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Effects of a Mental-Health Clinical Simulation Experience Using Standardized Patients and Two Debriefing Styles on Prelicensure Nursing Students' Knowledge, Anxiety, and Therapeutic Communication and Psychiatric Assessment Skills

Debrayh Gaylle

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The University of San Francisco

EFFECTS OF A MENTAL-HEALTH CLINICAL SIMULATION EXPERIENCE
USING STANDARDIZED PATIENTS AND TWO DEBRIEFING STYLES
ON PRELICENSURE NURSING STUDENTS' KNOWLEDGE,
ANXIETY, AND THERAPEUTIC COMMUNICATION AND
PSYCHIATRIC ASSESSMENT SKILLS

A Dissertation Presented
to
The Faculty of the School of Education
Learning and Instruction Department

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
Debrayh Gayle
San Francisco
May 2015

ABSTRACT

Dissertation Abstract

The purpose of this quasi-experimental pretest-posttest study was to compare the effects of two debriefing styles (insimulation and postsimulation) on (a) students' knowledge of psychiatric assessment and therapeutic communication, (b) students' performance of a psychiatric assessment using therapeutic communication, (c) students' perceived anxiety related to a clinical rotation in psychiatric mental-health, and (d) students' perceptions of the efficacy of the insimulation debriefing. The participants ($n = 67$) were senior, prelicensure nursing students enrolled in a baccalaureate degree program. Students were assigned randomly to either the treatment or the comparison group and participated in a series of simulated interviews using student volunteers as standardized patients.

The simulation strategy was a formative experience designed to introduce students to psychiatric assessment while concurrently providing a forum to practice therapeutic communication. The simulations replicated common patient diagnoses that students would encounter during their psychiatric clinical rotation.

The results of this simulation learning experience suggest that both methods of debriefing are effective for the acquisition of knowledge. Both groups showed a statistically significant gains in knowledge on the posttest; however, there were no statistically significant differences between the groups. The results of the paired-sample t test for the Psychiatric Assessment Rubric showed both groups had statistically significant differences from pretest to posttest with effect sizes ranging from 1.45 to 3.30; however, there were no statistically significant difference between groups. Additionally, both groups reported an overall decrease in anxiety for both groups with no important variations in the qualitative data between groups.

The treatment group was higher, on average, for therapeutic and nontherapeutic communication. Differences in means between the insimulation and the postsimulation group for therapeutic ($M = 1.39, 0.83$) and nontherapeutic communication ($M = -1.95, -0.79$) were statistically and practically significant from pre- to posttest with effect sizes of 0.98 and -1.50. Suggesting that insimulation debriefing was an effective tool for teaching therapeutic communication.

Results from the postsimulation survey indicated that the treatment group (insimulation) rated the effectiveness of the debriefing higher than their peers in the postsimulation group. Postsimulation qualitative data from the treatment group revealed several themes. The students in the insimulation group reported that being able to stop, rethink, and redo helped reinforce concepts and decrease anxiety. Several students stated that they would prefer to have a combination of insimulation and postsimulation debriefing.

Even though nursing literature has documented the effectiveness of simulation and suggested that debriefing is an essential component of the simulation learning experience, this research addressed a gap in the nursing literature. The large gains in communication skill observed in the treatment group clearly suggest a need for further investigation of debriefing methods.

This dissertation, written under the direction of the candidate's dissertation committee and approved by the members of the committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Education. The content and research methodologies presented in this work represent the work of the candidate alone.

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May 14, 2015
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May 14, 2015

DEDICATION

It is with a love and gratitude that I dedicate this body of work to my beautiful wife Linda Clark. You never gave up on me and refused to allow me to lose sight of my goal. Thank you for loving me, nagging me, and believing in me when I did not believe in myself.

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This dissertation represents my commitment to lifelong learning and a dedicated pursuit to developing my ability as a nurse educator. Earning the degree of Doctor of Education is a very significant step the long strange trip that has lead me to where I am today. I could not have met this goal without the support and guidance of so many important individuals. I wish to thank each of you for assisting me on this journey.

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TABLE OF CONTENTS

	Page
ABSTRACT	ii
SIGNATURE PAGE	iv
DEDICATION	v
ACKNOWLEDGMENTS	vi
TABLE OF CONTENTS.....	vii
LIST OF TABLES	xi

CHAPTER

I.	INTRODUCTION TO THE STUDY	1
	Purpose of the Study	5
	Theoretical Framework	6
	Background and Need	11
	History of Simulation in Healthcare	13
	Role of Debriefing in Simulation.....	14
	Traditional Teaching Methods	16
	Student Anxiety and Learning	18
	Simulation and Debriefing in Undergraduate Curricula	20
	Educational Significance	22
	Research Questions	24
	Definition of Terms.....	24
	Summary	27
II.	REVIEW OF THE LITERATURE	29
	Debriefing Research.....	31
	Nursing Student Anxiety.....	46
	Therapeutic Nurse-Patient Communication.....	53
	Psychiatric Assessment	58

TABLE OF CONTENTS CONTINUED

CHAPTER	Page
Simulation with Standardized Patients	61
Summary	66
 III. METHODOLOGY	 69
Research Design.....	69
Sample.....	70
Location of Study.....	71
Recruitment of Subjects	72
Protection of Human Subjects	73
Researcher Qualifications	74
Instruments.....	75
Psychiatric Assessment &Therapeutic Communication Test	75
Psychiatric Assessment Rubric	76
Therapeutic Communication Rubric.....	78
Anxiety Questionnaire	78
Demographic Questionnaire	79
Postsimulation Questionnaire	80
Data Collection	80
Preparation for Simulation.....	82
Simulation	83
Debriefing	86
Simulation Scenarios	87
Recruitment and Training of Standardized Patients	88
Restatement of Research Questions.....	89
Data Analysis	89
Steps in CQR Analysis.....	92

TABLE OF CONTENTS CONTINUED

CHAPTER	Page
IV. RESULTS.....	93
Research Question One.....	95
Research Question Two.....	97
Research Question Three.....	98
Research Question Four.....	100
Qualitative Analysis for Research Question One.....	104
Qualitative Analysis for Research Question Two.....	109
Qualitative Analysis for Research Question Three.....	109
Research Question Five.....	109
Summary.....	111
V. DISCUSSION, SUMMARY OF RESULTS, LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS	113
Summary of Findings.....	114
Limitations	115
Discussion of Results.....	116
Student Knowledge.....	116
Therapeutic Communication.....	117
Psychiatric Assessment.....	119
Anxiety.....	121
Debriefing Methods	122
Conclusion	123
Recommendations for Further Research.....	124
Recommendations for Practice	125
Afterward	126
REFERENCES	128

TABLE OF CONTENTS CONTINUED

	Page
APPENDICES	141
A. Psychiatric Assessment and Therapeutic Communication Pre- and Posttest.....	142
B. Content Experts Validity Rubric	149
C. Anxiety Questionnaire.....	181
D. Therapeutic Communication Rubric	183
E. Psychiatric Assessment Rubric	186
F. Postsimulation Questionnaire	190
G. Demographic Questionnaire	193
H. Clinical Simulation Confidentiality Agreement	195
I. Simulation Manual.....	198
J. Consent to Videotape.....	280
K. Invitation to Participate in Research, Informed Consent, and Research Subjects Bill of Rights.....	282

LIST OF TABLES

Table	Page
1. Results of Dependent-Sample <i>t</i> Tests on Student Level of Anxiety at Pre- and Postsimulation (<i>n</i> = 44)	49
2. May et al. (2009) Adaptation of Kirkpatrick's (1998) Model for Evaluating Outcomes	61
3. May et al. (2009) Summary of Outcomes.....	62
4. Psychiatric Assessment Rubric Items and Categories of Behaviors	77
5. Phases of the Research Process	81
6. Simulation Flow Chart	84
7. Means, Standard Deviations, Paired-Sample <i>t</i> -test Results, and Effect Sizes for the Psychiatric Assessment and Therapeutic Communication Knowledge Test and the Therapeutic and Nontherapeutic Communication Rubric for Both Groups Combined (<i>N</i> = 65).....	95
8. Means, Standard Deviations, Paired-Sample <i>t</i> -test Results, and Effect Size for Psychiatric Assessment for Both Groups Combined (<i>N</i> = 65)	97
9. Means, Standard Deviations, Paired-Sample <i>t</i> -test Results, and Effect Sizes for the Psychiatric Assessment and Therapeutic Communication Knowledge Test, Nontherapeutic and Therapeutic Communication, and Psychiatric Assessment Rubrics for Insimulation Group (<i>n</i> =32)	98
10. Means, Standard Deviations, Independent-Sample <i>t</i> -test Results for Psychiatric Assessment Knowledge Test Between Insimulation (<i>n</i> = 32) And Postsimulation Groups (<i>n</i> = 33).....	99
11. Change from Pretest to Posttest Means, Standard Deviations, Independent-samples <i>t</i> -test Results, and Effect Sizes for Therapeutic and Nontherapeutic Communication for Both Groups	99
12. Means, Standard Deviations, Independent-samples <i>t</i> -test Results for the Psychiatric Assessment Rubric Comparing Postsimulation and Insimulation Change from Pre- to Posttest.....	100

LIST OF TABLES CONTINUED

Table	Page
13. Postsimulation Survey Chi-square Results for Item One ($N = 65$)	101
14. Postsimulation Survey Chi-square Results for Item Two ($N = 65$).....	101
15. Postsimulation Survey Chi-square Results for Item Three ($N = 65$).....	102
16. Postsimulation Survey Chi-square Results for Item Four ($N = 65$)	102
17. Postsimulation Survey Chi-square Results for Item Five ($N = 65$).....	103
18. Postsimulation Survey Chi-square Results for Item Six ($N = 65$).....	103
19. Postsimulation Survey Chi-square Results for Item Seven ($N = 65$)	104
20. Presimulation Response to Question One with Major Themes for Both Groups ($N = 65$).....	105
21. Presimulation Response to Question Two with Major Themes for Both Groups ($N = 65$).....	106
22. Presimulation Response to Question Three with Major Themes for Both Groups ($N = 65$).....	107
23. Postsimulation Response Anxiety Questionnaire with Major Themes for Both Groups ($N = 65$).....	108
24. Themes for Postsimulation Student Perceptions for the Two Debriefing Methods ($n = 31$).....	110

CHAPTER I

INTRODUCTION TO THE STUDY

The goal of nursing faculty is to graduate student nurses who have the knowledge, skills, and attitudes needed to provide safe, quality, patient-centered care. The expectation of many nurse managers and experienced nurses at the bedside is that newly licensed registered nurses (RN) will transition quickly from student to professional. The readiness of new graduate registered nurses to provide patient care is a topic that generates lively debates and divergent perspectives among nurse educators in academic settings and nurse managers in practice (Dyess & Sherman, 2009). A growing body of research strongly suggests that many new graduates are not prepared to assume the professional responsibilities required in 21st-century healthcare environments (Burns & Poster 2008; Del Bueno, 2005; Li & Kenward, 2006; Spector & Li, 2007; Tanner, 2006; Thomas, Hodson-Carlton & Ryan, 2011).

A nationwide study conducted by the Nursing Executive Center found that 90% ($n = 3265$) of hospital nurse executives reported that the majority of new graduate nurses were not prepared adequately for entry into practice (Berkow, Virkstis, Stewart, & Conway, 2009). Berkow et al. (2009) reported that 59% of the responding nurse executives surveyed indicated that 53% of new graduate nurses who are baccalaureate prepared lacked the communication and assessment skills needed to provide safe patient care. The American Association of Colleges of Nursing (AACN, 2009) wrote in *The Essentials of Baccalaureate Education for Professional Nursing Practice* that therapeutic communication between nurse and patient is essential to the collection of detailed assessment data and safe patient care. Conversely, Aled (2007) reported that on average most student nurses understand the principles of assessment and communication; however, theoretical knowledge does not transfer consistently to practice.

The theory-practice gap is not a new issue in nursing education. In 1993, Rolfe wrote that “Despite the efforts of nursing theorists, educationalists, and practitioners, the theory-practice gap continues to defy resolution” (p. 173). Nursing students develop clinical competency by practicing nursing skills and interventions during a series of clinical rotations. Opportunities in the clinical setting are often inconsistent, and the need to balance student learning and patient safety, however, contributes to the theory-practice gap (Onda, 2014). Gallagher (2004) described the theory-practice gap as a “dissonance between desired learning and demonstrated learning” (p. 264). Nurse educators maintained that narrowing the theory-practice gap requires integrating current educational research into curriculum (Gallagher, 2004; Higginson, 2004; Maben et al., 2006; Martin & Mitchell, 2001; Ousey & Gallagher, 2007; Sharif Masoumi, 2005).

The clinical setting is the traditional environment for nursing students to apply didactic theory to real patient issues. Tanner (2002) noted that changes in the current healthcare delivery systems have created a shortage of quality clinical placements. The lack of quality clinical experiences may be a contributing factor to the reports of new graduate registered nurses (RNs) leaving nursing school unprepared to assume the responsibilities expected in the workplace (APNA, 2005; De Bueno, 2005; Tanner, 2002). Kameg, Mitchell, Clochesy, Howard, and Suresky (2010) wrote that simulation is a powerful tool for providing students with a safe environment to apply theory-to-practice while receiving timely instructor feedback. The current interest in simulation as a clinical teaching tool has been driven partially by a shortage of appropriate clinical placements and the need to balance student learning with patient safety (Durham & Alden, 2008; Hall, 2006; Patzel, Ellinger, & Hamera, 2007).

The AACN (2008) recommended that all baccalaureate curricula should include

simulation as an adjunct to clinical learning. Simulation recreates reality and allows students to assume the role of the nurse without jeopardizing patient safety. Nurse educators use a variety of tools to recreate the clinical environment in the simulation learning laboratory. These tools include task trainers, standardized patients, computer simulation programs, and computerized manikins. Medical and nursing literature supports the use of simulation as an adjunct to traditional educational methodology (Brown, 2008; Feingold, Calaluce, & Kallen, 2004; Gaba 2004, 2011).

The pedagogy of simulation consists of three parts. First students are preparation for simulations includes reading assignments, class discussions, or instructions from the instructor. During the second phase, the student assumes the role of the nurse and actively participates in the scenario. The final step of the process is debriefing or active reflection. The debriefing process is based on the concept of reflective thinking and considered to be the most crucial part of simulation-based learning (Childs, Sepples, & Chambers, 2007; Dreifuerst, 2009; Fanning & Gaba, 2007; Jeffries, 2005, 2007).

Debriefing is defined in the literature as an interaction between instructor and student that fosters the development of clinical reasoning, clinical judgment, and communication skills (Arafeh, Hansen, & Nichols 2010; Cantrell, 2008; Dufrene & Young, 2014; Levett & Jones, 2014). The debriefing process provides the opportunity for reflection and encourages the scaffolding of new knowledge with existing knowledge (Dreifuerst, 2009; Rudolph, Simon, Raemer, & Eppich, 2008; Waxman, 2010; Wickers, 2010). Simulation experts asserted that simulation without effective debriefing is not a useful addition to the curriculum (Childs et al., 2007; Dreifuerst, 2009; Fanning & Gaba, 2007; Jeffries, 2005, 2007).

Simulation research in the literature has focused on the effect of simulation on dependent

variables such as student skill acquisition, student knowledge, and student satisfaction (Brannon & Bezanson, 2008; Brown & Chronister, 2009; Hoffman, O'Donnell, & Kim, 2007; Howard, Ross, Mitchell, Nelson, & Nelson, 2010). Faculty-led debriefing follows most simulation activities and is described as vital for the transfer of knowledge to practice (McGaghie, Issenberg, Petrusa, & Scalese, 2010; Rudolph et al., 2008; Van Heukelom, Begaz, & Treat, 2010). Research guiding the dynamics and structure of the debriefing process, however, is minimal (Dreifuerst, 2009; Fanning & Gaba, 2007), and studies comparing debriefing styles are extremely limited (Van Heukelom, et al., 2010).

The need to address the theory-to-practice gap is essential for patient safety (Burns & Poster 2008; Del Bueno, 2005; Dyess & Sherman, 2009; Li & Kenward, 2006; Tanner, 2006; Thomas, Hodson-Carlton, & Ryan, 2011). The nurse's ability to conduct assessments using therapeutic communication has been identified as a core competency of nursing practice (AACN, 2008; Kurtz, Silverman, & Draper, 2005). This research study utilized a formative simulation experience with standardized patients to teach therapeutic communication and psychiatric assessment to prelicensure, undergraduate nursing students. Standardized patients are individuals trained to portray specific illnesses and emotional responses.

The researcher compared the effectiveness of two debriefing styles on changes in student knowledge, skill performance, and anxiety levels pre- and postsimulation. The debriefing methods were insimulation and postsimulation. Insimulation debriefing provides immediate feedback during the simulation experience and allows the student to redo their interaction with the standardized patient (see chapter III). Van Heukelom et al. (2010) stated that this method provides students with the opportunity to correct mistakes as they happen during the simulation. Postsimulation debriefing occurred at the conclusion of the simulation experience; Fanning and

Gaba (2007) explained that postsimulation debriefing encourages the reconstruction of the students' thought process and promotes consolidation of theory to practice. Careful review of the literature found no nursing research that used simulation with standardized patients to compare the effects of these two debriefing styles on student outcomes. The following section explains the purpose of this research.

Purpose of the Study

Schools of nursing have increased dramatically the use of simulation as an adjunct to traditional nursing curricula (Dufrene & Young, 2013; Levett-Jones & Lapkin, 2014). The goal of simulation is to improve learning, enhance future performance, and ultimately address the theory-practice gap (McCaughey & Traynor, 2010). Arafeh, Hansen, and Nichols (2014) stated that the debriefing process is the most important component of the simulation experience. Debriefing provides an opportunity to clarify the learner's knowledge and rationale for nursing interventions during the simulation scenario (Metcalf, Hall, & Carpenter, 2007).

The importance of debriefing has been highlighted in the literature and is considered to be the most critical component of the simulation learning experience (Arafeh, Hansen, & Nichols 2010; Cheng, et al., 2014; Fanning & Gaba, 2007; Issenberg, McGaghie, Petrusa, Gordon, & Scalese, 2005; McGaghie, Issenberg, Petrusa, & Scalese, 2010). Cheng et al. (2014) noted in a comprehensive review of nursing simulation literature that only 10% of simulation studies involving debriefing compared one style of debriefing with another.

This study used a quasi-experimental pretest-posttest design with participants serving as their own control. The sample population ($n = 67$) were senior; prelicensure nursing students enrolled in a baccalaureate degree program. Students participated in a series of simulations using standardized patients to practice psychiatric assessment and therapeutic communication. In

addition to providing a formative learning experience, the sample was assigned randomly to two groups to compare the effects of two debriefing styles (insimulation and postsimulation) on (a) students' knowledge of psychiatric assessment and therapeutic communication, (b) students' performance of a psychiatric assessment using therapeutic communication, (c) students' perceived anxiety related to a clinical rotation in psychiatric mental-health, and (d) students' perceptions of the efficacy of the insimulation debriefing.

The simulation activity is a formative experience to assist nursing students in integrating theoretical knowledge into practice. The simulations replicate four common patient diagnoses that students will encounter during their psychiatric clinical rotation. The simulations, as well as the two styles of debriefing (independent variable), were designed to scaffold new knowledge and skills with students' prior experience, encourage the development of therapeutic communication skills, and provide a venue for students to practice psychiatric assessment in a supportive environment. Additionally, this research added to the existing body of knowledge related to the efficacy of debriefing styles in nursing curriculums.

Theoretical Framework

The acquisition of a diverse range of communication, assessment, and critical-thinking skills are essential to preparing prelicensure undergraduate nursing students for entry into the 21st century's complex healthcare system. Nursing educational pedagogy focuses on facilitating the acquisition and practice of the knowledge, skills, and attitudes needed to provide safe patient-centered care. Paige and Daley (2009) have suggested that traditional nursing education uses an eclectic approach to curriculum design. According to Paige and Daley (2009), "behaviorist principles are necessary to acquire new skills (psychomotor domain), and cognitive principles support conceptualization of knowledge such as nursing process (cognitive domain), while

constructivist principles explain personal meaning of the knowledge gained (affective domain)" (p. 98). The varied nature of education in the art and science of nursing makes it difficult to focus exclusively on a single learning theory. The theory of situated cognition was chosen as the theoretical framework for this research as it supports all simulated learning environments and is appropriate for learning in the affective domain (Lave & Wenger, 1991; Paige & Daley, 2009; Woolley & Jarvis, 2007).

The theory of situated cognition, also known as situated learning, was developed from the work of cognitive scientists such as Vygotsky and Piaget. The central premise of situated cognition is that all learning outcomes are influenced by the situation within which they occur (Brown, Collins, & Duguid, 1989; Lave & Wenger, 1991). Leaders in the area of situated cognition believe that effective learning is a function of the activity, context, and culture in which it occurs (Brown et al., 1989; Lave & Wenger, 1991; Spouse, 1998, 2001). Situated cognition theorists contended that traditional classroom learning involves abstract knowledge that is not always transferable to practice and is dependent on social interaction; therefore, the context in which learning transpires is essential to learners' ability to apply newly acquired knowledge to practice (Lave & Wenger, 1991; Roschelle, 1992; Vygotsky 1962, 1978; Wenger, 1998).

Current educational perspectives have been reconceptualized. Learning is no longer considered an additive process in which knowledge is transferred into the waiting minds of the learner but is characterized by the acquisition of knowledge as a socially facilitated developmental process (Borthick, Jones, & Wakai, 2003). Borthick et al. (2003) suggested that "accepting the dual cognitive-social nature of learning creates a new problem for instructors: designing learning experiences that meld the cognitive and social aspects without subordinating

either to the other" (p. 107). The construction of new knowledge occurs during interactions between individuals within a social milieu, and social interaction is instrumental to language acquisition, human development, and learning (Vygotsky, 1978).

Specialty groups within the profession of nursing have a specific social structure and language defining that individual specialty for example, expert psychiatric nurses will be well versed in the management of delusional behaviors. Benner, Tanner, and Chesla (2009) wrote that nursing is a complex and situational profession and the skills needed for proficiency are acquired through practical experiential learning. The role of nursing faculty is to provide an environment that gives the prelicensure nursing student the experiences needed to achieve an understanding of the unique contextual components of each nursing specialty and to acquire the nursing competencies needed.

Lave and Wenger (1991) believed that learning should not be viewed as merely the transmission of knowledge from one person to another but as a social process where knowledge is co-constructed among individuals with similar interests. Situated cognition provides a framework that places the student in a cognitive apprenticeship or community of practice and allows the student to become acculturated into a profession through authentic activities and social interactions (Brown et al., 1989; Lave & Wenger, 1991; Wenger, 1998). Simulation is a controlled environment that provides immediate feedback and mentorship, making it the ideal learning environment for acquiring the skills needed for safe patient-centered care (Howard, Englert, Kameg, & Perozzi, 2011).

Student nurses in the clinical setting are excluded from participating in activities that would jeopardize the patient. For example, the "code team" of expert doctors and nurses with years of experience care for a patient having a heart attack. The patient's needs necessitate that

nursing students become observers during this critical event. Many nurse educators agree that observation is a valuable component of the students' educational process and provides important insights into the role of the nurse. Observational activities do not provide adequate training because they do not incorporate the cognitive, psychomotor, and affective domains of learning into a single experience that can assist in the transfer of knowledge from theory to application (Benner et al., 2009; Buykx et al., 2011). Simulations designed to replicate real-world experiences can provide students with the scaffolding that enables them to perform naturally and to gain insight into the complexity of competencies needed in actual clinical settings (Flanagan, Nestel, & Joseph, 2004; Paige & Daley, 2009; Woolley & Jarvis 2007).

Situational cognition uses modeling and coaching to support the three stages of skill acquisition: the cognitive stage, the associative stage, and the autonomous stage (Anderson, 1983; Wenger, 1998). The cognitive stage focuses on a declarative understanding of the expected knowledge and skills needed for the given task (Anderson, 1983; Wenger, 1998). The associative stage uses modeling and coaching to correct any misunderstandings learned in the cognitive stage and strengthens the associations between critical components of the task (Anderson, 1983; Wenger, 1998). During the autonomous stage, students perfect the knowledge and skills of the task and transition to the role mentor within the community of practice (Anderson, 1983; Wenger, 1998). When novice students are learning new tasks, the psychomotor skills are observable, but the thought process that provides the rationale for the behaviors is often unclear (Benner et al., 2010; Brown et al., 1989). The debriefing strategies used in this research are designed to provide transparency and to make specific processes explicit.

The debriefing activities used the core concepts of situated cognition. The first three steps

include modeling, coaching, and scaffolding to encourage cognitive and metacognitive development (Brown et al., 1989). The next two steps articulation and reflection are designed to increase awareness of problem-solving strategies and encourage performance of skills on par with those of the experts. The last step, exploration, encourages independent thought processes, identification of issues, and resolution of problems (Benner et al., 2010; Brown et al., 1989).

During the presimulation activities, the researcher provided the participants with the information needed to add new concepts to prior knowledge. Brown et al. (1989) argued that coaching is a key component of cognitive apprenticeship. For successful integration of new knowledge, coaching should be consistent throughout the learning process. The simulation and debriefing experience is designed to provide participants in the treatment group with immediate feedback. The coaching process during insimulation debriefing provides participants with immediate feedback, coupled with examples of expected behaviors, from expert psychiatric mental-health faculty. Additionally, after each coaching session, students repeated the interaction with the standardized patient allowing them to correct their mistakes. Reflection is critical to the learning process and supports acquisition of new knowledge and skills (Benner et al., 2010; Brown et al., 1989). Although reflection is emphasized for the nontreatment group, during structured postsimulation debriefing, students in both groups were encouraged to reflect on their performance.

Nursing is a collaborative profession, and nurses are members of a community of practice. The successful transition from novice to expert requires a transformation of accumulated knowledge to a practical application of that knowledge (Benner et al., 2010; Evensen, 2000). Experts have suggested that the theory of situated cognition is an appropriate theoretical model for the design of simulated learning experiences (Onda, 2011; Paige & Daley,

2009). The simulations and debriefing designed for this research create a community of practice that reinforces the role of the nurse and provides the novice student with the opportunity to practice core competencies in a supportive environment without the risk of harm to patients or students.

Lave and Wenger (2005) proposed that comprehension and performance were linked, being what they term as “mutually constitutive” (p. 152). Wilson (1993) stated "knowledge and learning have to be understood as inextricably integrated with the setting in which they occur" (p. 73). Student nurses require a variety of experiences in order to consolidate their theoretical knowledge of patient care with clinical practice (Woolly & Jarvis, 2006). The barriers that exist in 21st-century healthcare have created situations where experiences needed to become proficient are frequently unavailable to students; therefore, new graduate nurses often lack the skills needed to provide safe patient care (Cronenwett et al., 2007; Del Bueno, 2005; Donley, 2005).

Background and Need

Nursing research has established that many new graduate nurses are unprepared for entry to practice (Berkow et al., 2009; Del Bueno, 2008). Changes in the healthcare system and increased competition between schools of nursing has created a shortage of appropriate clinical placement; therefore providing undergraduate nursing students with safe and meaningful learning experiences in all clinical settings have become increasingly more challenging (Berkow et al., 2009; Del Bueno, 2005; Richardson, Goldsamt, Simmons, Gilmartin, & Jefferies, 2014). Robinson-Smith et al. (2009) stated that shift from inpatient care to outpatient care has effected further decreased the number of quality clinical placement for psychiatric mental health. In response to the shortage of clinical placements and according to regulations established in 2014

by the California Board of Registered Nursing 25% of required clinical hours can be simulation activities.

The American Psychiatric Nurses Association and International Society of Psychiatric Nursing (APNA & ISPN, 2008) advised that providing care for the mentally ill is not limited to the psychiatric mental-health settings because all nurses will encounter persons with mental-health issues throughout their careers. It is crucial that all nurses are prepared to recognize the symptoms of mental illness and provide safe and appropriate care (APNA & ISPN, 2008). The American Nurses Association (ANA, 2000) stated that nurses must be able to establish and maintain a therapeutic and professional nurse–patient relationship in order to provide safe patient-centered quality care. Therapeutic communication is an essential element of psychiatric nursing and the key to establishing therapeutic nurse-patient relationships (Becker, Rose, Berg, Park, & Shatzer, 2006; Mohr, 2009; Peplau, 1991, 1997).

Existing nursing research suggests that prelicensure undergraduate nursing students benefit from the implementation of simulation with standardized patients in psychiatric and mental-health nursing (Becker et al., 2006; Brown, 2008; Robinson-Smith et al., 2009). Simulation with a standardized patient allows the student to assume the role of the nurse without the potential risk inherent in an actual patient encounter. The intention is not to replace actual patient encounters with standardized patients but to augment the learning experiences by providing nursing students with the opportunity to practice formative skills in a safe environment (Becker et al., 2006; Robinson-Smith et al., 2009).

Simulation debriefing designed using the theory of situated cognition has the potential to address and narrow the gap between theoretical knowledge and application of that knowledge to real-world practice (Brown et al., 1989; Onda, 2011). Learning objectives built into clinical

course curriculums are designed to consolidate the students' understanding of didactic theory and enable the students to apply their knowledge to actual patient encounters; however, the need to assure patient and student safety frequently overshadows the ability to provide optimal learning experiences in the psychiatric setting. Simulations can create authentic reenactments of real-world scenarios and potentially build a bridge between pedagogy and practice. The debriefing process allows "modeling" and "coaching" by experts and supports the cognitive, associative, and autonomous stages of skill acquisition (Lave & Wenger, 1991).

The remainder of this section contains (a) a brief history of simulation and debriefing in healthcare, (b) an overview of traditional teaching methods in nursing curricula, (c) a review of mental-health issues in all nursing disciplines, and (d) a summary of the effect of student anxiety on learning. This section concludes with the need for further investigation comparing the effects of insimulation and postsimulation debriefing on students' knowledge, skills, and anxiety.

History of Simulation in Healthcare

In 1963, Dr. Howard S. Barrows was the first person to use standardized patients as a formative and evaluative teaching method. The majority of his peers ridiculed the methodology (Barrows, 1993). Although Dr. Barrows was asked frequently to speak at conferences, he was prohibited from discussing the use of standardized patients (Wallace, 1997). Barrows (1993) wrote that the use of standardized patients took the learning process a step beyond the books and put the learning of medicine as close to the truth of an authentic patient encounter as possible. Although the methodology was slow to catch on, in 1993, the Medical Council of Canada incorporated standardized patients into the medical licensure examination process, and, in that year, approximately 79% of all American Schools of Medicine were using standardized patients (Barrows, 1993).

The use of simulation to engage the learner in realistic and meaningful activities is not new pedagogy; military, commercial aviation, business, and medicine have used simulation to duplicate real-life situations for several centuries (Feingold, Calaluca, & Kallen, 2004; Gaba, 2004, 2011; Robinson-Smith et al., 2009). In schools of nursing across the United States, nurse educators have embraced simulation as an innovative tool to teach and test psychomotor, communication, and clinical decision-making skills (Bligh & Bleakley, 2006; Brown, 2008; DeBourgh & Prion, 2011; Feingold et al., 2004; Gaba, 2004, 2011). Many schools of nursing have obtained grant funding to purchase highly technical computerized manikins that can replicate human physiological functions accurately. Psychiatric mental-health curricula have been notably absent in using simulation given the computerized manikins' inability to display body language and realistic emotion. Psychiatric mental-health instructors are beginning to investigate the use of standardized patients in prelicensure undergraduate nursing education. Extensive research supports the use of standardized patient as an effective tool in schools of medicine; however, there are only a few published articles on using the standardized patients in undergraduate nursing (Lin et al., 2013; May & Lee, 2009).

The Role of Debriefing in Simulation

Pearson and Smith (1986) reported that historically, the term debriefing originated in the military and referred to the reports given by soldiers returning from a mission. This debriefing process was used as an educational tool for planning future missions (Pearson & Smith, 1986). Fanning and Gaba (2007) noted that additional forms of debriefing included the development of therapeutic processing of a traumatic event with the goal of reducing psychological damage. The therapeutic approach emphasized the importance of reconstruction of the event. This style of debriefing brought individuals together in a group to describe the event, to evaluate their thought

processes, and to develop new strategies and coping mechanisms (Fanning & Gaba, 2007).

Debriefing has an expanding role in nursing and medical education (Fanning & Gaba, 2007; Rudolph, Simon, Raemer, & Eppich, 2008). Brett-Fleegler et al. (2014, p. 292) wrote that “Regardless of the specific setting, the goal of debriefing remains the same: to promote reflection and learning and, ultimately, to thereby improve performance.” Simulation researchers strongly suggest that debriefing is the most important aspect of simulated learning (Brett-Fleegler et al., 2014; Fanning & Gaba, 2007; Neill & Wotton, 2011; Wazonis, 2014). The debriefing process effectively supports learning and the consolidation of skills (Issenberg et al., 2005; Lasater, 2007a, 2007b; Shinnick, Woo, Horwich, & Steadman, 2011).

Even though there is evidence supporting the importance of debriefing to the simulation process, the research on simulation debriefing practices is limited (Wazonis, 2014). According to Wazonis (2014), a variety of terms are used in the literature to describe debriefing, including “debriefing, reflection, and feedback” (p. 460). International Nursing Association for Clinical Simulation and Learning (2014) has defined debriefing as an activity led by a facilitator that encourages reflective thinking and provides feedback regarding performance where aspects of the simulation are discussed. Participants are encouraged to explore emotions, to question, and to reflect as they move toward assimilation and accommodation in order to transfer theory to practice (Johnson-Russell & Bailey, 2010; National League of Nursing and Simulation Innovation and Resource Center, 2010).

The use of simulation in nursing education is expanding rapidly as a result of the decrease in appropriate clinical sites, the increased support from nursing organizations, and the identification of the advantages of simulation as a venue for the acquisition of knowledge and skills (Nehring & Lashley, 2009; Seropian, Brown, Gavilanes, & Driggers, 2004). Even though

there is wide-spread use of simulation in undergraduate nursing education, research on debriefing practices is limited. Existing debriefing research suffers from weak methodology, and current simulation debriefing practices are not evidence based (Reamer et al., 2011; Wazonis, 2014).

Traditional Teaching Methods

In traditional clinical instruction, one instructor is assigned 8 to 10 students; the instructor is dependent on the assistance of RNs within the hospitals or healthcare facilities to supervise and mentor the students. Although this method has worked for generations, Benner et al. (2010) argued that, in the 21st-century fast-paced healthcare environment, many teachable moments are missed and new and innovative teaching methods are required to maintain the quality of nursing education. Many nursing faculty have reported increasing difficulties with providing quality clinical placements and diverse experiences for their students. The APNA and ISPN (2008) have suggested that a shortage of quality clinical placements and experiences may be contributing to the phenomena of graduate RNs being unprepared to assume the responsibilities expected in the workplace.

Nationwide Boards of Nursing, accrediting bodies, and hospital executives have issued a challenge to nurse educators, asking them to investigate creative ways to provide quality clinical experiences for undergraduate nursing students (Prion, 2008). Tanner (2002, p. 51) warned that the traditional "clinical placement" model "is beginning to unravel in the whirling dervish of nursing practice change." Many nurse educators believe that the future of nursing education is dependent on the nurse educator's ability to think beyond traditional pedagogy, to challenge current processes of nursing education, and to develop innovative strategies for preparing student nurses who can provide safe and effective patient care (Benner et al., 2010; Olejniczak, Schmidt,

& Brown, 2010).

The psychiatric mental-health clinical practicum is where prelicensure undergraduate nursing students apply the didactic content learned in the classroom to actual patient situations. Kluge and Glick (2006) cautioned that the gap between the didactic theory and actual practice in the psychiatric clinical setting places both students and patients at risk. Spade and Mulhall (2010) stated that therapeutic communication "is the key element to assessing and responding to psychosocial variables of health" (p. 145). Hildegard Peplau (1956, 1968, 1987, 1991, 1997), a pioneer in the field of psychiatric nursing, emphasized the importance of establishing an effective therapeutic nurse–patient relationship. Therapeutic communication is the foundation of nursing practice, an effective assessment tool, and a therapeutic modality for patient healing (Kameg, Mitchell, Clochesy, Howard, & Suresky 2010; Mohr, 2009).

Building on the works of Hildegard Peplau (1956, 1968, 1987, 1991, 1997), Navarra, Lipkowitz, and Navarra (1990) postulated that therapeutic communication was developed because patients frequently are traumatized during the communication process. Small talk, teasing, gossip, sarcasm, or a noncommittal response does not contribute to the healing environment needed for positive patient outcomes. Therapeutic communication establishes relationships that encourage and support a healing environment. The personal comments that one person makes to another are often nontherapeutic; until an individual becomes aware of his or her communication process he or does not know how to be therapeutic (Navarra et al., 1990; Peplau, 1991, 1997; Rosenberg & Gallo-Silver, 2011). Student nurses must become aware of the implications of what they are saying to the patient (Navarra et al., 1990; Rosenberg, & Gallo-Silver, 2011). For example, asking a patient "Why do you feel that way?" is often perceived as judgmental, or telling a depressed patient "Don't worry, you will feel better soon," discounts their

feelings, even if the nurse is attempting to be sincere and helpful (Hagerty, & Patusky, 2003; Navarra et al., 1990).

Student Anxiety and Learning

It is well documented in the literature that student nurses experience some level of anxiety in any clinical setting; however, many students report higher than average levels of anxiety in the psychiatric clinical setting (Morrisette, 2004; Shipton, 2002; Szpak & Kameg, 2011). Kameg et al. (2010) found that student nurses' anxiety increased exponentially prior to beginning a psychiatric clinical rotation. Szpak and Kameg (2011) reported that failure to address student anxiety may lead to students' inability to show empathy and develop rapport with patients. In addition, high levels of anxiety impair cognition and hinder the students' ability to maintain personal and patient safety (Becker & Neuwirth, 2002; Schmeiser & Yehle, 2001; Szpak & Kameg, 2011).

Nursing is an art and a science. The classroom and clinical experiences encountered during nursing school prepare the undergraduate nursing student for an understanding of these dual concepts. The AACN (2008) listed communication as a crucial core competency for delivering safe patient care. The APNA and the ISPN (2008) stated that student nurses must be able to apply therapeutic communication techniques with patients experiencing common psychiatric symptoms including depressive states, suicidal ideation, disorganized speech, hallucinations, and delusions. Nurses play a vital role in the lives of their patients. Acquiring the ability to provide for the emotional wellbeing of patients and their families regardless of the setting is essential to the education of all student nurses.

The Education Council Task Force of the APNA and ISPN (2008) developed *Essentials of Psychiatric Mental-Health Nursing in the BSN Curriculum*. This document stressed the

important role that all nurses have in promoting the mental-health of patients in all settings.

Therapeutic relationships are a critical component underlying all nursing skills, and nurses must be able to assess a patient's developmental needs, mental status, neurological function, and risk for suicide (APNA & ISPN, 2008).

A systematic review of the nursing literature revealed that many nurses did not believe that they possessed the skills to care for individuals with mental illness. The same researchers noted that individuals with psychiatric disorders tended to have higher rates of readmissions for nonpsychiatric medical issues than the general population (Hardcastle & Hardcastle, 2003; Reed & Fitzgerald 2005; Ross & Goldner, 2009; Sartorius & Schulze 2005; Schulze, 2007). Zolnierrek (2009) suggested that nurses' perceived inability to care for psychiatric patients admitted for medical reasons is a possible cause of higher readmission rates.

Hung et al. (2009) reported that nursing students in the mental-health clinical setting experienced extremely high levels of anxiety and many feared that they would not respond appropriately to the patient's concerns, inadvertently harming the patient. Many prelicensure student nurses are unprepared for the unique challenges of clinical practice in the psychiatric setting (Morrissette, 2004). Many student nurses report anxiety, feelings of inadequacy, and a lasting fear of future encounters with mentally ill individuals after witnessing patient behaviors in the psychiatric setting (Morrissette, 2004). Providing students with positive experiences and supportive role models during their psychiatric mental-health clinical rotation potentially can change the way nurses of the future respond to individuals with mental illness.

Researchers have noted that, at the completion of the mental-health clinical rotation, many nursing students had negative attitudes that potentially influence and shape their view of psychiatric nursing and mentally ill patients for the remainder of their careers (Laws & Hawkins,

1995; Morrisette, 2004; Sullivan, 1993; Tully, 2004). The myth among student nurses and some nursing faculty is that students need to "tough it out" and finish the psychiatric rotation so they can move on to nonpsychiatric settings and never have to encounter another psychiatric patient. The reality is that the number of mentally ill patients hospitalized for nonpsychiatric issues is increasing every year (Hermanns & Russell-Broadus, 2006). Between 1992 and 2001, mental-health related emergency department visits in the United States increased from 4.9% to 6.3% (Larkin, Claassen, Emond, Pelletier, & Camargo, 2005). The AACN (2008) wrote that the nurse's ability to establish a therapeutic nurse-patient relationship is fundamental to all patient encounters.

Nursing research suggests that simulation decreases student anxiety levels (Becker et al., 2006; Gore, Hunt, Parker, & Raines, 2011; May, Park, & Lee, 2009). Lehr and Kaplan's (2013) research used computerized manikins in two psychiatric mental-health simulation scenarios that included difficult-to-address behaviors and topics encountered in psychiatric settings. They reported that the percentage of students self-reporting high levels of anxiety in caring for mental-health patients decreased from 28% presimulation to 7% postsimulation. Lehr and Kaplan's (2013) research used simulation as an anxiety-reducing strategy; this research study focused the effects of two debriefing styles on student anxiety, knowledge, and skill acquisition.

Simulation and Debriefing in Undergraduate Curricula

Novice nursing students do not have the experience needed to respond proficiently to psychiatric patients who may be disclosing distressing or painful information (Morrisette, 2004; Robinson-Smith et al., 2009). According to Morrisette (2004), student nurses are genuinely interested in reducing patient suffering but are uncertain about how to accomplish this task. Nursing instructors have used a variety of teaching strategies to prepare students for the

psychiatric mental-health clinical; however, research indicates that many students continue to complete this clinical rotation feeling unprepared to deal with mentally ill patients (Morrisette, 2004; Sullivan, 1993; Tully, 2004).

Simulation is a teaching strategy that complements traditional clinical experience with actual patients and enables students to integrate knowledge with practice without risks to patient safety (McCaughey & Traynor, 2010). Simulation allows faculty to develop a core set of controllable patient-centered clinical problems that can be repeated reliably for multiple student groups (Barrows, 1993; Brown, 2008; Fay-Hillier, Regan, & Gallagher, 2012). Researchers have suggested that standardized patients are a safe and effective mode of teaching therapeutic communication and psychiatric assessment skills to undergraduate nursing students, medical students, physicians, and nurse practitioners (Benner, Sutphen, Leonard, & Day, 2010; Gaba, 2011; Ironside, Jeffries, & Martin, 2009; O'Connor, Albert, & Thomas, 1999; Robinson-Smith et al., 2009; Seropian, 2003; Thomas, O'Connor, Albert, Boutain, & Brandt, 2001).

May and Lee (2009) conducted a comprehensive review of the medical and nursing literature on simulation with standardized-patients from 1996 to 2005 and found that the most common use for standardized-patient simulation was teaching communication skills (55%). Standardized patients are an appropriate choice for teaching psychiatric assessment and therapeutic communication due to the inability to recreate emotional responses and body language using computerized manikins. In addition to training the standardized patient to portray specific illness symptoms, training can include how to provide cues and reinforcement of appropriate student behaviors.

During simulation, students can apply theory to patient-care scenarios and receive immediate feedback without risks to student or patient safety. Kardong-Edgren, Starkweather,

and Ward (2008) argued that the heart of simulation is debriefing, a process that encourages the skills of self-reflection and discovery. Debriefing provides an opportunity for students to discuss rationales for behavior and clinical judgments (Hammer, Fox, & Hampton, 2014). The simulation instructor is expected “to relinquish the role of sage on the stage and become a guide on the side” (Kardong-Edgren et al., 2008, p. 4). Effective debriefing is facilitated in a collegial atmosphere, and students are expected to support their peers and participate in the debriefing process (Dreifuerst, 2012; Kardong-Edgren et al., 2008).

The prospective benefit of simulation with effective debriefing is decreased student anxiety and increased competence. Nurse educators have suggested that skills learned during simulation will be transferred to the clinical setting, thus increasing patient safety and narrowing the theory-practice gap (Arafeh, Hanson, & Nichols, 2014; McCaughey & Traynor, 2010).

Effective simulation requires a considerable commitment of time from faculty, both in the planning and implementation of the simulations (Dreifuerst, 2012; Kardong-Edgren et al., 2008). Faculty conduct the scenario, observe students, and facilitate the debriefing. The typical debriefing session is two to three times as long as the simulation scenario and often lasts longer than the simulation scenario (Arafeh et al., 2014; Dreifuerst, 2012; Kardong-Edgren et al., 2008). Simulation is conducted in groups of 8 to 10 students, and a complete simulation session including debriefing can last over 3 hours (Dreifuerst, 2012; Kardong-Edgren et al., 2008). In order to better utilize simulation in a nursing curricula, research is needed that compares the effects of postsimulation and insimulation debriefing methods on student knowledge acquisition, skills, and anxiety.

Educational Significance of the Study

Nursing students today are preparing to function in a complex healthcare environment

where the standards of care demand that students enter the work-force with the knowledge, communication, and assessment skills needed to provide safe quality patient-centered care (Dreifuerst, 2012; Ironside et al., 2009). Even though debriefing is a commonly accepted component of simulation, there is paucity of literature on debriefing. Debriefing has been defined many ways; however, for faculty and students to obtain meaningful benefit from simulation, study of the debriefing process is crucial (Dreifuerst, 2012; Fey, Scrandis, Daniels, & Haut, 2014). Debriefing is an essential component of simulation, and this study will add to the existing body of knowledge, as well as, answer an identified need for empirical research comparing the effectiveness of the two approaches for debriefing.

A unique feature of this study is the research design. This research utilized two different debriefing styles: traditional postsimulation and insimulation debriefing. Students participating in simulations with standardized patients as formative experience, in preparation for a psychiatric mental-health clinical rotation, were assigned randomly to receive insimulation debriefing or postsimulation debriefing. Although other researchers have investigated the use of standardized patients to teach assessment skills and therapeutic communication, this research focused on the effect of the debriefing method on student anxiety, knowledge, and skill. Data were collected on changes in student performance over time, using psychiatric assessment and therapeutic communication rubrics developed by the researcher. Changes in student knowledge were measured using a 30-item multiple-choice test. Additional data were collected using a postsimulation and a student anxiety questionnaire.

The complex competencies expected of new graduate nurses are increasing. The majority of nurse educators will agree that knowledge is essential to the formation of these competencies; nevertheless, knowledge on its own is not sufficient. In order to be effective,

knowledge must accompany behaviors that are applicable to actual clinical situations. It is vital that students gain a mastery of therapeutic communication and psychiatric assessment skills to ensure safe patient care in all clinical settings (Becker et al., 2006). Developing best practices for debriefing simulation is critical for student learning.

Research Questions

This proposed quasi-experimental pretest-posttest study asked five research questions.

The questions are as follows:

1. What is the extent of change from pretest to posttest in knowledge, anxiety, and performance (using the rubric to measure performance) for the two groups combined?
2. What is extent of change in knowledge, anxiety, and performance after insimulation debriefing?
3. Is there a difference in the change from pretest to posttest in knowledge, anxiety, and performance between the two groups (insimulation debriefing and postsimulation debriefing)?
4. How do the two groups describe and rate the debriefing experience?
5. Is there a difference in the student perceptions of the effectiveness of the insimulation debriefing and the postsimulation (comparing the responses of those students who received both)?

Definition of Terms

This study operationally defined the following terms and concepts according to commonly accepted definitions found in the literature. There may be many other ways to define the terms, but the definitions supplied here were the ones used in this study.

Anxiety definitions vary throughout the literature. This research used the definition of

Lazarus and Folkman who were pioneers in anxiety research in the 1960s. These researchers defined anxiety as "a vague, uncomfortable feeling exacerbated by prolonged stress and the presence of multiple stressors" (Lazarus & Folkman, 1984 p. 4). Student anxiety was measured using a 5-item reflective questionnaire pre- and postsimulation (see chapter III).

Clinical setting and clinical practicum are used interchangeably to refer to the actual agencies in which student nurses participate in a therapeutic environment with the intention of providing care to psychiatric mental-health clients (AACN, 1998). Students participating in this study were preparing for enrollment in a psychiatric mental-health clinical.

Debriefing is defined as a standardized analysis that follows or occurs during a simulation experience and is led by a trained facilitator. Student reflective thinking is encouraged, and feedback is provided regarding performance within various aspects the simulation. Students are encouraged to explore attitudes and emotions, reflect on learning points and existing knowledge, and improve patient-centered care. The purpose of debriefing is to progress toward assimilation and accommodation in order to transfer the knowledge and skills to actual patient-care situations (Johnson-Russell & Bailey, 2010; National League for Nursing Simulation Innovation Resource Center, 2010). Group A received insimulation debriefing during the second and third simulations and postsimulation debriefing during the first and fourth simulation. During the simulation with insimulation debriefing, the instructor or researcher called a brief timeout every 5 minutes and provided 1 to 2 minutes of feedback for the student. Group B's simulations concluded with a 10- to 15-minute postsimulation debriefing. Both groups rated the effectiveness of the debriefing method using a postsimulation questionnaire. Additionally, the treatment group was asked to comment on the effectiveness of the insimulation and postsimulation debriefing.

Insimulation debriefing for the purpose of this research insimulation debriefing was one aspect of the independent variable. Insimulation debriefing was used to coach the participants during the simulation process and allowed them to correct mistakes and restart the simulation at a point prior to the error.

Knowledge generally is defined as a compilation of facts or ideas acquired by study, investigation, observation, or experience. The goal of nursing education is for student nurses to employ higher level thinking skills to synthesize concepts and theories and apply the knowledge gained to new situations (Oermann & Gaberson, 2009). Measurement of knowledge acquisition was completed using a 30-item multiple-choice psychiatric assessment and therapeutic communication pre- and posttest.

Postsimulation or traditional debriefing For the purpose of the research, postsimulation debriefing will refer to the debriefing process that occurs at the conclusion of the simulation.

Skill has many definitions. This research used the Oermann and Gaberson (2009) definition of skill as the ability to use one's knowledge effectively and readily in execution or performance of a specific nursing task. The skills measured by this research followed the AACN (2009) the APNA and ISPN (2008) guidelines for psychiatric assessment and therapeutic communication. Changes in prelicensure undergraduate nursing students' psychiatric assessment and therapeutic communication skills were tracked using a therapeutic communication and psychiatric assessment rubric developed by the researcher.

Simulation has numerous definitions. The one described by Gaba (2007) has been adopted for this research. Gaba defined simulation as a technique used “to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner” (p. 126). This research used the terms simulation and clinical

simulation interchangeably. Standardized patient volunteers were taught to simulate patients with mental illness. All study participants completed four simulations during the two phases of the research.

Standardized patients are individuals trained to portray patients with medical or psychiatric conditions (Wallace, 1997). Standardized patients in this study portrayed patients experiencing varying degrees of depression, anxiety, or psychotic states.

Therapeutic communication is a planned process used by nurses and other healthcare professionals to establish a therapeutic relationship with a patient (Mohr, 2009). Therapeutic communication is based on a specific set of skills that allows the nurse to demonstrate empathy and respond to the patient's thoughts, needs, or concerns (Mohr, 2009). Therapeutic communication skills include giving broad openings, paraphrasing, offering general leads, reflecting feelings, focusing, voicing doubt, clarification, placing events in a time sequence, testing discrepancies, and encouraging the formulation of a plan.

Summary

Simulated experiences with standardized patients trained to portray mentally ill patients and provide constructive feedback to students during the debriefing process can provide prelicensure undergraduate nursing students with the skills needed to respond therapeutically to psychiatric patients in the clinical setting. These skills provided student nurses with effective tools that they can incorporate into all of their interactions with patients.

To provide the readers with a sense of organization, the dissertation started with an introductory chapter (present chapter) that primarily reviewed the background and need for the investigation of the effects of insimulation debriefing versus postsimulation debriefing on student anxiety, knowledge, and skill.

Chapter II, the Review of the Literature, contains relevant nursing literature and provides a historical perspective explaining the need for additional empirical research to establish best practices for debriefing methods used during simulation in undergraduate curricula. Chapter II has current nursing research related to debriefing styles, standardized patients, simulation, therapeutic communication, psychiatric assessment, and student anxiety.

Chapter III, the Methodology, contains the description of the pretest-posttest methodology used in this research. The research design, sample selection, instruments, and data analysis procedures also were provided in chapter III. The results of the research are found in chapter IV. Chapter V has the conclusions drawn from the study including limitations and educational significance of the research. Suggestions for future research are included.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this research is to investigate the effectiveness of teaching therapeutic communication and psychiatric assessment to prelicensure undergraduate nursing students using two different debriefing styles during simulation with standardized patients. Clinical rotations are the traditional method used for preparing prelicensure nursing students for the transition to practicing nurse. During a clinical rotation, nursing instructors in partnership with the facilities' Registered Nurses (RN) assist students to consolidate and apply didactic knowledge to actual patient situations. Opportunities in the psychiatric mental-health clinical, however, are inconsistent and students complete the rotation with varying degrees of experience (Onda, 2011; Patzel, Ellinger, & Hamera, 2007).

The potential benefits of simulation as a tool to address the theory to practice gap in undergraduate nursing education were outlined in chapter I. Justification for simulation with standardized patients as an instructional approach to teaching therapeutic communication and psychiatric assessment was presented. The theoretical framework situated cognition, using a cognitive apprenticeship model, was defined. Two debriefing styles in simulation and postsimulation were introduced, and the need for further investigation of the effectiveness of debriefing methods in undergraduate nursing curricula was delineated.

The foundation presented in the introductory chapter is built upon in this chapter. The current literature as it relates to the effects of simulation debriefing methods, nursing student anxiety, and the importance of therapeutic communication and psychiatric assessment in all aspects of nursing are presented. As noted in Chapter I, mental-health issues are not limited to

the psychiatric unit, and many nurses believe that they lack the essential skills needed to care for mentally ill patients (Hardcastle & Hardcastle, 2003).

The art and science of nursing encompasses the cognitive, psychomotor, and affective domains of learning. Before the computer age, nurse educators relied on anatomical models, task trainers, and role-play to conduct simulation in the psychomotor domain (Nehring & Lashley, 2009). One of the first references to simulation was in 1874 when Lees advocated for a skeleton in the nursing classroom (as cited in Nehring & Lashley, 2009). Mrs. Chase, a life-sized task trainer, was introduced to nursing students in 1910. She had an injection site for needles and an internal mechanism for procedures involving the rectum, urethra, and vagina (Nehring & Lashing, 2009). With the advent of the computer age, Mrs. Chase retired, and computerized mannequins, computer-assisted instruction, and virtual reality environments moved into the teaching arena. Simulation has become an accepted practice in nursing education. Researchers have suggested that simulation is an effective modality for increasing student self-confidence and decreasing anxiety (Becker, Rose, Berg, Park, & Shatzer, 2006; Gore et al., 2011). Dufrene and Young (2014) wrote that nurse educators have increased the use of simulation as a teaching stratagem; however, research investigating simulation debriefing methods in undergraduate nursing curriculum is limited. Defining the characteristics of debriefing that contribute to student learning will enable nursing faculty to maximize the effectiveness of simulation.

The investigation for the literature review included peer-reviewed journals, books, doctoral dissertations, and Internet resources. Key words and phrases included Baccalaureate and prelicensure nursing students, debriefing styles and simulation, student anxiety, therapeutic communication and psychiatric assessment, standardized patient, and simulation. The chapter

includes research by known experts in simulation and nursing education. The focus of interest is debriefing in undergraduate nursing education, although the literature on simulation and debriefing in other healthcare disciplines was included for their relevance to the topic.

Chapter two begins with a presentation of debriefing research. An assumption of this dissertation is that debriefing is the most important component of the simulation process. Most nursing research encompasses the entire simulation process, which includes orientation, scenario, and debriefing. Jeffries (2007) stated that the goal of simulation is to produce enhanced student outcomes through experiential learning, whereas Fanning and Gaba (2007) described debriefing as a guided reflective discussion that attempts to bridge the gap between experiencing an event and understanding or learning from the event.

The effectiveness of simulation is supported in the literature, and the American Association of Colleges of Nursing (2008) has recommended the inclusion of simulation in all baccalaureate curricula. A review of recent simulation literature found a greater focus on debriefing factors such as learner outcomes, who should conduct debriefing, and methods of debriefing. There is, however, a lack of consensus regarding best practice for debriefing. The following section provides empirical research that is related to debriefing in nursing and medical education.

Debriefing Research

The National Council of State Boards of Nursing completed a survey of simulation use in prelicensure nursing programs. Eighty-seven percent of responding programs reported using simulation. Fifty-eight percent of Baccalaureate programs and 77% of Master's programs reported simulation was a required component of the curriculum (Hayden, 2010; Kardong-Edgren, Willhaus, Bennett, & Hayden, 2010). Simulation is an important component of

prelicensure nursing education. Providing inexperienced nursing students with a simulated environment where they can develop clinical skills and consolidate didactic theory with practice protects patients from errors that are inherent in the apprenticeship model of nursing education (Levine, DeMaria, Schwartz & Sim, 2014). Debriefing is vital to simulation-based learning; although there is no single debriefing model, there are, however, consistent themes related to the most efficacious characteristics of debriefing (Fey, Scrandis, Daniels, & Haut, 2014). Shinnick and Woo (2010) wrote that learning does not occur in simulation in the absence of debriefing. Jeffries (2012) argued that debriefing poorly conducted potentially creates persistently poor clinical judgment and jeopardizes patient safety. The remainder of this section presents relevant research relating to successful characteristics of debriefing and research utilizing the insimulation and postsimulation debriefing methods.

Fey et al. (2014) phenomenological study investigated baccalaureate nursing students' ($n = 68$) perceptions of the characteristics of debriefing that contributed to their learning process. Five themes were identified (a) a safe environment, (b) debriefing to explore thoughts, (c) feedback from multiple perspectives, (d) all in this together, and (e) group facilitation. The definition of safe environment was twofold. First, real patients could not be harmed during simulation, thus students could assume completely the role of the RN. Second, students needed psychological safety. Faculty behaviors and attitudes were identified as the key to providing psychological safety. Students in this study described debriefing to explore thoughts as a process of self-discovery and self-reflection. Reflective conversations were described as being collaborative and nonjudgmental (Fay et al., 2014). This collaborative approach to debriefing has been described by some as a Socratic method of teaching (Dreifuerst, 2009). Students valued feedback from all perspectives. "Students wanted to hear about their mistakes from peers at their

own level" (Fay et al., 2014, p. 253). Students found that "normalizing" feelings, performance, and actions through peer support allowed them to understand that "we were all in this together" (Fay et al., 2014, p. 253). Fay et al. (2014) noted that when the instructor normalizes the student's thoughts, feelings, and behaviors by using positive reassuring feedback students are willing to question and express concerns. The final theme group facilitation requires the instructor to use several techniques to create a positive learning environment. Those techniques include a nonjudgmental feedback, cueing questions, active listening, positive nonverbal communication, eye contact, and allow enough time to address student questions and concerns (Fay et al., 2014). The debriefing styles used in this research incorporated the debriefing themes identified in Fey et al. (2014) research. The following three research studies are presented as being similar in design to the current research.

Van Heukelom, Begaz, and Treat (2010) used a self-report retrospective survey to compare two debriefing methods. The study evaluated students' self-reported levels of self-confidence and perceived effectiveness of the debriefing methods. The convenience sample of third-year medical students ($n = 161$) were assigned randomly to the postsimulation debriefing group or the insimulation debriefing group. Students were oriented to the simulation and debriefing methods prior to the start of the simulation. Each group participated in two Advanced Cardiac Life Support simulations using Laerdal SimMan®, a life-like computerized manikin that can replicate physiological human responses. During the insimulation scenarios, the simulation was stopped when a participant made an error, then the facilitator would inform the participants of the correct actions and restart the simulation. In the postsimulation scenarios, participants were allowed to make errors during the simulation, and no instruction occurred until the debriefing session at the conclusion of the simulation.

Two days after the simulations, participants completed an anonymous 12-item survey. Participants were asked to rate their self-confidence pre- and postsimulation, as well as rate their perceptions of the facilitator and the effectiveness of the debriefing methods. Van Heukelom et al. (2011) reported that internal consistency for retrospective pretest and posttest data was a Cronbach coefficient alpha of .91, indicating a high level of reliability for the interrelated student self-confidence survey items. Although participants in both groups had statistically significantly higher posttest ratings on self-reported confidence items, there was no statistical difference between groups.

Cronbach coefficient alpha of .69 for four of the survey items specifically targeting the debriefing methods was acceptable. Van Heukelom et al. (2010) reported that Wilcoxon signed-rank test showed statistically significant differences between the groups for three of the four questions: the debriefing helped me learn effectively, the debriefing helped me to understand the correct and incorrect actions, and the debriefing style was effective. All three were rated higher by the postsimulation group. Van Heukelom et al. (2010) concluded that postsimulation debriefing was more effective for teaching Advanced Cardiac Life Support to third-year medical students.

The Van Heukelom et al. (2010) study had several limitations. First, the participants were limited to third-year medical students performing a specific skill using a life-like computerized manikin, thus results are not generalizable to other groups or types of simulation. Second, self-report data are subject to social desirability bias thereby limiting the validity of the data. Third, data were collected 2 days after the simulation experience. The researchers did not control for contamination during the 2-day delay. Discussion of the experience between participants potentially could skew individual responses. Finally, Van Heukelom et al. (2010)

wrote that their study was a pre- and posttest design. All survey questions were completed postsimulation, and a retrospective analysis of self-confidence is not a true pretest measure.

Van Heukelom et al. (2010) wrote, "A key portion of medical simulation is self-reflection and instruction during a debriefing session; however, there have been surprisingly few direct comparisons of various approaches" (p. 91). Thus, they recommended further research "using standardized patient encounters, pre- and posttest questionnaires on the subject matter, or repeat simulation experiences" (p. 96). Postsimulation and insimulation debriefing have the potential to be effective tools for learning, and there are potential advantages and disadvantages to each approach. The advantage to postsimulation debriefing is that students can experience the consequences of their errors, thus providing a high level of clinical realism. In contrast, insimulation debriefing suspends the simulation when the student is struggling, then a short debriefing occurs, and the student is allowed to redo the procedure (Van Heukelom et al., 2011).

The Walsh, Ling, Wang, and Carnahan (2009) study aimed to investigate the optimal timing of feedback (insimulation versus postsimulation) in promoting skill acquisition and retention in first- and second-year medical students learning to perform an endoscopic procedure. Participants were assigned randomly to either the expert feedback during performance ($n = 15$) or the expert feedback after task completion ($n = 15$). All participants then received feedback either during or after each of their 12 practice trials (Walsh et al., 2009). Walsh et al. (2009) reported that all participants viewed a live 5-minute scripted demonstration explaining proper technique for holding and manipulating a flexible colonoscope. Participants were then pretested on the simulator.

The performances during the pretest, posttest, retention, and transfer test were videotaped. The videotapes underwent a blind review by experts, using a 5-point Likert-like

scale that assessed five essential tasks of the endoscopy procedure. Then a global rating scale was utilized to measure overall performances on the pretest, posttest, retention, and transfer tests (Walsh et al., 2009).

Walsh et al. (2009) compared performance between the two groups on the pretest using independent sample *t* tests. To evaluate learning, mixed analyses of variance (ANOVAs) were performed for each dependent variable (time, checklist, and global rating scores). Walsh et al. (2009) reported that “ANOVA differences significant at $p < .05$ (Holm-Bonferroni correction applied) were further analyzed using the Newman-Keuls post hoc method for identifying pair-wise differences between three or more means when ANOVA effects are statistically significant” (p. 56). Additionally, Walsh et al. (2009) reported strong interrater reliability for the global rating scale ($r = .78$) and the checklist ($r = .81$).

Walsh et al. (2009) reported that there were no statistically significant differences between groups in the pretest. Additionally, practice times were similar between the two groups. The Newman-Keuls post-hoc procedure revealed no statistically significant differences between the posttest and retention test. Walsh et al. (2009) reported that the insimulation group had a statistically significant slower mean performance time, as well as lower checklist and global rating scores, than the postsimulation group for the transfer test. The postsimulation group’s performance remained stable for all three tests. The insimulation group demonstrated a statistically significant decrease in performance over time (Walsh et al., 2009).

Walsh et al. (2009) noted that their results were consistent with the results of Xeroulis, Park, Moulton, Reznick, LeBlanc, and Dubrowski (2007) study that examined the effects of feedback on discrete skill learning (suturing and instruments knot-tying). All participants viewed an instructional video then were assigned randomly to the comparison group (no

debriefing), the computer-based video instruction group (no debriefing), the postsimulation group, or the insimulation group. All participants were pretested, posttested, and retested one-week after the initial training. Xeroulis et al. (2007) noted that the computer-based video instruction, insimulation, and postsimulation were equally effective for the instruction of basic technical skills. The computer-based video instruction and postsimulation group retained superior suturing and knot-tying performance over time (Xeroulis et al., 2007).

Walsh et al. (2009) suggested that:

There are temporary effects caused by providing feedback throughout the skill performance (concurrent feedback) positively influence practice performance but have detrimental effects on learning. (p. 56)

According to Walsh et al. (2009), cognitive load theory may explain the learning benefit to postsimulation debriefing (Sweller, van Merriënboer, & Paas, 1998). The amount of cognitive processing needed to perform a task while receiving, processing, and responding to feedback may put excessive cognitive demands on the student (Walsh et al. 2009). The skills, knot-tying and manipulation of a flexible colonoscope follow a specific sequence and require precise psychomotor skills, and advanced life support follows a specific algorithm. An extensive search of medical and nursing literature identified Van Heukelom et al. (2010), Walsh et al. (2009), and Xeroulis et al. (2007) as the only research similar to the current study; however, the differences are greater than the similarities. Van Heukelom et al. (2010) research focused on the effects of two debriefing styles on the knowledge and very specific psychomotor skills needed to perform advanced cardiac life-support. Walsh et al. (2009), and Xeroulis et al. (2007) focused on the effects of debriefing on specific psychomotor tasks that required repeated practice to master. This research focused the effects of insimulation and postsimulation on student anxiety and learning outcomes related to therapeutic communication and psychiatric assessment. The

students who participated in this research were expected to respond appropriately to the patient's changing emotional, psychological, and cognitive function, while conducting an assessment that focused on maintaining patient safety.

The remaining studies in this section report the effects of debriefing on student learning.

Shinnick, Woo, Horwich, and Steadman (2011) evaluated the effect of simulation on learning by measuring heart-failure knowledge immediately after the simulation and then again after the simulation and debriefing. Heart-failure knowledge was measured using parallel forms of a 12-item multiple-choice exam. One-hundred-sixty-two prelicensure nursing students from three schools of nursing participated in the study. Data were collected on two sequential days, and a coin toss determined if the day was a comparison or experimental day. Shinnick et al. (2011) reported that although the groups were unequal due to the variability of cohort sizes at each site (Comparison $n = 72$ and Experimental $n = 90$). No statistically significant differences were found in age, gender, or baseline knowledge scores between groups. Additionally a priori power analysis estimated a desired sample size of 128 would allow detection of a moderate effect size (.25) on a paired sample t test for a power of .80.

Both groups completed the heart-failure knowledge pretest prior to the simulation. The experimental group then completed the hands-on portion of the simulation and posttest one. After a short break and a 30-minute debriefing session, the experimental group completed posttest two. The comparison group completed the same pretest as the experimental group, and then one hour before the simulation they completed posttest one. The comparison group completed posttest two after participating in the simulation and 30-minute debriefing.

The maximum score for heart-failure knowledge on the 12-item multiple choice exam was 100. Shinnick et al. (2011) reported heart-failure knowledge scores decreased on posttest

one and increased on posttest two for both groups. There were statistically significant differences between the groups for both posttests with the experimental group outperforming the comparison group. Effect-size calculation for posttest one was .42 (small to moderate effect), and for posttest two, .21 (small effect). Shinnick et al. (2011) study validates the findings that there is no learning in the absence of debriefing (Dreifuerst, 2009; Fanning & Gaba, 2007; Fey, et al., 2014; Issenberg, Petrusa, & Scalese, 2010; Lusk & Fater, 2013).

Dreifuerst (2012) used a structured a nonequivalent group, quasi-experimental, pre- and posttest design to investigate the effect of Debriefing for Meaningful Learning on the development of clinical-reasoning skills in prelicensure nursing students. Debriefing for Meaningful Learning is a structured style of debriefing designed by the researcher and employs exercises designed to explicate reflection and scaffold new meaning to existing knowledge and experiences. The participants were 238 undergraduate nursing students enrolled in a baccalaureate nursing program at a Midwestern university. The comparison group received “usual and customary debriefing” based on the work by Childs, Sepples, and Chambers (2007). The experimental group participated in simulation using the Debriefing for Meaningful Learning.

Outcomes for the experimental group and comparison groups were measured with the Health Sciences Reasoning Test©, the student version of the Debriefing Assessment for Simulation in Healthcare©, as well as, researcher-designed follow-up questions. The change in the means on the Health Sciences Reasoning Test© were statistically significant with the experimental group demonstrating greater change in scores on average. Additionally, the effect of Debriefing for Meaningful Learning on the total Health Sciences Reasoning Test© score was statistically significant ($F(1, 237) = 23.55$) with a large effect size of .84. Analysis of the student version of the Debriefing Assessment for Simulation in Healthcare© scores

demonstrated that on average groups perceived a difference in the quality of debriefing between Debriefing for Meaningful Learning and the usual and customary method.

Dreifuerst's (2012) study had several limitations. Dreifuerst (2012) reported that

It was challenging to find quantitative, objective instruments that measure clinical reasoning in nursing students. The Health Sciences Reasoning Test®, while intended for assessment of healthcare professionals, is not specific to the discipline of nursing. As a result, the items in the instrument may not measure change in reasoning in nursing students. (p. 141)

The second limitation of this study was selection basis. Although the researcher attempted to maintain random assignment, the participants were divided between sites, based on clinical groups. Dreifuerst (2012) noted that there was no control or measure to account for differences between groups. Last, the generalizability to other schools of nursing is limited. The researcher designed Debriefing for Meaningful Learning using Socratic dialog method and the nursing process as teaching strategies. According to Dreifuerst (2012), students who volunteered to participate in the study were familiar with both teachings styles prior to the simulation and debriefing. Without background preparation, students from other schools who are unfamiliar with Socratic dialog, method might find the teaching strategy challenging and difficult to understand.

Kardong-Edgren, Willhaus, Bennett, and Hayden (2012) reported the findings from The National Council of State Boards of Nursing survey on simulation use in prelicensure nursing programs throughout the United States. Eighty-seven percent of the prelicensure nursing programs that responded reported using simulation as part of the nursing curriculum ($N=1,060$). Additionally, 58% of Baccalaureate programs and 77% of prelicensure Masters programs stated that required simulation experiences were built into the curriculum. Additional findings included one-third of responding programs reporting the use of standardized patients and 50% of

respondents reporting that scenarios were medical surgical. Eighty-one percent of respondents indicated that simulation should be used more in their programs (Kardong-Edgren et al., 2012). Kardong-Edgren et al. (2012) noted that although the original survey was conducted in 2010 it would be relevant to repeat the survey to track further the use of simulation in prelicensure nursing curriculum. The abundance of nursing research related to simulation suggests that schools of nursing have continued to incorporate simulation into the curriculum. Benner et al. (2010) suggested that “only experiential learning can yield the complex, open-ended, skilled knowledge required for learning to recognize the nature of the particular resources and constraints in equally open-ended and underdetermined clinical situations” (p. 42). Although there is an abundance of research related to the efficacy of simulation as an effective method of providing complex experiential learning, the research on simulation debriefing practices is limited and lacks rigor.

Wazonis (2015) conducted a cross-sectional, descriptive online survey targeting faculty who used debriefing in simulations with undergraduate nursing students at accredited Baccalaureate Nursing Schools (BSN). Although study respondents were a self-selected convenience sample, Wazonis (2015) employed widespread recruitment methods that included

(a) e-mail requests to administrators of accredited BSN programs (b) advertisement at the National League for Nursing (NLN)/Boise State University 2nd Simulation Conference, (c) request posted on the LinkedIn discussion board for International Nursing Association for Clinical Simulation and Learning (INACSL), (d) personal recruitment at an INACSL research conference booth, and (e) \$15 gift cards to amazon.com as incentive to complete the survey. (p. 112)

The survey contained 62 questions, and all survey questions were factual with no scaled measures of attitude or satisfaction. Three survey items were open-ended, and 22 items included the answer option of other that when selected prompted respondents to provide short-answer responses. Data collection took place between April and June of 2014.

Wazonis (2015) reported that faculty from 219 traditional BSN programs in 42 states and Washington DC completed the survey. Eighty-seven percent of respondents were full-time faculty. Seventy-one percent held a Masters degree with 10 or fewer years of teaching experience. Approximately half (47%) reported their graduate degree focused on nursing education. The most frequently reported areas of expertise were adult health (43%), medical surgical nursing (43%), and critical-care nursing (35%). Responding faculty ($n = 209$) reported that teaching load was divided between the clinical setting 41% , the simulation laboratory 32%, the skills laboratory 17%, and other duties 10% (Wazonis, 2015).

Wazonis (2015) compared the survey data with the five criteria for debriefing outlined in the International Nursing Association for Clinical Simulation and Learning (INACSL) standards of best practice (Decker et al., 2013). Criterion one recommends that individuals conducting simulation and debriefing receive formal training (Decker et al., 2013). Wazonis (2015) reported that 94% of faculty had received some form of debriefing training. The majority of the training was informal, and there was no reported on-going evaluation of the faculty competency effectiveness of the debriefing process. Criterion two recommends the creation of a safe environment for debriefing (Decker et al., 2013). Wazonis (2015) noted that just over half of respondents reported having a written policy for confidentiality during debriefing. The potential threat to student privacy was not addressed as there was not a consensus on the access, storage, and destruction of audio or video recordings used during debriefing. Wazonis (2015) argued that lack of a clear policy for protecting student privacy when using audio or visual recordings potentially decrease the effectiveness of the debriefing process. Criterion three states that faculty should debrief using methods that engage students in reflection on outcomes and clinical practice (Decker et al., 2013). Wazonis (2015) revealed that respondents reported using

debriefing methods such as guided reflection and discussion that were consistent with the INACSL guidelines. Waznonis (2015) noted that the most frequently reported challenge to the debriefing process was student engagement. Criterion four recommends that faculty conducting debriefing follow a structured framework (Decker et al., 2013). Waznonis (2015) stated that survey results were not only promising in that 44% of respondents reported the use of a structured debriefing process, but also disappointing as only 18% of respondents reported using a specific debriefing method. Criterion five recommends that faculty use participant and scenario-specific objectives as a focus for the debriefing process (Decker et al., 2013). Waznonis (2015) concluded that although respondents reported using a variety of approaches to guide debriefing toward learning objectives, the efficacy of these approaches was lacking.

Self-selection of the survey respondents was a limitation of Waznonis' (2015) study and findings may not represent the entire target population. Additionally, individuals not trained in simulation or debriefing might not have responded to the survey further confounding the results. Notwithstanding the limitations of using a self-selected survey, Waznonis (2015) stated that the cross-sectional survey design did not allow causal inferences and captured debriefer characteristics and practices. Waznonis (2015) posited that this research begins to define the complexity of simulation debriefing practices, whereas the INACSL guidelines provide an outline of best practice. Waznonis (2005) further stated that

Debriefers who participated in this study were mostly newer full-time faculty who are facilitating a large amount of debriefings with limited support and resources and a lack of evaluation of its effectiveness. Steps should now be taken to move from this beginning portrait of debriefing toward one that will ensure optimal student learning occurs in simulation. (p. 118)

Levett-Jones and Lapkin (2014) conducted a literature review of simulation-based learning for health professionals. The authors employed peer-reviewed a priori methodology;

published in the database of systematic review protocols from the Joanna Briggs Institute to conduct the review. The initial search strategy identified 1,567 papers, and 29 were deemed potentially relevant. Review of abstracts further eliminated 18 studies. Eleven research papers were chosen for detailed examination, and 10 randomized control trials describing different debriefing methods were included. Differences in outcomes, control groups, and interventions presented in the various studies prevented the researchers from conducting a meta-analysis (Levett-Jones & Lapkin, 2014).

Levett-Jones and Lapkin (2014) wrote that review studies relied upon convenience sampling and conducted randomized control trials. The 10 studies were conducted in the United States, Canada, and the United Kingdom. Study participants consisted of anesthesiologist, anesthesia residents, nursing students, medical students, and qualified nurses. Participants were assigned either the comparison or experimental group and each group received different debriefing methods as part of the simulation learning experience (Levett-Jones & Lapkin, 2014). Levett-Jones and Lapkin (2014) reported mixed findings with statistically significant outcomes in some studies but not others between the comparison and experimental groups. Levett-Jones and Lapkin (2014) noted that although some studies did not report statistically significant differences the results have important clinical and practical implications as these studies demonstrated large improvements in learning.

The studies reviewed reported some positive outcomes, Levett-Jones and Lapkin (2014) emphasized that the limited number of studies coupled with the heterogeneity of interventions indicated that generalizability of the individual study results is not possible. Levett-Jones and Lapkin (2014) recommended that debriefing be included as an integral part of the learning

experience and that further research focused on the debriefing component of simulation be conducted.

McGaghie et al. (2010) proposed that the goal of simulation is to improve learning and enhance future performance. Debriefing is used to answer questions and correct misconception that may have occurred during the simulation scenario. If the purpose of simulation is to provide practice for a particular skill set, such as inserting a foley catheter, there may not be a need for an extended debriefing session. If the purpose of simulation is to strengthen assessment and communication skills, then nursing researchers have posited that a form of facilitated debriefing is needed (Dreifuerst, 2009; Fanning & Gaba, 2007; Fey, et al., 2014; Issenberg, Petrusa, & Scalese, 2010; Lusk & Fater, 2013).

Empirical research has demonstrated that simulation without debriefing does not support the scaffolding new knowledge with existing information (Mahmood & Dezi, 2005; Shinnick & Woo, 2010). Currently, there is a lack of nursing research exploring the effectiveness of debriefing methods. A unique feature of this study is the research design and the investigation of the effects of two debriefing styles on changes in undergraduate nursing students' knowledge acquisition, skill performance, and perceived anxiety. Although Van Heukelom et al.'s (2010) Walsh et al.'s (2009) and Xeroulis et al.'s (2007) research investigated insimulation and postsimulation debriefing, their results cannot be generalized to the prelicensure undergraduate nursing population. The researchers conducted procedural or task-oriented simulations, whereas this study focused on the students' ability to adjust their therapeutic communication and assessment techniques in response to the standardized patient's presentation of symptoms. Additionally, this research investigated the effects of insimulation debriefing and postsimulation

debriefing on student knowledge and anxiety related to working with mentally ill patients. The following section presents literature pertaining to student anxiety.

Nursing Student Anxiety

Anxiety is a common experience for all students at all levels of education with many students reporting some level of anxiety related to grades or testing. George Mandler and Seymour Sarason (1952) were one of the first research teams to identify a strong correlation between anxiety and student performance. Over the ensuing decades, educational researchers have continued to investigate methods for decreasing student anxiety and increasing student performance (Hancock, 2001; Prato & Yucha, 2012; Putwain, Woods, & Symes, 2010). Cook (2005) reported that in addition to grade and test anxiety nursing students experienced high levels of anxiety related to clinical learning environments. Nursing is a practice profession; the curriculum is divided between the classroom and the clinical setting. Locken and Norberg (2005) noted that the number of hours spent in the clinical setting is often three times greater than in the classroom. Benner, Sutphen, Leonard, and Day (2010) suggested that to increase the transfer of knowledge from classroom to the clinical setting, nursing faculty must investigate new teaching methods to address the issue of student anxiety.

Howard, Englert, Kameg, and Perozzi (2011) conducted a mixed-methods study using high-fidelity human-patient simulators to evaluate undergraduate students' perceptions related to incorporation of simulation throughout the undergraduate nursing curriculum at a private university in Western Pennsylvania. The researchers integrated simulation scenarios that included health assessment ($n = 24$), introduction to care of the adult patient ($n = 42$), intermediate care of the adult patient ($n = 18$), care of mothers and newborns ($n = 21$), care of the

mentally ill patient ($n = 38$), and transitions to practice ($n = 6$). Data were analyzed using descriptive statistics.

The overall simulation experiences were found to be successful addition to the curriculum. The participants ($n = 149$) reported that simulations were valuable learning experiences, stimulated critical thinking, and decreased anxiety about caring for patients in the clinical setting. Howard et al. (2011) concluded that this research supports the use of simulation throughout the curriculum as an instructional method for decreasing student anxiety.

The Howard et al. (2011) study added to the existing body of knowledge regarding simulation as a tool to decrease student anxiety; however, the research had several limitations. Howard et al. (2011) used a convenience sample of 149 traditional and accelerated baccalaureate nursing students in multiple courses across the curriculum with each course serving as a subsample. Although the overall sample size was large, the subsample sizes were inconsistent, and each subsample experienced a different simulation scenario. The largest cohort ($n = 42$) of the subsample was disproportionally larger than the smallest cohort ($n = 6$). The disparity in sample size between subgroups limits the generalizability of this research (Creswell, 2008).

A self-report survey was used for data collection. Creswell (2008) noted that self-report surveys have several disadvantages. Respondents may provide answers that they believe are socially desirable or pleasing to the researcher. Conversely, if the participants have negative feelings toward the researcher, they may respond negatively. Howard et al. (2011) reported that several participants responded many weeks after the simulation; thus, they may have forgotten pertinent details, and the data could be compromised.

Gore, Hunt, Parker, and Raines (2011) conducted an experimental randomized study to investigate the efficacy of using high-fidelity human patient simulators to decrease anxiety levels

in junior-level baccalaureate nursing students enrolled in a nursing fundamentals and health-assessment course at a Southeastern university. High-fidelity human-patient simulators are life-size computerized manikins with realistic anatomical structures that can mimic diverse parameters of human physiology and respond to nursing or pharmacological interventions (Alinier et al., 2006; Holcomb et al., 2002; Nehring & Lashing, 2009; Seropian et al., 2004).

In the study conducted by Gore et al. (2011), student nurses were assigned randomly to group 1 (experimental) or group 2 (comparison). Group 1 ($n = 24$) participated in the simulation experience (intervention) before interaction with actual patients in the clinical setting. Group 2 ($n = 16$) participated in the simulation after having contact with patients in the clinical setting. All student nurses who participated in this research completed a 4-hour simulation with the high-fidelity human patient simulators (Gore et al., 2011).

Anxiety data were collected using the Spielberger, Gorsuch, and Lushene (1983) State-Trait Anxiety Inventory. Analysis using a two-tailed dependent-sample t test resulted in a statistically significant difference in the State-Trait Anxiety Inventory means. The self-reported anxiety scores of students who participated in the simulation before actual patient contact were statistically significantly lower on average than the comparison group. Gore et al. (2011) concluded that simulation is a valuable tool for reducing anxiety levels among junior-level nursing students. Overall, Gore et al.'s (2011) research offered evidence to support the use of simulation as an approach to decreasing junior student nurses' anxiety levels prior to their first clinical experience. Their research, however, is limited in that the researchers used a small homogeneous convenience sample from one school of nursing in the Southeastern United States; therefore, results cannot be generalized to the larger population. Additionally, The State-Trait Anxiety Inventory is a tool most frequently used in clinical settings to diagnose anxiety and to

distinguish it from depressive syndromes (American Psychological Association, 2015). The inventory uses a 4-point Likert-like scale with 40 self-report questions and as such the self-report measure of anxiety level may be subject to the general limitation of all self-report measures.

Szpak and Kameg (2013) used a quantitative nonrandomized quasi-experimental study to investigate the effect of high-fidelity human patient simulators on nursing student anxiety before interacting with mentally ill patients. The undergraduate nursing students ($n = 44$) attended a 2-hour lecture on therapeutic communication, followed by a simulation with high-fidelity human-patient simulators (Szpak & Kameg, 2013). Data were collected over the course of two semesters using a demographic questionnaire, a Pre- and Postsimulation Evaluation Survey, Anxiety Visual Analogue Scale (VAS), and pre- and post-State-Trait Anxiety Inventory (Spielberger et al., 1983; Szpak & Kameg, 2013).

The means and standard deviations for the Visual Analogue Scale and the State-Trait Anxiety Inventory are reported in Table 1. Statistically significant differences were found pre- and posttest on the Visual Analogue Scale and the State-Trait Anxiety Inventory, Y-1 with a moderate effect size for both the VAS ($d = .73$) and State-Trait Anxiety ($d = .73$).

Table 1

Results of Dependent-Sample t Tests on Student Level
Anxiety at Pre- and Postsimulation ($n = 44$)

Instruments	Presimulation		Postsimulation		t ($df = 43$)
	M	SD	M	SD	
STAI Y-1 (state)	1.8	0.4	1.5	0.3	4.9*
VAS	39.5	26.7	26.5	19.8	4.9*

*Statistically significant at the .01 level.

The State-Trait Anxiety Inventory form Y-1 (STAI Y-1) measures the temporary condition of “state anxiety,” and form Y-2 measures “trait anxiety,” a more general and long-standing attribute indicative of an individual's personality rather than a given situation (Spielberger et al., 1983). Szpak and Kameg (2011) used a homogenous convenience sample ($n = 44$) from a small private, suburban university. The researchers did not control for the extraneous variables of prior experience, given that 81% of the participants had previous degrees and 67% had prior experience with mentally ill persons.

Szpak and Kameg (2011) and Gore et al. (2011) used the Spielberger et al. (1983) State-Trait Anxiety Inventory tool to measure nursing student anxiety pre- and postsimulation. Unlike the work of Szpak and Kameg (2011) and Gore et al. (2011), the current study investigated the root causes of student anxiety by using written reflective questions pre- and postsimulation (see chapter III). Preparing students for the psychiatric clinical setting can be a challenge for nurse educators. Even with careful preparation, Robinson-Smith et al. (2009) declared “until students have their first interaction with patients who have psychiatric problems, they may not know what to expect from the patients or themselves” (p. 203). Simulation with standardized patients is a powerful educational method, as it does not rely on random patient encounters. Additionally, this approach provides students with comparable patient experiences within the confines of a controlled environment (Barrows, 1993; Becker et al., 2006).

Using a descriptive design, Robinson-Smith et al. (2009) developed and evaluated a standardized-patient simulation activity designed to increase student critical thinking and self-confidence. One-hundred-twelve junior-level undergraduate nursing students took part in the standardized-patient encounters. Students took an active role in preparing for the standardized patient encounter by using textbooks and other literature to develop questions to use during the

assessment interview (Robinson-Smith et al., 2009). The students were told to prepare to interview and assess a depressed, suicidal patient. Student objectives for the simulated interview included completing a mental-status exam and a suicide-risk assessment (Robinson-Smith et al., 2009). At the conclusion of the interviews, the researchers and the standardized patients provided verbal and written feedback using the standardized-patient observation form, a dichotomous (yes–no format) evaluation tool (Robinson-Smith et al., 2009). The standardized patient observation tool listed 15 expected behaviors. The researchers did not compute any statistical data related to the standardized patient observation form; however, the majority of the students reported that the feedback was helpful (Robinson-Smith et al., 2009).

At the completion of the simulation, data were collected, and the means of the three subscales of the National League of Nursing (NLN) Student Satisfaction and Self-Confidence in Learning Survey were calculated (Jefferies, & Rizzolo, 2006; Robinson-Smith et al., 2009). On average, the majority of students reported increased self-confidence, increased critical thinking, and satisfaction with the teaching methodology. Robinson-Smith et al. (2009) concluded that the overall the teaching strategy was successful.

The Robinson-Smith et al. (2009) study had several limitations. A convenience sample from a single school limits the generalizability of the data to a broader population. Data were collected postsimulation, and there was no comparison group. Robinson-Smith et al. (2009) noted that nine different faculty members conducted the simulations and that interrater reliability for the standardized patient observation form was not established. The researchers concluded that the standardized-patient simulations were a valuable teaching tool; however, additional empirical research is needed (Robinson-Smith et al., 2009). Although Robinson-Smith et al.

(2009) conducted postsimulation debriefing, they did not collect any data related to the debriefing process.

This research addressed some of the limitations of the aforementioned studies by using quasi-experimental pretest-posttest design, with participants serving as their own control. Pre- and postsimulation data collection used written reflective questions to investigate changes in student anxiety. Additionally, the debriefing process designed for this research encouraged student reflection on performance and investigated their emotional responses to patient behaviors.

Although research suggests that simulation increases student self-confidence and decreases student anxiety (Gore et al., 2011; Howard et al., 2011; Jeffries, 2007; Robinson-Smith et al., 2009; Szpak & Kameg, 2013), the components of simulation that most effectively aid in the reduction of student anxiety have not been identified. White (2003) reported that when student nurses lacked self-confidence in their abilities they focused on their fears rather than the patient. Megel et al. (2011) wrote that "one of the accepted assumptions in education is that disproportionately high levels of anxiety affect student performance" (p. 420). The student nurses' anxiety increases when they fear making a mistake or lack the self-confidence needed to perform the required assessment (Baxter & Rideout, 2006; Chesser-Smyth, 2005; White, 2003). Nurse educators are aware of the necessity of teaching strategies that will increase not only knowledge and skills but also decrease student anxiety. Preliminary research has established a positive correlation between nursing student anxiety and simulation (Gore et al., 2011; Howard et al., 2011; Jeffries, 2007; Lusk & Fatter, 2013; Robinson-Smith et al., 2009; Szpak & Kameg, 2013).

Therapeutic Nurse-Patient Communication

The term therapeutic communication was first used by Ruesch in 1961 and was defined as a purposeful conversation serving as a point of contact between the nurse and patient with the intention of generating mutual health-related goals. The importance of nurse-patient therapeutic communication has been a subject of discussion by nurse researchers beginning with Florence Nightingale in the 19th century and continuing as a topic of research today (Fleischer et al., 2009). Communication is an essential element of nursing practice and recently has become a focus of attention nationally and internationally (Kameg, Mitchell, Clochesy, Howard, & Suresky, 2010). Effective communication improves health outcomes, patient compliance, and patient satisfaction (Chant, Jenkinson, Randle, & Russell, 2002; Stewart, 1995; Williams, Weinman, & Dale, 1998). Although nurse-patient communication has been a topic of research and discussion among nurse leaders for over a century, a review of current research indicated that communication continues to be a major issue in the profession of nursing (Chant et al., 2002; Cronenwett et al., 2007). Research supports the use of standardized patients for formative teaching and evaluative assessment of communication in medicine and advanced practice nursing (Barrows, 1993; Becker et al., 2009; Lane & Rollnick, 2007; May, Park, J. & Lee, 2009).

To increase understanding of student nurse-patient communication, Aled (2007) conducted an exploratory study of undergraduate nursing students' therapeutic communication skills. The research was undertaken in two phases. During the first phase, data relating to student nurses' actual communication skills during an assessment interview were collected and analyzed. The participants were nursing students in their final year of a 3-year full-time adult nursing degree at a university in the United Kingdom. In the Aled (2007) study, participants had a variety of clinical experiences, as well as classroom theory that focused on communications skills,

during the course of their educational process. During Phase One, student nurse–patient interactions were audio recorded, the conversations were transcribed, and the data analyzed for conversation styles such as leading questions, providing information, closed- or open-ended questions. Aled (2007) noted that question-and-answer sequences represented in the interview interactions were task-centered and did not follow "best-practice" guidelines for patient-centered communication.

Phase Two of the study used the tapes and transcripts as a teaching resource in the classroom. During a 2-hour lecture and discussion, the students read the transcripts, then listened to the taped segments and rated each segment for nonpatient-centered interactions ($n = 48$). The students were able to identify nonpatient-centered interactions; however, the same students were not able to demonstrate patient-centered communication during actual patient encounters (Aled, 2007).

Aled (2007) strongly suggested that the style of communication used by the students during the assessment process was task focused and imposed restrictions on patients' involvement in the assessment process. Student-patient communication where questioning is the major activity of student nurses imposes an obligation to respond; thus, the patient's communications are confined to responding rather than sharing information. The researcher concluded that "the student nurses' interactions with patients followed a much more institutionalized or bureaucratic (and therefore restrictive) model of interaction than that promoted in literature, policy and in the nursing students' educational curriculum" (p. 2303).

Communication skills are a core competency for nurses, and without appropriate patient-centered communication skills, a large portion of clinical efforts might be wasted (Kurtz, Silverman, & Draper, 2005). Schlegel, Woermann, Rethans, and van der Vleuten (2012) using a

randomized posttest-only comparison-group design investigated the efficacy of teaching communication skills using standardized patients and role-play. The participants were first-year nursing students in Berne, Switzerland. The participants were assigned randomly to two different sites with identical curriculum taught by the same instructors (Schlegel et al., 2012). Students at both sites participated in the same 6-month introductory program prior to attending their first clinical rotation; included in the curriculum was a module on communication. The participants in the intervention group conducted a pain assessment using a standardized patient; concurrently at the other site their peers, the same assessment using peer-to-peer role-play (Schlegel et al., 2012).

Schlegel et al. (2012) conducted a summative assessment of both groups at the completion of the communication module. Both groups were given a student self-efficacy survey, and the researchers reported no statistically significant differences between groups (Schlegel et al., 2012). After the completion of the communication module, the entire cohort was assigned to different hospitals for their clinical experience. The supervising nurses at the assigned hospitals were aware of the research but did not know which students were in the intervention group ($n = 48$) or the nonintervention group ($n = 46$). Three weeks after the start of the clinical rotation, supervising nurses and patients were asked to rate the students' communication skills. The patients were given the Art of Medicine Survey (AMS), an 8-item scale designed to rate student communications. The AMS uses a response scale ranging from *not good at all* (1) to *very good* (6) and has a reported Cronbach coefficient alpha of .97 for the reliability of internal consistency. The researchers found no statistical difference between groups. Schlegel et al. (2012) speculated that these findings could be the result of patients having an overall positive view of students.

In Schlegel et al. (2012) study, the supervising nurses evaluated student communication skills using the 10-item Workplace-Related Competences scale (WRC). The WRC uses a 6-point rating scale with *standard not met* (1) to *standard well-met* (6). Schlegel et al. (2012) used independent-samples *t* test and the Kolmogorov-Smirnow test to calculate the results. Results of the Kolmogorov-Smirnow test showed that, on average, the item-level ratings of the students in the intervention group were higher than the comparison group. The independent-samples *t* test indicated statistically significant differences between groups with a medium effect size of .47 (Schlegel et al., 2012).

The research conducted by Schlegel et al. (2012) has several limitations. First, the research was conducted outside of the United States; therefore, results are not generalizable to students in the United States due to differences in the healthcare system and academic standards. The intervention group was given an objectively structured clinical examination, and the comparison group completed a written examination at the end of the communication module, potentially confounding the results because the outcome measures were not congruent between groups. The potentially inherent differences between the two instruments were not tested or controlled for by the researchers. Finally, the instruments used in the research were translated from English to German. The translated copy was not evaluated for accuracy; thus potentially invalidating the reliability and validity of the instruments.

Schlegel et al. (2012) stated "the results of our study provide evidence that in communication training, using standardized patients is superior to peer role-playing" (p. 21). Although their results suggested that simulation with standardized patients was an effective method of teaching therapeutic communication and given the limitations of their work, further investigation is warranted. Schlegel et al. (2012) reported the value of simulation with

standardized patients; however, they did not address the debriefing process. Guided reflection, during or after the simulation, allows students' to consolidate knowledge and explore emotional responses.

The theory-to-practice gap is well documented in the literature (Benner, Tanner, & Chesla, 2009; Chant et al., 2002; Del Bueno, 2005). Nurse researchers have suggested that simulation has the potential to narrow the theory-to-practice gap by creating an environment where students can practice and receive immediate feedback on their performance (Brereton, 1995; Feingold, Calaluce, & Kallen, 2004; Gaba, 2011; Jeffries, 2005). This research study investigated the effect of debriefing styles during and after simulation on students' knowledge, communication skills, and anxiety.

Richardson, Resnick, Leonardo, and Pearsall (2009) developed an innovative strategy that used 20 undergraduate nursing student volunteers as standardized patients. The student volunteers assessed the performance of 22 advanced practice nursing students during a simulation scenario. The researchers reported the qualitative data suggested a positive reciprocal learning experience for both student groups. Richardson et al. (2009) suggested that using undergraduate nursing-student volunteers as standardized patients was a viable cost-effective option that benefited the volunteers and the learners.

Becker et al. (2006) conducted a randomized controlled study comparing teaching undergraduate nursing students therapeutic communication using standardized patients ($n = 58$) versus the traditional instructive methods ($n = 89$). The researchers reported that students in the standardized-patient cohort described the experience as positive and enjoyable learning; however, there were no statistically significant differences between the two groups. The researcher suggested that although the findings of the pilot study were preliminary the results support the use of standardized patients to augment the traditional teaching methods.

Jeffries (2005) stated that simulation in nursing education is an important teaching tool to address the theory-to-practice gap; however, more robust empirical research is needed to support best practice and evidence-based educational practices. Lin, Chen, Chao, and Chen (2012) wrote that teaching therapeutic communication in the classroom may increase students' knowledge of communication styles and theories, but it generally does not facilitate changes in student performance. Knowledge and skills are not concepts that can stand alone; separating one from the other contributes to the gap between theory and practice (Benner et al., 2010; Donley, 2005). The information gathered from this research contributes to existing nursing knowledge and serves as a foundation for future research.

Psychiatric Assessment

Nearly 800,000 people in the United States attempt suicide every year and approximately 30,000 are successful (Giordano & Stichler, 2009). Assessment of patients at risk for self-harm is an enormous concern for the general acute-care hospital unit as well as the psychiatric hospital unit (Giordano & Stichler, 2009). Many of patients seeking treatment in emergency rooms and acute-care hospitals with depression, anxiety, or thoughts of suicide are misdiagnosed or not referred appropriately for psychiatric care (Giordano & Stichler, 2009). In an effort to address this issue, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2006) established National Patient Safety (goal 15A) requiring documented suicide-risk assessment for patients in psychiatric hospitals and patients admitted to acute-care hospitals with emotional or behavioral disorders. The issues of misdiagnoses and inappropriate referrals is subject for future research; however, it has been suggested that the clinician's inability to establish a therapeutic relationship using caring and compassionate therapeutic communication techniques plays a key role in this phenomenon (Mohr, 2005; Varcarolis & Halter, 2009).

The psychiatric clinical rotation is where students learn to apply the therapeutic communication and assessment skills they have been discussing and learning in the classroom. Mohr (2009) stated that therapeutic-communication techniques might seem artificial in that they differ greatly from conversational communication and, therefore, require practice. Becker et al. (2006) pointed out that those nursing students who are unable to establish trusting relationships with patients are placing themselves and the patient at risk.

Traditionally, nursing students learn psychiatric assessment in the classroom. The students' are expected to transfer that knowledge to the clinical setting where their ability to transfer knowledge-to-practice is evaluated by expert clinical faculty (Becker et al., 2006). This approach can be problematic as the faculty-to-student ratio does not allow for constant one-on-one supervision and the novice student potentially could disregard key assessment findings (Becker et al., 2006). Faculty evaluation of student performance based on secondhand reports from nursing staff and the lack of consistent teaching and evaluation opportunities potentiates the theory-to-practice gap. Many students complete the clinical rotation with substandard assessment skills (Becker et al., 2006).

As noted in chapter I, changes in the mental-health setting have created challenges for psychiatric nursing faculty. Patzel et al. (2007) wrote that many nursing students are not obtaining the core competencies needed to conduct a comprehensive psychiatric assessment. Patzel et al. (2007) conducted a nationwide survey of undergraduate nursing faculty ($n = 160$) asking them to describe clinical experiences in psychiatric mental-health nursing. The survey contained open-ended questions regarding obstacles to a successful clinical experience and the modes of simulation used in psychiatric mental-health curriculum (Patzel et al., 2007). The majority of respondents reported lack of appropriate clinical sites and appropriate RN role

models as the most frequent obstacles to quality clinical experience. The researchers reported that 58 of the 160 respondent reported using some form of simulation. Patzel et al. (2007) reported that the most frequent use of simulation was for practicing therapeutic communication skills.

Coombs, Curtis, and Crookes (2011) conducted a compressive review of the literature using three computer databases. The researchers used the same keyword search terms across all three databases. Coombs et al. (2011) discovered that "not a single article that described the information that mental-health nurses collect as part of a comprehensive mental-health nursing assessment or how they go about obtaining that information could be located" (p. 366). Given the lack of empirical research related to psychiatric assessment skills, it is not surprising to note that a further review of nursing literature found a scarcity of research related to the acquisition of psychiatric assessment skills in undergraduate nursing curriculum.

Varcarolis and Halter (2009) noted that virtually all mental-health facilities have standardized nursing assessment forms to aid in organization and consistency of assessment data. The measurement of assessment-skill acquisition and performance continues to pose a challenge for nursing educators (Norman, Watson, Murrells, Calman, & Redfern, 2002). Becker et al. (2006) stated that the need to provide for student and patient safety often prevents the student nurse from participating in or completing a patient assessment during the clinical rotation.

This research study provided student nurses with a formative simulation experience that addressed five of the components of a psychiatric assessment: establishing rapport with the patient, obtaining an understanding of the chief complaint, assessing current physical status, assessing risk factors that affect patient safety, and assessing the patient's thought process and mental status (Varcarolis & Halter, 2009). The researcher and psychiatric clinical faculty used a

psychiatric assessment rubric to track the students' assessment skills as they progressed through the simulation experience.

Simulation with Standardized Patients

May et al. (2009) conducted a comprehensive review of the literature to investigate the educational value of standardized patients on the knowledge, skills, and behaviors of learners in the health professions. The researchers reviewed English-language articles covering the period from 1996 to 2005. May et al. (2009) reviewed 797 abstracts and selected 69 articles that met the review criteria. May et al. (2009) reported that three (4.3%) of the 69 articles used random sampling, 14 (20.3%) used a qualitative descriptive design, 17 (24.6%) used a pretest and posttest design, 18 (26.1%) used a posttest only design, and 20 (29%) used a case-control design.

May et al. (2009) adapted Kirkpatrick's (1998) four-level educational evaluation model designed to evaluate training (Table 2).

Table 2

May et al. (2009) Adaptation of Kirkpatrick's (1998) Model for Evaluating Outcomes		
Level	Type of Outcome	Description
1	Reaction	Learners' views on the learning experience
2 A	Modification of attitudes and perceptions	Changes in attitude and perceptions of learners
2 B	Acquisition of knowledge	Acquisition of principles and concepts
2 C	Acquisition of skill	Acquisition of psychomotor, or cognitive skills such as problem-solving
3	Behavioral change	Transfer of learning to their practice setting
4 A	Change in organizational practice	Wider changes in the program
4 B	Benefits to patients	Improvement in health or well-being of patients

The results of the review are presented in Table 3. May et al. (2009) reported that 41 studies (59%) measured self-reported student or faculty satisfaction; 49 studies (71%) measured gains in attitude, knowledge, or skills; and 5 (7.3%) measured changes in behavior.

Table 3

May et al. (2009) Summary of Outcomes		
Level	Reported Outcomes	%
1	Reported satisfaction	59.0
2 A	Self-reported change in attitudes	11.6
2 B	Changes in knowledge	62.3
2 C	Changes in skills	62.3
3	Behavioral change	6.0
4 A	Organizational change	0.0
4 B	Change in health and well-being of patient	0.0

May et al. (2009) noted that most articles reviewed had weak research designs. Fourteen of the studies (20.3%) did not report sample size, and 40 (57.97%) did not have separate comparison groups. May et al. (2009) wrote that "most of the studies in this review assessed outcomes at Levels 1 and 2 (41 studies, 59% and 49 studies, 71%, respectively), only five studies assessed at Level 3" (p. 49). This dissertation research added to the body of knowledge by investigating changes in knowledge, skill, and behavior between the treatment and comparison group. Additionally the focus of this research (debriefing method) investigated a specific component of the simulation process.

Faculty at a Midwestern college conducted a two-group posttest-only randomized experimental design study using standardized patients to facilitate the development of student

leadership skills and increase awareness of quality and safety competencies required of the new graduate nurses (Sharpnack, Goliat, & Rogers, 2013). Sharpnack et al. (2013) stated that student participants were responsible for task delegation, allocation of resources, and prioritization of care for a group of patients. Participants were students enrolled in a nursing leadership course over three consecutive semesters ($n = 66$). Students were assigned randomly to two groups. One group completed the Nursing Leadership Content Mastery Assessment, developed by Assessment Technologies Institute (ATI), and then participated in the simulation scenario. The second group participated in the standardized patient simulation scenario first and then completed the Nursing Leadership Content Mastery Assessment (Sharpnack et al., 2013).

Sharpnack et al. (2013) reported that students who completed the simulation prior to taking the Nursing Leadership Content Mastery Assessment scored at the 83rd percentile for baccalaureate programs and 73rd percentile nationally on the assessment. Students who completed the Nursing Leadership Content Mastery Assessment prior to participating in the simulation scored at the 68th percentile in both baccalaureate and national levels. Sharpnack et al. (2013) reported statistically significant differences in scores for the subscales on the Nursing Leadership Content Mastery Assessment. The mean for the group that completed Nursing Leadership Content Mastery Assessment after simulation was 72.30 ($SD = 6.09$), and the mean for the other group that completed the assessment before the simulation was 67.76 ($SD = 4.1$). The researchers reported that the increase for group that completed the assessment after the simulation was statistically significant with a very large measure of practical importance ($\eta^2 = .61$).

Although students showed improvement on the written assessment after the simulation with the standardized patients, many students struggled with the leadership tasks embedded in

the scenarios reported by Sharpnack et al. (2013). The researchers concluded that the study findings exposed gaps in the transference of knowledge learned in the classroom to simulation scenarios. Nursing research related to the use of standardized patients in prelicensure undergraduate nursing curriculum is limited, and researchers are recommending additional research (Benner et al., 2010; Feingold et al., 2004; Gaba, 2011; Jeffries, 2005; May et al., 2009; Sharpnack et al., 2013).

Yoo and Yoo (2003) conducted a quasi-experimental research study using a nonequivalent comparison group posttest design comparing the effects of teaching sophomore-level student nurses fundamental nursing skills using traditional methodology versus standardized patients. The researchers reported that, on average, the students in the standardized patient group ($n = 36$) had statistically significantly higher scores in clinical skill performance, clinical judgment, and communication skills than students in the traditional group ($n = 40$).

A quasi-experimental, pretest and posttest study with 264 first-year prelicensure nursing students enrolled in a clinical nursing course was conducted by DeBourgh and Prion (2011). The researchers stated "experienced nurses are able to predict patient risk and harm based on experience and knowledge and to act to recognize and respond to this risk" (DeBourgh & Prion, 2011, p. 47). The researchers stated that most students have an understanding of the potential for patient harm, however; initiating the actions needed to provide safe patient-care and prevent harm requires clinical experience and clinical judgment. To evaluate the effectiveness of simulation as an instructional strategy to teach fall prevention, the researchers designed a simulation learning experience using standardized patients (DeBourgh & Prion, 2011). The researchers reported results from paired-sample two-tailed t tests. Data analysis found a practical

and statistically significant difference between pre- and posttest scores with a Cohen's *d* of 1.32 indicating a very large effect size.

DeBourgh and Prion (2011) collected evaluative data from students and instructors following the simulation and at the end of the semester. Postsimulation qualitative data found 100% of the clinical instructors and 94% of students would like more simulation included in the curriculum. Additionally, at the end of the semester, 74% of student respondents reported they applied the skills learned in simulation during their clinical rotations (DeBourgh & Prion, 2011).

Jenkins and Schaivone (2007) noted that challenges faced by nursing faculty necessitate the creation of realistic learning experiences, together with meaningful evaluation tools. Alfes (2013) wrote that nursing instructors are being encouraged to make a pedagogical shift toward student-centered learning and interactive approaches that incorporate realistic clinical scenarios into clinical instruction. Anderson, Holmes, LeFlore, Nelson, and Jenkins (2010) stated that standardized patients have the potential to create a learning environment that provides interactive student-centered learning; however, faculty must decide how standardized patient simulations will be evaluated. Standardized patients are used in medical education to teach and evaluate students without a risk to actual patients; however, nurse educators have been slow in adopting this methodology (Jenkins & Schaivone, 2007; Wallace, 1997). DeBourgh and Prion (2011) stated that as simulation becomes embedded into nursing curricula, research is needed to develop accurate outcome measurement tools.

The studies chosen for this review support the use of standardized patients in undergraduate nursing curricula. The pre- and postsimulation changes in knowledge, performance, student anxiety and self-confidence were documented in the aforementioned research. Simulation is recognized as an important component of nursing curriculum, and both

students and faculty value simulation as a learner-centered activity that provides inexperienced students to develop clinical skills in a safe environment. Students in this research participated in a series of clinical simulations with standardized patients portraying individuals at risk for self-harm. It is not sufficient for students to acquire the principles of therapeutic communication and psychiatric assessment in the classroom; it is essential to create learning opportunities that engage students in realistic experiences that support the development of the knowledge, skills, and attitudes needed to provide for safe patient-centered care. The results of this study provided additional information on the effectiveness of debriefing style during simulations with standardized patients.

Summary

Conclusions drawn from the review of the literature are as follows: The current state of simulation debriefing literature in nursing and medical education was examined. The results of the studies that examined debriefing methods were presented, and the necessity of further research comparing the different methods is evident. Although several debriefing methods are practiced widely and recommended in nursing and medical literature, it is not evident that they are the only effective methods, and alternative methods may be viable options. Simulation requires an exhaustive amount of faculty resources. Therefore, methods of debriefing should be investigated to establish best practice. Research examining traditional and alternate methods of debriefing will contribute to a growing body of nursing knowledge.

Anxiety is a common student experience, and there is a correlation between anxiety and student performance. Nursing students experience high levels of anxiety related to clinical learning environments (Cook, 2005). Methods to decrease anxiety and increase performance is a common topic in educational research (Hancock, 2001; Prato & Yucha, 2012; Putwain,

Woods, & Symes, 2010). Increased anxiety has a negative effect on learning, patient outcomes, and self-confidence. Self-confidence is a major factor in nursing education, and increased confidence is associated with lower levels of anxiety (Morrissette, 2006; Szpak et al., 2011).

Nurse-patient communication is essential to positive patient outcomes, patient safety, and patient-centered care (AACN, 2008; APNA & ISPN, 2008). Many nurses are poor communicators, and there is a gap between knowledge of therapeutic communication and the application of that knowledge to practice (Chant et al., 2002). Communication is a core competency for all nurses (AACN, 2008). Psychiatric assessment skills are needed not only in the mental-health setting, but also in all areas of nursing.

New graduate RNs are expected to have the knowledge necessary to provide safe patient care; however, in the fast-paced environment of 21st-century healthcare, knowledge on its own is not sufficient. Benner et al. (2010) wrote that knowledge must be transferable to current patient-care situations in the clinical setting.

Becker et al. (2006) stated that it was imperative that students gain a mastery of therapeutic communication and psychiatric assessment skills to ensure safe patient care in all clinical settings. Simulations based on course objectives, desired learning outcomes, and didactic knowledge are potentially powerful learning tools (Thomas et al., 2001). Simulation allows faculty to create exemplary cases, as well as introduce sensitive topics such as racism, suicide assessment, and substance abuse in a supportive environment. Simulation offers a bridge between the theory-laden classroom and the experiential environment of the clinical setting. Debriefing is believed to be an essential component of the simulation experience (Dreifuerst, 2009; Fanning & Gaba, 2007; Fey, Scrandis, Daniels, & Haut, 2014; Issenberg, Petrusa, &

Scalese, 2010; Lusk & Fater, 2013). This research addressed a gap in nursing literature by exploring how debriefing methods contribute to student learning.

Presented in chapter III are the research methods for this quasi-experimental pretest-posttest mixed-methods design with participants serving as their own control. The method of recruiting an appropriate sample, the tools used to gather data, the research questions, and methods of data analysis. Examined in the study were the effects of two debriefing styles on knowledge, skill acquisition, and student anxiety. The simulation debriefing methods used were postsimulation and insimulation.

CHAPTER III

METHODOLOGY

The research was designed to investigate the effects of insimulation debriefing and postsimulation debriefing on prelicensure undergraduate nursing students' knowledge, performance, and anxiety. Quantitative methods were used to measure student knowledge of psychiatric assessment and therapeutic communication. Rubrics created by the researcher documented changes in performance as the student conducted a psychiatric assessment over the course of four simulated interviews with a standardized patient. Student perceptions of the effectiveness of the different debriefing methods were measured at the conclusion of the learning activities. Qualitative open-ended questions evaluated student anxiety related to anticipation of participating in a psychiatric clinical rotation. This chapter contains a description of the research design, sample selection, data collection, analysis, data validity and reliability, human subject considerations, study limitations, and a restatement of the research questions.

Research Design

This study used a quasi-experimental pretest-posttest mixed-methods design with participants serving as their own control. This research increased and added to the existing body of knowledge related to the effectiveness of two different debriefing methods. This study used simulation, an artificial representation of a situation, environment, or event for the purposes of learning, evaluation, or research (Jefferies, 2007), as the vehicle for testing the independent variables. Simulations designed to portray situations that students might encounter in the mental-health clinical setting were employed in this study. Simulation has become a teaching strategy for a variety of topics, in undergraduate nursing courses, and there are multiple

examples in the literature of the efficacy of simulation (Alinier, Hunt, Gordon, & Harwood, 2006; Jefferies, 2005; Kaplan & Ura, 2010).

The independent variable was the two debriefing styles: insimulation and postsimulation debriefing. Students were assigned randomly to treatment group, insimulation debriefing, or comparison group, postsimulation. Both groups participated in the same set of simulation scenarios. The dependent variables were student (a) knowledge and performance of therapeutic communication and psychiatric assessment, (b) perceptions of the effectiveness of the two debriefing styles, and (c) anticipatory anxiety as related to participating in a psychiatric mental-health clinical rotation.

Sample

This research used a convenience sample ($n = 67$) of senior-level prelicensure undergraduate nursing student enrolled in a psychiatric mental-health clinical practicum. Two of the participants had significant prior experience with mentally ill persons, therefore their responses were not used in the study. Participants were assigned randomly to either the treatment group ($n = 32$) or the comparison group ($n = 33$). The sample population was recruited from a baccalaureate degree program in the San Francisco Bay Area.

University students are admitted to the nursing program in their junior or senior year and have completed at least 96 units of prerequisite course work. In the Fall of 2014, the university had a total of 31,049 undergraduates. In the Fall of 2014, the School of Nursing (SON) had a total enrollment of 452 students, of which 18% were male and 82% were female. University ethnicity data compiled by the registrar's office indicate that 22% of undergraduate students are European American, 32% are Asian American, 4% are African American, 23% are Hispanic American, and 11% are International Students. University-wide 48% of undergraduate students

are between the ages of 20 to 24; however, the average age of students enrolled in the SON is 25 to 29 years of age. Additionally, the percentage of Asian American students enrolled in the SON of is higher than the general university population (32%, 72%).

Demographic data related to age, prior experience in healthcare, and prior contact with mentally ill individuals were collected at the start of the research. Martin (2002) and Ruth-Sahd and Hendy (2005) have suggested that prior experiences can influence performance; therefore, data obtained were used to control for this variable by excluding data from participants with prior experience working with mentally ill patients. Prior experience with mentally ill persons was defined as anyone who had worked in a mental-health facility or has a family member with a chronic mental illness. Two students were excluded from the study based on these criteria. The students, however, were allowed to participate in the simulations. These students completed the scenarios after everyone else had finished, thus controlling for contamination of the data.

Location of Study

The study was conducted in the undergraduate nursing program of a large public university in Northern California. The SON offers a Bachelor of Science in Nursing program, bridge program for registered nurses to obtain their Bachelor of Science in Nursing, a Masters of Nursing program with tracks in nursing education and nursing administration, and a Doctorate of Nursing Practice. The undergraduate baccalaureate program is accredited nationally by the Commission of Collegiate Nursing Education and approved by the California State Board of Registered Nursing.

The university's SON simulation laboratory allows for a variety of simulation settings. Simulations can be conducted in the Sim Hospital or Sim Home. The Sim Hospital is designed to replicate two hospital units, complete with beds and equipment commonly found in a modern-

day hospital. Each hospital room is equipped with closed circuit cameras for video recording of simulations. Attached to each hospital room is a debriefing room and an observation room equipped with a closed-circuit television. Faculty and students can observe the simulation via the closed circuit television system. Nursing instructors have access to a control room equipped with a phone, computers that control equipment, monitors in the hospital room, and a one-way glass window that allows observation of the simulation.

The simulations used in this research were conducted in the sim home. The sim home is a designed to replicate a studio apartment. Sim home is dual purpose and strategic placement of room dividers converts the apartment into an interview room. The room is equipped with closed-circuit cameras for video recording of simulations. The recording equipment is activated from a separate control room with one-way glass window that allows observation of the simulation by faculty or the simulation technician. During the semester, the simulation technician is available assist with the audio- and video-recording equipment. The researcher was responsible for operating the audio and video equipment during simulations that were conducted during the summer months and on weekends.

Next door to the sim home is the debriefing conference room. The debriefing room is equipped with comfortable chairs, a large conference table, Wi-Fi access, a computer, and a large screen television monitor. The large screen television monitor allows the students and faculty who are not involved directly in the simulation to view the action as it happens. The computer controls the video playback, and the instructor can play video during the postsimulation debriefing. Video playback was not used during the traditional postsimulation debriefing.

Recruitment of Subjects

Students enrolled in the mental-health clinical practicum participated in the simulation

activity as part of their clinical experience. Study volunteers were recruited from senior students enrolled in semester five during the Fall of 2014 and Spring of 2015. Information pertaining to the study, study design, and instruments were emailed to senior students in semester five (Appendix K). The course content for semester five includes the psychiatric clinical rotation. Sixty-seven of a possible 124 students volunteered and participation in the study was strictly voluntary. Pursuant to SON policy and to protect the integrity of the simulation scenarios, all student participants, study volunteers, and standardized patients were asked to sign a confidentiality agreement (Appendix H).

Protection of Human Subjects

The study complied with the standards set by the American Psychological Association (2010) by the University of San Francisco and by the university where the study was conducted. Institutional Review Board for the Protection of Human Subjects approval from the University of San Francisco and the university where the study was conducted was obtained prior to data collection. Written permission was obtained from the Chair of the SON, the Nursing Evaluation and Research committee, and the student participants. Nursing students who volunteered to participate in the study were given a participant informed consent letter explaining the research study, protection of human subjects, and potential benefits of participation (Appendix K). The general intention of the study and procedures to protect the confidentiality of all study materials was stated in the letter. The presimulation-simulation-and postsimulation-data-collection processes were explained. The purpose of the research was defined and participants were assured that participation in this research did not affect their clinical or theory course grades.

To protect the participants' confidentiality during the data-evaluation process, all data-collection materials were coded using four numbers unique to each participant. All data

collected were stored in a locked file cabinet in the researcher's office. All participation in this study was voluntary, and students could decline to participate or withdraw from the study at any time. There was no foreseeable harm to the student volunteers, and there are no consequences for withdrawing or refusing to participate. Although the researcher did not anticipate any foreseeable harm to participants, psychiatric mental-health topics and simulation can produce unforeseen emotional responses. Student volunteers were provided with contact information for counseling services at the university where the study was conducted. Additionally, students were provided with the researcher's contact information and invited to contact her with any questions or concerns that might have arisen during the course of or at the conclusion of the research study. The researcher teaches Professional Role Development a required course for all nursing students; however at the time of the study none of the volunteers were enrolled in a course taught by the researcher.

Researcher Qualifications

The primary researcher has a Master's degree in Nursing Education and a valid California license as a Registered Nurse. In 2005, she received board certification in Psychiatric Mental-Health Nursing from the American Nurses Credentialing Center, the largest credentialing organization for nurses in the United States. In October of 2006, the primary researcher received a level one, simulation certification from the Laerdal Corporation, makers of SimMan® patient simulators. To date of the study, she has attended numerous conferences and workshops on simulation. In 2010 and 2111, she completed level one, two, and three simulation training, as well as a scenario writing and debriefing workshop. All courses were sponsored by the California Simulation Alliance. In preparation for this research, the primary researcher completed a standardized patient workshop, conducted by Dr. Susan Prion at the University of

San Francisco. She is has certified by the California Board of Registered Nurses to teach psychiatric mental-health nursing and adult medical-surgical nursing. She has been a full time faculty member for 13 years at the university where the research was conducted.

Faculty from the university where the study was conducted were invited to observe or assist with the simulations. The qualifications of psychiatric mental-health faculty at the university where the study was conducted varies; however, all participating faculty are, at minimum, Masters prepared and have over 10 years of experience in psychiatric mental-health nursing. One of the faculty volunteers from the participating faculty had completed level one simulation training sponsored by the California Simulation Alliance. The other faculty member was new to simulation and relied upon the researcher's expertise.

The researcher recruited a nurse educator from Kaiser Permanente as a second rater for the videotaped simulations and qualitative data. The research assistant has over 35 years of experience as a registered nurse, a masters degree in nursing education, and 15 years of experience teaching therapeutic communication in the hospital setting.

Instruments

Six data-collection instruments were used in this study: (a) 30-item psychiatric assessment and therapeutic communication pre- and posttest, (b) pre- and postsimulation anxiety questionnaire, (c) therapeutic communication rubric, (d) psychiatric assessment rubric, (e) postsimulation survey, and (f) a demographic questionnaire (Appendices A C,D, E, F, and G).

Psychiatric Assessment and Therapeutic Communication Test

Knowledge acquisition was measured by a 30-item psychiatric assessment and therapeutic communication knowledge test (Appendix A). The test contained 15 items related to therapeutic communication and 15 items related to psychiatric assessment. The possible range of

scores for psychiatric assessment is 0 to 15 and the possible range in scores for therapeutic communication of 0 to 15. Test items were taken from the psychiatric theory course textbook test bank (Mohr, 2009). Test items are based on competencies delineated in the *Essentials of Psychiatric Mental-Health Nursing in the BSN Curriculum* document (The American Psychiatric Nurses Association and International Society of Psychiatric Nursing (APNA & ISPN, 2008).

A pilot study was completed with a group of nursing students ($n = 30$) to obtain difficulty and discrimination indices for each item and to estimate reliability using Cronbach's coefficient alpha. To obtain content validity, a three-member panel of doctorally-prepared content experts was provided with a packet containing the test items and a rubric to assist in the analysis of the instrument (appendix B). Changes to the test were made based on recommendations from the panel. Revision to the test included; (a) changing wording to be gender neutral, (b) minor grammatical changes, (c) revision of potentially confusing language, and (d) changes to five incorrect response to increase difficulty. The revised test was piloted in January of 2014, prior to use in the research study ($\alpha = .66$). This test was administered to all study participants pre- and postsimulation to assess changes in the students' knowledge.

Psychiatric Assessment Rubric

An extensive search of the nursing literature revealed a lack of suitable instrumentation to measure therapeutic communication and psychiatric assessment skills. The researcher created the items for the psychiatric assessment rubric using content taken directly from *The Essentials of Psychiatric Nursing in the BSN Curriculum* (APNA & ISPN, 2008). The competencies listed in the APNA and ISPN document have been evaluated by content experts in these two national psychiatric mental-health professional organizations and are used by schools of nursing to guide curriculum. The content of the psychiatric assessment rubric represent skills needed to conduct a

psychiatric assessment. The rubric consisted of 20 essential assessment behaviors divided into seven categories (Introduction, Patient History, Symptoms, Mental Status, Social Support, and Situation, Background, Assessment, and Recommendation (SBAR)). Five of the categories were further divided into expected behaviors appropriate to that category (Table 5). Social Support and SBAR consist of one expected behavior. Student performance was rated using a scale from 1 (*not met*) to 4 (*competent*). Total scores were obtained for each category and used for the data analysis.

Table 4

Psychiatric Assessment Rubric Items and Categories of Behaviors				
Categories	Expected Behaviors			
Introduction	Washes Hands	Introduces Self	Identifies Patient	Explain Purpose of Interview
Patient History	Medical History	Prior Medical Hospitalizations	Prior Psychiatric Hospitalizations	History of Drug and Alcohol Use
Symptoms	Current Symptoms	Onset Symptoms	Severity	Duration
Mental Status	Orientation	Mood & Affect	Thought Process	
Risk Assessment	Suicidal Ideation	Plan	Ability to Contract for Safety	
Social Support	Assess Social Support			
SBAR	SBAR Report			

A team of three doctorally-prepared content experts were provided with a packet containing the psychiatric assessment rubric and an additional rubric for scoring the instrument. The rubric was reviewed for content validity, and two minor changes were made based on the panel's recommendations. After the minor wording changes were completed, the rubric was used to evaluate student behaviors during the first simulation (to establish a baseline) and the last

simulation (for comparison). All simulations were videotaped. The videotapes were reviewed by two raters who viewed the tapes simultaneously. Any disagreements were reviewed and discussed until a consensus was reached. Percentage of agreement between the two raters was 100% agreement.

Therapeutic Communication Rubric

The therapeutic communication rubric was designed to count the number of therapeutic and nontherapeutic responses the student made during the course of the first and last simulations. The two-part rubric consisted of a list of commonly used therapeutic and nontherapeutic responses compiled using textbooks required for the psychiatric mental-health theory course (Arnold & Boggs, 2010; Halter, 2014; Mohr, 2009). The therapeutic rubric consisted of total of 18 items with 10 therapeutic and 8 nontherapeutic (Appendix D). Scores for each part were tallied for each student and the total was divided by the number of items in that part.

The panel of content experts agreed unanimously that the rubric represented the most common therapeutic and nontherapeutic responses expected from nursing students at this level. Two raters viewed the videotaped scenarios and tallied the scores. The rubrics were compared for accuracy and agreement. Discrepancies were resolved by reviewing the videotape a second time. Interrater reliability was 100% agreement between the two raters as to the accuracy of the data.

Anxiety Questionnaire

Szpak and Kameg (2011) believed that even "moderate to severe levels of anxiety can interfere with a student's ability to process thoughts and ultimately may impede the ability to establish a therapeutic relationship" (p. 1). Understanding the sources of increased student anxiety as it relates to working with psychiatric mental-health patients is a crucial step toward

designing learning activities that promote positive experiences in the clinical setting.

Researchers have suggested that there is a correlation between student nurses' anxiety and negative preexisting attitudes about mental illness (Fisher, 2002; Ojanen, 1992; Perese, 1996; Szpak & Kameg, 2011). Further review of the literature indicated that the existing tools that measure student anxiety were inadequate. Kolb and Shugart (1984) claimed that the evaluation of nursing students' knowledge, attitudes, and skills is "complicated by the problem of trying to evaluate each domain separately when, in most instances, several behaviors occur simultaneously" (p. 84).

In order to gather data, a questionnaire with open-ended reflective questions was used pre- and postsimulation to investigate student changes in perceived anticipatory anxiety related to working with mentally ill patients (Appendix C). The open-ended questions were developed by the researcher over the course of several years and had been used repeatedly during student orientation to mental-health clinical rotations. The reflective questions were evaluated by a three-member panel of mental-health faculty. The panel suggested minor wording changes to increase readability, but no other changes were made to the content of the questions. The participants were given the questionnaire before the start of the first simulation. The students were instructed to put the last four numbers of their student identification on the form and given approximately 20 minutes to answer the questions. Students who were uncomfortable using their student identification were asked to use four numbers that they could remember. The students were given the same three questions postsimulation and instructed to reflect on changes that may have occurred.

Demographic Questionnaire

Participants completed a demographic questionnaire prior to the start of the research

activities (Appendix G). Given that the sample represented the demographics of the SON, the primary purpose for the questionnaire was to control for the extraneous variable of prior experience with mentally-ill persons. Two questions addressed the extraneous variable; prior experience working in healthcare and prior experience with mentally-ill persons.

Postsimulation Questionnaire

The postsimulation questionnaire assessed student perceptions of the debriefing experience (Appendix F). The survey has seven items and used a 5-point rating scale with 1 (*do not agree*) to 5 (*agree completely*). The survey questions were identical for both groups. The rating-scale questions were adapted from a similar survey used by Van Heukelom, Begaz, and Treat (2010). The questionnaire also contained a section for comments, and participants were encouraged to comment on the simulations and debriefing methods. The insimulation group was asked specifically to comment on both debriefing methods.

Data Collection

This section contains data-collection procedures. Preparation for simulation included training of student volunteers to assume the role of the standardized patient, contacting mental-health faculty to coordinate simulation schedules, review of demographic data to control for participant prior experience, and random assignment of students to groups.

Data collection took place in two phases during Summer 2014, Fall semester 2014, and Spring semester 2015. All simulations were conducted prior to the start of the participants' mental-health clinical rotation. Student participants were divided into groups of four and each group of four was assigned randomly to the treatment or comparison group.

During Phase I, all participating students began the research activity by completing the 30-item pretest on psychiatric assessment and therapeutic communication knowledge and the

anxiety questionnaire. Each student participated in three different 10- to 15-minute simulated interviews with a standardized patient.

To establish a baseline, the treatment group received traditional postsimulation debriefing during the first simulation scenario (Table 5). Then the treatment group received insimulation debriefing for scenarios two and three. The comparison group received traditional postsimulation debriefing for all four scenarios. All simulations were videotaped for later review by the researcher. In accordance with the policy of the SON and to protect student privacy, all videotapes were erased after the data had been collected and reviewed for accuracy and interrater reliability assessed.

Table 5

Phases of the Research Process				
Group	Phase I	Phase II		
	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Treatment	Postsimulation Debriefing	Insimulation Debriefing	Insimulation Debriefing	Postsimulation Debriefing
Comparison	Postsimulation Debriefing	Postsimulation Debriefing	Postsimulation Debriefing	Postsimulation Debriefing

*Phase II was conducted 7 days after the completion of Phase I

During Phase II of the research, each student in both groups participated in one simulation with postsimulation debriefing. All participants completed the 30-item posttest on psychiatric assessment and therapeutic communication knowledge, the anxiety questionnaire, and the postsimulation survey. The insimulation group (treatment group) was asked to use the comment portion of the postsimulation survey to share their thoughts, feelings, and comments about the two debriefing styles.

The researcher and a second rater (Masters-prepared nurse educator) used the psychiatric assessment rubric and therapeutic communication rubric to compare changes in student performance from the first with the fourth simulation scenario.

Preparation for Simulation

One week before the simulation activity, the researcher and a mental-health faculty member met with the standardized-patient student volunteers to practice the simulations, answer questions, and evaluate the standardized patient's performance. Standardized patients received a Starbucks' gift card in addition to course credit in Nursing 180, an independent study course.

All students in the Nursing 147A Psychiatric Mental-Health Clinical course received an email explaining the purpose of the research study and the researcher's contact information. Students who wished to participate in the study notified the researcher by email, and these students were sent the link to the online demographic survey. Students were assigned randomly to insimulation debriefing and postsimulation debriefing. The groups were designated treatment (insimulation debriefing, $n=32$) or comparison (postsimulation debriefing, $n=33$). The treatment group consisted of eight groups of four students per group. The comparison groups consisted of nine groups of four each. One student did not sign the research consent but did participate in the simulation. Two students signed consents and completed the study instruments; however, their data were not included in the research as these students had significant prior knowledge working with mentally ill patients.

One week prior to the simulation activity, all student participants reviewed a packet of material related to psychiatric assessment and therapeutic communication. The packet included textbook chapters and library links to articles related to therapeutic communication, psychiatric assessment, and suicide-risk assessment.

Simulation

The beginning of Phase I students were assigned to 4-hour time slots for the simulation. As per the instructions previously provided, participants were dressed as if they are going to the clinical site. Students met with the researcher in one of the debriefing conference rooms where the researcher explained the research process. Participants were provided with the consent packet containing the participant consent letter, the informed consent, the consent to videotape, the SON confidentiality agreement, and the research subjects' bill of rights (Appendices H, J, and K). After consent was obtained, participants were asked to complete the pretest anxiety questionnaire and the 30-item multiple-choice psychiatric assessment and therapeutic communication knowledge pretest. The estimated time to complete the questionnaire and pretest was approximately 45 minutes.

Following a short break, the researcher or a member of the psychiatric mental-health faculty explained the simulation procedures. The experimental group (insimulation) was provided with additional information on insimulation debriefing. Both groups were given the opportunity to ask questions before each student was assigned randomly to a patient scenario. Each scenario presented a different psychiatric illness (see p. 92 for an explanation of psychiatric illnesses). The simulations were designed to provide the student with a realistic portrayal of a typical psychiatric hospitalization from admission to discharge.

The first simulation began with the admission process. Each patient's story progressed or unfolded in a series of interactions as the patient moved from admission to inpatient to preparation for discharge. The student remained with the same standardized patient until the conclusion of the simulation activity (Table 6).

Patient symptoms varied as the student progressed through the simulation experience with each patient having a different set of symptoms (see simulation manual Appendix I). All simulations were videotaped for later review. Simulation sessions lasted approximately 10 to 15 minutes. All students in the group completed the first simulated interview before starting second simulation. The postsimulation group participated in a group debriefing after all four students had completed on patient interview.

Table 6
Simulation Flow Chart

	Phase I	Phase II		
Student	Scenario 1	Scenario 2	Scenario 3	Scenario 4
1	Mrs. Nguyen	Mrs. Nguyen	Mrs. Nguyen	Mrs. Nguyen
	Admission	Tearful & hopeless	After visit with family	Discharge home
2	Mr. Barrett	Mr. Barrett	Mr. Barrett	Mr. Barrett
	Admission	Paranoid	After visit with family	Discharge
3	Mrs. Clarkson	Mrs. Clarkson	Mrs. Clarkson	Mrs. Clarkson
	Admission	Angry phone call	After visit with family	Discharge
4	Ms. Whipple	Ms. Whipple	Ms. Whipple	Ms. Whipple
	Admission	Angry & tearful	Increased anxiety	Discharge
	End of Phase I	Break	Break	End of Phase II

Each student participated in three simulated patient interviews with the standardized patient during the first day of simulation (Phase I). Students were given a short break between each set of four simulations.

To establish a baseline, both groups followed the same simulation format during the first patient interview. The student participant received information on the assigned patient in the form of a medical record and nurse-to-nurse patient report. The simulation started with the participant entering the room and meeting the standardized patient. The simulation continued until the student had completed the assessment or the patient had become uncooperative and it was impossible to complete the interview. All simulations were stopped after 15 minutes had elapsed. The standardized patients were instructed to respond appropriately to the questions, providing the student used therapeutic communication techniques. As the simulation continued, if the student asked a question using nontherapeutic communication, the patient became increasingly uncooperative.

Both groups participated in the same scenarios for simulations one, two, and three. All debriefing questions were designed to encourage reflective thinking and problem solving. At the conclusion of simulations, the researcher conducted a brief check-in with the participants. The purpose of this activity was to assure that none of the participants left with unresolved questions or emotional issues related to the simulation experience. The participants were reminded to maintain confidentiality and were instructed to return in one week for the conclusion of the research process.

One week later after the conclusion of Phase I, students returned at the assigned time to the simulation laboratory. Phase II of the research study started with a brief reorientation to the simulation process. The students were assigned to standardized patient with the same diagnosis

that they had encountered in simulation one through three. Insimulation debriefing was not used; debriefing occurred only at the conclusion of the scenario. The rationale for the return to postsimulation debriefing was to maintain the same process for collecting pre- and postsimulation data for both groups. Phase II concluded after the students had completed the postsimulation anxiety questionnaire, the 30-item psychiatric assessment and therapeutic communication knowledge posttest, and the postsimulation survey.

Debriefing

Students in the insimulation debriefing group were given report and then started the patient interview. The researcher allowed the simulation to continue until 2 to 3 minutes had elapsed or the standardized patient has become increasing uncooperative. At this point, a brief timeout was called for a 1- to 2-minute debriefing with the student. For example, if the student had asked a nontherapeutic question or missed an important component of the assessment process, the research asked, "What do you think is missing from your assessment or how can you rephrase your question to the patient?" Asking the student to think about what he or she could do differently encourages reflective learning (Dreifuerst, 2009). Debriefing during the simulation was individualized to each student's learning needs, behaviors, and performance. Debriefing questions and guidelines were included in the simulation manual. Insimulation debriefing last 1 to 2 minutes, then the simulation restarted from the point where the standardized patient became uncooperative, thus providing the student with the opportunity to redo a portion of the interview. Simulation two and three consisted of four to five cycles of 3 to 4 minutes of simulation with 1 to 2 minutes of timeout for debriefings.

The comparison (postsimulation debriefing) group completed the same simulations; however, they received a 20- to 30-minute postsimulation debriefing. Postsimulation debriefing

questions were included in the simulation manual. The researcher conducted 90% of all the simulations and debriefing, 10% were conducted by a mental-health faculty member, under the supervision of the researcher. Simulation activities for Phase I were concluded when all students had completed three simulation scenarios. At the conclusion of the final debriefing, the researcher was available to answer student questions. The researcher reminded the participants that she was available by text or email to assist them with any emotional issues that may have occurred as a result of this research.

Simulation Scenarios

The standardized patients who participated in this study utilized a scripted clinical scenario portraying a psychiatric patient. The clinical scenarios used in this study represented common psychiatric issues and a variety of patient ages and backgrounds and consisted of a patient profile with four unfolding scenarios for each profile. Unfolding scenarios transitioned the same patient through multiple events. For example, the Sheila Nguyen's patient profile is of a suicidal postpartum Asian woman. The patient profile contains four scenarios: (a) scenario one is the admission process, (b) scenario two is 24 hours later, (c) scenario three is day 3 of the hospitalization, and (d) scenario four is the day of discharge.

This study contained four patient profiles that included the following psychiatric issues: (a) a young mother with postpartum depression and active suicidal ideation, (b) an elderly patient with depression and passive suicidal ideation, (c) a middle-aged person with hallucinations, paranoid delusions and suicidal ideation, and (d) a college student with depression, anxiety, and suicidal ideation. This research used four patient profiles with each profile containing four scenarios for a total of 16 scenarios. With slight modifications to the scenarios, three of the four scenarios could be portrayed by either a male or a female student. The standardized patients

presented different moods, degrees of suicidal thoughts, and symptoms of their illness as the scenario progressed from admission to discharge. Although each patient profile presented different psychiatric conditions and symptoms, all four supported the student learning objective of assessing all patients for suicidal ideation.

Recruitment and Training of Standardized Patients

The standardized patient volunteers used for this research study were nursing students enrolled in Nursing 180, a one- to two-unit independent study course. The researcher gave the standardized patient volunteers a gift card as a token of appreciation for assistance with this research. To protect the standardized patient volunteers from fatigue and to accommodate the students varied school schedules, the researcher recruited and trained eight students (three males and five females). Participation in the standardized patient role was voluntary, and only students who had completed the psychiatric mental-health clinical practicum were eligible to participate, because they were familiar with the symptoms exhibited by patients experiencing mental-health issues.

Standardized patient volunteers were provided with the scenario objectives and the patient profiles. Patient profiles included instructions for scripted responses to the student nurses' therapeutic and nontherapeutic communication techniques (Appendix I). The standardized patient was responsible for portraying appropriate body language such as nervous pacing, clinched fists, and distressed facial expressions, as well as distortions of speech and thought processes. The researcher provided the standardized patients with wigs, make-up, and clothing for each scenario. Standardized patient directions for portraying specific symptoms were contained in the scenario outlines and patient profile (Appendix I). The volunteers received 2 hours of training on 2 consecutive days for a total of 4 hours. The researcher conducted training

prior to the start of this research project. During the training process, the researcher played the role of the nursing student conducting the interview. The training process was videotaped and viewed by the student volunteers and the researcher for the purpose of providing feedback on the students' performances. On the day of simulation, standardized patient volunteers reviewed the simulation roles and rehearsed the role prior to each simulation session.

Restatement of Research Questions

This proposed quasi-experimental pretest-posttest study asked five research questions.

The questions are as follows:

1. What is the extent of change from pretest to posttest in knowledge, anxiety, and performance (using the rubric to measure performance) for the two groups combined?
2. What is extent of change in knowledge, anxiety, and performance after insimulation debriefing?
3. Is there a difference in the change from pretest to posttest in knowledge, anxiety, and performance between the two groups (insimulation debriefing and postsimulation debriefing)?
4. How do the two groups describe and rate the debriefing experience?
5. Is there a difference in the student perceptions of the effectiveness of the insimulation debriefing and the postsimulation (comparing the responses of those students who received both)?

Data Analysis

To address the first research question: What is the extent of change from pretest to posttest in knowledge, anxiety, and performance (using the rubric to measure performance) for the two groups combined? The 30-item multiple-choice psychiatric and therapeutic

communication knowledge pre- and posttest was compared using means, standard deviations, and a paired-sample t tests. The psychiatric assessment rubric was divided into categories and analyzed using paired-sample t test for each category. The two categories that did not have multiple items (social support and SBAR) were analyzed using chi-square tests. The Therapeutic Communication rubric was designed to count the number of therapeutic and nontherapeutic questions and comments made by each participant and the rubric was divided into two sections (therapeutic and nontherapeutic). The Therapeutic Communication data were analyzed using paired-sample t test. Anxiety was analyzed using Consensual Qualitative Research (CQR) a method that uses a team consensus approach to interpret meaning from qualitative data (Hill et al., 2005). Using CQR methods, written comments were coded and analyzed for emerging themes. Student identifiers were removed from all qualitative data. The data were coded treatment or compression group and transcribed from handwritten to typed format for ease of interpretation.

To address the second research question: What is the extent of change in knowledge, anxiety, and performance after the insimulation debriefing? Means and standard deviation were calculated and paired-sample t tests were used to evaluate changes between pre- and postsimulation for the insimulation group for knowledge and performance. For anxiety, qualitative analysis was conducted using CQR methods.

Research question three: Is there a difference in the change from pretest to posttest in knowledge, anxiety, and performance between the two groups (insimulation debriefing and postsimulation debriefing)? Independent-samples t test were computed for group differences in knowledge and performance. Qualitative analysis of student anxiety was evaluated using CQR methodology (Hill et al., 2005). Written responses to the pre- and postsimulation anxiety

questionnaire were coded and analyzed for emerging themes.

For each of the research questions, overall error rate was controlled at that .05 level. For statistical significant results in independent- and paired-sample t tests, effect sizes were calculated using Cohen's D. For statistical significant results in Chi-Square, Cramer's V calculated as the measure of practical importance.

The fourth research question: How do the two groups rate the debriefing experience? The questions was evaluated using chi-square test to evaluate for group differences. Cramer's V was compute for practical interpretation.

The fifth research question: Is there a difference in the student perceptions of the effectiveness of the insimulation debriefing and the postsimulation (comparing the responses of those students who received both)? Analysis of qualitative data were conducted using the CQR method (Hill et al., 2005). CQR is an inductive method of analysis developed in 1997 by Hill, Thompson, and Williams. The CQR method is characterized by open-ended questions, the importance of context, and consensus of the research team. CQR is appropriate for research that requires descriptions of inner experiences, attitudes, and convictions (Hill et al., 1997).

The qualitative portion of research questions one and three were analyzed using CQR method. The written responses to the open-ended pre- and postsimulation anxiety questions were analyzed for emerging themes. Student comments related to debriefing on the postsimulation survey were transcribed into a single document and analyzed. The qualitative data were reviewed by the primary researcher and one assistant.

The review team consisted of two individuals. The primary researcher and a Masters prepared nurse educator with over 30 years of experience.

Steps in the CQR Analysis

The primary researcher removed identifying features from the pre- and postsimulation anxiety questions and transcribed the comments from the postsimulation survey verbatim. An auditor checked the transcriptions for accuracy. In compliance with CQR data-analysis procedures (Hill et al., 2005), a primary list of main topics were developed from the literature (Kameg, Howard, Clochesy, Mitchell, & Suresky, 2010; Lehr, & Kaplan, 2013; Morrissette, (2004). Robinson-Smith, Bradley, & Meakim, 2009). Next the raters reviewed data independently and sorted the related data into appropriate categories. The team members met and shared opinions and ideas related to the identified categories. Hill et al. (2005) stated that consensus requires respectful and equitable discussion data and shared respect. The team members met and discussed disagreements until they reached agreement. Then the team developed a consensus version for each category. The consensus version was reviewed by the auditor. The auditor met with the team and provided feedback. The feedback was discussed until a consensus was reached at which point the team determined that the data analysis was complete.

CHAPTER IV

RESULTS

The purpose of quasi-experimental pretest-posttest mixed methods design with participants serving as their own control was to examine student perceptions of the effectiveness of traditional postsimulation debriefing versus insimulation debriefing. The research questions were designed to investigate the effects of two debriefing methods on prelicensure baccalaureate nursing students' knowledge, performance, and anxiety. Students participated in simulations with standardized patients; the intervention was insimulation debriefing, and the comparison was traditional postsimulation debriefing. A convenience sample of 65 senior-level Baccalaureate nursing students preparing to start a psychiatric mental-health clinical rotation participated in the study. Students took a pretest before the simulation exercise with debriefing and a posttest at the conclusion of the research.

Chapter IV contains an analysis of all scores relating to the research questions. Type of debriefing was the independent variable, and nursing student perceptions of the two debriefing styles and changes in student knowledge, performance, and anxiety were the dependent variables. Quantitative and quantitative results are reported as they relate to the five research questions.

Sixty-seven senior undergraduate prelicensure baccalaureate nursing students at a San Francisco Bay Area public university participated in simulations designed to teach therapeutic communication and psychiatric assessment. Students were assigned randomly to the treatment group ($n = 32$) insimulation and the comparison group ($n = 33$) postsimulation. Data from two

students were excluded, as both students, had significant prior experience working with mentally-ill persons.

The research was conducted in two phases. During Phase I both groups completed a baseline simulation that used postsimulation debriefing. Seven days after Phase I both groups participated in three additional simulations. During the second and third simulations insimulation debriefing was used with the treatment group, whereas the comparison group continued with postsimulation debriefing. At the conclusion of Phase II (day two) the final simulation for both groups used postsimulation debriefing.

Data were collected at the end of summer break 2014 and the beginning of the Fall 2014 and Spring 2015 semesters. All simulations were conducted prior to the start of the each student's psychiatric mental-health clinical rotation. Participants in the treatment and comparison were divided into groups of four, and each cohort then participated in Phase I and Phase II of the research.

Five instruments were used in the study. The first instrument, a 30-item Psychiatric Assessment and Therapeutic Communication test, and the second instrument, a self-report reflective anxiety questionnaire, were administered at the beginning of Phase I and the end of Phase II. The third and fourth instruments, the Psychiatric Assessment and Therapeutic Communication Rubrics, were used by the researcher and second rater to measure changes in student performance. The fifth instrument, the two-part self-report Postsimulation Survey, was administered at the conclusion of Phase II. The results of the data analysis follow.

The assumptions for the independent-samples and paired-sample t tests were robust with respect to violation. The sample sizes are large so that the Central Limit Theorem applies for both statistical procedures. The assumption of equal population variances is robust with respect

to violation because the sample sizes for the Postsimulation and Insimulation groups are nearly equal with 32 and 33, respectively. The exact chi-square tests were employed so that no assumptions were needed for those tests. Effect sizes for Independent Samples *t* test were measured using Cohn's *d*.

Research Question One

What is the extent of change from pretest to posttest in knowledge, anxiety, and communication and assessment performance (using the rubric to measure performance) for the two groups combined? To investigate if the simulation experience positively effected the participants' knowledge, anxiety, and communication and assessment performance paired-sample *t* test and chi-square tests were calculated. The means, standard deviations, paired-sample *t*-test results, and effect sizes for knowledge and therapeutic communication pre- and posttest are found in Table 7.

Table 7

Means, Standard Deviations, Paired-Sample *t*-test Results, and Effect Size Results for the Psychiatric Assessment and Therapeutic Communication Knowledge Test and the Therapeutic and Nontherapeutic Communication Rubric for both Groups Combined (*N*=65)

Instrument	Test	<i>M</i>	<i>SD</i>	<i>t</i> (<i>df</i> =64)	<i>ES</i>
Knowledge Test	Post	26.02	2.29	19.11*	2.37
	Pre	20.18	3.69		
Therapeutic Communication	Post	2.70	0.57	10.88*	1.34
	Pre	1.68	0.42		
Nontherapeutic Communication	Post	1.04	0.79	-14.39*	-1.75
	Pre	2.42	0.47		

*Statistically significant when the overall error rate is controlled at the .05 level.

On the 30-item Psychiatric Assessment and Therapeutic Communication knowledge test, the overall change from presimulation to postsimulation is not only statistically significant but

also practically important with a very large effect size of 2.37. The overall change from pre- to posttest for therapeutic communication is not only statistically significant but also practically important with a large effect size of 1.34. The change from pre- to posttest for nontherapeutic communication is negative indicating a statistical significant and practically important ($ES = -1.75$) decrease in nontherapeutic communication across both groups. On average, both groups showed statistically significant improvement; however, the treatment group had a larger increase in therapeutic-communication techniques and a larger decrease in nontherapeutic communication than their peers in the comparison group.

The results of the paired-sample t test for the Psychiatric Assessment Rubric are presented in Table 8. In place of a total score on the Psychiatric Assessment Rubric, the items were grouped into the following categories: Introduction, Patient History, Symptoms, Mental Status, Risk Assessment, Social Support, and SBAR. There are statistically significant differences from pretest to posttest for all categories with effect sizes ranging from 1.45 to 3.30. Qualitative data related to anxiety are presented at the end of this chapter.

The categories social support and SBAR did not have multiple items; therefore, these were analyzed using a chi-square test and Cramer's V . The results for the chi-square test and Cramer's V indicated that the both groups had statistically significant increases. Chi-square test for the SBAR and social support were statistically significant and practically important ($\chi^2 = 12.07$ ($df = 1$), $V = .43$) and ($\chi^2 = 35.50$ ($df = 1$), $V = .52$).

Table 8

Means, Standard Deviations, Paired-Sample *t*-test Results, and
Effect Sizes for Psychiatric Assessment Rubric for
Both Groups Combined (*N* = 65)

Categories	Test	<i>M</i>	<i>SD</i>	<i>t</i> (<i>df</i> =64)	<i>ES</i>
Introduction	Post	3.91	.17	11.54*	1.45
	Pre	3.61	.13		
Patient History	Post	3.62	.24	19.77*	2.48
	Pre	2.85	.40		
Symptoms	Post	3.66	.30	26.42*	3.30
	Pre	2.77	.36		
Mental Status	Post	3.61	.31	20.81*	2.55
	Pre	2.48	.52		
Risk Assessment	Post	3.14	.58	21.50*	2.67
	Pre	1.62	.40		

* Statistically significant when the overall error rate is controlled at the .05 level.

Research Question Two

What is the extent of change in performance after the insimulation debriefing? The paired-sample *t*-test results for the Psychiatric Assessment and Therapeutic Communication knowledge pre- and posttest, and the therapeutic and nontherapeutic rubric pre- and posttest are found in Table 9.

The insimulation group had statistically significant and practically important increases from pretest to posttest in knowledge, therapeutic communication, and psychiatric assessment with effect sizes ranging from - 1.72 to 5.42. The value for nontherapeutic communication paired-sample *t* test is negative with a negative effect size of -1.72 indicating a very large decrease in the number of nontherapeutic questions and comments.

The categories social support and SBAR did not have multiple items; therefore, these items were analyzed using a chi-square test and Cramer's V. The results for the chi-square test

and Cramer's V indicated that the insimulation group had statistically significant increase in performance for SPAR ($\chi^2 = 7.99$, (df = 1), $V = .48$) and social support ($\chi^2 = 22.99$, (df = 1), $V = .85$).

Table 9

Means, Standard Deviations, Paired-Sample *t*-test Results, and Effect Sizes for the Psychiatric Assessment and Therapeutic Communication Knowledge Test, Nontherapeutic and Therapeutic Communication, and Psychiatric Assessment Rubrics for Insimulation Group ($n=32$)

Instrument	Test	<i>M</i>	<i>SD</i>	<i>T</i> (<i>df</i> =31)	<i>ES</i>
Knowledge Test	Post	26.02	2.31	14.99*	2.65
	Pre	19.69	3.73		
Therapeutic Communication	Post	2.49	0.36	7.98*	1.41
	Pre	1.66	0.51		
Nontherapeutic Communication	Post	1.64	0.64	-9.75*	-1.72
	Pre	2.43	0.49		
Introduction	Post	3.91	0.18	7.41*	1.30
	Pre	3.61	0.14		
History	Post	3.73	0.22	15.22*	2.68
	Pre	2.88	0.43		
Symptoms	Post	3.76	0.24	18.00*	3.18
	Pre	2.78	0.41		
Mental Status	Post	3.74	0.24	15.06*	2.66
	Pre	2.53	0.49		
Risk Assessment	Post	3.57	0.31	30.71*	5.42
	Pre	1.60	0.39		

*Statistically significant when the overall error rate is controlled at the .05 level.

Research Question Three

Is there a difference in the change from pretest to posttest in knowledge, anxiety, and performance between the two groups (insimulation debriefing and postsimulation debriefing)? Pretest and posttest results for the Psychiatric Assessment and Therapeutic Communication (knowledge) test are presented in Table 10. There is no statically significant difference between groups.

Table 10

Means, Standard Deviations, and Independent-sample *t* test Results for the
Psychiatric Assessment and Therapeutic Communication Knowledge
Test Between Insimulation and Postsimulation Groups

Test	Postsimulation (<i>n</i> =33)		Insimulation (<i>n</i> =32)		<i>t</i> (<i>df</i> =63)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Knowledge	6.38	2.41	5.30	2.43	-1.79

The results for and the Therapeutic Communication Rubric (divided into therapeutic and nontherapeutic categories) are presented in Table 11. The results for both groups are statistically and practically significant from pre- to posttest for therapeutic and nontherapeutic communication effect sizes ranging from -1.51 to 0.98. The negative effect sizes for nontherapeutic communication indicates a large decrease in nontherapeutic comments and questions.

Table 11

Change from Pretest to Posttest Means, Standard Deviations, Independent-sample
t-test Results, and Effect Sizes for Therapeutic and Nontherapeutic
Communication for Both Groups

Communication for Both Groups								
		Postsimulation		Insimulation				
Group	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i> <i>df</i> = 63	<i>ES</i>
Therapeutic	33	.83	0.59	32	1.39	0.56	3.96*	0.98
Nontherapeutic	33	-.79	0.46	32	-1.95	0.55	9.20*	-1.51

*Statistically significant when the overall error rate is controlled at the .05 level.

The results of the independent-samples *t* test for Psychiatric Assessment Rubric are presented in Table 12.

Table 12

Means, Standard Deviations, Independent-Samples *t* test Results for
The Psychiatric Assessment Rubric Comparing Postsimulation
and Insimulation Change from Pre- to Posttest

Categories	Postsimulation (<i>n</i> =33)		Insimulation (<i>n</i> =32)		<i>t</i> (<i>df</i> =63)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Introduction	0.30	0.23	0.27	0.17	0.44
Patient History	0.85	0.32	0.68	0.29	0.14
Symptoms	0.98	0.63	0.81	0.21	2.56
Mental Status	1.21	0.45	1.04	0.41	0.16
Risk Assessment	1.97	0.36	1.09	0.37	0.60

*See Table 6 for explanation of categories

SBAR and social support were analyzed with a chi-squared test and Cramer's V. The results of the chi-square test for social support and SBAR were not statistically significant.

Research Question Four

How do the two groups rate the debriefing experience? Data were collected from both groups using a 7-item postsimulation survey. The postsimulation survey scale ranged from 1 to 5, with anchors at 1 indicating complete disagreement with the statement and 5 indicating complete agreement with the statement. Each question also allowed the participant to indicate that they were neutral.

Survey question one asked the students to rate the realism of the simulations. Participants in both groups rated the simulation as realistic (Table 13). One hundred percent of the insimulation group reported that they agreed somewhat or agreed completely that simulations were realistic, as compared to eighty-four percent of postsimulation group.

Table 13Postsimulation Survey Chi-square Results for Item One ($N=65$)

Group		Neutral	Somewhat Agree	Agee completely
Postsimulation	<i>f</i>	5	18	9
	%	15.6	56.3	28.1
Insimulation	<i>f</i>	0	11	22
	%	0.0	33.3	66.7

$\chi^2 = 12.13^*$, $df = 2$, Cramer's $V = .43$ *Statistically significant when the overall error rate is controlled at the .05 level.

Results for postsimulation survey item two are presented in Table 14. Sixty-three percent of the students in the treatment group agreed completely with the statement: I feel more comfortable with mentally-ill patients postsimulation, whereas 48% of the comparison group agreed somewhat and only one student agreed completely.

Table 14Postsimulation Survey Chi-Square Results for Item Two ($N=65$)

Group		Somewhat Disagree	Neutral	Somewhat Agree	Agee completely
Postsimulation	<i>f</i>	4	11	16	1
	%	12.5	34.37	48.48	3.03
Insimulation	<i>f</i>	0	0	12	21
	%	0.0	0.0	36.36	63.64

$\chi^2 = 33.74^*$, $df = 3$, Cramer's $V = .69$ *Statistically significant when the overall error rate is controlled at the .05 level.

Survey item three was worded negatively and reverse coded to minimize response bias. The comparison group that received only postsimulation debriefing responded unanimously that the facilitator was not disruptive during the simulation (Table 15). A small number (15%) of students in the treatment group found the insimulation debriefing to be slightly disruptive.

Table 15

Postsimulation Survey Chi-Square Results for Item Three (<i>N</i> =65)					
Group		Somewhat Disagree	Neutral	Somewhat Agree	Agee completely
Postsimulation	<i>f</i>	0	0	0	32
	%	0.0	0.0	0.0	100
Insimulation	<i>f</i>	0	0	5	28
	%	0.0	0.0	15.15	84.84

$\chi^2 = 5.25^*$, *df* = 1, Cramer's *V* = .28 *Statistically significant when the overall error rate is controlled at the .05 level.

Item four states that the debriefing helped me learn effectively. Sixty-eight percent of the comparison group stated that they somewhat agreed with that statement, whereas nine participants were neutral and one agreed completely (Table 16). One-hundred percent of the treatment group agreed with the effectiveness of the debriefing, whereas their peers in the comparison group were 81% in agreement.

Table 16

Postsimulation Survey Chi-Square Results for Item Four (<i>N</i> =65)					
Group		Somewhat Disagree	Neutral	Somewhat Agree	Agee completely
Postsimulation	<i>f</i>	0	9	22	1
	%	0.0	0.0	68.75	3.03
Insimulation	<i>f</i>	0	0	6	27
	%	0.0	0.0	18.18	81.81

$\chi^2 = 42.28^*$, *df* = 2, Cramer's *V* = .77 *Statistically significant when the overall error rate is controlled at the .05 level.

Item five results are presented in Table 17. Item five stated the debriefing lessened the realism of the simulation. This item was worded negatively and reverse coded.

Table 17

Postsimulation Survey Chi-Square Results for Item Five (<i>N</i> =65)					
Group		Somewhat Disagree	Neutral	Somewhat Agree	Agee completely
Postsimulation	<i>f</i>	0	0	0	32
	%	0.00	0.00	0.00	100.00
Insimulation	<i>f</i>	0	0	4	29
	%	0.00	0.00	12.12	87.87

$\chi^2 = 4.13$, *df* = 1, Cramer's *V* = .25

One hundred percent of the students in the comparison group agreed that the debriefing did not lessen the realism of the simulation. The treatment group, however, had a small percentage of participants who responded that the debriefing did lessen the realism of the simulation (12%). The difference was not statistically significant when the overall error rate is controlled at the .05 level.

Survey item six stated the debriefing helped me understand the correct and incorrect actions. The results are presented in Table 18. The majority of the students in the treatment group

Table 18

Postsimulation Survey Chi Square Results for Item Six (<i>N</i> =65)					
Group		Somewhat Disagree	Neutral	Somewhat Agree	Agee completely
Postsimulation	<i>f</i>	0.0	8	23	1
	%	0	25	71.87	3.12
Insimulation	<i>f</i>	0.0	0.0	4	29
	%	0	0	12.12	87.87

$\chi^2 = 47.5^*$, *df* = 2, Cramer's *V* = .80 *Statistically significant when the overall error rate is controlled at the .05 level

(87%) agreed completely with item six, as compared with only 3% of the comparison group.

Seventy-one percent of the comparison group agreed somewhat as compared with only 12% of

the treatment group. The difference was not statistically significant when the overall error rate is controlled at the .05 level.

Seventy-three percent of the students in the treatment group rated the debriefing style as effective as compared to 78% of the postsimulation group who “somewhat agreed” that

Table 19

Postsimulation Survey Chi-Square Results for Item Seven ($N=65$)

Group		Somewhat Disagree	Neutral	Somewhat Agree	Agee completely
Postsimulation	<i>f</i>	0	7	25	0
	%	0.00	21.87	78.12	0.00
Insimulation	<i>f</i>	0	0	9	24
	%	0.00	0.00	27.27	72.72

$\chi^2 = 38.53^*$, $df = 2$, Cramer's $V = .74$ *Statistically significant when the overall error rate is controlled at the .05 level.

the debriefing style was effective (Table 19). The differences between the postsimulation group and the insimulation group were statistically significant. One hundred percent of the participants in the insimulation group responded positively to the debriefing style.

Qualitative Analysis for Research Question One

This section addresses the anxiety component of research question one. Research Question one: what is the extent of change from pretest to posttest in knowledge, anxiety, and communication and assessment performance (using the rubric to measure performance) for the two groups combined? Anxiety was measured using presimulation and postsimulation self-report anxiety questionnaire. The questionnaire was administered prior to the start of Phase I and at the conclusion of Phase II. The questionnaire consisted of three open-ended questions. Data were transcribed and reviewed using the Consensual Qualitative Research (CQR) method (Hill, Thompson, & Williams, 2005).

The first open-ended question is how do you feel about working with mentally ill clients? Using CQR methods the researchers developed three themes. The three themes are presented and described in Table 20. The first theme anxiety related to personal safety. One student articulated concerns regarding personal safety in the following statement:

I am nervous I don't want to be perceived by patients as judgmental, impersonal, distant, disconnected, and afraid. I do not want patients to mistake my reservations for not caring. I think, as a result of caring too much and having fear of the unknown, I can come off as distant when in actuality I am trying to figure out what to say, how to say it, and how to position my body in a way that is therapeutic.

Another student stated “I don’t want to stereotype....the stuff on TV makes the mentally ill look like really bad, I want to stay open-minded.” Eighty-seven percent of the participants in both groups reported feeling nervous or anxious. Fifty-nine percent expressed concerns related to providing appropriate quality care, whereas a smaller number expressed concerns related to how

Table 20

Presimulation Response to Question One with
Major Themes for Both Groups (*N* = 65)

Student Response	Themes	Percentages
I feel, nervous, anxious, uncertain, and worried about personal safety.	Anxiety related to personal safety.	87
I am afraid I will not know what to say or how to respond the patient that is suicidal, psychotic or paranoid. I don't want to make the patient worse.	Anxiety related to how to respond to the patient who is psychotic, suicidal, manic, or paranoid. Anxiety related to patient safety.	59
I do not want to be seen as judgmental, incompetent, or fearful.	Anxiety related to how others will perceive the student's performance or behaviors.	18

they would be perceived by the patients (18%). There were no differences between the insimulation and postsimulation groups' responses.

The second open-ended question asked: What concerns you the most about the psychiatric mental-health clinical rotation? Table 21 presents and describes the two themes. The most frequent concern was "saying or doing the wrong thing and harming or upsetting the patients." The second most frequent response was "a concern for personal safety." One student wrote that

I don't know what to say to a mentally-ill person and if I say the wrong thing I am worried I might get injured. I see stuff on the news and the internet and I am scared. My mom is even afraid for me to go to this clinical.

Another student wrote "if I don't say the right thing and the patient kills themselves I would never forgive myself."

Table 21

Presimulation Response to Question Two With
Major Themes for Both Groups (*N* = 65)

Student Response	Themes	Percentages
I feel, nervous, anxious, uncertain, and worried about personal safety.	Anxiety related to lack of knowledge about psychiatric patient and anxiety related to patient safety.	93
I don't feel safe, I don't want to get injured, patients are unpredictable I could get hurt.	Anxiety related to personal safety.	88

The last open-ended question asked: When you are doing an assessment on a patient with mental illness, what questions are you the most concerned about asking the patient? A majority of students responded with comments expressing anxiety related to not knowing how to respond

to delusional thought processes and suicidal ideation. Themes for question three are presented and explained in Table 22.

Themes that were identified presimulation were anxiety related to personal and patient safety. Anxiety related to students' perceived lack of knowledge about psychiatric assessment and perceived lack of ability to apply existing knowledge to patient care. Anxiety related to how patients might perceive the students ability to perform their role in the clinical setting.

Yeh and Inman (2007) noted that qualitative data allow the researcher to apply meaning to the themes present in participant's responses. Participants were asked the same three questions at the conclusion of the Phase II.

There were no differences between the insimulation and the postsimulation group. Table 23 presents the postsimulation themes for all three survey questions and both groups.

Table 22

Presimulation Response to Question Three with Major Themes for Both Groups (<i>N</i> = 65)		
Student Response	Themes	Percentages
What should I say to a patient who hears voices? I am not sure how to talk about abuse or substance use. I do not know how to talk to someone that attempted suicide and failed.	Anxiety related to unfamiliarity with psychiatric assessment questions.	77
Not remembering what to say. I know what assessment questions to ask, but if I am nervous I might forget.	Anxiety related to applying knowledge to practice.	29

Two themes emerged from the analysis of the data. The first theme was in response to questions one and two. Students from both groups overwhelming agreed that simulation decreased their fear of working with mentally-ill patients. One student wrote "I was worried but

now, I am feeling more comfortable. Seventy-eight percent of the participants reported feeling less anxious after the simulation experience.

The second theme that emerged in response to question three was a greater understanding psychiatric assessment and potential patient behaviors. One student wrote

I never understood how real hallucinations are for the patient. Watching the patient (standardized patient) respond to the voices was so real I forgot that it was a simulation. I clearly understood that the voices were real and the patient was afraid and upset.

Another student stated “watching the (standardized) patient huddle under the blanket, not making eye contact, and when she spoke she sounded so sad and hopeless. I understood how someone that (sic) feels that way would consider taking their own life”.

Table 23

Postsimulation Response Anxiety Questionnaire with
Major Themes for Both Groups (*N* = 65)

Student Response Questions 1 & 2	Themes	Percentages
I am less fearful. Still nervous but not as much as before simulation. I am feeling more comfortable.	Decreased anxiety	78
Student Response Question 3	Themes	Percentages
I have a greater understanding of mental illness. I know how to respond to unusual patient behaviors. I am more confident. I am more prepared for clinical.	Decreased anxiety and increased feelings of self-confidence.	68

A majority (68%) of students reported being more prepared and less anxious postsimulation

Surprisingly a third theme emerged that was unrelated to the three open-ended questions.

Many students commented that “simulation with standardized patients” should be part of the

preparation for psychiatric mental-health clinical (48%). One student wrote “This experience was stressful (I always get nervous doing simulation); however, I learned so much this simulation should be offered to all students before they go to meet the actual patients.” The themes that emerged postsimulation were decreased anxiety, increased feelings of competence, and a strong suggestion to continue offering simulation with standardized patients prior to the start of the psychiatric mental-health clinical rotation.

Qualitative Analysis for Research Question Two

Research question two what is extent of change in knowledge, anxiety, and performance after insimulation debriefing? In the analysis for questions one and three, no differences were found between the groups. Therefore, the findings for insimulation group are those reported for research questions one and three.

Qualitative Analysis for Research Question Three

Research question three is there a difference in the change from pretest to posttest in knowledge, anxiety, and performance between the two groups (insimulation debriefing and postsimulation debriefing)? Using CQR methods the researchers reviewed the student responses for the pre- and postsimulation anxiety questionnaire for both groups. There were no differences between the postsimulation group and the insimulation group. The themes that emerged in response to research questions pre- and postsimulation were consistent for both groups.

Research Question Five

Is there a difference in the student perceptions on the effectiveness of the insimulation and postsimulation debriefing (analysis of the responses from students who received both)? The themes for the postsimulation qualitative data from the insimulation group are presented in Table 24.

The students in the insimulation group were instructed to use the comment section of the survey to record their perception of the two debriefing styles. Ninety-three percent ($n = 31$) of the students responded. Approximately 60% of the students responded positively to the insimulation debriefing method. After careful review of the data, two major themes emerged.

The first theme based on the highest percentage of student comments was related to the opportunity to stop the simulation, receive feedback, and redo the interaction with the standardized patient. Approximately 65% of student responses contained the terms “backtrack” and “redo.” For example being one student stated “being able to stop and correct my error was beneficial to my understanding. Additionally, the majority of students who comment that being able to stop and correct mistakes also comment that the process “helped to reinforce content” or “clarified correct and incorrect actions.” One student wrote “having the instructor coach me when I did not know what to say was extremely helpful.”

Table 24

Themes for Postsimulation Student Perceptions for the
Two Debriefing Methods ($n = 31$)

Student Response	Themes	Percentages
Being able to correct mistakes was helpful. The instructor helped me understand. The feedback was helpful. I liked being able to take a timeout to think and then start again. Restarting after a mistake reinforces the correct actions.	Ability to correct mistakes and receive immediate feedback	65
Both types of debriefing are useful. I would like to have more time at the end of the simulation to ask questions, although the feedback during the simulation was helpful.	Preference for simulation with insimulation debriefing and postsimulation debriefing.	45

One student wrote, “I wish I could do all simulations with insimulation debriefing. I think I learned more when I can correct my mistakes and practiced the therapeutic communication instead of just talking about it after the simulation.”

The second major theme focused on both methods being beneficial. Forty-five percent of participants wrote comments asking for or commenting on the benefits of using both methods of debriefing. One student wrote, “I liked being able to correct mistakes as they happened, but I had more questions at the end. I would like to have both types of debriefing.” One student wrote “either way works as long as I have a good teacher.”

Approximately, 40% of students made comments not related to the debriefing process. Those comments are not reported in this section; however, those comments will be taken into consideration by the researcher as an opportunity for further research and be discussed in chapter V. It should be noted that the participants in this research study are in the first semester of their senior year and that they have been participating in simulation with traditional postsimulation debriefing for 2 years.

Summary

A review of the data analysis revealed seven findings. First, no statistically significant differences were observed between the groups on any of the Psychiatric Assessment and Therapeutic Communication multiple-choice pre- and posttest. Second, the simulation scores for knowledge and performance were statistically significantly higher from presimulation to postsimulation for both groups. Third, on average, the insimulation group made statistically significantly higher gains in performance than the comparison group. Fourth, students responded positively on the postsimulation survey; however, chi-square analysis found statistically significant differences between groups on six of the seven survey items. Fifth, qualitative self-

report from the insimulation group reported that insimulation debriefing was helpful. Sixth, self-report data from both groups reported a decrease in anxiety and an increase in feelings of competence. Last, approximately 65% of students suggested that simulation with standardized patients be offered before all psychiatric mental-health clinical rotations. Chapter V contains the discussion of the results, limitations of the study, implications to practice, and suggestions for future research based upon the results from this chapter.

CHAPTER V

DISCUSSION, SUMMARY OF RESULTS, LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS

Nursing-school curriculum is designed to provide student nurses with the theoretical and practical skills needed for competent practice. New nurses are expected to enter the workforce prepared to provide safe patient care (Benner, Tanner, & Chesla, 2009; Donley, 2005). The gap between knowledge and theory is well documented in nursing literature, and nurse educators must develop evidence-based teaching strategies to prepare student nurses for the realities of clinical practice (Benner et al., 2009; Donley, 2005). Increasing numbers of nursing programs are adding simulation as an adjunct to the clinical practicum. Simulation has been well documented in nursing literature as an effective tool for decreasing the theory-to-practice gap (Brereton, 1995; Feingold, Calaluce, & Kallen, 2004; Gaba, 2011; Jeffries, 2005). Even though nursing literature has documented the effectiveness of simulation and suggested that debriefing is an essential component of the simulation learning experience, there is a paucity of research related to debriefing methods and learning outcomes.

A need was identified, and this study was designed to investigate the effects of two debriefing methods on prelicensure baccalaureate nursing students' knowledge, performance, and anxiety in relationship to a formative simulation experience designed to practice therapeutic communication and teach psychiatric assessment. The simulation activity was a formative experience to assist nursing students in integrating theoretical knowledge into practice. The simulations replicated four common patient diagnoses that students may encounter during their psychiatric clinical rotation. The simulations and debriefing methods (independent variable) were designed to scaffold new knowledge and skills with students' prior experience, encourage the development of therapeutic communication skills, and provide a venue for students to

practice psychiatric assessment in a supportive environment. Additionally, this research added to the existing body of knowledge related to the efficacy of debriefing methods.

In this chapter, a discussion of the study results is presented by category: knowledge, performance of psychiatric assessment using therapeutic communication, and student perceived anxiety related to working with mentally-ill patients. Student perceptions of the debriefing process are presented, including student perceptions of both debriefing methods (treatment-group responses). Following the discussion, study limitations, conclusions, recommendations for further research, and practical implications are presented. This chapter begins with a summary of findings and limitations.

Summary of Findings

The study used a formative simulation designed to teach therapeutic communication and psychiatric assessment to senior-level nursing students to investigate two debriefing methods: insimulation debriefing and traditional postsimulation debriefing. The research was conducted in two phases with four simulations per student. Phase I and Phase II were one week apart, and both groups had postsimulation debriefing for simulation one and four. The treatment group had insimulation debriefing for simulations two and three, whereas the comparison group continued with postsimulation debriefing. Phase I consisted of three simulations, and Phase II consisted of the fourth simulation (see Table 6, p. 83). The variables that were assessed were knowledge of psychiatric assessment and therapeutic communication, performance of psychiatric assessment and therapeutic communication, student anxiety, and student perceptions of the debriefing methods.

There was statistically significant change in knowledge from pretest to posttest for both groups, but there was no difference in change between the groups. There was a decrease in

anxiety from presimulation to postsimulation for both groups. Analysis of themes related to anxiety revealed no differences between the groups. There was improvement from pretest to posttest in both groups for therapeutic communication and nontherapeutic communication. The insimulation group had a larger change in therapeutic and nontherapeutic communication than the postsimulation group. There were no statistically significant differences between the groups for psychiatric assessment, and both groups had statistically significant improvement from pre- to posttest. This improvement was practically important with very large effect sizes.

Limitations

This study has a number of limitations. First, the interpretation of qualitative data in this study created potential limitations. Qualitative research endeavors to interpret inductively specific experiences. The real world, rather than the laboratory, is the setting for this category of research (Creswell 2008). Given the nature of qualitative research and available observational data-collection tools, the research limitations are inevitable. One possible limitation is researcher bias given that the researcher was one half of the team that interpreted the data. Anxiety and the perceived effectiveness of the debriefing methods by each participant was obtained using self-report methodology. Although the student volunteers are not enrolled currently in any courses taught by the researcher, she is well known to the student nurses at the University, which increases the likelihood that student responses may be influenced by previous encounters with the researcher.

Second, the research used a convenience sample of volunteers potentially limiting the ability to generalize findings to the larger population. Student volunteers were enrolled in a large public university with a nursing curriculum that adheres to all accreditation standards. The demographic data for the student population at this university are similar to that of other large

public universities within the same geographic area. It is possible that students in a 2-year program or those attending school in a less demographically diverse geographic area would respond differently. Convenience sample self-selection bias must be considered a limiting factor in this study.

Third, standardized patient volunteers were senior students enrolled in the school of nursing. The potential for the study participants to have prior or concurrent contact with the standardized patients potentially could effect their performance during the simulation. Additionally, students observing and learning from their peers during the simulation creates a potential limitation. Treatment or scenario order can be viewed as a benefit or the simulation process, as well as, a limitation to this research.

Discussion of Results

The discussion of the research results focuses on each of the outcome variables: changes from presimulation to postsimulation in student knowledge of psychiatric assessment and therapeutic communication, anxiety, student performance (behaviors) in therapeutic communication and psychiatric assessment. Student perceptions of debriefing methods also are discussed.

Student Knowledge

Researchers have found that debriefing has resulted in increased knowledge regardless of the method used (Brown & Chronister, 2009; Mahmood & Dezi, 2005; Shinnick, Woo, Horwich, & Steadman, 2011). Pretest scores for both groups were, on average, equivalent. Both groups showed a statistically significant increase in knowledge acquisition on the posttest; however, there was no statistically significant differences between the groups. Both groups had access to the same presimulation materials and textbooks. Admission criteria for the school of nursing at

the university where the study was conducted require incoming student to have a minimum grade-point-average (GPA) of 3.2 for admission. The students enrolled in this nursing program are motivated high-achieving individuals, and the majority continue to maintain a GPA of 3.0 or higher throughout their undergraduate career.

Therapeutic Communication

Data were collect during Phase I and Phase II using the therapeutic communication rubric. During Phase I, all participating students completed the three simulated interviews with a standardized patient. To establish a baseline, the treatment group received traditional postsimulation debriefing during the first simulation scenario. Then the treatment group received insimulation debriefing for scenarios two and three and the comparison group received traditional postsimulation debriefing. During Phase II, each student in both groups participated in one simulation with postsimulation debriefing. All simulations were videotaped for later review by the researcher.

Therapeutic and nontherapeutic responses were counted for each student during the first and last simulations. Both groups had statistically significant gains in performance; however, comparison of the means for the therapeutic communication rubric indicated that the insimulation group had a greater change in performance than the postsimulation group. The decreased use of nontherapeutic communication was greater for the treatment group as compared with the postsimulation group.

The insimulation debriefing positively effected the treatment group's use of therapeutic communication. Duvivier et al. (2011) stated that the repetitive performance of intended cognitive or psychomotor skills improves clinical-skill acquisition. Students in the postsimulation group had the opportunity to clarify concepts during postsimulation debriefing,

whereas the insimulation group had the opportunity to stop, debrief, and redo during the simulation sessions. The insimulation debriefing provided repeated practice of appropriate communication skills and immediate feedback when the student used nontherapeutic questions or comments. Additionally the ability to start over reinforced the correct communication techniques during the simulation.

The researcher noticed that when the simulation with the depressed patient was followed by a simulation with a psychotic patient the student in the second simulation struggled with therapeutic communication, whereas if the simulation with the depressed patient was followed by a simulation with a patient who was similar the second student had less difficulty with therapeutic communication. Leading to the conclusion that the students benefitted from observing the insimulation debriefing of the prior simulation.

The theory of situated cognition states that students benefit from learning experiences that are situated within a community of practice (Lave & Wenger, 1991). Learning is not only a transmission of knowledge but also a social process where knowledge is co-constructed among individuals. Insimulation debriefing provided immediate feedback and mentorship and, even though the insimulation group did not have as many postsimulation discussions as the comparison group, the students clearly benefited from observing their peers.

The quality of a therapeutic nurse-patient relationship depends on the ability of the nurse to communicate effectively. Therapeutic communication is holistic and patient-centered and essential to quality patient-centered care in all aspects of nursing. Insimulation debriefing is an effective method for teaching therapeutic communication.

Psychiatric Assessment

Results from the psychiatric assessment rubric indicated that, on average, both groups showed statically significant improvement in assessment skills. Items on the psychiatric assessment rubric were grouped into seven categories. The first category introduction had four aspects. Students were expected to wash their hands, introduce themselves, identify the patient, and explain the purpose of the interview. The effect size 1.45 was unexpected as the researcher expected senior students to be proficient in this category. Many students appeared anxious during the first simulation, and this increased anxiety may account for these findings.

The senior students participating in this research are familiar with the process of collecting data on patient history and symptoms; however, both of these items had large effect sizes for change from pretest to posttest. The researcher and second reviewer noted in the comment section of the rubric that during the first simulation a majority of participants asked specific medical-related questions, such as, have you ever had surgery and failed to ask questions related to psychiatric assessment. The students were relying on prior knowledge of clinical practice by focusing on medical-assessment questions. Although scores on the knowledge pretest indicated that the students had a theoretical understanding of therapeutic communication and psychiatric assessment, participants did not apply the knowledge needed to conduct a comprehensive psychiatric assessment during the first simulation.

Mental-status assessment is not new content for this student group; however, after establishing that the patient was oriented to person, place, and time, a majority of students struggled with assessing mood, thought process, and affect during the first simulation. Both groups made statistically significant and practically important gains in this category with a very large effect size of 2.55; however, there was no statistically significant difference between the

groups. The researcher noted that during the first simulation with postsimulation debriefing, students in both groups focused on the assessment process.

Risk assessment requires that the student ask about thoughts of self-harm and suicidal ideation, determine if the patient has a plan to harm himself or herself and assessing the patient's ability to contract for safety. During the first simulation, many students either did not ask directly about suicidal ideation or they used a nontherapeutic approach in the assessment process. Both groups had statistically significant and practically important change in this category with a very large effect size of 2.67.

The large increase shown in the risk-assessment category correlates with the concerns expressed on the self-report anxiety questionnaire. Students overwhelmingly responded to the question, what questions are you most concerned about asking patients, with statements related to risk assessment. The researcher noted that approximately half of the questions asked during postsimulation debriefings were related to mental status and risk assessment. During insimulation debriefing, risk assessment and assessment of mental status were the two areas that required the greatest amount of coaching.

Assessing a patient's social support-system in relationship to psychiatric issues was new content, and a majority of students failed to address this item adequately during the first simulation. The situation, background, assessment, and recommendation (SBAR) handoff report is not new content for the participants. The researcher and second reviewer noted that the inadequate SBAR reports during the first simulation were a result of inadequate assessment data, rather than unfamiliarity with the handoff tool. Both items (social support and SBAR) had statistically significant and practically important changes from pretest to posttest for both groups. Both groups combined had statistically significant and practically important gains for

performance of psychiatric assessment; however, comparison of the data for the two groups individually indicated no statistically significant difference between the groups.

The findings of this study support Aled's (2007) research that indicated communication used by students during the assessment process is often task focused and not always therapeutic. When students in the postsimulation group asked assessment questions without regard to therapeutic communication techniques, the patient became increasingly uncooperative but the simulation continued. Some students corrected themselves when the standardized patient became uncooperative, whereas others just continued to focus on the task of completing the assessment.

The majority of insimulation debriefing occurred when the student used nontherapeutic communication to ask an assessment question and the patient became uncooperative. The researcher would call time-out giving the student the opportunity to reflect on how he or she had asked the question. Then the simulation would restart with the student asking the question using a therapeutic approach. The different debriefing methods account for the lack of differences between the groups in relationship to assessment and the increase in therapeutic communication techniques for the insimulation group.

Anxiety

Review of the self-report anxiety questionnaire indicated a high degree of anxiety related to working with mentally ill patients. Students in both groups expressed concerns related to personal and patient safety. These findings support previously published research (Morrissette, 2004; Shipton, 2002; Szpak & Kameg, 2011). Additionally, student performance during the first simulation was related to student responses on the presimulation anxiety questionnaire. A majority of students expressed concerns related to knowing "what to say and how to say it" when working with a mentally-ill patient. Even though the pretest knowledge scores indicated that the

participants had an understanding of therapeutic communication and psychiatric assessment, there was a clear gap between knowledge and application.

Although data were not collected during the simulations, comments made by the researcher and faculty observers noted that student anxiety appeared to decrease as the simulations progressed. Review of the self-report comments made on the postsimulation survey concurred with faculty observations. A majority of the participants stated that the insimulation debriefing decreased their anxiety and increased their self-confidence. Decreased student anxiety is a well-documented outcome of simulation (Becker, Rose, Berg, Park, & Shatzner, 2006; Gore, Hunt, Parker, & Raines, 2011; May, Park, & Lee, 2009). Both groups reported a decrease in anxiety postsimulation, and there was no distinguishable difference between the groups. Therefore, it is difficult to discern whether the decrease in anxiety is due to the simulations or the debriefing methods.

Debriefing Methods

Review of the postsimulation survey indicated 51% of the postsimulation group and 98% of the insimulation group reported feeling more comfortable working with mentally-ill patients postsimulation. This disparity between the two groups may be related to the additional practice experienced by the insimulation group during simulations with insimulation debriefing. A majority of the insimulation group commented that they appreciated the opportunity to correct mistakes and start over using appropriate questions and therapeutic communication techniques.

The treatment group (insimulation) rated the effectiveness of the debriefing higher than their peers in the postsimulation group. Qualitative data collect in the comment section from the insimulation group supported these findings. The students in the insimulation group reported that being able to stop, rethink, and redo helped reinforce the concepts. The students in both groups

indicated that the simulations were realistic and the debriefing was effective. The majority of students in both groups reported increased self-confidence and decreased anxiety related to working with mentally ill patients.

Conclusions

The findings of this research support previous research that simulation increases performance, decreases anxiety, and increases knowledge (Cantrell, 2009; Chronister & Brown; Issenberg, McGaghie, Petrusa, Gordon, & Scalese, 2005; Shinnick, Woo, & Evangelista, 2012; Shinnick et al., 2011). Both groups had statistically significant and practically important gains in knowledge related to psychiatric assessment and therapeutic communication and performance of psychiatric assessment using therapeutic communication techniques. There were no statistically significant differences between the groups for either knowledge or performance.

The treatment group (insimulation) and the comparison group (postsimulation) reported decreased anxiety and increased confidence related to working with mentally-ill patients. There were no differences between the two groups on the self-report presimulation and postsimulation anxiety questionnaire.

Arafeh, Hansen, and Nichols (2010) wrote that when learners are placed in a setting that replicates closely actual patient encounters the gaps in performance easily are recognized. Insimulation allows the instructor to correct mistakes as they happen. The opportunity for the insimulation group to correct mistakes during the simulation may account for the students' statistically significant gains in therapeutic communication as compared with the postsimulation group. The use of simulation for nursing education has grown exponentially since 1995 (Nehring & Lashley, 2009); however, debriefing that is considered to be the most vital component of simulation has received limited attention from nurse researchers (Arafeh et al., 2010; Issenberg

et al., 2005; Shinnick et al., 2011; Shinnick & Woo, 2015). The increases demonstrated by the large and very large effect sizes in performance of therapeutic communication suggest that the debriefing method contributed to student outcomes. The results of this research support the findings in previous studies and contribute further understanding of debriefing in simulation-based education.

Recommendations for Further Research

Debriefing requires skill, and planning successful debriefing is more than telling students what they did correctly or incorrectly (Fey, Scrandis, Daniels, & Haut, 2014). Continued research on the effect of the different methods of debriefing on student learning and outcomes is needed. Several students in the insimulation debriefing group commented that they would like to have both the insimulation debriefing and postsimulation debriefing. Given that the results of this research support both the effectiveness of postsimulation debriefing and insimulation debriefing, further research related to the use of both methods to teach therapeutic communication and assessment skills is needed.

New graduate nurses have the knowledge needed to provide safe-patient care as evidenced by passing scores on their state-board exams; however, that knowledge does not always transfer to practice (Berkow, Virkstis, Stewart, & Conway, 2009). Additional research is needed to measure the effects of simulation debriefing methods on student retention and application of learned content in the clinical setting.

Debriefing is considered to be a major component of simulation and crucial to the learning process. Several students comment that the qualities of the instructor were more important than the debriefing method, and one student wrote that “it is not what the instructor says that matters, it is how she or he says it.”

Insimulation debriefing the process of stopping the simulation providing guidance and mentoring then allowing the student to start over embodies the theory of situated cognition and cognitive apprenticeship. During this research, one student stated that it did not matter what type of debriefing he had as long as he had a good instructor. Further research to establish the best methods of combining mentorship and debriefing to create a community of practice that supports student learning.

Nurse educators engaged in clinical simulations need to be aware that student learning outcomes are dependent on faculty's mentorship and feedback. Students in the treatment group described their need for guidance and support during the simulation, as well as, voicing a desire for debriefing at the conclusion of the simulation. A second finding emphasized by student responses in both groups is that feedback and interactions with faculty must reflect caring, nurturing. Additionally, the instructors' body language and tone of voice are as important as the content of the message. To fully utilize the efficacy simulation and to provide maximal benefit to students' learning faculty must begin to evaluate themselves during the debriefing process. Videotapes of simulations are used frequently during the debriefing process and videotapes of the actual debriefing could be utilized for faculty development and as a foundation for future research.

Recommendations for Practice

Two recommendations can be made for practice. First, debriefing, postsimulation and insimulation, contributes to student learning and the acquisition and consolidation of skills. This study has demonstrated simulation to be an effective learning tool for decreasing student anxiety and increasing student knowledge and performance in preparation for a psychiatric mental-health clinical. Berkow, Virkstis, Stewart, and Conway (2009) reported that 53% of new graduate

nurses lacked the communication and assessment skills needed to provide safe patient care. The American Association of Colleges of Nursing (AACN, 2009) stated that therapeutic communication is essential to conducting a comprehensive assessment. Most student nurses understand the principles of assessment and communication; however, theoretical knowledge does not transfer consistently to practice (Aled, 2007). This research demonstrated that insimulation debriefing had a statistically significant and practically important effect on therapeutic-communication skills.

Second, the changes in healthcare that have led to a decrease in appropriate clinical sites and the need to balance patient safety with student learning have created a situation that has contributed to a gap between theory and practice (Benner et al., 2009; Chant, Jenkinson, Randle, & Russell, 2002; Del Bueno, 2005). Providing nursing students with simulation immersion prior to the start of each clinical rotation potentially will send students into the clinical setting more fully prepared, thus enriching the learning experience in the clinical setting. This study demonstrated that an intensive series of simulations prior to the start of a mental-health clinical rotation had a statistically significant and practically important effect on student knowledge, anxiety, and performance. Schools of nursing and nurse educators must continue the research needed to define and apply evidenced-based educational modalities to nursing education.

Afterword

There are several lessons learned from this research. First, it is essential that standardized patients have understanding of the patient conditions that they are to portray during the simulation. Due to the unpredictability of individual schedules, researchers should train several standardized patients. Standardized-patient volunteers who are recognized by the student participants potentially decrease the realism of the simulation.

Simulation requires commitment from the facilitator, the standardized-patient volunteers, and the student participants. It is an active learner-centered approach to education and is ineffective without the commitment of all parties. Simulation is time consuming, both in writing and in conducting the simulated experience. Successful simulation requires the support of colleagues and the head of the department. Flexibility and a sense of humor are essential components of any teaching strategy.

Debriefing is an essential component of the simulation process. Students must feel psychologically safe in order for debriefing to be successful. One student stated that the debriefing method did not matter, as long as he had a good instructor. The individual conducting the debriefing must be nonjudgmental, supportive, and knowledgeable about the subject being taught. Cantrell (2008) noted that simulation in nursing education continues to be refined and expanded and debriefing is crucial to the teaching–learning process. As noted in the literature and validated by this research debriefing is valued by students; however, students are acutely aware of the method of delivery. The instructor’s body language and tone of voice play a key role in establishing a psychologically safe environment and the feedback received during debriefing is a significant component of the successful student learning.

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Appendices

Appendix A

Psychiatric Assessment and Therapeutic Communication Knowledge Pre- and Posttest

PSYCHIATRIC ASSESSMENT AND THERAPEUTIC COMMUNICATION
PRETEST POSTTEST

1. Which of the following examples best defines active listening?
 - A. The nurse makes eye contact with the patient.
 - B. The nurse states: "I hear what you are saying."
 - C. The nurse listens to the patient but continues to work on his or her charting.
 - D. **The nurse repeats the message back to the patient to ensure that he or she has understood.**
2. Which of the following is the best example of patient centered communication?
 - A. The nurse explains expected and acceptable behaviors to the patient.
 - B. The nurse limits communication to information about the patient's disease.
 - C. **The nurse uses goal-directed communication that considers the patient's needs, culture, and educational levels.**
 - D. The nurse provides the patient with handouts about the patient's diagnosis.
3. Which of the following statements would be an appropriate response to the patient's statement, "I am a failure and I do not deserve to live?"
 - A. "You say that you feel like a failure. You know that is not true."
 - B. "Tell me more about your feelings what makes you feel like a failure."
 - C. **"You feel that you do not deserve to live, do you have any thoughts of harming yourself."**
 - D. "Have you always felt like you were a failure and deserved to die?"
4. Knowledge and skills in the care of patients is vital in the psychiatric unit. A nurse observes that a client is agitated, pacing up and down the hallway. Which of the following statements is most appropriate to make to this patient?
 - A. You will need to be restrained if you do not change your behavior.
 - B. You will need to be placed in seclusion.
 - C. You need to stop that behavior now.
 - D. **What is causing you to become agitated?**
5. Which of the following is not a true statement?
 - A. Suicide is more common in gay and lesbian adolescents than heterosexual adolescents.
 - B. Women between the ages of 40 and 65 have the highest suicide rate.
 - C. Previous attempts and feelings of hopelessness are important risk factors for suicide.
 - D. **Talking about suicide will give the patient the idea of suicide and increase the risk.**

6. When interviewing a patient with suicidal ideation, you realize that you have made a non-therapeutic response and the patient's body language suggests that they have become less receptive to you. What is your best course of action?
- A. Ignore the patient's body language and proceed with the interview.
 - B. Listen for key themes in the patient's response and conclude the interview.
 - C. Finish the interview and take time to reflect and rethink your communication techniques.
 - D. Apologize and say you want to revise something you said.**
7. A client with bipolar disorder, exhibits extreme excitement, delusional thinking, and command hallucinations. Which of the following is the priority assessment?
- A. Risk for self-harm or aggression toward others**
 - B. Ask the client what the voices are saying
 - C. Assess for side-effects to the medications
 - D. Check the clients blood pressure
8. Which method would a nurse use to determine a client's potential risk for suicide?
- A. Wait for the client to bring up the subject of suicide.
 - B. Observe the client's behavior for cues of suicide ideation.
 - C. Question the client directly about suicidal thoughts.**
 - D. Question the client about future plans.
9. The majority of person-to-person communication is:
- A. Verbal
 - B. Process
 - C. Nonverbal**
 - D. Content
10. When the nurse asks a client, "How are you?" the client states, "I am fine." As the client turns away, she is crying. This is an example of:
- A. Nonverbal communication
 - B. Incongruence**
 - C. Depression
 - D. Congruence
11. During assessment of a patient, who has a history of suicide attempts, you identify her protective factors. Which of the following would not be considered a protective factor?
- A. Social support system.
 - B. Limited interest in baseball.**
 - C. Fear of social disapproval.
 - D. Problem solving ability.

12. The nurse observes a client pacing in the hall. Which statement by the nurse may help the client recognize his anxiety?
- A. "I guess you're worried about something, aren't you?"
 - B. "Can I get you some medication to help calm you?"
 - C. "Have you been pacing for a long time?"
 - D. "I notice that you're pacing. How are you feeling?"**
13. You are assessing a psychotic patient with a diagnosis of manic-depressive disorder. The emergency room is extremely busy and loud. The patient is exhibiting the following behaviors. Labile mood, hyper-verbal speech, with delusions of grandeur. Which nursing communication technique is most appropriate for this situation?
- A. Move the patient to a quieter space to decrease the stimulation.**
 - B. Tell the patient to ignore the noisy environment and focus on the interview questions.
 - C. Use logic to point out aspects of reality and correct the patient's delusional thought process.
 - D. Offer the patient ear plugs to block out the noise.
14. You are assessing an Asian American patient. Which of the following statements is true concerning communication with patients from different cultures?
- A. If the patient speaks English, communication should not be an issue.
 - B. Nonverbal communication varies widely among cultures.**
 - C. Nonverbal communication is not as important as verbal communication.
 - D. Keeping the conversation goal-centered and focused on the interview conveys respect for the patient's culture.
15. Your client is a 19 year old college student. When you introduce yourself at the start of the shift the client mumbles walks away? What should you do next?
- A. Give the client some space and check back with him in a few minutes**
 - B. Follow him and tell him that you need to ask him some questions
 - C. Report his behavior to the doctor and ask for an order for Haldol
 - D. Tell him that you need to ask him a few questions
16. While talking to the nurse the client says "I don't know what to do, I can't live without him" then she says "I hate him, he was a jerk" How should the nurse respond?
- A. "I know how you feel, it must be hard to think about living alone".
 - B. "You are exactly right. All men are jerks. My ex was a total loser"
 - C. "Ending a relationship can be hard, you look upset. Do you have thoughts of harming yourself"**
 - D. "Let's not talk about it. Talking about it will just make you more upset. Why don't you work on your art project and forget about him for a while".

17. The assessment of a patient with psychiatric issues differs from the assessment of a patient with medical issues. Although both assessments should include data that is descriptive, concise, and complete and the nurse should not include:
- A. Subjective data from the client.
 - B. Description of body language
 - C. Risk for self-harm or violence toward others
 - D. **Inferences or interpretative statements not supported with data.**
18. The patient is seeking treatment for depressive symptoms. During the initial assessment, the nurse gathers information about the patient's condition. Which of the following is objective information to be included in the patient's medical record?
- A. **Patient has a flat affect.**
 - B. Patient is depressed.
 - C. Patient denies suicidal ideation.
 - D. Patient is anxious.
19. A patient with paranoid schizophrenia tells the nurse, "The FBI is listening through fluorescent lights in this room. Be careful what you say." Which response by the nurse would be most therapeutic?
- A. "Let's talk about something other than the FBI."
 - B. **"It sounds like you're concerned about your privacy."**
 - C. "The FBI is prohibited from operating in health care facilities."
 - D. "You have lost touch with reality, which is a symptom of your illness."
20. A nurse interacts with a newly hospitalized patient. Select the example of offering self.
- A. "I've also had traumatic life experiences. Maybe it would help if I told you about them."
 - B. "Why do you think you had so much difficulty adjusting to this change in your life?"
 - C. "I hope you will feel better after getting accustomed to how this unit operates."
 - D. **"I'd like to sit with you for a while to help you get comfortable talking to me."**
21. A patient discloses several concerns and associated feelings. If the nurse wishes to seek clarification, which comment would be appropriate?
- A. "What are the common elements here, do you see a pattern?"
 - B. "Tell me again about your experiences."
 - C. **"Am I correct in understanding that you are concerned about...and are feeling...?"**
 - D. "Tell me everything from the beginning, so that I have a clear picture of the events."

22. Documentation in a patient's record shows: During 5-minute interview, patient fidgeted, tapped foot, periodically covered face with hands, looked under chair. Stated, "I enjoy spending time with you." Which assessment is most accurate?
- A. The patient gave positive feedback about the nurse's communication techniques.
 - B. The nurse is viewing the patient's behavior through a cultural filter.
 - C. The patient's verbal and nonverbal messages were incongruent.**
 - D. Psychotic thought processes are likely.
23. During an interview, a patient attempts to change the focus from self to the nurse by asking personal questions. Select the nurse's most therapeutic response.
- A. "Are you trying to avoid answering these questions?"
 - B. "I am uncomfortable talking to patients about my personal life."
 - C. "I am sure we can solve your problems if you describe them to me."
 - D. "The time we spend together is for you to discuss your problems and concerns."**
24. When assessing an elderly patient for depression and thoughts of suicide. Which statement by the patient requires additional follow-up?
- A. Peter was such a wonderful husband, I miss him every day.
 - B. I am tired all the time and I don't get out much anymore**
 - C. I use to like to cook but cooking for one is not fun
 - D. I wish God would just let me go to sleep forever.**
25. The statement made by the patient during the assessment interview that should alert the nurse to the patient's need for immediate, active intervention.
- A. "I am mixed up, but I know I need help."
 - B. "I have no one to turn to, you're my last hope."**
 - C. "Why doesn't anyone care anymore?"
 - D. "It's a long, rough road out there, very hard."
26. Which issues should a nurse address during the first assessment interview with a patient with a psychiatric disorder?
- A. Trust, congruence, attitudes, and boundaries.
 - B. Goals, resistance, unconscious motivations, and diversion.
 - C. Relationship parameters, the contract, confidentiality, and termination.**
 - D. Transference, counter transference, intimacy, and developing resources.

27. How should the nurse respond if during the assessment process the patient says, "Please don't share information about me with the other people"?

- A. "I cannot tell anyone about you. We can help each other by keeping it between us."
- B. "I won't share information with your family or friends without your permission, but I will share information with other staff."**
- C. "It depends on what you choose to tell me. I will be glad to disclose at the end of each session what I will report to other staff."
- D. "Therapeutic relationships are between the nurse and the patient. It's up to you to tell others what you want them to know."

28. The nurse is assessing a patient who is experiencing extreme anxiety after making an introductory statement to orient the patient to the purpose of interview questions. The next assessment question the nurse should ask?

- A. You aren't thinking about killing yourself are you?
- B. Tell me what is going on with you, do you usually get this upset?
- C. What helps you to feel calmer? Are you currently taking any medication for anxiety?**
- D. Take a deep breath and calm down you are in a safe place and no one will hurt you.

29. Do you have any medical issues that I need to know about? The patient is a 55-year-old white, non-Hispanic male whose son found him unconscious in his home. The son called 911 and the patient was brought to the emergency department. The son reported that his Dad's social drinking has increased from one drink per week to one six-pack of beer per day. The son reported that his dad attempted suicide with opiates and alcohol ten years ago after his wife died from cancer. During the assessment interview, the patient denies suicidal ideation and states that his church believes in "the sanctity of life" and "the people there would not understand; they would shun me." He admits to having opiates in his possession. Based on the Lethality Assessment Scale, the patient is:

- A. High risk for suicide**
- B. Moderate risk for suicide
- C. Low risk for suicide
- D. no risk of suicide

30. You are assessing a patient for risk of suicide and you determine that the patient has a high-risk level of suicide, what symptoms indicate the greatest risk for self-harm?

- A. A specific plan, impaired self-control, and limited protective factors.**
- B. The patient's anxiety level and ability to express feelings are impaired.
- C. The patient's availability of social support is limited.
- D. The patient has thoughts of death but does not have a suicide plan.

Appendix B
Content Validity Rubric for Content Experts

Content Expert Rating Rubric

Dear Content Expert,

Thank you for your expertise and support.

The questions on this form are intended for use in my dissertation as a pretest and posttest. The two areas are being measured, knowledge of therapeutic communication and knowledge of psychiatric assessment

A copy of the complete test has been provided for your reference. Please feel free to make corrections and suggestions. Please return both the rating rubric and the full instrument to

Debrayh Gayle ([REDACTED])

.

Instructions for content experts:

Please select the best answer to the following questions, supplementing your answers with comments, suggestions, or corrections. If you have, any questions please contact Debrayh Gaylle at debrayh.gaylle@sjsu.edu. Thank you for your time and support.

<p>1. Which of the following examples best defines active listening?</p> <p>A. The nurse makes eye contact with the patient</p> <p>B. The nurse states: "I hear what you are saying</p> <p>C. The nurse listens to the patient but continues to work on his or her charting.</p> <p>D. The nurse repeats the message back to the patient to ensure that she has understood</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>4. Is the content of the question clear and unambiguous?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>2. Which of the following is <u>the best</u> example patient centered communication?</p> <p>A. the nurse telling the patient what to do</p> <p>B. the nurse limits communication to information about the patient's disease</p> <p>C. Goal-directed communication that considers the patient's needs, culture, and educational levels.</p> <p>D. Giving the patient handouts to read because the nurse is too busy to answer questions.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>4. Is the content of the question clear and unambiguous?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>3. Which of the following statements would be an appropriate response to the patient's statement, "I am a failure and I do not deserve to live?"</p> <p>A. "You say that you feel like a failure. You know that is not true." B. "Tell me more about your feelings what makes you feel like a failure." C. "You feel that you do not deserve to live, do you have any thoughts of harming yourself." D. "Have you always felt like you were a failure and deserved to die?"</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>4. Is the content of the question clear and unambiguous?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>4. Knowledge and skills in the care of patients is vital in the psychiatric unit. A nurse observes that a client is agitated, pacing up and down the hallway. Which of the following statements is most appropriate to make to this patient?</p> <p>A. You will need to be restrained if you do not change your behavior. B. You will need to be placed in seclusion. C. You need to stop that behavior now. D. What is causing you to become agitated?</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>5. Which of the following is not a true statement?</p> <p>A. Suicide is more common in gay and lesbian adolescents than heterosexual adolescents.</p> <p>B. Women between the ages of 40 and 65 have the highest suicide rate.</p> <p>C. Previous attempts and feelings of hopelessness are important risk factors for suicide.</p> <p>D. Talking about suicide will give the patient the idea of suicide and increase the risk.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>6. When interviewing a patient with suicidal ideation, you realize that you have made a non-therapeutic response and the patient's body language suggests that they have become less receptive to you. What is your best course of action?</p> <ol style="list-style-type: none"> 1. Ignore the patient's body language and proceed with the interview. 2. Listen for key themes in the patient's response and conclude the interview. 3. Finish the interview and take time to reflect and rethink your communication techniques. 4. Apologize and say you want to revise something you said. 	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>7. Which A client with bipolar disorder, exhibits extreme excitement, delusional thinking, and command hallucinations. Which of the following is the priority assessment?</p> <p>A. Risk for self-harm or aggression toward others B. Ask the client what the voices are saying C. Assess for side-effects to the medications D. Check the clients blood pressure</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured? Comments:</p>	<p>Yes No</p>
<p>2. Is the intent of the question clear? Comments:</p>	<p>Yes No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners? Comments:</p>	<p>Yes No</p>
<p>4. Is the content of the question clear and unambiguous? Comments:</p>	<p>Yes No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students? Comments:</p>	<p>Yes No</p>
<p>6. Is the Do you have any suggestions for changes in content or format? Comments:</p>	<p>Yes No</p>

<p>8. Which method would a nurse use to determine a client's potential risk for suicide?</p> <p>A. Wait for the client to bring up the subject of suicide. B. Observe the client's behavior for cues of suicide ideation. C. Question the client directly about suicidal thoughts. D. Question the client about future plans.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>9. The majority of person-to-person communication is:</p> <p>E. Verbal F. Process G. Nonverbal H. Content</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>10. When the nurse asks a client, "How are you?" the client states, "I am fine." As the client turns away, she is crying. This is an example of:</p> <p>D. Nonverbal communication E. Incongruence F. Depression E. Congruence</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>11. During assessment of a patient, who has a history of suicide attempts, you are trying to identify her protective factors. Which of the following factors would not be considered a protective factor?</p> <p>A. Social support system. B. Limited interest in baseball. C. Fear of social disapproval. D. Problem solving ability.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured? Comments:</p>	<p>Yes No</p>
<p>2. Is the intent of the question clear? Comments:</p>	<p>Yes No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners? Comments:</p>	<p>Yes No</p>
<p>4. Is the content of the question clear and unambiguous? Comments:</p>	<p>Yes No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students? Comments:</p>	<p>Yes No</p>
<p>6. Do you have any suggestions for changes in content or format Comments:</p>	<p>Yes No</p>

<p>12. The nurse observes a client pacing in the hall. Which statement by the nurse may help the client recognize his anxiety?</p> <p>A. "I guess you're worried about something, aren't you?"</p> <p>B. "Can I get you some medication to help calm you?"</p> <p>C. "Have you been pacing for a long time?"</p> <p>E. "I notice that you're pacing. How are you feeling?"</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format)?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>13. You are assessing a psychotic patient with a diagnosis of manic-depressive disorder. The emergency room is extremely busy and loud. The patient is exhibiting the following behaviors. Labile mood, hyper-verbal speech, with delusions of grandeur. Which nursing communication technique is most appropriate for this situation?</p> <p>A. Move the patient to a quieter space to decrease the stimulation.</p> <p>B. Tell the patient to ignore the noisy environment and focus on the interview questions.</p> <p>C. Use logic to point out aspects of reality and correct the patient's delusional thought process.</p> <p>D. Offer the patient ear plugs to block out the noise.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>14. You are assessing an Asian American patient. Which of the following statements is true concerning communication with patients from different cultures?</p> <p>A. If the patient speaks English, communication should not be an issue.</p> <p>B. Nonverbal communication varies widely among cultures.</p> <p>C. Nonverbal communication is not as important as verbal communication.</p> <p>D. Keeping the conversation goal-centered and focused on the interview conveys respect for the patient's culture.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>15. Your client is a 19 year old college student. When you introduce yourself at the start of the shift the client mumbles walks away? What should you do next?</p> <p>A. Give the client some space and check back with him in a few minutes B. Follow him and tell him that you need to ask him some questions C. Report his behavior to the doctor and ask for an order for Haldol D. Tell him that you need to ask him a few questions</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>16. While talking to the nurse about breaking up with her boyfriend the client says “I don’t know what to do, I can’t live without him” then she laughs and say “It’s no big deal. I mean, he was a jerk” How should the nurse respond?</p> <p>A. "I know how you feel, it must be hard to think about living alone. However you are a strong women you will be all right without him.”</p> <p>B. "You are exactly right. All men are jerks. My ex was a total loser"</p> <p>C. "Ending a relationship can be really difficult. It looks like you are upset. Have you had any thoughts of harming yourself"</p> <p>D. "Let's not talk about it. Talking about it will just make you more upset. Why don't you work on your art project and forget about him for a while".</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>17. The assessment of a patient with psychiatric issues differs from the assessment of a patient with medical issues. Although both assessments should include data that is descriptive, concise, and complete and the nurse should not include:</p> <p>A. Subjective data from the client. B. Description of body language C. Risk for self-harm or violence toward others D. Inferences or interpretative statements not supported with data.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured? Comments:</p>	<p>Yes No</p>
<p>2. Is the intent of the question clear? Comments:</p>	<p>Yes No</p>
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<p>6. Do you have any suggestions for changes in content or format Comments:</p>	<p>Yes No</p>

<p>18. The patient is seeking treatment for depressive symptoms. During the initial assessment, the nurse gathers information about the patient's condition. Which of the following is objective information to be included in the patient's medical record?</p> <p>A. Patient has a flat affect. B. Patient is depressed. C. Patient denies suicidal ideation. D. Patient is anxious.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured? Comments:</p>	<p>Yes No</p>
<p>2. Is the intent of the question clear? Comments:</p>	<p>Yes No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners? Comments:</p>	<p>Yes No</p>
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<p>6. Do you have any suggestions for changes in content or format Comments:</p>	<p>Yes No</p>

<p>19. A patient with paranoid schizophrenia tells the nurse, "The FBI is listening through fluorescent lights in this room. Be careful what you say." Which response by the nurse would be most therapeutic?</p> <p>A. "Let's talk about something other than the FBI."</p> <p>B. "It sounds like you're concerned about your privacy."</p> <p>C. "The FBI is prohibited from operating in health care facilities."</p> <p>D. "You have lost touch with reality, which is a symptom of your illness."</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>20. A nurse interacts with a newly hospitalized patient. Select the example of offering self.</p> <p>A. "I've also had traumatic life experiences. Maybe it would help if I told you about them."</p> <p>B. "Why do you think you had so much difficulty adjusting to this change in your life?"</p> <p>C. "I hope you will feel better after getting accustomed to how this unit operates."</p> <p>D. "I'd like to sit with you for a while to help you get comfortable talking to me."</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>21. A patient discloses several concerns and associated feelings. If the nurse wishes to seek clarification, which comment would be appropriate?</p> <p>A. "What are the common elements here, do you see a pattern?"</p> <p>B. "Tell me again about your experiences."</p> <p>C. "Am I correct in understanding that you are concerned about...and are feeling...?"</p> <p>D. "Tell me everything from the beginning, so that I have a clear picture of the events."</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>22. The Documentation in a patient's record shows: During 5-minute interview, patient fidgeted, tapped foot, periodically covered face with hands, looked under chair. Stated, "I enjoy spending time with you." Which assessment is most accurate?</p> <p>A. The patient gave positive feedback about the nurse's communication techniques. B. The nurse is viewing the patient's behavior through a cultural filter. C. The patient's verbal and nonverbal messages were incongruent. D. Psychotic thought processes are likely.</p>	
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<p>6. Do you have any suggestions for changes in content or format Comments:</p>	<p>Yes</p> <p>No</p>

<p>23. During an interview, a patient attempts to change the focus from self to the nurse by asking personal questions. Select the nurse's most therapeutic response.</p> <p>A. "Are you trying to avoid answering these questions?"</p> <p>B. "I am uncomfortable talking to patients about my personal life."</p> <p>C. "I am sure we can solve your problems if you describe them to me."</p> <p>D. "The time we spend together is for you to discuss your problems and concerns."</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>24. The When assessing an elderly patient for depression and thoughts of suicide. Which statement by the patient requires additional follow-up?</p> <p>A. Peter was such a wonderful husband, I miss him every day. B. I am tired all the time and I don't get out much anymore C. I use to like to cook but cooking for one is not fun D. I wish God would just let me go to sleep forever.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
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<p>6. Do you have any suggestions for changes in content or format</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>25. The statement made by the patient during the assessment interview that should alert the nurse to the patient's need for immediate, active intervention.</p> <p>A. "I am mixed up, but I know I need help." B. "I have no one to turn to, you're my last hope." C. "Why doesn't anyone care anymore?" D. "It's a long, rough road out there, very hard."</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured? Comments:</p>	<p>Yes</p> <p>No</p>
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<p>5. Is the question written at an appropriate level for senior undergraduate nursing students? Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format Comments:</p>	<p>Yes</p> <p>No</p>

<p>26. Which issues should a nurse address during the first assessment interview with a patient with a psychiatric disorder?</p> <p>A. Trust, congruence, attitudes, and boundaries. B. Goals, resistance, unconscious motivations, and diversion. C. Relationship parameters, the contract, confidentiality, and termination. D. Transference, counter transference, intimacy, and developing resources.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>4. Is the content of the question clear and unambiguous?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>27. How should the nurse respond if during the assessment process the patient says, "Please don't share information about me with the other people"?</p> <p>A. "I cannot tell anyone about you. We can help each other by keeping it between us."</p> <p>B. "I won't share information with your family or friends without your permission, but I will share information with other staff."</p> <p>C. "It depends on what you choose to tell me. I will be glad to disclose at the end of each session what I will report to other staff."</p> <p>D. "Therapeutic relationships are between the nurse and the patient. It's up to you to tell others what you want them to know."</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>4. Is the content of the question clear and unambiguous?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

<p>28. The nurse is assessing a patient who is experiencing extreme anxiety after making an introductory statement to orient the patient to the purpose of interview questions. The next assessment question the nurse should ask?</p> <p>A. You aren't thinking about killing yourself are you?</p> <p>B. Tell me what is going on with you, do you usually get this upset?</p> <p>C. What helps you to feel to calmer? Are you currently taking any medication for anxiety?</p> <p>D. Take a deep breath and calm down you are in a safe place and no one will hurt you.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>4. Is the content of the question clear and unambiguous?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

29. The Do you have any medical issues that I need to know about? The patient is a 55-year-old white, non-Hispanic male whose son found him unconscious in his home. The son called 911 and the patient was brought to the emergency department. The son reported that his Dad's social drinking has increased from one drink per week to one six-pack of beer per day. The son reported that his dad attempted suicide with opiates and alcohol ten years ago after his wife died from cancer. During the assessment interview, the patient denies suicidal ideation and states that his church believes in "the sanctity of life" and "the people there would not understand; they would shun me." He admits to having opiates in his possession. Based on the Lethality Assessment Scale, the patient is:

- A. High risk for suicide**
- B. Moderate risk for suicide**
- C. Low risk for suicide**
- D. no risk of suicide**

1. Does the question clearly relate to one of the two content areas being measured? Comments:	Yes No
2. Is the intent of the question clear? Comments:	Yes No
3. Is the wording of the question clear and understandable to English as second language learners? Comments:	Yes No
4. Is the content of the question clear and unambiguous? Comments:	Yes No
5. Is the question written at an appropriate level for senior undergraduate nursing students? Comments:	Yes No
6. Do you have any suggestions for changes in content or format Comments:	Yes No

<p>30. You are assessing a patient for risk of suicide and you determine that the patient has a high-risk level of suicide, what symptoms indicate the greatest risk for self-harm?</p> <p>A. A specific plan, impaired self-control, and limited protective factors. B. The patient's anxiety level and ability to express feelings are impaired. C. The patient's availability of social support is limited. D. The patient has thoughts of death but does not have a suicide plan.</p>	
<p>1. Does the question clearly relate to one of the two content areas being measured?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>2. Is the intent of the question clear?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>3. Is the wording of the question clear and understandable to English as second language learners?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>4. Is the content of the question clear and unambiguous?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>5. Is the question written at an appropriate level for senior undergraduate nursing students?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>
<p>6. Do you have any suggestions for changes in content or format?</p> <p>Comments:</p>	<p>Yes</p> <p>No</p>

Appendix C
Anxiety Questionnaire

Anxiety Questionnaire

Last four numbers of your student ID _____

Explanation to participants:

This is a reflective questionnaire designed to allow everyone to express his or her thoughts and feelings related to working with mentally ill patients during the psychiatric mental-health clinical.

Directions:

Please put the last four numbers of your student ID on this form. If you do not want to use your student ID please choose four numbers that you can remember as you will need them for the anxiety questionnaire at the conclusion of the simulation experience. Thank you for your participation in this research project.

Read each question carefully and write answers in the space provided.

1. How do you feel about working with mentally ill clients?

2. What concerns you the most about this clinical rotation?

3. When you are doing an assessment on a patient with mental illness, what questions are you the most concerned about asking the patient?

Appendix D

Therapeutic Communication Rubric

THERAPEUTIC COMMUNICATION RUBRIC

Instructions: Tally the number of therapeutic or nontherapeutic techniques used during the segment of the scenario.

Therapeutic Techniques	Scenario One	Scenario Two
Encouraging Comparison		
Reflecting		
Giving Information		
Seeking clarification		
Asking Open-ended Question		
Focusing		
Interpreting		
Suggesting collaboration		
Encouraging Formulation of Short-term Goals		
Encouraging Consideration of Options		

Additional Observations and Comments:

NONGHERAPUTIC COMMUNICATION

Non-therapeutic Techniques	Totals	
Overloading		
Value Judgments		
Incongruence		
False reassurance or agreement		
Invalidation		
Focusing on self		
Changing the subject		
Giving advice		

Additional Observations and Comments:

Appendix E
Psychiatric Assessment Rubric

Directions: Rate the students' performance on each identified portion of the assessment.

Not met – Student did not complete the task.

Beginning – Student asks assessment questions, but does not seek clarification to vague or incomplete answers.

Developing – Student demonstrates acceptable performance, uses therapeutic communication to clarify incomplete answers and redirects patient as needed 50% of the time.

Competent – Student uses therapeutic communication to clarify incomplete answers and redirects patient as needed 90% of the time.

Expected Behaviors	Performance on a scale of 1 to 4				Comments:
Washes Hands	Not met 1	Beginning 2	Developing 3	Competent 4	
Introduces self	Not met 1	Beginning 2	Developing 3	Competent 4	
Identifies the Patient	Not met 1	Beginning 2	Developing 3	Competent 4	
Explains the Purpose of the Interview	Not met 1	Beginning 2	Developing 3	Competent 4	
Establishes Chief Complaint (reason for current hospitalization)	Not met 1	Beginning 2	Developing 3	Competent 4	
Reviews Physical Status (Pain, Vital Signs, etc.)	Not met 1	Beginning 2	Developing 3	Competent 4	
Establishes History of Present Illness	Not met 1	Beginning 2	Developing 3	Competent 4	
Establishes Onset of Current Symptoms	Not met 1	Beginning 2	Developing 3	Competent 4	
Establishes Severity of Symptoms (May use a scale of 1 to 10)	Not met 1	Beginning 2	Developing 3	Competent 4	

Establishes Duration of Current Symptoms	Not met 1	Beginning 2	Developing 3	Competent 4	
Reviews Medical History	Not met 1	Beginning 2	Developing 3	Competent 4	
Reviews Prior Hospitalizations for Medical Issues	Not met 1	Beginning 2	Developing 3	Competent 4	
Reviews Psychiatric History	Not met 1	Beginning 2	Developing 3	Competent 4	
Reviews Prior Psychiatric Hospitalizations	Not met 1	Beginning 2	Developing 3	Competent 4	
Reviews Alcohol and Substance Use (current & past history)	Not met 1	Beginning 2	Developing 3	Competent 4	
Identifies Psychosocial Stressors & Identifies Support Systems	Not met 1	Beginning 2	Developing 3	Competent 4	
Assesses for Thoughts of Self-harm (Suicidal Ideation)	Not met 1	Beginning 2	Developing 3	Competent 4	
Assesses Plan for Self-harm	Not met 1	Beginning 2	Developing 3	Competent 4	
Assesses Ability to Contract for Safety	Not met 1	Beginning 2	Developing 3	Competent 4	

Assesses Mood & Affect	Not met 1	Beginning 2	Developing 3	Competent 4	
Assesses Thought Content	Not met 1	Beginning 2	Developing 3	Competent 4	
Gives SBAR Hand-off Report	Not met 1	Beginning 2	Developing 3	Competent 4	

Additional Comments or Observations

Appendix F
Postsimulation Questionnaire

Postsimulation Survey Insimulation Debriefing

Last 4 digits of your student ID _____

Dear Students:

Thank you for participating in this study.

Please mark below on a scale of 1-5

1 Do not agree 5 Agree completely

**Do Not
Agree**

**Agree
Completely**

1. The simulation was realistic	0 1	0 2	0 3	0 4	0 5
2. I feel more comfortable with mentally ill patients Postsimulation	0 1	0 2	0 3	0 4	0 5
3. The facilitator was disruptive during the simulation	0 1	0 2	0 3	0 4	0 5
4. The debriefing helped me learn effectively	0 1	0 2	0 3	0 4	0 5
5. The debriefing lessened the realism of the simulation	0 1	0 2	0 3	0 4	0 5
6. The debriefing helped me understand the correct and incorrect actions	0 1	0 2	0 3	0 4	0 5
7. The debriefing style was effective	0 1	0 2	0 3	0 4	0 5

Comments: Please provide comments related to the two debriefing methods.

**Postsimulation Survey
Postsimulation Debriefing**

Last 4 digits of your student ID _____

Dear Students:

Thank you for participating in this study.

Please mark below on a scale of 1-5

1 Do not agree 5 Agree completely

**Do Not
Agree**

**Agree
Completely**

1. The simulation was realistic	0 1	0 2	0 3	0 4	0 5
2. I feel more comfortable with mentally ill patients Postsimulation	0 1	0 2	0 3	0 4	0 5
3. The facilitator was disruptive during the simulation	0 1	0 2	0 3	0 4	0 5
4. The debriefing helped me learn effectively	0 1	0 2	0 3	0 4	0 5
5. The debriefing lessened the realism of the simulation	0 1	0 2	0 3	0 4	0 5
6. The debriefing helped me understand the correct and incorrect actions	0 1	0 2	0 3	0 4	0 5
7. The debriefing style was effective	0 1	0 2	0 3	0 4	0 5

Comments:

Appendix G
Demographic Questionnaire

Demographic Questionnaire

Thank you for completing the survey. Please complete that following informational items by circling the data that most describes you.

1. Age:

- | | |
|----------|------------|
| a. 18-25 | e. 40-45 |
| b. 25-30 | f. 45-50 |
| c. 30-35 | g. over 50 |
| d. 35-40 | |

2. Gender

- | | |
|---------|-----------|
| a. male | b. female |
|---------|-----------|

2. Previous healthcare experience

- a. No previous experience
- b. Certified nursing assistant
- c. Medical assistant, EMT, or paramedic
- d. LVN

3. Do you have any prior experience with mentally ill persons? This could be a patient you cared for in clinical, a friend, or family member.

- | | |
|--------|-------|
| a. Yes | b. No |
|--------|-------|

4. If you answered yes to question 3 please briefly explain.

Appendix H

Clinical Simulation Confidentiality Agreement

[REDACTED]

Clinical Simulation Confidentiality Agreement

As a user of or visitor to the Nursing Simulation Laboratory (NSL), operated by [REDACTED] I understand the significance of confidentiality with respect to information concerning patients – real or simulated -- and other users and visitors including, but not limited to, [REDACTED] students, instructors, and staff. I will uphold the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and all other federal or state laws regarding confidentiality. Further, I agree to adhere to the stipulations stated below, and I agree to report any violations of confidentiality that I become aware of to my facilitator or instructor.

- I understand that all patient information is confidential, even information developed for or as part of a simulation session, and any inappropriate viewing, discussion, or disclosure of this information is a violation of [REDACTED] policy.
- I understand that simulated patient information and simulation session information is privileged and confidential regardless of format -- electronic, written, overheard, or observed.
- I understand that I may view, use, disclose, or copy information only as it relates to the performance of my educational duties. Any inappropriate viewing, discussion, or disclosure of this information is a violation of [REDACTED] policy and may be a violation of HIPAA and other state and federal laws.
- I understand that the NSL is a learning environment. All simulation sessions or scenarios, regardless of their outcome, and all debriefing sessions should be treated in a professional manner. All students participating in any simulation session or debriefing session should have everyone's respect and attention. Situations simulated in the NSL are to be used as a learning tool and not to be used for the humiliation or ridicule of nursing students, instructors, or other participants.
- I understand that the simulation mannequins are to be used with respect and treated as if they were living patients in every sense – legal, moral, or philosophic.
- I understand that simulation and debriefing sessions may be videotaped, audio taped or otherwise recorded and I agree to maintain the confidentiality and security of any and all recordings.

- I agree to not remove, release, or make publicly available any written documentation that may be provided to me as part of my educational experience in the NSL.
- I agree to not remove, release, or make publicly available any recordings or portions of recordings made during any simulation sessions, except as allowed under the Visual/Audio Image Release Form or as part of [REDACTED] sponsored academic research.
- I understand that I may be contacted after this simulation experience and asked to allow image(s) or recordings(s) of me during this simulation session to be used for other educational and/or promotional use. I also understand that I am NOT REQUIRED to agree to this use of my image(s) or recordings(s).

Signature: _____

Printed Name: _____

Date: _____ Course and Section: _____

Email: _____ Telephone: _____

Appendix I
Simulation Manual

SECTION I: SCENARIO OVERVIEW

(Do not show to students)

Scenario Title:	Schizophrenia with Command Hallucinations and History of Suicide Attempt		
Original Scenario Developer(s):	Debrayh Gaylle, MS, RN		
<u>Estimated Scenario Time:</u> 10-15 min.		<u>Debriefing time:</u> 20-30 min. (postsimulation only). Insimulation debriefing will increase simulation time to approximately 20 minutes.	
<u>Target group:</u> Undergraduate nursing students preparing to participate in a psychiatric mental-health clinical rotation. Students will use therapeutic communication techniques to: Conduct a psychiatric assessment. Recognize and respond to patient's suicidal ideation, anxiety, and depression.			
<u>Core case:</u> Sam Barrett 22-year old schizophrenic brought to ER by his older brother. Pt is experiencing command hallucinations telling him to kill himself.			
<u>OSEN Competencies:</u> Safety Patient Centered Care Teamwork and Collaboration			
<u>Brief Summary of Case:</u> Mr. Sam Barrett is a 22-year-old Hispanic male diagnosed with schizophrenia. His brother brought him into the emergency room because Mr. Barrett stated that, "the voices in my head are telling me to kill myself." The case will follow Mr. Barrett from admission on the psychiatric unit through discharge planning two weeks after admission.			

REFERENCES

- Cronenwett, L., Sherwood, G., Bransteiner, J., Disch, J., Johnson, J., Mitchell, P., Sullivan, D. T., & Warren, J. (2007). Quality and safety education for nurse. *Nurse Outlook* 122-131.
- Mohr, W. K. (2009). *Psychiatric Mental-health Nursing: Evidence-Based Concepts, Skills, and Practices*, (7th ed.), Philadelphia: Lippincott

SECTION II: CURRICULUM INTEGRATION SCENARIO LEARNING OBJECTIVES	
Learning Outcomes	
Provide patient care that promotes safety	
Student will use therapeutic communication techniques as defined by the APNA and ISPN	
Integrate understanding of multiple dimensions of patient centered care	
Communicate effectively with nursing and members of inter-professional team.	
Specific Learning Objectives	
Introduce him or herself and explain purpose of the interview	
Establish patient's reason for seeking treatment (chief complaint)	
Establish current symptoms (including onset, duration, and severity of symptoms)	
Review Past psychiatric and medical history	
Reviews alcohol and substance use (current and past)	
Assess for psychological stressors which maybe a contributing factor to patient's current symptoms	
Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language)	
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	
Assess patient's knowledge of medications and provide medication teaching	
Critical Learner Actions	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Assesses for psychosocial stressors that maybe contributing factors to current symptoms	
Assess patient's current mood (anxiety, depression, feelings of hopelessness etc.)	
Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)	
Assess patient's though process delusional thinking auditory or visual hallucinations (AH, VH).	
Assesses for history of self-harm behavior i.e. cutting, burning, skin picking	
Assess for history of suicidal ideation or suicide attempts	
Assess patient for current suicidal ideation (if pt. has past history of suicide attempt explore lethality of the attempt)	
If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)	
Assess patient's ability to contract for safety	
As case unfolds assess patients current status and provide appropriate teaching	

PRE-SCENARIO KNOWLEDGE AND EXPECTED SKILLS AND BEHAVIORS	
Prerequisite Knowledge Required Prior to Simulations	Skills and Attitudes Exhibited During the Simulation
Nursing Process Components of Psychiatric Assessment Therapeutic Communication	Conducts psychiatric assessment: includes assessment of mood, thought content, orientation, audio and visual hallucinations (AV, HV), suicidal ideation (SI), prior suicide attempts (SA), and ability to contract for safety
Therapeutic communication techniques as defined by the APNA and ISPN	Recognizes significance of abnormal assessment findings, including safety assessment, and makes appropriate referrals
Patient teaching related to psychiatric medications.	Utilizes therapeutic communication skills during patient interview to collect assessment data and provide patient teaching
Structured Communication Tools (SBAR)	Request assistance, as needed, based on assessment data and gives SBAR report to MD, RN, or other appropriate team member

SECTION III: SCENARIO SCRIPT

Case summary

Sam Barrett 22-year old schizophrenic brought to ER by his older brother George. George became concerned when his brother told him, "I do not deserve to live." The emergency room doctor completes Mr. Barrett's examination and places him on a 5150 for suicidal ideation. Mr. Barrett is diagnosed with Paranoid Schizophrenia when he was 19 years old. Mr. Barrett is experiencing command hallucinations telling him to kill himself. Additionally, his brother states that the patient has paranoid delusions related to the National Security Agency. The patient is anxious and guarded. His speech is tangential and he asks the doctor several times if there are hidden cameras in the room.

Day one of the case: (scenario one)

The nurse (student) receives report via phone from the emergency room nurse.

Mr. Barrett arrives on the psychiatric unit escorted by security.

The nurse goes to Mr. Barrett's room to conduct the interview. Mr. Barrett is disheveled but appropriately dressed; he appears suspicious and paces the perimeter of the room. He is wearing headphones and seems to be intently listening to his iPod. The security officer gives the nurse Mr. Barrett's chart and leaves the room. The nurse conducts the admission assessment (see scenario flow sheet).

The case unfolds: (scenario two)

Day three of the hospital stay Mr. Barrett has become increasingly paranoid. He is experiencing delusional thoughts related to the National Security Agency. He has psychomotor agitation and is anxious. He denies active SI but states that if things do not get better he might consider killing himself. The doctor discontinued his Haldol due to muscle stiffness and started him on Zyprexa.

When the nurse enters the room to conduct the assessment. Mr. Barrett is visibly upset, talking to himself, and pacing. He believes that the NSA has placed him in the hospital and that they are going to harm him or his family. He tells the nurse he can build an atomic bomb. He is refusing all medication because he believes it is poison (see scenario flow sheet).

The Case unfolds: (scenario three)

Day five of the hospital stay Mr. Barrett refused his Zyprexa this morning he stated, "it is poison". He denies SI, AH and VH. He is currently delusional and insists that the NSA is using his brother George "to get to him". He is not sleeping and is hyper vigilant. Last night he slept 3 hours. He refused all offers of PRN medication. He becomes agitated if the TV is on in the dayroom. He is alert and oriented, his mood is guarded, his thought process is tangential and he is responding to internal stimuli. He is intrusive at times, but responds to gentle reassurance and limit setting (see scenario flow sheet).

The Case unfolds: (scenario four)

Day twelve of the hospital stay Mr. Barrett was placed on a 5250 when his 5150 expired. The doctor filled a Reece petition and the court granted permission to give Mr. Barrett Ativan and Zyprexa IM if he refuses the oral medication. Mr. Barrett has been receiving medication for six days and his thought process has cleared. He becomes delusional when the television is on in the day room. However, he is self-regulating and stays out of the day room if other patients are watching television. He denies SI and the hallucinations have decreased. Mr. Barrett tells the nurse that the voices return if he watches television. Mr. Barrett's depression has improved and his anxiety has decreased. He is going to be discharged the tomorrow. He has questions about the medication. Because Mr. Barrett has a history of stopping his medication, medication teaching is essential (see scenario flow sheet).

Key Contextual Details

Patient has a history of mental illness and no significant medical issues. Patient was diagnosed with Paranoid Schizophrenia when he was 19 years old. The patient lives with his parents and his older brother George.

Scenario Cast

Role	Brief Descriptor	Confederate (C) or Learner (L)
RN 1	Reports on pt's current condition	Confederate (instructor or learner)
RN 2	Assumes care of the patient	Learner
Standardized patient	Volunteer portraying psychiatric patient	Confederate (volunteer standardized patient)
Security Officer	Remains with pt until RN arrives in the room	Confederate (faculty or learner)

Patient Profile

Last name: Barrett			First name: Sam	
Gender: Male	Age: 22	Ht: 6'2"	Wt: 180#	Code Status: Full
Spiritual Practice: None stated		Ethnicity: Hispanic		Primary Language spoken: English and Spanish

History of Present Illness

Patient is a 22-year old Schizophrenia male experiencing command hallucinations with suicidal ideation (SI)

Primary Medical Diagnosis	Paranoid Schizophrenia with SI
---------------------------	--------------------------------

Review of Systems	
CNS	Anxious, alert and oriented to person, place, time and situation
Cardiovascular	Sinus rhythm 96; no murmurs, thrills B/P 130/85
Pulmonary	Smokes a pack a day. RR-28, O2 saturation (SAT) 98% Room air (RA), Lungs clear
Renal/Hepatic	No complaints of urinary difficulties
Gastrointestinal	Bowel habits once daily
Musculoskeletal	Moves all extremities
Integument	Clear and intact
Psychiatric Hx	Dx with Schizophrenia at age 19
Social Hx	Lives with parents and older brother
Other	Occasionally smokes marijuana

Current Medications			
Drug	Dose	Route	Frequency
Haldol	15 mg tab	oral	HS
Ibuprofen	1 tab	oral	Occasional use for headache
Lorazepam	1 mg	Oral	PRN Q 3 hours for anxiety

Laboratory and Diagnostic Study Results					
Na: 138	K: 3.8	Cl: 100	HCO ₃ : 24	BUN: 12	Cr: 0.8
Ca: 9.0	Mg:	Phos: 3.5	Glucose: 98	Drug screen Positive for THC Positive for benzodiazepine	
Hgb: 11.2	Hct: 32	Plt: 145	WBC: 12.4		

Standardized Patient State (This may vary as scenario unfolds)					
Initial Physical Appearance					
Gender: male		Attire: jeans and tee shirt			
Clothing is clean but tattered and hair is uncombed. Scenario one patient is pacing the room and listening to his iPod as the case unfolds the patients behavior will change (see flow sheets) however all four scenarios will take place in the same setting. As the case unfolds patient changes from street clothes to hospital gowns and then back into street clothes.					
X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
X	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable
Initial Vital Signs or Monitor Display					
x	No monitor display		Monitor on, but no data displayed		Monitor on, standard display
BP: 110/80		HR: 90	RR: 24	T: 97.0 F.	
				Sp O2: 94% on RA	

Environment, Equipment, Essential Props Standardized setup for each simulation							
Scenario setting							
Interview room with table with two chairs (see each scenario for additional props) iPod, newspaper, hospital gowns							
Equipment, supplies, monitors							
x	Blood pressure machine		Stethoscope	x	Water Pitcher and glass		
Documentation and Order Forms							
x	MD orders	x	Med Admin Record	x	H & P	x	Lab Results
x	Actual medical record binder				Other: Patient has iPod with head phones		

Debriefing Guide
Postsimulation Debriefing Questions with Video Recording
<p>What went well during the interview with the patient</p> <p>What are or is the rationale behind the question (s) you asked? (This question may be used to discuss a specific question or behavior that took place in the simulation).</p> <p>Was the decision effective or appropriate?</p> <p>What were the outcomes of the decision?</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting</p>
Insimulation Debriefing Questions with Video Recording
<p><i>Use these questions if the simulation is progressing appropriately.</i></p> <p>What additional questions do you need to ask the patient?</p> <p>What were you thinking when the patient said _____?</p> <p>Think about what just went on in the last 5 minutes. What would you like to do over?</p> <p><i>If the student is using nontherapeutic communication, ask this question.</i></p> <p>How could you have phrased that question differently?</p> <p><i>If the student has forgotten a key component of the psychiatric assessment, ask these questions.</i></p> <p>What additional information do you need to gather?</p> <p>What do you need to know to provide for patient safety?</p> <p><i>Postsimulation Debriefing Questions</i></p> <p>What went well during the interview with the patient</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting?</p>

HEALTH CARE PROVIDER ORDERS

(Provided to student in patient's chart)

(Note: Patient's name and gender may change depending on available standardized patients)

Physician Orders Day One from the Emergency Room

Patient Name: Sam Barrett DOB: 12-25-1982 Age: 22 MR#: 669247782		Diagnosis: Paranoid schizophrenia with suicidal ideation
No Known Allergies		
Date	Time	Orders
12-31-12	1730	1 to 1 supervision, pt is on 5050, Danger to self
12-31-12	1800	Labs, CBC, TOX Screen, Chem Panel, UA
12-31-12	1850	1 mg Ativan po stat
12-31-12	2100	1 mg Ativan po every 4 hours for extreme anxiety
12-31-12	2150	Transfer to 2 west psychiatric unit as soon as a bed is available
		Signed S. Rued MD

Physician Orders Day One

Patient Name: Sam Barrett DOB: 1-1-1991 Age: 22 MR#: 669247782		Diagnosis: Paranoid Schizophrenia with SI
No Known Allergies		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Admit to psychiatric unit
		Diagnosis: Schizophrenia with SI
		Q 15 minute safety checks
		Activity, up ad lib
		Haldol 15 mg po Q HS
		Ibuprofen 400 mg Q 4 hours prn for HA
		Lorazepam 1 mg po Q 4 hour prn mild to moderate anxiety
		S. Rued MD

Physician Orders Day Three

Patient Name: Sam Barrett DOB: 1-1-1991 Age: 22 MR#: 669247782		Diagnosis: Paranoid Schizophrenia with SI
No Known Allergies		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Admit to psychiatric unit
		Diagnosis: Schizophrenia with SI
		Q 15 minute safety checks
		Activity, up ad lib
		D/ C Haldol 15 mg po Q HS
		Start Zyprexa 0.5 mg Every morning and 1 mg Q HS
		Ibuprofen 400 mg Q 4 hours prn for HA
		Lorazepam 1 mg po Q 4 hour prn mild to moderate anxiety
		S. Rued MD

History and Physical
(Provided to the Student as Part of the Chart)

Chief Complaint:

Pt reports hearing voices telling him to "cut, cut, cut" Pt states he promised his brother he would not cut himself. Pt states the voices are hard to ignore. Pt states, "I deserve to die."

History of Present Illness:

Twenty two year old male in apparent distress with significant psychomotor agitation. Pt reports that he stopped taking his Haldol two weeks ago. Pt's brother stated that the pt had complained of muscle stiffness but that the family was unaware that he had stopped his medications. Pt was dx with Paranoid Schizophrenia at age 19. Currently + SI, AH, and delusion of persecution, pt states, "they are watching me all the time." Pt told triage RN that he knew how to build an atomic bomb and that "they were going to punish his family." Duration of current sx's approximately one week.

Surgical History:

None

Medical History:

No significant medical history

Family History:

Older brother no significant medical history

Father +asthma

Mother + DM 2

Allergies:

NKDA

Medications:

Haloperidol 15 mg q hs

Lorazepam 1 mg q 4 hrs for extreme anxiety

Ibuprofen 200 mgs prn for HA

Review of Systems:

Eyes - no changes in vision, double vision, blurry vision, wears glasses

ENT - No congestion, changes in hearing

Skin/- no rashes

Cardiovascular - No SOB, chest pain, heart palpitations

Pulmonary - lungs clear, smokes a pack a day

Endocrine - No changes in appetite

Gastrointestinal - No n/v/d or constipation

Genitourinary - No increased frequency or pain on urination.

Musculoskeletal - no joint tenderness or swelling c/o Haldol causes muscle stiffness

Neurologic - No changes in memory

Psychological - + passive SI, delusional thoughts, + AH, + anxiety, + depression.

Assessment:

Twenty two year old Hispanic male with + SI, paranoid delusions of persecution, and command hallucinations. No significant medical issues, vital signs within normal limits, no c/o of pain.

Axis I

295.30 Schizophrenia paranoid type

Axis II

Deferred

Axis III

None

Axis IV

Social isolation

Axis V

GAF = 35 (current)

Plan:

Labs:

CBC, Chem 7, and Drug Screen

Restart:

Haloperidol 15 mg q hs

Lorazepam 1 mg q 4 hrs for extreme anxiety

Admit to the psychiatric unit on a 5150, the pt is a danger to himself.

Scenario One

Student Objectives:

Student will conduct a 10-to-15-minute interview and psychiatric assessment.

Student will use therapeutic communication techniques as defined by the APNA and ISPN.

Student will conduct a psychiatric assessment that includes the following components as appropriate to the each scenario:

Introduce him or herself and explain purpose of the interview	Establish patient's reason for seeking treatment (chief complaint) Assess for hallucinations.
Establish current symptoms (including onset, duration, and severity of symptoms).	If patient is currently, experiencing hallucinations assess type (audio, visual, tactile) and content (command, pleasant, negative).
Reviews prior hospitalizations and current and past medical history.	Review past psychiatric and medical history.
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language).
Reviews alcohol and substance use (current and past).	If patient has history of substance, use establish date, last used.
Assess patient's history of self-harm (cutting, burning, skin picking or suicidal ideation or attempts).	Assess for current suicidal ideation.
If patient has current, thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means).	If patient has a history of suicide, attempts assess lethality of the attempt.
Establish patient's willingness to contract for safety.	Conclude the interview and give report to appropriate team members.

Scenario One
Flow Sheet for Postsimulation Debriefing
Paranoid Schizophrenia with Suicidal Ideation

Background	
Mr. S. Barrett is a 22-year-old white male diagnosed with Paranoid Schizophrenia. His brother brought him into the emergency room because Mr. Barrett stated that, "the voices in my head are telling me to kill myself".	
Scenario Summary	
Day One Admission to the Psychiatric Unit	
<p>His brother George brought Mr. S. Barrett to the emergency room of the Valley hospital, George became concerned when his brother told him that, "I do not deserve to live". The emergency room doctor examines Mr. Barrett and determines that he is stable. The doctor places Mr. Barrett on a 5150, as he is currently suicidal and admits him to the psychiatric unit.</p> <p>The nurse (student) receives report via phone from the emergency room nurse. Mr. Barrett has just arrived on the psychiatric unit and is waiting quietly in his room. The nurse goes to Mr. Barrett's room to conduct the interview. Mr. Barrett is disheveled but appropriately dressed; he appears suspicious and paces the perimeter of the room he is warning headphones and seems to be intently listening to his iPod.</p>	
Begin Scenario	
<p>As the student nurse enters the room. Mr. Barrett pacing and talking to himself."</p> <p>Appropriate student response: My name is _____ and I am going to be your student nurse today. How are you feeling?</p>	
When the student (St) uses appropriate therapeutic communication (open-ended questions) the patient (Pt) response is appropriate	When the student uses non-therapeutic communication (closed-ended or why questions) the patient's response is inappropriate.

St: "Can you tell me what brought you to the hospital today?" (the patient comes and sets across from the student)

Pt: "My brother brought me to the hospital, because I listen to too much music."

St: "Can you tell me more about why you your brother is worried about you? "

Pt: "Well my brother worries because the music helps keep the voices quiet".

St: "Do you like music"

Pt: "Yeah" (patient moves away from student stares at the floor and keeps pacing)

St: "Why are you in the hospital?"

Pt: "People die in hospitals, (pt paces faster and volume of his voice increases) dead dead grateful to be dead."

Scenario Continues

Expected student behaviors:

Review and assess onset, duration, and severity of current symptoms

Review prior hospitalizations including medical and psychiatric history

When the student uses appropriate therapeutic communication (open-ended questions, clarification, and reflection) the patient response is appropriate

When the student uses non-therapeutic communication (closed-ended or why questions) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:

St: "You said that the music helps keep the voices quiet, can you tell me what the voices are like without the music."

Pt: "They yell and say bad things."

St: "Can you tell me when the voices started getting louder?"

Pt: "I stopped taking my Haldol about a week ago."

(During conversation, Pt sets facing student he fidgets and frequently looks away and there are long pauses before he answers each question).

Example of inappropriate questions and responses:

St: "Why do you like that music?"

Pt: "Ice tea, purple moon, going away too soon."

St: "I like ice tea with milk. Do you like ice tea?"

Pt: "Rubber bands around your head" (pt begins to twirl and dance around the room)

Scenario Continues

<p>Expected student behaviors:</p>

<p>Assesses for psychosocial stressors that maybe contributing factors to current symptoms</p>
--

<p>Assess patient's current mood (anxiety, depression, feelings of hopelessness etc.)</p>

<p>Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)</p>
--

<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate</p>

<p>Examples of appropriate student questions and patient responses:</p>

<p>St: "Can you tell me what the date is today?"</p>
--

<p>Pt: "Sure it is _____"</p>

<p>St: "and do you know what this place is?"</p>
--

<p>Pt: (Pt laughs or smiles) "Yeah I hear voices but I am not disoriented yet, this is the Valley hospital."</p>
--

<p>St: "You said that the voices make you feel bad can you tell me more about how you are feeling right now?"</p>

<p>Pt: "I feel anxious and a little sad"</p>
--

<p>St: "On a scale of 1 to 10 with 0 being no anxiety and 10 being the worst anxiety. Can you tell me how anxious you feel?"</p>
--

<p>When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?</p>
--

<p>Example of inappropriate questions and responses:</p>
--

<p>St: "You know what day it is and where you are don't you?"</p>

<p>Pt: "What do you think of course I do, I am not stupid?"</p>

<p>St: "That is good"</p>

<p>Pt: "I crazy crazy (pt's speaks loudly and yells out the window) I will never be right in the head".</p>

<p>St: "Don't worry the doctors here are very good and they will find the right medication for you."</p>
--

Scenario Continues

<p>Expected student behaviors: Assess for audio and visual hallucinations.</p>
--

<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate</p>

<p>When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?</p>
--

<p>Examples of appropriate student questions and patient responses: St: "You told me you were hearing voices, have the voices ever told you to hurt yourself or anyone else?" Pt: "Yes (long pause pt appears to listening to someone) they tell me to cut, cut, cut." St: "That must be frightening to hear." Pt: (Pt looks at the floor and fidgets) "Yes my brother does not want me to die." St: "You said the voices want you to cut, have you ever cut yourself or someone else?" Pt: "No my brother always helps me not do hurt myself."</p>
--

<p>Example of inappropriate questions and responses: St: "So you hear voices what do they say/" Pt: "Why do you want to know, who are you the FBI?" St: "No I am the nurse her at the hospital" Pt: "Yeah and you are crazy nurse Ratchet". St: "That is not very nice."</p>

Scenario Continues	
<p>Expected student behaviors:</p> <p>Assess patient for current suicidal ideation (if pt has past history of suicide attempt explore lethality of the attempt)</p> <p>If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)</p> <p>Assess patient's ability to contract for safety</p>	
<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate</p>	<p>When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?</p>
<p>Examples of appropriate student questions and patient responses:</p> <p>St: "You seem to be very distressed by the voices, have you ever felt like ending your life because of your illness?"</p> <p>Pt: "Yes (long pause pt appears to listening to someone) I feel that way often."</p> <p>St: "Have you ever acted on those feelings."</p> <p>Pt: "No"</p> <p>St: "Are you currently feeling like you want to end your life?"</p> <p>Pt: "No I promised my brother. I will never hurt myself"</p>	<p>Example of inappropriate questions and responses:</p> <p>St: "Tell me you are not planning to kill yourself"</p> <p>Pt: "Why do you care?"</p> <p>St: "You seem like a nice guy and your brother loves you"</p> <p>Pt: "How do you know you don't know anything about us"?</p>
End Simulation Start Debriefing	
<p>What went well during the interview with the patient</p> <p>What are or is the rationale behind the question (s) you asked? (This question may be used to discuss a specific question or behavior that took place in the simulation). Was the decision effective or appropriate?</p> <p>What were the outcomes of the decision?</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting?</p>	

Note: Both groups receive postsimulation debriefing during scenario one.

Scenario Two

Student Objectives:

Student will conduct a 10-to-15-minute interview and psychiatric assessment.

Student will use therapeutic communication techniques as defined by the APNA and ISPN.

Student will conduct a psychiatric assessment that includes the following components as appropriate to the each scenario:

Introduce him or herself and explain purpose of the interview	Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language)
Assess patient's current mood and thought process (depression, anxiety, feelings of hopelessness, paranoid or delusional thoughts etc.)	Reassure patient that he is in a safe environment
Assess for hallucinations	If patient is currently, experiencing hallucinations assess type (audio, visual, tactile) and content (command, pleasant, negative).
Assess for current suicidal ideation	If patient has current, thoughts of suicide assess plan and ability to contract for safety.
Review patient medications.	Offer patient PRN medications if appropriate to situation.
Conclude the interview	Give report to appropriate team member or ask for assistance if needed.

Scenario Two
Flow Sheet for Insimulation Debriefing
Paranoid Schizophrenia with Suicidal Ideation

Background
Mr. S. Barrett is a 22-year-old Hispanic male diagnosed with schizophrenia. His brother brought him into the emergency room because Mr. Barrett stated that, "the voices in my head are telling me to kill myself". Mr. Barrett has been on the unit for three days. He was restarted on his medications and he has been attending some group activities. Yesterday evening he became paranoid after seeing a news report on the television in the day room. He has been making repeated phone calls to his brother George and pacing the halls and his room.
Scenario Summary Setting the Scene Day Three of Hospitalization
Mr. Barrett is pacing talking on the phone to his brother. He is wearing two hospital gowns and his hair is uncombed. Report: From the night shift nurse. Mr. Barrett had a quiet night. He did not sleep much and he appears to responding to internal stimuli. He refused his PRN medication for sleep. He said he had to keep watching. "I am not sure what he is watching. He is alert and oriented times 4, mood is guarded and he is taking all of his routine medications. The doctor discontinued his Haldol because of muscle stiffness and started him on Zyprexa. Do you have any questions?"
Begin Scenario
The nurse enters the room after receiving report. Mr. Barrett is talking on the loudly on the phone. He says "George why don't you listen to me. You are in danger the National Security Agency (NSA) is monitoring your email and cell phones. They know everything that you say. (long pause) I cannot tell you what is going on right now. They know that I have the formula" The patient slams the phone down and walks away.
The student approaches the patient, introduces him or herself, and begins the interview process. Student objective for first 5 minutes is to introduce self and establish patient's current condition. Sample of expected student behaviors: Introduction: "Hello Mr. Barrett, my name is _____ and I am going to be your nurse today". Open-ended questions hospitalization: "How are you feeling? You seem upset do you want to talk about what is bothering you?"

When the student (St) uses appropriate therapeutic communication (open-ended questions) the patient (Pt) response is appropriate.

When the student uses non-therapeutic communication (closed-ended or why questions) the patient response is inappropriate.

St: "You seem upset can you tell me what is happening?" (the patient comes and sets across from the student)
 Pt: "My brother brought me to the hospital for my protection."
 St: "Can you tell me more about why you your brother is worried about you?"
 Pt: "Well my brother worries about my voices, but he will not listen to me when I tell him they are watching".
 St: "Can you tell me more about who they are?"
 Pt: "I can't talk about them right now."

St: "You listen to your iPod a lot. Do you like music"
 Pt: "Yeah" (patient moves away from student stands up and begins pacing)
 St: "Why are you in the hospital?"
 Pt: "People die in hospitals, they can get you here it is not safe George is wrong (pt paces faster and volume of his voice increases) dead dead grateful to be dead."
 "Help me I don't want them to get me. You who are you? The Who they were a great band."
 (Pt has difficulty staying focused and becomes disorganized with flight of ideas).

Scenario facilitator will allow interview to continue for 5 minutes
 Then call a timeout for a 2-minute debriefing.

Scenario Continues	
<p>Expected student behaviors:</p> <p>Review and assess onset, duration, and severity of current symptoms</p> <p>Review prior hospitalizations including medical and psychiatric history</p>	
<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, and reflection) the patient response is appropriate</p>	<p>When the student uses non-therapeutic communication (closed-ended or why questions) the patient response is inappropriate?</p>
<p>Examples of appropriate student questions and patient responses:</p> <p>St: "You said that the music helps keep the voices quiet, can you tell me what the voices are like without the music."</p> <p>Pt: "They yell and say bad things."</p> <p>St: "Can you tell me when the voices started getting louder?"</p> <p>Pt: "I stopped taking my Haldol about a week ago."</p> <p>(During conversation, Pt sets facing student he fidgets and frequently looks away and there are long pauses before he answers each question).</p>	<p>Example of inappropriate questions and responses:</p> <p>St: "Why do you like that music?"</p> <p>Pt: "Ice tea, purple moon, going away too soon."</p> <p>St: "I like ice tea with milk. Do you like ice tea?"</p> <p>Pt: "Rubber bands around your head" (pt begins to twirl and dance around the room).</p>

Scenario facilitator will allow interview to continue for 5 minutes
Then call a timeout for a 2-minute debriefing.

Scenario Continues

Expected student behaviors:

Assesses for psychosocial stressors that maybe contributing factors to current symptoms
 Assess patient's current mood (anxiety, depression, feelings of hopelessness etc.)
 Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)

When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate

When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:

St: "Can you tell me what the date is today?"

Pt: "Sure it is _____"

St: "and do you know what this place is?"

Pt: (Pt laughs or smiles) "Yeah I hear voices my not disoriented yet, this is the Valley hospital."

St: "You said that the voices make you feel bad can you tell me more about how you are feeling right now?"

Example of inappropriate questions and responses:

St: "You know what day it is and where you are don't you?"

Pt: "What do you think of course I do, I am not stupid?"

St: "That is good"

Pt: "I crazy crazy (pt's speaks loudly and yells out the window) I will never be right in the head".

St: "Don't worry the doctors here are very good and they will find the right medication for you."

Scenario facilitator will allow interview to continue for 5 minutes
 Then call a timeout for a 2-minute debriefing.

Scenario Continues

Expected student behaviors:

If patient currently is experiencing hallucinations assess type and content of hallucinations or delusional thoughts (audio, visual, command, and pleasant or negative message content)

Assesses for history of self-harm behavior i.e. cutting, burning, skin picking

Assess for history of suicidal ideation or suicide attempts

When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate

When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:

St: "You told me you were hearing voices, have the voices ever told you to hurt yourself or anyone else?"

Pt: "Yes (long pause pt appears to listening to someone) they tell me to cut, cut, cut."

St: "That must be frightening to hear."

Pt: (Pt looks at the floor and fidgets)

"Yes my brother does not want me to die."

St: "You said the voices want you to cut, have you ever cut yourself or someone else?"

Pt: "No my brother always helps."

Example of inappropriate questions and responses:

St: "So you hear voices what do they say/"

Pt: "Why do you want to know, who are you the FBI?"

St: "No I am the nurse her at the hospital"

Pt: "Yeah and you are crazy nurse Ratchet".

St: "That is not very nice."

Scenario facilitator will allow interview to continue for 5 minutes
Then call a timeout for a 2-minute debriefing.

Scenario Continues

Expected student behaviors:

Assess patient for current suicidal ideation (if pt has past history of suicide attempt explore lethality of the attempt)

If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)

Assess patient's ability to contract for safety

When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate

When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:

St: "You seem to be very distressed by the voices, have you ever felt like ending your life because of your illness?"

Pt: "Yes (long pause pt appears to listening to someone) I feel that way often."

St: "Have you ever acted on those feelings."

Pt: "No"

St: "Are you currently feeling like you want to end your life?"

Example of inappropriate questions and responses:

St: "Tell me you are not planning to kill yourself"

Pt: "Why do you care?"

St: "You seem like a nice guy and your brother loves you"

Pt: "How do you know you don't know anything about us"?

Scenario facilitator will allow interview to continue for 5 minutes

Then call a timeout for a 2-minute debriefing.

DEBRIEFING QUESTIONS

Insimulation Debriefing

The objective for the in-simulation debriefing is to provide clues that enable the student to recall prior knowledge or to assist the student by modeling appropriate communication and assessment techniques before resuming the simulation.

Use these questions if the simulation is progressing appropriately.

1. What additional questions do you need to ask the patient?
2. What were you thinking when the patient said she or he wanted to die?
3. Think about what just went on in the last 5 minutes. What would you like to do over?

Use these questions if the student is having difficulty with the assessment or therapeutic communication.

If the student is using nontherapeutic communication, ask this question.

1. How could you have phrased that question differently?

If the student has forgotten a key component of the psychiatric assessment, ask these questions.

2. What additional information do you need to gather?
3. What do you need to know to provide for patient safety?

Postsimulation Debriefing Questions

1. What went well during the interview with the patient
2. What would you change, if anything, in the future?
3. What have you learned today, that will help you care for patients in the clinical setting

Scenario Three

Student Objectives:

Student will conduct a 10-to-15-minute interview and psychiatric assessment.

Student will use therapeutic communication techniques as defined by the APNA and ISPN.

Student will conduct a psychiatric assessment that includes the following components as appropriate to the each scenario:

Introduce him or herself and explain purpose of the interview	Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language)
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	Provide reorientation to reality. Reassure patient that this is a safe place.
Assess for hallucinations	If patient is currently, experiencing hallucinations assess type (audio, visual, tactile) and content (command, pleasant, negative).
Assess for current suicidal ideation	If patient has current, thoughts of suicide assess plan and ability to contract for safety. (passive death wish, vague plan, or detailed plan with access to lethal means)
Review patient medications.	Provide medication teaching
Offer patient PRN medications if appropriate to situation	Conclude interview
Give report to appropriate team member or ask for assistance if needed.	

Scenario Three
Flow Sheet Insimulation Debriefing Paranoid
Schizophrenia with Suicidal Ideation

Background

Mr. S. Barrett is a 22-year-old white male diagnosed with Paranoid Schizophrenia. His brother brought him into the emergency room because Mr. Barrett stated that, "the voices in my head are telling me to kill myself". Mr. Barrett has been on the unit for five days. Two days ago, he started refusing his antipsychotic medication.

Scenario Summary Setting the Scene
Day Five of Hospitalization

Mr. Barrett is on the phone. He is yelling loudly. He is dressed in jeans and a hospital gown. He is not wearing shoes and his hair is uncombed.

Report: From the previous nurse.

Mr. Barrett refused his Zyprexa this morning he stated, "it is poison". He denies SI, AH and VH. He is currently delusional and insists that the NSA is using his brother George "to get to him". He slept poorly last night about 3 hours and is refusing all PRN medication. He becomes agitated if the TV is on in the dayroom, we have been encouraging him to attend groups and stay out of the dayroom. He is alert and oriented times 4, mood is guarded and he is refusing all of his medications. He is exhibiting some psychomotor agitation. At times, he is intrusive, but he does respond to gentle reassurance and limit setting. Do you have any questions?

Begin Scenario

The nurse enters the room. Mr. Barrett is yelling "No George No!" "You are in danger the National Security Agency (NSA) is watching you." They know we are brothers and they will use you to get me to talk." (Pause Mr. Barrett is listening) "No I am not taking that damn medication it is poison." The patient slams the phone down and begins pacing and muttering incoherently. (Pts current behavior pacing, talking in a loud voice tangential with flight of ideas).

The student introduces him or herself and begins the interview process. Student objective for first 5 minutes is to introduce self, explain purpose of interview, and assess pts current condition.

Sample of expected student behaviors:

Introduction: "Hello Mr. Barrett, my name is _____ and I am going to be your nurse today".

Open-ended questions:

How are you feeling? You seem upset do you want to talk about what is bothering you. (Mr. Barrett is clearly agitated and his paranoid thoughts have increased from the prior simulation)

When the student uses appropriate therapeutic communication (open-ended questions) the patient response is appropriate.

St: "You seem upset can you tell me what is happening?" (the patient continues to pace and the student must walk with him to carry on the conversation)
 Pt: "My brother will not listen, he is in danger and I am locked up in this damn place." (pt uses loud pressured speech with an angry edge)
 St: "You seem really worried about your brother?"
 Pt: (Pt raises his voice)"Wouldn't you be worried if you were me". "The NSA has total power, they can lock him away forever and I will never find him again."
 St: "It sounds like you are afraid that something bad will happen to your brother"

When the student uses non-therapeutic communication (closed-ended or why questions) the patient response is inappropriate.

St: "Why are you so upset"
 Pt: "The NSA is everywhere, maybe you are working for them" (patient moves away from student stands up and begins pacing)
 St: "What is the NSA?"
 Pt: "National Security Agency what are you stupid don't you know anything."
 (Pt continues to pace speaks in a loud pressured voice and does not make eye contact with the student nurse).

Scenario facilitator will allow interview to continue for 5 minutes
 Then call a timeout for a 2-minute debriefing.

Scenario Continues	
<p>Expected student behaviors:</p> <p>Assess patients level of anxiety and agitation</p> <p>Encourage pt to take PRN medication</p>	
<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, and reflection) the patient response is appropriate</p>	<p>When the student uses non-therapeutic communication (closed-ended or why questions) the patient response is inappropriate?</p>
<p>Examples of appropriate student questions and patient responses:</p> <p>St: "You said you are worried about your brother and you look very anxious." "Would you like an Ativan to help you calm down?"</p> <p>Pt: "That stuff is poison and I don't want it".</p> <p>St: "You are talking very loud and it is freighting to some of the other patients. What can we do to help you calm down?"</p> <p>Pt: "Tell me what that pill does again." (During conversation pt continues to pace and as when student uses calm voice and therapeutic questions he briefly calms down. If the student provides appropriate explanation of medication, he agrees to take the medication).</p>	<p>Example of inappropriate questions and responses:</p> <p>St: "The NSA is too busy to pay attention to you and your brother"</p> <p>Pt: "You don't understand they know that I know how to make and atomic bomb."</p> <p>St: "Wow how did you figure out how to do that?"</p> <p>Pt: "Easy the internet it is all there if you know where to look, get the uranium ore from the dessert and spin it down, the heavy water can't go down the drain, it will kill the fish and I like fish. People lie but animals never do, I would animal not even a fish" (pt talk louder and violates student nurses personal space by getting too close when he is talking about the fish)</p>

Scenario facilitator will allow interview to continue for 5 minutes
Then call a timeout for a 2-minute debriefing.

Scenario Continues

Expected student behaviors:

Continue to offer reassurance that he is in a safe place

Assess patient's current mood (anxiety, depression, feelings of hopelessness etc.)

Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)

When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate

When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:

St: "That medication should start working right away" (Ativan was given sublingual to speed absorption).

St: "I would like to ask you a few questions do you feel calm enough to answer them?"

Pt: "Sure if we can keep walking"

St: "Sure I will walk with you. Do you know what this place is?"

Pt: (Pt looks around fearfully) "Yeah Valley hospital, the NSA locked me up here"

St: "You seem very fearful of the NSA, remember your brother brought you here because you were hearing voices?"

Pt: "Yes I remember"

Example of inappropriate questions and responses:

St: "Now that you took your medication let's get this assessment completed so you can go to group?"

Pt: "I am sick of those stupid questions every day, every nurse, I am smarter than all of you, and I know what day it is and where I am."

St: "Why do you think you are smarter"

Pt: "Don't you listen I know how to make an atomic bomb, I can see the photons and the electrons and I know everything, why do you think the NSA is looking for me".

St: "The NSA is too busy to look for you."

Pt: "You have no idea; you could be in danger just talking to me."

Scenario facilitator will allow interview to continue for 5 minutes
Then call a timeout for a 2-minute debriefing.

Scenario Continues
<p>Expected student behaviors:</p> <p>If patient currently is paranoid and delusional, assess for hallucinations</p> <p>Continue to reassure patient that he is in a safe environment</p>

<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate</p>	<p>When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?</p>
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<p>Examples of appropriate student questions and patient responses:</p> <p>St: "When you came to the hospital you were hearing voices are you still hearing voices?"</p> <p>Pt: "Yes (long pause pt appears to listening to someone)</p> <p>St: "You told me before that the voices were telling you to hurt yourself, has that stopped?"</p> <p>Pt: "No" (long pause) I can't talk about the voices they are listening."</p> <p>St: "When you say they are you refereeing to the NSA?"</p> <p>Pt: "Yes."</p>	<p>Example of inappropriate questions and responses:</p> <p>St: "You aren't still hearing voices are you?"</p> <p>Pt: "Why should I tell you? You work for them?"</p> <p>St: "No I am a student nurse here at the hospital and I do not know them"</p> <p>Pt: "Yes you do (raises his voice) Don't lie to me".</p> <p>St: "Do not yell at me, if you keep yelling I will tell doctor and the other nurses and you will be put in restraints."</p> <p>Pt: Yells loudly "Do not threaten me lady, I have powerful friends".</p>
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Scenario facilitator will allow interview to continue for 5 minutes
Then call a timeout for a 2-minute debriefing.

Scenario Continues	
<p>Expected student behaviors:</p> <p>Assess patient for current suicidal ideation</p> <p>If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)</p> <p>Assess patient's ability to contract for safety</p>	
<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate</p>	<p>When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?</p>
<p>Examples of appropriate student questions and patient responses:</p> <p>St: "Are you having any thoughts of harming yourself"</p> <p>Pt: "No"</p> <p>St: "When you first came to the hospital you told us that the voices were telling you to harm yourself. Has that stopped?"</p> <p>Pt: "Yes (long pause pt appears to listening to someone) I can't talk about them right now:</p> <p>St: "You seem very fearful."</p> <p>Pt: "Yes they have eyes and ears everywhere" (Pt whispers)</p> <p>St: "I want to remind you that this is a safe place and that your brother would never take you to a place where people could harm you?"</p> <p>Pt: "I know George cares about me, but he does not understand."</p>	<p>Example of inappropriate questions and responses:</p> <p>St: "Those voices still telling you to cut yourself open?"</p> <p>Pt: "Quiet the NSA is listening, they don't know about my secret powers"</p> <p>St: "What secret powers?"</p> <p>Pt: "I would not tell you. You are them and they are you, don't you know I can see your thoughts, I know your mind and you can never know mine, go away, go far away, it don't matter anymore".</p> <p>(Pt is visibly agitated alternates between whispering and yelling as he paces).</p>

Scenario facilitator will allow interview to continue for 5 minutes
Then call a timeout for a 2-minute debriefing

DEBRIEFING QUESTIONS

Insimulation Debriefing

The objective for the in-simulation debriefing is to provide clues that enable the student to recall prior knowledge or to assist the student by modeling appropriate communication and assessment techniques before resuming the simulation.

Use these questions if the simulation is progressing appropriately.

What additional questions do you need to ask the patient?

What were you thinking when the patient said _____?

Think about what just went on in the last 5 minutes. What would you like to do over?

If the student is using nontherapeutic communication, ask this question.

How could you have phrased that question differently?

If the student has forgotten a key component of the psychiatric assessment, ask these questions.

What additional information do you need to gather?

What do you need to know to provide for patient safety?

Postsimulation Debriefing Questions

What went well during the interview with the patient?

What would you change, if anything, in the future?

What have you learned today, that will help you care for patients in the clinical setting?

Scenario Four

Student Objectives:

Student will conduct a 10-to-15-minute interview and psychiatric assessment.

Student will use therapeutic communication techniques as defined by the APNA and ISPN.

Student will conduct a psychiatric assessment that includes the following components as appropriate to the each scenario:

Introduce him or herself and explain purpose of the interview	Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language)
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	Offer patient PRN medications if appropriate to situation
Assess for hallucinations	If patient is currently, experiencing hallucinations assess type (audio, visual, tactile) and content (command, pleasant, negative).
Assess for current suicidal ideation	If patient has current, thoughts of suicide assess plan and ability to contract for safety. (passive death wish, vague plan, or detailed plan with access to lethal means)
If patient has history of alcohol and substance use, assess plans for sobriety after discharge.	Review patient medications
Provide patient teaching.	Assess patient readiness for discharge.
Conclude the interview.	Give report to appropriate team member or ask for assistance if needed.

Scenario Four
Flow Sheet for Postsimulation Debriefing
Paranoid Schizophrenia with Suicidal Ideation

Background
<p>Mr. S. Barrett is a 22-year-old white male diagnosed with Paranoid Schizophrenia. His brother brought him into the emergency room because Mr. Barrett has been in the hospital for two weeks. During that time, he was started on a new antipsychotic medication. His condition has stabilized and he is ready to be discharged home with his family.</p>
Scenario Summary Day Twelve of Hospitalization
<p>Mr. Barrett is sitting at the table in the group room. He is reading the sports section of the local paper. He is dressed in clean blue jeans and a tee shirt. His hair is combed and he has recently shaved. He looks up and makes eye contact when the student nurse enters the room.</p> <p>Report: From the previous nurse: Mr. Barrett has attended two groups this morning. He denies SI, AH and VH. He reports that he is less paranoid. He states he is worried about going home. He is taking all his medications. He states his mood has improved although he still gets upset when the TV is on in the day room. He is alert and oriented times four, his mood and affect are congruent, and his speech is goal directed. Do you have any questions?</p>
Begin Scenario
<p>The student approaches the patient, introduces him or herself, and begins the interview process. Student objective introduce self and establish patient's status, assess SI, readiness for discharge and understanding of current medications. Provide patient teaching related to medication.</p>
<p>As the student nurse enters the room. Mr. Barrett looks up from his reading and makes eye contact. He says, "Hello, I remember you from last week but I do not remember your name."</p> <p>Appropriate student response: My name is _____ and I am going to be your student nurse today. How are you feeling?</p>

When the student uses appropriate therapeutic communication (open-ended questions, clarification, and reflection) the patient response is appropriate

When the student uses non-therapeutic communication (closed-ended or why questions) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:
 St: "You seem to be doing better, I noticed you shaved and combed your hair."
 Pt: "Yeah my brother told me I looked like a bum so I got cleaned up."
 St: "The last time we talked you were having some disturbing thoughts. Are those thoughts still bothering you?"
 Pt: "They have me on a new medication, I do not know what it is exactly but it seems to be helping."
 (During conversation, Pt sets facing student makes occasional eye contact and smiles).

Example of inappropriate questions and responses:
 St: "Hay how's it going?"
 Pt: "Okay I guess."
 St: "The other nurse said your medication is working. So do you still think the NSA is out to get you?"
 Pt: "Well you can never be too sure. Do you know something, did they tell you to watch me and report back to them?"

Scenario Continues

Expected student behaviors:

Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)

When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate

When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:

St: "I need to ask you some questions is that okay with you?"

Pt: "Sure"

St: "Can you tell me what the date is today?"

Pt: "Sure it is _____"

St: "and do you know what this place is?"

Pt: (Pt laughs) "It is the Valley hospital. Some things never change"

St: "Can you tell me about your mood?"

Pt: "I feel anxious about going home but I am not depressed anymore"

St: "On a scale of 1 to 10 with 0 being no anxiety and 10 being the worst anxiety. Can you tell me how anxious you feel?"

Pt: "About 2, I am worried that my brother

Example of inappropriate questions and responses:

St: "You know what day it is and where you are don't you?"

Pt: "Of course I do"

St: "That is good"

Pt: "Why do you people keep asking me the same questions over and over?"

St: "Well it is part of the assessment process"

Pt: "What you think I am going to forget from one day to the next. I do not have dementia"

Scenario Continues

<p>Expected student behaviors: Assess for audio and visual hallucinations.</p>
--

<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate</p>

<p>When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?</p>
--

<p>Examples of appropriate student questions and patient responses: St: "When you came into the hospital you were hearing voices. Have you noticed any changes with the new medication?" Pt: "Yes they are not as loud" St: "You say they are not as loud, can you tell me more about that?" Pt: (Short pause before answering) "Well when I am reading, talking to people, or listening to music I don't hear them at all. It is only when the TV is on that I can hear them." St: "Have you thought about staying away from the television?" Pt: "Yeah we do not have a TV at home and if the other patients are watching TV I stay out of the dayroom."</p>
--

<p>Example of inappropriate questions and responses: St: "So you still hearing voices what do they say" Pt: "Only when the TV is on?" St: "Wow what do they say to you?" Pt: "Stuff about the NSA and guns". St: "What else do they tell you?" Pt: "Spying they want me to spy for the government and they put thoughts in my head." St: "You know these voices are not real right?" Pt: "Yes they are real because I am special."</p>
--

Scenario Continues

<p>Expected student behaviors:</p> <p>Assess patient for current suicidal ideation</p> <p>If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)</p> <p>Assess patient's ability to contract for safety</p>
--

<p>When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate.</p>
--

<p>When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?</p>
--

<p>Examples of appropriate student questions and patient responses:</p> <p>St: "When you first came to the hospital you told me that you were feeling that you did not deserve to live, how are you feeling now?"</p> <p>Pt: "I am not having those feelings now."</p> <p>St: "When you go home tomorrow, explain to me what you will do if those feelings return."</p> <p>Pt: "I will call my doctor or talk to my brother. Also, I can take a PRN Ativan if I feel really anxious"</p> <p>St: "That sounds like a good plan."</p>

<p>Example of inappropriate questions and responses:</p> <p>St: "Tell me you are not planning to kill yourself when you go home"</p> <p>Pt: "What kind of question is that?"</p>
--

Scenario Continues

Expected student behaviors:

Assess patients understanding of new medication

Answer patient's questions and provide patient teaching.

When the student uses appropriate therapeutic communication (open-ended questions, clarification, reflection, appropriate silence, and refocusing) the patient response is appropriate.

When the student uses non-therapeutic communication (closed-ended, why questions, giving advice, or false reassurance) the patient response is inappropriate?

Examples of appropriate student questions and patient responses:

St: "I understand that you are currently taking a new medication. Can you tell me about this new drug?"

Pt: "Well it is called Zyprexa and it has fewer side effects than the Haldol."

St: "Can you tell me about the side effects?"

Pt: "It gives me dry mouth but I just suck on hard candy all day and drink lots of water"

St: "Can you tell what the dosage is and when you take this medication?"

Pt: "I think it is 2 mg and I take it at night and in the morning. I am not really sure."

St: "Tell me about your other medications, what else do you take?"

Example of inappropriate questions and responses:

St: "Do you understand all the medications you are taking?"

Pt: "Sure"

St: "Okay great let me know if you have any questions"

Pt: "Okay"

End Simulation Start Debriefing

What went well during the interview with the patient

What are or is the rationale behind the question (s) you asked? (This question may be used to discuss a specific question or behavior that took place in the simulation).

Was the decision effective or appropriate?

What were the outcomes of the decision?

What would you change, if anything, in the future?

What have you learned today, that will help you care for patients in the clinical setting?

Case Three SCENARIO OVERVIEW

Scenario Title:	Postpartum depression with SI
Original Scenario Developer(s):	Debrayh Gayle, MS, RN
<u>Estimated Scenario Time:</u> 10-15 min.	<u>Debriefing time:</u> 20-30 min. (postsimulation only). Insimulation debriefing will increase simulation time to approximately 20 minutes.
<p><u>Target group:</u> Undergraduate nursing students preparing to participate in a psychiatric mental-health clinical rotation. Students will use therapeutic communication techniques to:</p> <p>Conduct a psychiatric assessment.</p> <p>Recognize and respond to patient's suicidal ideation, anxiety, and depression.</p> <p><u>Core case:</u> Sheila Nguyen is 30 year-old mother of two children who had been married for eight years. She lives with her husband and in-laws in a small apartment in South San Francisco. Two months ago, she had given birth to her second child. Her pregnancy and labor were uneventful.</p> <p><u>QSEN Competencies:</u></p> <p>Safety</p> <p>Patient Centered Care</p> <p>Teamwork and Collaboration</p> <p><u>Brief Summary of Case:</u></p> <p>Shelia does not drive and has did not received any postnatal care. Sheila is reluctant to ask her father in law to drive her to her appointments and taking the cross-town bus with a 2-year-old and newborn is difficult. Two and half months postpartum she became reclusive, stopped speaking to her in laws and lost interest in her daily activities. Sheila's mother in law became concerned and mentioned Sheila's behavior to her son. Sheila's husband stated, "I think she is just tired." Two days later Sheila asked her mother-in-law to watch the children and she took the bus across the city where the police found her climbing over the railing of the Golden Gate Bridge. The police officer was able to stop her attempted suicide. Sheila brought in by (BIB) the police on a 5150 for psychiatric evaluation.</p>	

REFERENCES

Mohr, W. K. (2009). Psychiatric Mental-health Nursing: Evidence-Based Concepts, Skills, and Practices, (7th ed.), Philadelphia: Lippincott.

SECTION II: CURRICULUM INTEGRATION SCENARIO LEARNING OBJECTIVES	
Learning Outcomes	
Provide patient care that promotes safety	
Use therapeutic communication techniques as defined by the APNA and ISPN	
Integrate understanding of multiple dimensions of patient centered care	
Communicate effectively with nursing and members of inter-professional team.	
Specific Learning Objectives	
Introduce him or herself and explain purpose of the interview	
Establish patient's reason for seeking treatment (chief complaint)	
Establish current symptoms (including onset, duration, and severity of symptoms)	
Review Past psychiatric and medical history	
Reviews alcohol and substance use (current and past)	
Assess for psychological stressors which maybe a contributing factor to patient's current symptoms	
Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language)	
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	
Assess patient's knowledge of medications and provide medication teaching	
Critical Learner Actions	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Assesses for psychosocial stressors that maybe contributing factors to current symptoms	
Assess patient's current mood (anxiety, depression, feelings of hopelessness etc.)	
Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)	
Assess patient's though process delusional thinking auditory or visual hallucinations (AH, VH).	
Assesses for history of self-harm behavior i.e. cutting, burning, skin picking	
Assess for history of suicidal ideation or suicide attempts	
Assess patient for current suicidal ideation (if pt has past history of suicide attempt explore lethality of the attempt)	
If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)	
Assess patient's ability to contract for safety	
As case unfolds assess patients current status and provide appropriate teaching	

PRE-SCENARIO KNOWLEDGE AND EXPECTED SKILLS AND BEHAVIORS	
Prerequisite Knowledge Required Prior to Simulations	Skills and Attitudes Exhibited During the Simulation
Nursing Process Components of Psychiatric Assessment Therapeutic Communication	Conducts psychiatric assessment: includes assessment of mood, thought content, orientation, audio and visual hallucinations (AV, HV), suicidal ideation (SI), prior suicide attempts (SA), and ability to contract for safety
Therapeutic communication techniques as defined by the APNA and ISPN.	Recognizes significance of abnormal assessment findings, including safety assessment, and makes appropriate referrals.
Patient teaching related to psychiatric medications.	Utilizes therapeutic communication skills during patient interview to collect assessment data and provide patient teaching.
Structured Communication Tools (SBAR)	Request assistance, as needed, based on assessment data and gives SBAR report to MD, RN, or other appropriate team member.

SECTION III: SCENARIO SCRIPT

Case summary

Mrs. Nguyen was BIB the police on a 5150 after a suicide attempt (SA) for psychiatric evaluation. She is Gravida 2; Para 2, and 8 weeks postpartum, pt states she is seldom sick and has never had surgery.

Day one of the case:

It is change of shift Mrs. Nguyen has completed the financial paperwork needed for admission. She is lying in a hospital bed wearing a hospital gown. She is withdrawn and does not make eye contact. The patient's labs have been drawn and her vital signs have been taken no other admission data has been completed, as it is change of shift. A nursing assistant has been assigned to the patient to monitor her for safety until the RN from the next shift arrives.

The student nurse receives report from pervious nurse and conducts the admission assessment.

During the assessment, Mrs. Nguyen is tearful and refuses to give any information concerning her family or place of residence. She repeatedly states that she wants to die.

The case unfolds:

Day two last evening, Mrs. Nguyen was admitted to the psychiatric unit for evaluation and treatment of suicidal ideation. This morning she gave the social worker consent to call her husband. This afternoon, Mr. Nguyen visited his wife in the hospital and met with the social worker and psychiatrist. Mr. Nguyen was supportive and loving towards his wife. After the husband visit Mrs. Nguyen became tearful, stated that she just wanted to "end everything", and that "my family will be better off without me." Mrs. Nguyen has not been started on any medications, as she wants to continue breastfeeding the baby. She is currently using a breast pump.

The Case unfolds:

Day three of the hospital stay Mrs. Nguyen continues to refuse antidepressant medication. She states she wants to continue breastfeeding her baby. During the assessment, she tells the nurse, that her mother in law has tried to poison her by giving her tea with marijuana. Mrs. Nguyen tells the nurse "I think I am going crazy I have never had such bad thoughts before". "I know that they can't be true." She becomes tearful and states, "I just want this all to end."

The Case unfolds:

Day eight of the hospital stay Mrs. Nguyen agreed to take a low dose of Sertraline as it has the lowest transfer rate to breast milk. She started on 25 mg day four of her hospital stay and yesterday the dose was increased to 50 mg. Mrs. Nguyen has been attending group activities, her husband and baby has visited every day. She reports a slight improvement in her mood. She denies SI. She says that she is looking forward to going home in a few days, although, she is embarrassed and anxious about what her in laws will say. She tells the nurse "my husband's family is very traditional I just do not know what to expect when I get home".

Key Contextual Details				
Patient has no prior history of mental illness.				
Patient has no significant medical issues.				
Patient is currently lactating she has a 2 year old and a two month old child				
Scenario Cast				
Role		Brief Descriptor		Confederate (C) or Learner (L)
RN 1		Reports on pt's current condition		Confederate (instructor or learner)
RN 2		Assumes care of the patient		Learner
Standardized patient		Volunteer portraying psychiatric patient		Confederate (volunteer standardized patient)
Nursing Assistant		Remains with pt until RN arrives in the room		Confederate (faculty or learner)
Patient/Client Profile				
Last name:		Nguyen		First name: Shelia
Gender: Fe		Age: 30	Ht: 4'10"	Wt: 120#
Code Status: Full		Primary Language spoken: Vietnamese & English		
Spiritual Practice: None stated		Ethnicity: Vietnamese		
History of present illness				
Patient is a 30 year old female Gravida 2, Para 2, 8 weeks postpartum with postpartum depression and SI				
Primary Medical Diagnosis		Postpartum depression with SI single episode		

Review of Systems	
CNS	Anxious, alert and oriented to person, place, time and situation
Cardiovascular	Sinus rhythm @ 78; no murmurs, thrills B/P 110/60
Pulmonary	RR-28, O2 sats 98% RA. Lungs clear
Renal/Hepatic	No complaints of urinary difficulties.
Gastrointestinal	Bowel habits – once daily
Musculoskeletal	Moves all extremities.
Integument	Clear and intact
Developmental Hx	
Psychiatric Hx	No prior history
Social Hx	Lives with husband, husband's parents, and her two children
Other	

Current medications	Drug	Dose	Route	Frequency
	None			
NKDA				

4. Laboratory and Diagnostic Study Results					
Na: 138	K: 3.8	Cl: 100	HCO3: 24	BUN: 12	Cr: 0.8
Ca: 9.0	Mg:	Phos: 3.5	Glucose: 98	Drug screen Negative	
Hgb: 11.2	Hct: 32	Plt: 145	WBC: 12.4		

Standardized Patient State (This may vary from the baseline data provided to learners)					
Initial physical appearance					
Gender: female		Attire: hospital gown			
30 year old female appears stated age wearing hospital gown					
X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
X	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable

Initial Vital Signs Monitor display in simulation action room:					
x	No monitor display	Monitor on, but no data displayed	Monitor on, standard display	x	Blood pressure machine and stethoscope in room
BP: 110/80		HR: 90	RR: 24	T: 97.0 F.	Sp O2: 94% on RA

Environment, Equipment, Essential Props Standardized setup for each simulation					
Scenario setting:					
Scenario one is in the emergency room. The other scenario are on the unit in the patients room or the dining room					
Equipment Supplies and Monitors					
x	Blood pressure machine	x	Stethoscope	x	Water Pitcher and glass
Documentation and Order Forms					
x	MD orders	x	Med Admin Record	x	H & P
x	Actual medical record binder			x	Lab Results

Debriefing Guide
Postsimulation Debriefing Questions
<p>What went well during the interview with the patient?</p> <p>What are or is the rationale behind the question (s) you asked? (This question may be used to discuss a specific question or behavior that took place in the simulation).</p> <p>Was the decision effective or appropriate?</p> <p>What were are the outcomes of the decision?</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting?</p>
Insimulation Debriefing Questions
<p>Use these questions if the simulation is progressing appropriately.</p> <p>What additional questions do you need to ask the patient?</p> <p>What were you thinking when the patient said she or he wanted to die?</p> <p>Think about what just went on in the last 5 minutes. What would you like to do over?</p> <p>If the student is using nontherapeutic communication, ask this question. How could you have phrased that question differently?</p> <p>If the student has forgotten a key component of the psychiatric assessment, ask these questions.</p> <p>What additional information do you need to gather?</p> <p>What do you need to know to provide for patient safety?</p> <p>Postsimulation Debriefing Questions</p> <p>What went well during the interview with the patient</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting?</p>

HEALTH CARE PROVIDER ORDERS
(Provided to student in patient's chart)

Physician Orders Day One from the Emergency Room

Patient Name: Sheila Nguyen		Diagnosis: Postpartum Depression single episode, with suicidal ideation
DOB: 12-25-1982		
Age: 30		
MR#: 669247782		
No Known Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
	1730	1 to 1 supervision, pt is on 5050, Danger to self
	1800	Labs, CBC, TOX Screen, Chem Panel, UA
	1850	1 mg Ativan po stat
	2100	Transfer to 2 west psychiatric unit as soon as a bed is available
		S. Rued MD

History and Physical

Chief Complaint:

Pt BIB police on 5150 for SA, pt found attempting to jump from the bridge. Pt reports feelings of severe depression, worthlessness, and anxiety. States, "I am a bad mother and I just want to die."

History of Present Illness:

30 year old female Gravida 2 Para 2, 8 weeks postpartum. Two weeks ago, she reports feeling tired and sad. She states that a few days ago she thought her mother in law was doing a better job of taking care of the children. Today she woke up and decided that the family would be "better off without me."

Surgical History:

None

Medical History:

No significant medical history

Family History:

Older brother no significant medical history

Father + COPD

Mother stomach CA deceased

Allergies:

NKDA

Medications:

None

Review of Systems:

Eyes - no changes in vision, double vision, blurry vision, wears glasses

ENT - No congestion, changes in hearing

Skin- clean dry and intact

Cardiovascular - No SOB, chest pain, heart palpitations

Pulmonary - lungs clear

Endocrine - Decreased appetite last two weeks

Gastrointestinal - No n/v/d or constipation

Genitourinary - No increased frequency or pain on urination.

Musculoskeletal - moves all extremities

Neurologic - No changes in memory

Psychological - Suicide attempt (stopped by police) SI, + anxiety, + depression.

Assessment:

Thirty year old Vietnamese female post SA BIB police. Depression and anxiety times two weeks and no significant medical issues, vital signs within normal limits, no c/o of pain.

Axis I

Postpartum depression with SI and anxiety

Axis II

Deferred

Axis III

None

Axis IV

Deferred

Axis V

GAF = 55 (current)

Plan:

Labs:

CBC, Chem 7, and Drug Screen

Lorazepam 1 mg STAT

Admit to the psychiatric unit on a 5150 the pt is a danger to self.

Case Three
SCENARIO OVERVIEW
(Do not give to students)

Scenario Title:	ETOH with Depression & SI with Axis II Behavior	
Original Scenario Developer(s):	Debrayh Gaylle, MS, RN	
<u>Estimated Scenario Time</u> : 10-15 min.	<u>Debriefing time</u> : 20-30 min. (postsimulation only). Insimulation debriefing will increase simulation time to approximately 20 minutes.	
<p><u>Target group</u>: Undergraduate nursing students preparing to participate in a psychiatric mental-health clinical rotation. Students will use therapeutic communication techniques to: Conduct a psychiatric assessment. Recognize and respond to patient's suicidal ideation, anxiety, and depression.</p>		
<p><u>Core case</u>: Sandy Wilson is 19-year-old college student she was brought to the emergency room by her roommate. She is intoxicated and according to the roommate, she was upset about her grade in chemistry 30A. She took 10 mgs of valium, and drank several wine coolers. Her roommate Sally told the nurse that she kept passing out on the way to the hospital and she was very difficult to arouse. The roommate stated that while Sandy was drinking she kept making jokes about passing out and dying. Sandy also called her boyfriend and was heard telling him, "I am going to drink until I die and then you will be sorry when I am gone." This case transitions from the ER to the psychiatric unit. Pt is placed on a 5150 for danger to self. The patient has an IV and the following labs are done: ETOH level, drug screen, CBC, Chem 7, UA pregnancy test, and a Liver Panel.</p>		
<p><u>QSEN Competencies</u>:</p> <p>Safety</p> <p>Patient Centered Care</p> <p>Teamwork and Collaboration</p>		
<p><u>Brief Summary of Case</u>:</p> <p>Sandy is in her second year of college and according to her roommate, she drinks a lot when she is upset about grades or conflicts with her boyfriend. Recently the roommate has noticed that Sandy is drinking every day approximately 8 to 12 wine coolers a day. The patient has a history of anorexia nervosa and cutting. The patient's mood is labile and she has made several statements about drinking until she dies. This case starts with admission in the ER and progress to the unit. In addition to passive suicidal ideation the patient is withdrawing from alcohol.</p>		

REFERENCES

Mohr, W. K. (2009). Psychiatric Mental-health Nursing: Evidence-Based Concepts, Skills, and Practices, (7th ed.), Philadelphia: Lippincott.

SECTION II: CURRICULUM INTEGRATION SCENARIO LEARNING OBJECTIVES	
Learning Outcomes	
Provide patient care that promotes safety	
Use therapeutic communication techniques as defined by the APNA and ISPN	
Integrate understanding of multiple dimensions of patient centered care	
Communicate effectively with nursing and members of inter-professional team.	
Specific Learning Objectives	
Introduce him or herself and explain purpose of the interview	
Establish patient's reason for seeking treatment (chief complaint)	
Establish current symptoms (including onset, duration, and severity of symptoms)	
Review Past psychiatric and medical history	
Reviews alcohol and substance use (current and past)	
Conduct an alcohol withdrawal assessment	
Assess for psychological stressors which maybe a contributing factor to patient's current symptoms	
Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language)	
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	
Assess patient's knowledge of medications and provide medication teaching	
Critical Learner Actions	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Assesses for psychosocial stressors that maybe contributing factors to current symptoms	
Assess patient's current mood (anxiety, depression, feelings of hopelessness etc.)	
Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)	
Assess patient's though process delusional thinking auditory or visual hallucinations (AH, VH).	
Assesses for history of self-harm behavior i.e. cutting, burning, skin picking	
Assess for history of suicidal ideation or suicide attempts	
Assess patient for current suicidal ideation (if pt has past history of suicide attempt explore lethality of the attempt)	
If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)	
Assess patient's ability to contract for safety	
As case unfolds assess patients current status and provide appropriate teaching	

PRE-SCENARIO KNOWLEDGE AND EXPECTED SKILLS AND BEHAVIORS	
Prerequisite Knowledge Required Prior to Simulations	Skills and Attitudes Exhibited During the Simulation
Nursing Process Components of Psychiatric Assessment Therapeutic Communication Alcohol withdrawal protocol (CIWA)	Conducts psychiatric assessment: includes assessment of mood, thought content, orientation, audio and visual hallucinations (AV, HV), suicidal ideation (SI), prior suicide attempts (SA), and ability to contract for safety
Therapeutic communication techniques as defined by the APNA and ISPN.	Recognizes significance of abnormal assessment findings, including safety assessment, and makes appropriate referrals.
Patient teaching related to psychiatric medications.	Utilizes therapeutic communication skills during patient interview to collect assessment data and provide patient teaching.
Structured Communication Tools (SBAR)	Request assistance, as needed, based on assessment data and gives SBAR report to MD, RN, or other appropriate team member.

SECTION III: SCENARIO SCRIPT

Case Summary

Sandy Wilson was brought in by her roommate her blood ETOH level is 0.2 she is somnolent and but responds to stimuli. She has an IV of 0.9 NS with 100 mg thiamine, 1 mg of folic acid, and one amp of multivitamins running at 125 an hour.

Sandy is dressed in a hospital gown lying in bed in the emergency room. She has an IV in her left AC; she appears to be asleep but awakens when spoken too by the ER staff. Labs have been drawn. Her assessment cannot be completed until she is more coherent. She is monitored closely using the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA) as ordered by Dr. Rued. Several hours later, she is awake and angry. She yells at the nurses, demands to be released, and calls her boyfriend and is heard screaming obscenities at him over the phone. The patient is placed on a 5150 in response to several statements she made requesting staff to let her alone "so I can die."

Day one of the case:

The student nurse receives report from pervious nurse and conducts the admission assessment.

During the assessment, the patient denies SI and then makes passive statements such as "They will be sorry when I am dead." The patient refuses to all the staff to contact her family or to speak with her boyfriend. Sandy's roommate has called the resident advisor (RA) and they are unwilling to all her back into the dorms until she receives counseling and treatment. She agrees to talk to and then refuses to sign the consent for the doctor to speak with the RA. The patient's mood is labile, alternating between tearful remorse, angry denial, demanding, and bargaining. (The student nurse will need to set firm limits during the assessment as the patient attempt to leave the emergency department against medical advice).

The case unfolds:

Day two of the hospitalization:

Patient is having significant withdrawal symptoms. Patient's mood is labile mood, demanding angry, bargaining with passive SI. During the morning she threw her breakfast tray across the room (no one was injured). She was given 5 mg of Librium. Her vital signs were Blood Pressure 180/100, Pulse 110, and Respirations 20. She is diaphoretic, irritable, and fine upper extremity tremors.

During the assessment with the student nurse, she demands to leave the hospital against medical advice (AMA). The student nurse explains to Sandy that she is a 5150. The patient becomes argumentative and begins yelling at the nurse. If nurse set appropriate limits then the patient calms down.

The Case unfolds:

Day five of the hospitalization:

Patient has been placed on a 5250 after she superficially cut both forearms with a pair of scissors that she stole from the occupational therapist. During the assessment, the patient is tearful and embarrassed she tells the nurse that she is considering dropping out of school; she states that she wishes she were dead because her parents are going to "kill her". The patient tells the nurse that she started drinking when she was 13 years old. She admitted that she has been drinking heavily for several years. The patient tells the nurse that she does not want to return to school and she does not want to go live with her parents.

The Case unfolds:

The patient is ready to be discharged to a sober living treatment center. She is on the phone with her mother when the nurse enters the room to do the assessment. The patient is yelling at her mom. The patient says, "What do you mean you are not going to provide me with any spending money while I am in the program?" The patient then begins cursing at her mother. The patient yells, "Mom you better send me some money because it is all your fault. (there is a pause as the patient listens to her mom). The patient then yells, "Of course it is your fault who do you think was my role model you and dad are both a couple of drunks." The patient then slams the phone down and kicks the chair. (at this point she notices the nurse) If the nurse interrupts the patient's phone call the patient will begin yelling at the nurse. The nurse will need to set limits on the patient's behavior before conducting the assessment and doing discharge teaching.

Key Contextual Details

The patient has a history of cutting, anorexia nervosa, and started drinking when she was thirteen. The patient's parents are also reported to be heavy drinkers. The patient has a volatile relationship with her boyfriend and parents she threatens to kill herself when she is upset or when she does not get what she wants.

Scenario Cast

Role	Brief Descriptor	Confederate (C) or Learner (L)
RN 1	Reports on pt's current condition	Confederate (instructor or learner)
RN 2	Assumes care of the patient	Learner
Standardized patient	Volunteer portraying psychiatric patient	Confederate (volunteer standardized patient)
Nursing Assistant	Remains with pt until RN arrives in the room	Confederate (faculty or learner)

Patient Profile				
Last name: Wilson			First name: Sandy	
Gender: Female	Age: 19	Ht: 5’2”	Wt: 120#	Code Status: Full
Spiritual Practice: None stated		Ethnicity: Caucasian		Primary Language English
History Of Present Illness				
Patient has history of alcohol abuse. She became suicidal after receiving a failing grade in one of her courses and having a fight with her boyfriend				
Primary Medical Diagnosis		Alcohol abuse with SI, borderline personality disorder		

Review of Systems				
CNS	Oriented to person, place and time			
Cardiovascular	Heart rate elevated due to ETOH withdrawal			
Pulmonary	Lungs clear			
Renal/Hepatic	Liver panel labs pending			
Gastrointestinal	No c/o NV			
Musculoskeletal	No pain or swelling			
Integument	Skin intact			
Psychiatric Hx	Hospitalized age 16 for anorexia nervosa, history of cutting. Patient is being treated by psychologist for anxiety and depression			
Social Hx	College sophomore lives in campus housing, has a boyfriend			
Other				
Current medications	Drug	Dose	Route	Frequency
	Valium	15 mg	PO	PRN for anxiety
	Zoloft	150 mg	PO	QHS
NKDA				

4. Laboratory and Diagnostic Study Results					
Na: 138	K: 3.8	Cl: 100	HCO3: 24	BUN: 12	Cr: 0.8
Ca: 9.0	Mg:	Phos: 3.5	Glucose: 98	Drug screen: + THC & Valium	
Hgb: 11.2	Hct: 32	Plt: 145	WBC: 12.4	Pregnancy test negative	
Alk Phos 91	AST 38	ALT 48			

Standardized Patient State (This may vary from the baseline data provided to learners)					
Initial Physical Appearance					
Gender: female		Attire: hospital gown			
Appearance and setting: 19 year old female Appears stated age wearing hospital gown					
X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable

Initial Vital Signs Monitor Display In Simulation Action Room						
No monitor display	Monitor on, but no data displayed		X	Monitor on, standard display	x	Blood pressure machine and stethoscope in room
BP: 118/78	HR: 70	RR: 16	T: 97.0 F.		Sp O2: 94% on RA	

Environment, Equipment, Essential Props Standardized setup for each simulation							
Scenario Setting							
This case begins in the emergency room and transitions to the psychiatric unit							
Equipment, supplies, monitors							
x	Blood pressure machine	x	Stethoscope	x	Water Pitcher and glass	x	Bedside monitor
Documentation and Order Forms							
x	MD orders	x	Med Admin Record	x	H & P	x	Lab Results
x	Actual medical record binder			x	CIWA Flow Sheet		

Debriefing Guide
Postsimulation Debriefing Questions with Video Recording
<p>What went well during the interview with the patient?</p> <p>What are or is the rationale behind the question (s) you asked? (This question may be used to discuss a specific question or behavior that took place in the simulation).</p> <p>Was the decision effective or appropriate?</p> <p>What were the outcomes of the decision?</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting?</p>
Insimulation Debriefing Questions with Video Recording
<p>Use these questions if the simulation is progressing appropriately.</p> <p>What additional questions do you need to ask the patient?</p> <p>What were you thinking when the patient said she or he wanted to die?</p> <p>Think about what just went on in the last 5 minutes. What would you like to do over?</p> <p>If the student is using nontherapeutic communication, ask this question. How could you have phrased that question differently?</p> <p>If the student has forgotten a key component of the psychiatric assessment, ask these questions. What additional information do you need to gather?</p> <p>What do you need to know to provide for patient safety?</p> <p>Postsimulation Debriefing Questions</p> <p>What went well during the interview with the patient</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting?</p>

Health Care Provider Orders
(Provided To Student in Patient's Chart)

Physician Orders Day One from the Emergency Room

Patient Name: Sandy Wilson DOB: 6-17-95 Age: 19 MR#: 5557892		
<input type="checkbox"/> No Known <input type="checkbox"/> Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
	1730	1 to 1 supervision, pt is on 5050, Danger to self
	1800	Labs, CBC, TOX Screen, Chem Panel, UA, Liver function, Pregnancy test
	1830	5150 danger to self
	1830	CIWA protocol A. Vitals, Assessment Now. B. If initial score eight repeat q1h x eight hrs, then if stable q2h x eight hrs, then if stable q4h. C. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs, d/c assessment. If score eight at any time, go to (b) above.
	1830	10 mg Librium po for CIWA score of 8 or greater not to exceed 600 mg in 24 hours CIWA score 24 or greater notify MD immediately
	2100	Transfer to 2 west psychiatric unit as soon as a bed is available
		S. Rued MD

History and Physical

Chief Complaint:

Intoxication with suicidal ideation

History of Present Illness:

Patient received a failing grade and had a fight with her boyfriend. She then went to her dorm room took 10 mg of Valium and drink several wine coolers. Her roommate became concerned when the patient started saying that she wanted to die. The roommate brought her to the ER.

Surgical History:

None

Medical History:

No significant medical history

Family History:

Both parents are heavy drinkers; Mother has been treated for ETOH abuse

Allergies:

NKDA

Medications:

Valium 10 mg prn for anxiety

Zoloft 150 mg q HS

Review of Systems:

Eyes - no changes in vision, double vision, blurry vision, wears glasses

ENT - No congestion, changes in hearing

Skin- clean dry and intact

Cardiovascular - No SOB, chest pain, heart palpitations

Pulmonary - lungs clear

Endocrine - Decreased appetite last two weeks

Gastrointestinal - No n/v/d or constipation

Genitourinary - No increased frequency or pain on urination.

Musculoskeletal - moves all extremities

Neurologic - No changes in memory

Psychological - History of cutting, treated for anorexia nervosa at age 16. Currently seeing a psychologist for depression and anxiety.

Assessment:

19 year old college student with a history of depression and anxiety no significant medical issues, currently intoxicated.

Axis I

293.20 Major Depression

350.00 ETOH Abuse

Axis II

301.83 Borderline Personality Disorder

Axis III

350.00 ETOH Abuse

Axis IV

Relationship stressors, failing grades in college

Axis V

GAF = 50(current)

Plan:

Labs:

CBC, Chem 7, and Drug Screen, liver function, UA, Pregnancy test

CIWA protocol

Admit to the psychiatric unit on a 5150 pt is a danger to self.

Insimulation Debriefing

The objective for the in-simulation debriefing is to provide clues that enable the student to recall prior knowledge or to assist the student by modeling appropriate communication and assessment techniques before resuming the simulation.

Use these questions if the simulation is progressing appropriately.

- What additional questions do you need to ask the patient?
- What were you thinking when the patient said she or he wanted to die?
- Think about what just went on in the last 5 minutes. What would you like to do over?

Use these questions if the student is having difficulty with the assessment or therapeutic communication.

If the student is using nontherapeutic communication, ask this question.

- How could you have phrased that question differently?

If the student has forgotten a key component of the psychiatric assessment, ask these questions.

- What additional information do you need to gather?
- What do you need to know to provide for patient safety?

Postsimulation Debriefing Questions

- What went well during the interview with the patient?
- What would you change, if anything, in the future?
- What have you learned today, that will help you care for patients in the clinical setting?

Case Four SCENARIO OVERVIEW

Scenario Title:	Major Depression Single Episode		
Original Scenario Developer(s):	Debrayh Gaylle, MS, RN		
<u>Estimated Scenario Time:</u> 10-15 min.		<u>Debriefing time:</u> 20-30 min. (postsimulation only). Insimulation debriefing will increase simulation time to approximately 20 minutes.	
<u>Target group:</u> Undergraduate nursing students preparing to participate in a psychiatric mental-health clinical rotation. Students will use therapeutic communication techniques to: Conduct a psychiatric assessment. Recognize and respond to patient's suicidal ideation, anxiety, and depression.			
<u>Core case:</u> William Hook an 89-year-old retired schoolteacher. His wife passed away 4 weeks ago and he has lost interest in all his hobbies and activities. His daughter convinced him to seek help when she came to visit this afternoon and found her dad in bed where the same clothes that he had worn to church on Sunday.			
<u>QSEN Competencies:</u> Safety Patient Centered Care Teamwork and Collaboration			
<u>Brief Summary of Case:</u> Mr. Hook affect is flat and his mood is depressed. He reports having no energy and he spends most of his time in bed. His appetite is decreased and he has lost 15 pounds in the last four weeks. He told his pastor that without his wife Ruth life no longer has any meaning.			

REFERENCES

- Cronenwett, L., Sherwood, G., Bransteiner, J., Disch, J., Johnson, J., Mitchell, P., Sullivan, D. T., & Warren, J. (2007). Quality and safety education for nurse. *Nurse Outlook* 122-131.
- Mohr, W. K. (2009). *Psychiatric Mental-health Nursing: Evidence-Based Concepts, Skills, and Practices*, (7th ed.), Philadelphia: Lippincott

SECTION II: CURRICULUM INTEGRATION SCENARIO LEARNING OBJECTIVES	
Learning Outcomes	
Provide patient care that promotes safety	
Student will use therapeutic communication techniques as defined by the APNA and ISPN	
Integrate understanding of multiple dimensions of patient centered care	
Communicate effectively with nursing and members of inter-professional team.	
Specific Learning Objectives	
Introduce him or herself and explain purpose of the interview	
Establish patient's reason for seeking treatment (chief complaint)	
Establish current symptoms (including onset, duration, and severity of symptoms)	
Review Past psychiatric and medical history	
Reviews alcohol and substance use (current and past)	
Assess for psychological stressors which maybe a contributing factor to patient's current symptoms	
Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language)	
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	
Assess patient's knowledge of medications and provide medication teaching	
Critical Learner Actions	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Review and assess onset, duration, and severity of current symptoms	
Review prior hospitalizations including medical and psychiatric history	
Assesses for psychosocial stressors that maybe contributing factors to current symptoms	
Assess patient's current mood (anxiety, depression, feelings of hopelessness etc.)	
Assess current mental status (oriented to place, time, and situation, speech is logical and congruent with body language)	
Assess patient's though process delusional thinking auditory or visual hallucinations (AH, VH).	
Assesses for history of self-harm behavior i.e. cutting, burning, skin picking	
Assess for history of suicidal ideation or suicide attempts	
Assess patient for current suicidal ideation (if pt has past history of suicide attempt explore lethality of the attempt)	
If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means)	
Assess patient's ability to contract for safety	
As case unfolds assess patients current status and provide appropriate teaching	

PRE-SCENARIO KNOWLEDGE AND EXPECTED SKILLS AND BEHAVIORS	
Prerequisite Knowledge Required Prior to Simulations	Skills and Attitudes Exhibited During the Simulation
Nursing Process Components of Psychiatric Assessment Therapeutic Communication Knowledge of SPICES	Conducts psychiatric assessment: includes assessment of mood, thought content, orientation, audio and visual hallucinations (AV, HV), suicidal ideation (SI), prior suicide attempts (SA), and ability to contract for safety
Therapeutic communication techniques as defined by the APNA and ISPN	Recognizes significance of abnormal assessment findings, including safety assessment, and makes appropriate referrals
Patient teaching related to psychiatric medications.	Utilizes therapeutic communication skills during patient interview to collect assessment data and provide patient teaching
Structured Communication Tools (SBAR)	Request assistance, as needed, based on assessment data and gives SBAR report to MD, RN, or other appropriate team member

SECTION III: SCENARIO SCRIPT

Case summary

Mr. Hook is 89 year old retired school teacher two months ago his wife of Ruth passed away. Ruth and Bill had been married for 65 years. Bill has two children a son who lives in New Orleans and a daughter who lives a few miles from her dad. Bill's daughter drove him to church on Sunday and 2 days later, when she visited her dad she found him in bed wearing the same clothes that he wore to church. Bill told his daughter that he was praying that God would take him soon because life without Ruth was unbearable.

Bill has become increasingly depressed over the past 2 months. He feels miserable and no longer enjoys reading or gardening. He feels irritated and restless when in the company of his daughter or friends. He has no energy, finds everything a struggle. He spends most of the day just lying in bed. He has a poor appetite for food and sometimes does not eat. He sleeps poorly at night and finds himself falling asleep during the day. He cannot see anything to look forward to in the future and thinks that life is not worth living now that Ruth has passed. He denies any suicidal intent, however he admits to praying to God to let him die.

Day one of the case: (scenario one)

Bill's daughter convinces him to seek treatment and takes her father to a local hospital that specializes in helping older adults with depression. Bill talks with the doctor and agrees to be admitted as a voluntary patient. After the doctor has completed her assessment the nurse comes into complete the admission process.

The case unfolds: (scenario two)

Bill has been in the hospital for 4 days and he is not feeling any better. The nurse has to encourage him to get out of bed in the morning. His appetite is still poor. He attends the groups but does not actively participate. The doctor has started him on a low dose of Paxil but he is having difficulty with the side effects. Bill tells the nurse that he is frustrated and angry. The nurse conducts his or her assessment. At the conclusion of the assessment process, the nurse encourages Bill to talk about his life with Ruth.

The Case unfolds: (scenario three)

Bill has been hospitalized for 10 days and he has shown slight improvement in his overall mood. This morning he woke up complaining of shortness of breath and chest pain. The doctor was called and she ordered a STAT EKG and cardiac labs. The EKG showed normal sinus rhythm with no changes from Bill's baseline. The cardiac labs also came back normal. However, Bill continued to complain that he felt like he could not breathe. The doctor concluded that Bill was having a panic attack and order Ativan 0.5 mg STAT. The medication was effective. However, Bill continued to insist that there was something wrong with his heart. He denied feeling anxious and became angry and agitated. He told the nurse "You just think I am a crazy old man." In addition to the standard psychiatric assessment, the nurse needs to provide Bill with some information on depression and anxiety.

The Case unfolds: (scenario four)

Bill has been in the hospital for 14 days. He has started participating in groups activities and his mood is improved. The doctor spoke with him about a possible discharge within the next two days. After meeting with the doctor, Bill began to complain about chest pain and shortness of breath. A STAT EKG and cardiac labs were completed and again the results were within normal limits. When the nurse did his or her assessment after this event, Bill stated that he was reluctant to go home. In addition to the standard psychiatric assessment the nurse needs to encourage Bill to explore his reluctance to be discharge home.

Key Contextual Details				
Patient no history of mental illness and no significant medical issues. Patient became depressed after his wife of 65 years passed away.				
Scenario Cast				
Role		Brief Descriptor		Confederate (C) or Learner (L)
RN 1		Reports on pt's current condition		Confederate (instructor or learner)
RN 2		Assumes care of the patient		Learner
Standardized patient		Volunteer portraying psychiatric patient		Confederate (volunteer standardized patient)
Patient Profile				
Last name: Hook			First name: William	
Gender: Male	Age: 89	Ht: 6'2"	Wt: 160#	Code Status: Full
Spiritual Practice: None stated		Ethnicity: Any		Primary Language spoken: English
History of Present Illness				
Bill is an 89 year old male with depression and passive SI				
Primary Medical Diagnosis		Depression single episode		

Review of Systems	
CNS	Anxious, alert and oriented to person, place, time and situation
Cardiovascular	Sinus rhythm 96; no murmurs, thrills B/P 110/75
Pulmonary	RR-28, O2 saturation (SAT) 98% Room air (RA), Lungs clear
Renal/Hepatic	No complaints of urinary difficulties
Gastrointestinal	Bowel habits once daily
Musculoskeletal	Moves all extremities
Integument	Clear and intact
Psychiatric Hx	Depression single episode
Social Hx	Lives alone
Other	Occasionally drinks a glass of wine

Current Medications					
Drug	Dose	Route	Frequency		
ASA	81 mg tab	oral	Every morning		
Ibuprofen	1 tab	oral	Occasional use for headache		
Laboratory and Diagnostic Study Results					
Na: 138	K: 3.8	Cl: 100	HCO3: 24	BUN: 14	Cr: 0.8
Ca: 9.0	Mg:	Phos:3.5	Glucose: 98		
Hgb: 11.2	Hct: 32	Plt: 145	WBC: 12.4		

Standardized Patient State (This may vary as scenario unfolds)					
Initial Physical Appearance					
Gender: male		Attire: slacks and dress shirt			
Clothing is clean but rumpled Scenario one patient is setting in the interview room. He has a flat affect with a depressed mood his thought process in linear, speech is slowed and he has significant psychomotor retardation. As the case unfolds patient changes from slacks to sweat pants and then back into slacks and a dress shirt.					
X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
X	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable
Initial Vital Signs or Monitor Display					
x	No monitor display		Monitor on, but no data displayed		Monitor on, standard display
BP: 110/80		HR: 90	RR: 24	T: 97.0 F.	
				Sp O2: 94% on RA	

Environment, Equipment, Essential Props Standardized setup for each simulation							
Scenario setting							
Interview room with table with two chairs (see each scenario for additional props) iPod, newspaper, hospital gowns							
Equipment, supplies, monitors							
x	Blood pressure machine		Stethoscope	x	Water Pitcher and glass		
Documentation and Order Forms							
x	MD orders	x	Med Admin Record	x	H & P	x	Lab Results

Debriefing Guide
Postsimulation Debriefing Questions with Video Recording
<p>What went well during the interview with the patient</p> <p>What are or is the rationale behind the question (s) you asked? (This question may be used to discuss a specific question or behavior that took place in the simulation).</p> <p>Was the decision effective or appropriate?</p> <p>What were the outcomes of the decision?</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting</p>
Insimulation Debriefing Questions with Video Recording
<p><i>Use these questions if the simulation is progressing appropriately.</i></p> <p>What additional questions do you need to ask the patient?</p> <p>What were you thinking when the patient said _____?</p> <p>Think about what just went on in the last 5 minutes. What would you like to do over?</p> <p><i>If the student is using nontherapeutic communication, ask this question.</i></p> <p>How could you have phrased that question differently?</p> <p><i>If the student has forgotten a key component of the psychiatric assessment, ask these questions.</i></p> <p>What additional information do you need to gather?</p> <p>What do you need to know to provide for patient safety?</p> <p><i>Postsimulation Debriefing Questions</i></p> <p>What went well during the interview with the patient</p> <p>What would you change, if anything, in the future?</p> <p>What have you learned today, that will help you care for patients in the clinical setting?</p>

History and Physical
(Provided to the Student as Part of the Chart)

Chief Complaint:

Lack of energy, loss of appetite, depression and anxiety

History of Present Illness:

89 year old male in no apparent physical distress complains of low energy levels, poor sleep and loss of appetite. He has lost 15 pounds in the last two months

Surgical History:

None

Medical History:

No significant medical history

Family History:

Older brother no significant medical history

Father +asthma

Mother + DM 2

Allergies:

NKDA

Medications:

ASA 81 mg Q AM

Review of Systems:

Eyes - no changes in vision, double vision, blurry vision, wears glasses

ENT - No congestion, hard of hearing wears hearing aids

Skin/- no rashes

Cardiovascular - No SOB, chest pain, heart palpitations

Pulmonary - lungs clear,

Endocrine - No appetite

Gastrointestinal - No n/v/d or constipation

Genitourinary - No increased frequency or pain on urination.

Musculoskeletal - Arthritis in knees and hands

Neurologic - No changes in memory

Psychological - passive SI and depression.

Assessment:

89 year old male with passive SI and depression. No prior history of mental illness

Axis I

Major depression single episode

Axis II

Deferred

Axis III

None

Axis IV

Social isolation

Axis V

GAF = 35 (current)

Plan:

Labs:

CBC, Chem 7,

Restart:

Start Paxil 5 mg po QD

Admit to geriatric psychiatric unit as a voluntary patient

Case Four Scenario One

Student Objectives:

Student will conduct a 10-to-15-minute interview and psychiatric assessment.

Student will use therapeutic communication techniques as defined by the APNA and ISPN.

Student will conduct a psychiatric assessment that includes the following components as appropriate to the each scenario:

Introduce him or herself and explain purpose of the interview	Establish patient's reason for seeking treatment (chief complaint) Assess for hallucinations.
Establish current symptoms (including onset, duration, and severity of symptoms).	If patient is currently, experiencing hallucinations assess type (audio, visual, tactile) and content (command, pleasant, negative).
Reviews prior hospitalizations and current and past medical history.	Review past psychiatric and medical history.
Assess patient's current mood (depression, anxiety, feelings of hopelessness etc.)	Assess patient's current thought process (oriented to place, time, situation, speech is logical and congruent with body language).
Reviews alcohol and substance use (current and past).	If patient has history of substance use establish date last used.
Assess patient's history of self-harm (cutting, burning, skin picking or suicidal ideation or attempts).	Assess for current suicidal ideation.
If patient has current thoughts of suicide assess plan and level of risk (passive death wish, vague plan, or detailed plan with access to lethal means).	If patient has a history of suicide attempts assess lethality of the attempt.
Establish patient's willingness to contract for safety.	Conclude the interview and give report to appropriate team members.

Note: Detailed flowsheets for case two, three, and four are not included in this document. They are available by request from the author.

Appendix J

Consent to Videotape

CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE A STUDENT DURING
SIMULATION

Student Name: _____

PLEASE PRINT

I hereby consent to the participation in simulation and the use of quotes and the taking of
photographs or video tapes of the Student named above.

I also grant to the right to edit, use, and reuse said photographs or video tapes for educational and
research purposes. I also hereby release the [REDACTED]
[REDACTED] and its agents and employees from all claims, demands, and liabilities
whatsoever in connection with the above.

Student Signature: _____

Date: _____

Appendix K

Invitation to Participate in Research

Informed Consent and Research Subjects Bill of Rights

Dear [REDACTED] Students

You are invited to participate in a study investigating the effects of two different debriefing styles during simulations that teach psychiatric assessment and therapeutic communication. The researcher is interested in understanding the how students learn from two different styles of debriefing. You are being asked to participate because you preparing for a psychiatric clinical.

You will be asked to participate in simulated interviews with standardized patient volunteers. The standardized patients will be playing the role of a mentally ill person. You will be asked to complete a pre-test and a post-test of knowledge related to psychiatric assessment and therapeutic communication. You will complete pre-simulation and post-simulation questionnaires. The simulations will use two debriefing styles, the traditional post-simulation debriefing currently used in [REDACTED] and in-simulation debriefing. During in-simulation debriefing the research will call brief timeouts during the simulation to provide coaching and feedback.

It is possible that some portions of the simulation experience or questionnaires may make me feel uncomfortable, you free to decline to answer any questions or to stop participation at any time. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only the researcher will have access to the files.

The anticipated benefit of this study is decreased anxiety related to working with mentally ill clients and a better understanding of therapeutic communication and psychiatric assessment.

Participation in the study is not required for participation in the simulation experience. All students preparing for or enrolled in a psychiatric clinical can participate in the simulation activity.

The results of this study maybe published, no information that can identify you will be included in the publication. Please reply to this email for more information concerning dates and times of the simulations.

Thank you

Debrayh Gaylle
[REDACTED]

Agreement to Participate in Research Responsible Investigator Debrayh Gayle, RN, MS

Title of Study: Effects Of A Mental-Health Clinical Simulation Experience Using Standardized Patients And Two Debriefing Styles On Prelicensure Nursing Students' Knowledge, Anxiety, And Therapeutic Communication And Psychiatric Assessment Skills

1. You have been asked to participate in this study investigating the effects of two different debriefing styles during simulations that teach psychiatric assessment and therapeutic communication. The researcher is interested in understanding the how students learn from two different styles of debriefing. You are being asked to participate because you preparing for a psychiatric clinical.

2. You will be asked to participate in simulated interviews with standardized patient volunteers. The standardized patients will be playing the role of a mentally ill person. You will be asked to complete a pre-test and a post-test of knowledge related to psychiatric assessment and therapeutic communication. You will complete pre-simulation and post-simulation questionnaires. The simulations will use two debriefing styles, the traditional post-simulation debriefing currently used in [REDACTED] and in-simulation debriefing. During in-simulation debriefing the research will call brief timeouts during the simulation to provide coaching and feedback.

3. It is possible that some portions of the simulation experience or questionnaires may make me feel uncomfortable, you free to decline to answer any questions or to stop participation at any

time. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only the researcher will have access to the files.

4. The anticipated benefit of this study is decreased anxiety related to working with mentally ill clients and a better understanding of therapeutic communication and psychiatric assessment.
5. Participation in the r study is not required for participation in the simulation experience. All students preparing for or enrolled in a psychiatric clinical can participate in the simulation activity.
6. The results of this study maybe published, no information that can identify you will be included in the publication.
7. All participants in this study will have their names entered into a drawing for a Littman stethoscope, a drug book, and iTunes gift card. Snacks will be provided during the simulation activities.
8. Questions about this research may be addressed to [REDACTED]
[REDACTED]
[REDACTED]. Questions about a research subjects' rights, or research-

related injury may be presented to [REDACTED]

9. No service of any kind, to which you are otherwise entitled, will be lost or jeopardized if you choose not to participate in the study.

10. Your consent is being given voluntarily. You may refuse to participate in the entire study or in any part of the study. If you decide to participate in the study, you are free to withdraw at any time without any negative effect on your relations [REDACTED]

[REDACTED] School of nursing.

11. At the time that you sign this consent form, you will receive a copy of it for your records, signed and dated by the investigator.

12. The signature of a subject on this document indicates agreement to participate in the study.

Participants Signature:

Date:

Investigators Signature:

Date:

INFORMED CONSENT FORM
UNIVERSITY OF SAN FRANCISCO
CONSENT TO BE A RESEARCH SUBJECT

Purpose and Background

Ms. Debrayh Gaylle, a graduate student in the School of Education at the University of San Francisco, is doing a study on the effects of Simulation with Standardized Patients to teach psychiatric assessment and therapeutic communication. Simulation has become a standard of practice in many schools of nursing. The researchers are interested in understanding the how nursing students respond to and learn from working with standardized patients as a method to prepare for working with mentally ill persons in the psychiatric clinical setting. Additionally, the researcher will be comparing two styles of debriefing insimulation debriefing and postsimulation debriefing.

I am being asked to participate because I am a nursing student in the 5th semester preparing to work with mentally-ill persons in a psychiatric clinical setting.

Procedures

1. I will complete a short questionnaire giving basic information about me, including age, and prior experience with working with mentally ill clients.
2. I will complete a 30 item pretest and posttest on therapeutic communication and psychiatric assessment.
3. I will complete answer 5 reflective questions working with mentally ill patients. Before and the conclusion of the simulation experience.
4. I will complete a short survey and answer 3 questions related to the simulation experience at the conclusion of the simulations
5. I will participate in four interview with a standardized patient, during which I will use therapeutic communication techniques to perform a psychiatric assessment.
6. I will participate in a debriefing sessions.

All activities will take place at

[REDACTED]

Risks and or Discomforts

1. It is possible that some of the questions on the anxiety and working with mentally ill patients may make me feel uncomfortable, but I am free to decline to answer any questions I do not wish to answer or to stop participation at any time.
2. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only study personnel will have access to the files.

3. Because the time required for my participation day one and day two may be up to 5 hours, I may become tired or bored.

Benefits

The anticipated benefit of this study is a better understanding of therapeutic communication and psychiatric assessment.

Costs/Financial Considerations

There will be no financial costs to me as a result of taking part in this study.

Payment/Reimbursement

I will my name will be entered into a drawing for an iTunes gift card. I will receive my gift card at the completion of the study. If I decide to withdraw from the study before I have completed participating or the researchers decide to terminate my study participation, I will still be entered in the drawing

Questions

I have talked to Ms Gaylle about this study and have had my questions answered. If I have further questions about the study, I may call her at [REDACTED].

If I have any questions or comments about participation in this study, I should first talk with the researcher. If for some reason I do not wish to do this, I may contact the IRBPHS, which is concerned with protection of volunteers in research projects. I may reach the IRBPHS office by calling (415) 422-6091 and leaving a voicemail message, by e-mailing IRBPHS@usfca.edu, or by writing to the IRBPHS, Counseling and Psychology department, School of Education, University of San Francisco, and 2130 Fulton Street, San Francisco, CA 94117-1080.

Consent

I have been given a copy of the "Research Subject's Bill of Rights" and I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as a student or employee at [REDACTED].

My signature below indicates that I agree to participate in this study.

Subject's Signature

Date of Signature

Signature of Person Obtaining Consent

Date of Signature

RESEARCH SUBJECTS BILL OF RIGHTS

Research subjects can expect:

5. To be told the extent to which confidentiality of records identifying the subject will be maintained and of the possibility that specified individuals, internal and external regulatory agencies, or study sponsors may inspect information in the medical record specifically related to participation in the clinical trial.
6. To be told of any benefits that may reasonably be expected from the research.
7. To be told of any reasonably foreseeable discomforts or risks.
8. To be told of appropriate alternative procedures or courses of treatment that might be of benefit to the subject.
9. To be told of the procedures to be followed during the course of participation, especially those that are experimental in nature.
10. To be told that they may refuse to participate (participation is voluntary), and that declining to participate will not compromise access to services and will not result in penalty or loss of benefits to which the subject is otherwise entitled.
11. To be told about compensation and medical treatment if research related injury occurs and where further information may be obtained when participating in research involving more than minimal risk.
12. To be told whom to contact for answers to pertinent questions about the research, about the research subjects' rights and whom to contact in the event of a research-related injury to the subject.
13. To be told of anticipated circumstances under which the investigator without regard to the subject's consent may terminate the subject's participation.

- 14.To be told of any additional costs to the subject that may result from participation in the research.
- 15.To be told of the consequences of a subjects' decision to withdraw from the research and procedures for orderly termination of participation by the subject.
- 16.To be told that significant new findings developed during the course of the research that may relate to the subject's willingness to continue participation will be provided to the subject.
- 17.To be told the approximate number of subjects involved in the study.
- 18.To be told what the study is trying to find out;
- 19.To be told what will happen to me and whether any of the procedures, drugs, or devices are different from what would be used in standard practice;
- 20.To be told about the frequent and/or important risks, side effects, or discomforts of the things that will happen to me for research purposes;
- 21.To be told if I can expect any benefit from participating, and, if so, what the benefit might be;
- 22.To be told of the other choices I have and how they may be better or worse than being in the study; To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study;
- 23.To be told what sort of medical or psychological treatment is available if any complications arise;
- 24.To refuse to participate at all or to change my mind about participation after the study is started; if I were to make such a decision, it will not affect my right to receive the care or privileges I would receive if I were not in the study;
- 25.To receive a copy of the signed and dated consent form; and to be free of pressure when

considering whether I wish to agree to be in the study. If I have other questions, I should ask the researcher or the research assistant. In addition, I may contact the Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. I may reach the IRBPHS by calling (415) 422-6091, by electronic mail at IRBPHS@usfca.edu, or by writing to USF IRBPHS, Counseling Psychology Department, Education Building, 2130 Fulton Street, San Francisco, CA 94117-1071.

References: JCAHO and Research Regulatory Bodies

1. To be told what the study is trying to find out;
2. To be told what will happen to me and whether any of the procedures, drugs, or devices are different from what would be used in standard practice;
3. To be told about the frequent and/or important risks, side effects, or discomforts of the things that will happen to me for research purposes;
4. To be told if I can expect any benefit from participating, and, if so, what the benefit might be;
5. To be told of the other choices I have and how they may be better or worse than being in the study;
6. To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study;
7. To be told what sort of medical or psychological treatment is available if any complications arise;
8. To refuse to participate at all or to change my mind about participation after the study is started; if I were to make such a decision, it will not affect my right to receive the care or privileges I would receive if I were not in the study;

9. To receive a copy of the signed and dated consent form; and to be free of pressure when considering whether I wish to agree to be in the study. If I have other questions, I should ask the researcher or the research assistant. In addition, I may contact the Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. I may reach the IRBPHS by calling (415) 422-6091, by electronic mail at IRBPHS@usfca.edu or by writing to USF IRBPHS, Counseling Psychology Department, Education Building, 2130 Fulton Street, San Francisco, CA 94117-1071.