were there any red flags that required immediate attention or collaboration?
   - *Encourage students to explain their clinical thinking and connect findings to evidence-based practice.*

3. **Summarize (What will you do differently?)**
   - Let's identify key takeaways and areas for growth:
     - What assessment technique will you refine for next time? (warming hands before palpation, systematic head-to-toe approach, measuring limb length accurately)
     - How will you improve your pain assessment to capture all relevant details?
     - What would you prioritize in your nursing care plan based on your findings?
     - How would you ensure patient safety related to mobility and fall prevention?
     - What's one thing you learned that will change your practice?

30 Minutes or More

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

Pearls (Promoting Excellence And Reflective Learning in Simulation) is a learner-centered debriefing framework that combines advocacy-inquiry with structured reflection.

Phase 1: Reactions

- Purpose: Allow emotional processing and set a safe learning environment.
- Facilitator prompts:
  - How are you feeling after completing the Ezra Levy assessment?
  - What surprised you during this simulation?
  - What was most challenging about the musculoskeletal assessment?

  Listen actively. Validate feelings. Normalize uncertainty—this builds psychological safety.

Phase 2: Description

- Purpose: Establish shared mental model of what occurred.
- Facilitator prompts:
  - Walk me through your systematic approach—how did you organize your inspection from head to toe?
  - What did you observe about the patient's gait, posture, and use of assistive devices?
  - Describe what you found during palpation—temperature, tenderness, swelling, or crepitation?
- *Keep this factual. Avoid judgment. Ensure everyone recalls the same scenario.*

Phase 3: Analysis

- Purpose: Deep dive into clinical reasoning using advocacy-inquiry.
- Assessment Technique
    - I noticed you [observed behavior]. Help me understand your thinking there.
    - How did you ensure your hands were warm before palpation to prevent muscle spasm
    - When comparing bilateral limbs for symmetry, what specific differences did you look for?
- Pain Assessment
    - You assessed pain using [method]. What made you choose that approach?
    - How did you determine whether movement affected the pain?
    - For patients with cognitive impairments, what nonverbal cues would you observe?*(Reference: grimacing, rigid body posture, limping, restlessness, clenched teeth)*
- Functional Impact
    - What connections did you make between musculoskeletal findings and ADL performance
    - How does pain affect mobility and fall risk, especially in older adults?
    - What self-care deficits did you identify?
- Clinical Judgment
    - Which findings required immediate attention or collaboration?
    - How would you differentiate between bone, joint, or muscle involvement?
    - What would be your priority nursing interventions?
    - Use advocacy-inquiry: "I noticed X, I'm curious about Y" to explore reasoning gaps without judgment.

Phase 4: Summary & Application

- Purpose**:** Consolidate learning and commit to practice change.
- Facilitator prompts:
    - What is the most important concept you'll take into clinical practice?
    - What assessment technique will you refine?
    - How will this experience change your approach to musculoskeletal assessment?

Closing Pearl: "Systematic inspection and palpation, combined with thorough pain assessment, directly impact patient safety and functional outcomes.

Debrief Single System Assessment: Integumentary (Lupe Sosa)

10 Minutes or Less

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

- What specific assessment techniques did you use to evaluate skin color changes in this patient? Why is assessing change in skin color more important than the color itself?
- When inspecting lesions, what characteristics did you document (color, size, height, distribution, location, shape)? How would you differentiate between primary and secondary skin lesions?
- How did you assess areas of least pigmentation (sclerae, conjunctivae, nail beds, lips, buccal mucosa) to detect erythema, cyanosis, pallor, or jaundice? Why are these areas most reliable?
- What clusters of assessment data did you identify that could support a nursing diagnosis of Impaired Skin Integrity or Risk for Impaired Skin Integrity?
- If you observed vascular lesions (petechiae, ecchymosis, purpura), how did you test the lesion's response to direct pressure? What does blanching versus non-blanching tell you about the underlying cause?
- Did you assess difficult-to-reach areas such as skinfolds, under breasts, or the perineal region? What specific risks does this patient have for skin breakdown in these areas?
- What factors did you identify that could directly affect this patient's skin condition (activity level, sun exposure, emotions, smoking, edema, or systemic disorders)?
- Did you identify any areas where medical devices or adhesives contact the skin? What signs of device-related pressure injury did you look for?
- What risk factors for impaired skin integrity did this patient present (reduced sensation, impaired circulation, nutrition/hydration alterations, moisture, decreased mobility)?
- How did you maintain patient privacy and dignity while conducting a thorough integumentary assessment, especially when examining sensitive areas?

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

1. What assessment techniques did you use to differentiate between blanchable and nonblanchable erythema, and why is this distinction clinically significant?
    - This question targets the critical skill of identifying Stage 1 pressure injuries. Blanchable erythema (skin that becomes pale with pressure and reddens when relieved) indicates normal reactive hyperemia with an intact capillary bed. Nonblanchable erythema (redness that persists with pressure) signals structural damage to the capillary bed and microcirculation—a Stage 1 pressure injury requiring immediate intervention. This distinction directly impacts patient safety and prevention of further skin breakdown.
2. What clusters of assessment data did you identify, and what nursing diagnosis would you formulate with its related factors?
    - This question develops clinical judgment by requiring students to analyze patterns rather than isolated findings. Students should identify data clusters supporting diagnoses like *Impaired Skin Integrity* or *Risk for Impaired Skin Integrity*. The related factors (pressure, shear, moisture, immobility, nutritional deficits) guide intervention selection. For example, identifying moisture and pressure as related factors leads to different interventions than pressure alone. This mirrors the nursing process and evidence-based decision-making.
3. Which high-risk areas did you assess based on the patient's positioning and mobility status, and what specific pressure points require ongoing monitoring?
    - This question emphasizes individualized, comprehensive assessment. Students should identify bony prominences at risk based on patient positioning (sacrum, heels, ischium when supine; ears, cheeks, knees when prone). They should also assess areas under medical devices, skin folds, and areas exposed to moisture. High-risk patients need

assessments as frequently as every 4 hours. This question reinforces prevention strategies and the importance of systematic head-to-toe inspection, including often-missed areas.

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these 3 questions:

1. **Gather (What happened?)**
    - Let's start by gathering what you observed and did during the assessment. Take a moment to share:
    - What areas of the skin did you assess?
    - What findings did you document (color changes, lesions, areas of redness)?
    - Did you identify any high-risk areas or concerning findings?
    - *Allow students 2-3 minutes to share their experiences without judgment.*

2. **Analyze (What does it mean?)**
    - Blanchable vs. Nonblanchable Erythema: If you found reddened areas, did you perform the blanch test? Nonblanchable erythema that persists with fingertip pressure indicates a Stage 1 pressure injury—structural damage to the capillary bed requiring immediate intervention.
    - High-Risk Areas: Based on the Braden Scale assessment and the patient's mobility status, which bony prominences were at highest risk? The sacrum, heels, and ischial tuberosities are critical areas when patients have limited mobility.
    - Assessment Frequency: For high-risk patients, skin assessments may be needed as often as every 4 hours. What factors in this patient's history indicated increased risk (immobility, moisture, nutrition, sensory perception)?
    - What data clusters supported a nursing diagnosis?
    - How did the patient's risk factors influence your assessment priorities?
    - What did you miss or wish you had assessed more thoroughly?

3. **Summarize (What will you do differently?)**
    - Clinical Pearls:
        - Always assess skin over bony prominences during repositioning
        - Perform systematic head-to-toe inspection, including under devices, between skin folds, and areas exposed to moisture
        - Document using objective criteria (size, location, characteristics)
        - Reassess reddened areas within 30-45 minutes to determine if reactive hyperemia is present
    - Commitment to Practice:
        - What is ONE specific skill you'll focus on improving in your next patient assessment?
        - How will you ensure you don't miss high-risk areas in future assessments?

30 Minutes or More

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

Phase 1: Individual Reflection

- Provide students with these prompts for silent journaling or individual reflection:
    - Describe the clinical situation. What did you notice first about the patient's skin?
    - What went well during your assessment? What was challenging?
    - What assumptions did you make? Were they accurate?
    - What would you do differently next time?

Phase 2: Guided Group Reflection

- When you are engaged in caring for patients, reflective reasoning improves the accuracy of making diagnostic conclusions.
- What cues did you recognize during the assessment? (skin color changes, moisture, temperature, turgor, lesions)
- Which cues did you miss or wish you had explored further? (areas under devices, skin folds, between toes)
- How did you interpret reddened areas? Walk through your blanch test technique and what the findings meant.
- What patient factors influenced your assessment priorities? (mobility, nutrition, moisture, sensory perception)

Respond & Reflect

- Reflection-on-practice occurs after care of the patient. The nurse contemplates what was successful and what was unsuccessful.
- What interventions would you prioritize based on your findings? (repositioning, moisture management, nutrition consult, pressure redistribution)
- How did you maintain patient dignity during sensitive assessments? (draping, explanation, privacy)
- What resources would have been helpful during the assessment? (Braden Scale, wound measurement tools, better lighting)
- Share a moment when you felt uncertain. How did you work through it?

Phase 3: Consolidation & Application

- Learning from Experience - Reflection-on-practice is when significant learning from practice occurs and is critical to the development of increasing skillfulness as a nurse.
- Share one clinical pearl you learned from this experience
- Discuss: How will you approach high-risk skin assessment differently in clinical practice?
- What patterns emerged across the group's experiences?
- Identify 2-3 key takeaways for future integumentary assessments
- Commitment to action: Each student states ONE specific skill they'll focus on improving
- Closing: Remind students that reflecting on both successful and unsuccessful outcomes develops clinical judgment. Encourage continued journaling after clinical experiences.

Debrief Single System Assessment: Neurological (Samuel Green)

10 Minutes or Less

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

- How did you assess level of consciousness, and what specific stimuli did you use to evaluate responsiveness? Describe your progression from mildest to most intense stimuli and how you documented the patient's responses.
- When testing motor strength, did you identify any asymmetry between right and left sides? What specific muscle groups did you assess at the shoulders, elbows, wrists, hips, knees, and ankles?
- Describe how you performed the pronator drift test. What does downward drifting or pronation of the palm indicate about upper extremity weakness?
- What open-ended questions did you use to gather subjective data about neurological symptoms? How did you avoid leading questions when asking about headaches, weakness, or sensory changes?
- When assessing coordination and balance, which tests did you perform (finger-to-nose, heel-to-shin, Romberg, gait observation)? What abnormalities would indicate cerebellar dysfunction versus cortical lesions?
- How did you differentiate between normal muscle tone and abnormal findings? Can you explain the difference between hypotonia (flaccidity) and hypertonia (spasticity)?
- What trends or patterns did you identify in the patient's neurological status? Why is it important to look at trends rather than isolated findings when assessing neurological function?
- Did you observe any involuntary movements such as tremors, tics, or athetosis? What do these findings suggest about underlying neurological function?
- Which cranial nerves did you assess, and what specific tests did you use? How would dysfunction in specific cranial nerves impact patient safety (swallowing, vision, facial sensation)?
- Based on your assessment findings, what fall risk factors did you identify? How would gait abnormalities, balance impairment, or coordination deficits influence your nursing care plan?

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

1. What asymmetries or abnormal findings did you identify during motor and sensory testing, and what do these suggest about potential neurological deficits or stroke risk?
    - This targets critical clinical judgment. Asymmetry between sides (weakness, sensory loss, hyperreflexia) indicates focal neurological involvement requiring immediate intervention. Students must connect findings to clinical significance—especially important for recognizing acute stroke presentations.
2. How did you systematically assess all 12 cranial nerves, and which findings would impact patient safety (swallowing, airway protection, vision)?
    - This emphasizes comprehensive assessment and safety priorities. Cranial nerve dysfunction directly affects aspiration risk, protective reflexes, and fall risk. Students should demonstrate systematic technique and understand functional implications.
3. What trends or changes in level of consciousness, motor function, or reflexes would warrant immediate notification to the provider, and why?
    - This develops clinical judgment about acuity and escalation. Students must recognize red flags (declining LOC, new weakness, hyperreflexia with clonus) that suggest neurological deterioration requiring urgent intervention.

If you would like to utilize the GAS (Gather, Analyze, Summarize) Model, we suggest these 3 questions:

1. **Gather (What happened?)**
    - What key findings did you observe during the neurological exam? (LOC, motor strength, cranial nerves, reflexes, gait)
    - Did you identify any asymmetries or abnormalities?
    - What subjective data did the patient report about neurological symptoms?

2. **Analyze (What does it mean?)**
    - What do asymmetrical findings suggest? Unilateral weakness or sensory loss indicates focal neurological involvement—potential stroke or nerve damage.
    - Which cranial nerve or motor findings concern you most? Why would these impact patient safety?
    - What patterns emerged? Do findings cluster to suggest a specific neurological problem?

3. **Summarize - Key Takeaways**
    - Always compare right vs. left for symmetry
    - Assess all 12 cranial nerves systematically
    - Recognize red flags: declining consciousness, new weakness, aspiration risk

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

Phase 1: Gather
Students document:
- Key assessment findings (LOC, motor strength, cranial nerves, coordination, gait)
- Any asymmetries or abnormalities noted
- Challenges encountered during the exam

Discussion:
- What was your initial impression of the patient's neurological status? What did you observe about speech, behavior, coordination, and alertness?
- Walk us through your motor assessment. Did you test strength at shoulders, elbows, wrists, hips, knees, and ankles? What about pronator drift?
- Which cranial nerves did you assess? What specific tests did you use? (CN II-optic/vision, CN III/IV/VI-eye movement, CN VII-facial symmetry, CN IX/X-gag/swallow, CN XII-tongue movement)
- Describe coordination testing. Did you perform finger-to-nose, heel-to-shin, rapid alternating movements? What did smooth versus jerky movements indicate?
- What did you observe about gait and balance? Was the stance wide-based or ataxic? Did arms swing symmetrically?

Phase 2: Analyze
Clinical Reasoning Discussion:
- What asymmetries did you identify between right and left sides? Why is asymmetry a critical red flag for stroke or focal neurological damage?
- How did you differentiate normal from abnormal muscle tone? What's the difference between hypotonia (flaccidity) and hypertonia (spasticity)?
- Which findings posed the greatest safety risk? Consider dysphagia (CN IX/X dysfunction), visual deficits (CN II), ataxic gait, or weakness affecting mobility.
- What involuntary movements did you observe? Tremors, tics, or dysarthria (slurred speech indicating speech muscle incoordination)?

- If you noted declining consciousness or new weakness, what would this suggest? When would you escalate to the provider immediately?

Phase 3: Summarize

Key Takeaways

- Always assess symmetry—compare right vs. Left
- Systematically evaluate all 12 cranial nerves
- Recognize safety priorities: aspiration risk, fall risk, acute changes

Each student shares:

- ONE specific neurological assessment technique to refine (e.g., pronator drift, heel-to-shin test, cranial nerve testing)
- How findings would change your nursing care plan (fall precautions, aspiration precautions, neuro checks frequency)

Closing: Emphasize that systematic neurological assessment and recognizing trends prevent deterioration and improve patient outcomes.