Nursing faculty teaching resource

EDUCATOR MASTER CONTENTS

Choose and distribute the pages

SBAR escalation call scenario. This master includes both support levels and both receiver cards using the original names and times. Choose one brief and worksheet pair and one receiver card for a round. It does not include website customizations.

Fictional scenario for formative communication practice. Not clinical guidance or a validated assessment. Confirm the facts and response pathway against your local policy before teaching.

Written for US practice settings; adapt terms and policies for your setting.

How to use this master

- Give the nurse learner one selected brief and worksheet pair. Keep the other support version with the instructor.
- Give the receiver only the chosen role card. Keep the unused card with the instructor.
- Keep the update card with the receiver until the initial decision is stated; then give it to the caller.
- Give the observer all reference pages and the worksheet. Use one worksheet for both attempts by the same nurse learner.
- Keep the guide and model answer with the instructor until debrief. The master is not a student handout.

Contents

Pages	Material
2-3	Guided nurse brief and worksheet
4-5	Unguided nurse brief and worksheet
6	Cooperative receiver card
7	Initially unavailable receiver card
8	Call update card
9-11	Observer references and worksheet
12-18	Instructor guide

The guide illustrates the “initially unavailable” receiver. Both cards use the same facts and response pathway. Accept equivalent wording; keep the receiver’s availability consistent across retries.

The editable Word version allows local adaptation. Review changes to the clinical facts and response pathway; label copies with editor and date. Page counts may change after editing.

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GUIDED LEARNER | CALLING NURSE CASE BRIEF

Recognize the change

It is 1:58 p.m. on 3 East. You are Lee Harmon, RN, caring for Robert Hayes. You have just found the change below. The charge nurse is available nearby, but no emergency call has yet been made. Compare the trend and decide what help is needed immediately.

> **Your task in two stages**
>
> First, state your immediate nursing actions and how you will summon help. Then receive the call update card and make an SBAR call to the covering clinician. Confirm who will respond, when, and what happens if the patient worsens or help is delayed. Do not perform procedures or call real emergency numbers.

Patient / location	Robert Hayes, 67 years; fictional MRN 593824; 3 East, room 318
Admission	Hospital day 2 with pneumonia; receiving prescribed antibiotics.
History / status	Hypertension; no chronic lung disease or home oxygen use. No known medication allergies. Full code.
Respiratory change	Earlier: speaking in full sentences. Latest: more short of breath at rest, accessory-muscle use and short phrases; awake and responding.

Observation	Earlier: 1:30 p.m.	Latest: 1:58 p.m.
Respiratory rate	18/min	30/min
Oxygen saturation	96% on 2 L/min	89% on 2 L/min
Heart rate	88/min	118/min
Blood pressure	126/74 mmHg	104/64 mmHg
Temperature	100.8 °F (38.2 °C)	100.8 °F (38.2 °C)

The oximeter probe and signal have been checked; saturation remains 89% on 2 L/min by nasal cannula.

Exercise response pathway

For this exercise, severe breathing difficulty, saturation persistently below 90% despite oxygen, or serious staff concern requires immediate rapid response activation without provider permission. The standing emergency protocol authorizes nasal-cannula oxygen adjustment and continuous oximetry while help is summoned. Flow and target selection are not assessed.

If the patient becomes unresponsive and is not breathing normally (including only gasping), call the code team (local emergency response) and start BLS as trained; return to SBAR only when immediate care is covered.

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GUIDED LEARNER | SBAR WORKSHEET

Prepare and record the call

Initial decision

Which changes need action now? What will you do and who will you call for help?

S - Situation

Identify yourself, the patient, and the urgent problem.

B - Background

Which background and earlier findings explain the change?

A - Assessment

What do you think is wrong? Support the concern and acknowledge uncertainty.

R - Recommendation or request

Make a clear request with timing. If the clinician cannot attend, agree on an immediate alternative.

Communication note and reflection

After the call, record the time, findings reported, contact method and clinician role, actions underway, and actual agreement. Then name one change for your retry. Do not invent new orders or patient results.

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UNGUIDED LEARNER | CALLING NURSE CASE BRIEF

Recognize the change

It is 1:58 p.m. on 3 East. You are Lee Harmon, RN, caring for Robert Hayes. You have just found the change below. The charge nurse is available nearby, but no emergency call has yet been made.

> **Your task in two stages**
>
> First, state your immediate nursing actions and how you will summon help. Then receive the call update card and make an SBAR call to the covering clinician. Confirm who will respond, when, and what happens if the patient worsens or help is delayed. Do not perform procedures or call real emergency numbers.

Patient / location	Robert Hayes, 67 years; fictional MRN 593824; 3 East, room 318
Admission	Hospital day 2 with pneumonia; receiving prescribed antibiotics.
History / status	Hypertension; no chronic lung disease or home oxygen use. No known medication allergies. Full code.
Respiratory change	Earlier: speaking in full sentences. Latest: more short of breath at rest, accessory-muscle use and short phrases; awake and responding.

Observation	Earlier: 1:30 p.m.	Latest: 1:58 p.m.
Respiratory rate	18/min	30/min
Oxygen saturation	96% on 2 L/min	89% on 2 L/min
Heart rate	88/min	118/min
Blood pressure	126/74 mmHg	104/64 mmHg
Temperature	100.8 °F (38.2 °C)	100.8 °F (38.2 °C)

The oximeter probe and signal have been checked; saturation remains 89% on 2 L/min by nasal cannula.

Exercise response pathway

For this exercise, severe breathing difficulty, saturation persistently below 90% despite oxygen, or serious staff concern requires immediate rapid response activation without provider permission. The standing emergency protocol authorizes nasal-cannula oxygen adjustment and continuous oximetry while help is summoned. Flow and target selection are not assessed.

If the patient becomes unresponsive and is not breathing normally (including only gasping), call the code team (local emergency response) and start BLS as trained; return to SBAR only when immediate care is covered.

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UNGUIDED LEARNER | SBAR WORKSHEET

Prepare and record the call

Initial decision

State your immediate actions and escalation decision.

S - Situation

Your notes:

B - Background

Your notes:

A - Assessment

Your notes:

R - Recommendation or request

Your notes:

Communication note and reflection

After the call, record the time, findings reported, contact method and clinician role, actions underway, and actual agreement. Then name one change for your retry. Do not invent new orders or patient results.

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COOPERATIVE RECEIVER | RECEIVER ROLE CARD

Play the covering clinician

You are Dr. Jordan Patel. Lee Harmon, RN, calls about Robert Hayes. Receiver: cooperative.

Before the call

Ask for immediate actions and the escalation decision. If activation is omitted or the learner would wait for permission, pause and clarify that emergency action cannot wait. The observer records the omission and prompt. Then give the call update card (page 8). Everyone uses the same update; it does not earn credit for the initial decision.

Opening

“This is the covering clinician. Tell me what is happening.” Let the learner finish the initial SBAR.

Cooperative response

Acknowledge the urgency. Agree to assess now. If the request is unclear, ask once: “What response do you need, and when?” The observer marks a prompt if that supplies a missing cue.

> **Confirm the chosen plan**
>
> Say: “I am coming to room 318 now. Continue with the rapid response pathway; do not wait for me.” Allow the nurse to confirm the agreed plan and contingency.

If a safe plan is not reached

End the conversation for debrief. Emergency help remains active; never withhold it to force the right words. Credit immediate coordination through the charge nurse and rapid response lead when a clinician is unavailable.

If asked for absent information, say “That information is not provided.” Do not invent orders, repeat measurements, arrival, or improvement. Keep this card separate from the calling learner.

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INITIALLY UNAVAILABLE RECEIVER | RECEIVER ROLE CARD

Play the covering clinician

You are Dr. Jordan Patel. Lee Harmon, RN, calls about Robert Hayes. Receiver: initially unavailable.

Before the call

Ask for immediate actions and the escalation decision. If activation is omitted or the learner would wait for permission, pause and clarify that emergency action cannot wait. The observer records the omission and prompt. Then give the call update card (page 8). Everyone uses the same update; it does not earn credit for the initial decision.

Opening

“This is the covering clinician. Tell me what is happening.” Let the learner finish the initial SBAR.

One realistic constraint

Say once: “I am tied up with another patient. Can this wait until I finish?” If the caller has already proposed the rapid response clinician as an alternative, say instead: “I cannot leave this patient. What response can we coordinate now?”

Accept either appropriate plan

Accept a clear request for immediate assessment. Choose your availability before the round and keep it the same for the retry. If unavailable, agree to response-team assessment with immediate covering-team contact. Accept equivalent wording; do not require your attendance or a diagnosis.

> **Confirm the chosen plan**
>
> If unavailable: “I cannot leave this patient yet. The rapid response clinician will assess on arrival. I am available by phone now; have that clinician contact me as soon as they arrive.” If attending: “I am coming to room 318 now. Continue with the rapid response pathway; do not wait for me.”

If a safe plan is not reached

End the conversation for debrief. Emergency help remains active; never withhold it to force the right words. Credit immediate coordination through the charge nurse and rapid response lead when a clinician is unavailable.

If asked for absent information, say “That information is not provided.” Do not invent orders, repeat measurements, arrival, or improvement. Keep this card separate from the calling learner.

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RELEASE AFTER THE INITIAL DECISION

Update for the SBAR call

RECEIVER: Keep this page until the learner states their initial decision. Then give it to the calling nurse to read and keep in view. This supplied update is the same for all learners, including anyone who needed a prompt.

Actions now underway

It is now 2:00 p.m. Rapid response was requested at 1:58 p.m., without waiting for the phone call. Bedside observation continued and the head of the bed was raised. After the oxygen equipment was checked, oxygen was increased to 4 L/min by nasal cannula under the standing emergency protocol. Continuous pulse oximetry is in place. The charge nurse now stays at the bedside while you call Dr. Jordan Patel; the rapid response team, including respiratory therapy and a clinician, is on its way. The 89% reading was on 2 L/min before this change. No post-adjustment reading is supplied in this exercise. Obtain and report current findings without delaying help; do not assume improvement.

Now make the call

Call Dr. Jordan Patel, the covering clinician, using SBAR. Communicate the change, your working concern, actions underway, and the response needed. Confirm the agreed plan.

Keep observations and actions separate

The chart readings describe the patient before the increase in oxygen. Do not report a new saturation or improvement. New treatment orders are outside this exercise; repeating the response plan is not medication-order read-back.

Response-team context

If the patient worsens or help is delayed, immediately alert the charge nurse and response lead.

If the patient becomes unresponsive and is not breathing normally (including only gasping), call the code team (local emergency response) and start BLS as trained; return to SBAR only when immediate care is covered.

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OBSERVER REFERENCE

Facts for the observer

Keep this reference and the worksheet together. Use the facts to check the report; do not give the caller the model answer.

Patient / location	Robert Hayes, 67 years; fictional MRN 593824; 3 East, room 318
Admission	Hospital day 2 with pneumonia; receiving prescribed antibiotics.
History / status	Hypertension; no chronic lung disease or home oxygen use. No known medication allergies. Full code.
Respiratory change	Earlier: speaking in full sentences. Latest: more short of breath at rest, accessory-muscle use and short phrases; awake and responding.

Observation	1:30 p.m.	1:58 p.m.
Respiratory rate	18/min	30/min
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Blood pressure	126/74 mmHg	104/64 mmHg
Temperature	100.8 °F (38.2 °C)	100.8 °F (38.2 °C)

Stage 1: initial decision

Before the update, no emergency call has occurred. Look for immediate help and rapid response, staying with the patient, upright positioning and oxygen/monitoring support under the standing emergency protocol. Do not require a specific oxygen flow at this stage. Record the learner’s words; the update does not earn retrospective credit.

Stage 2: supplied actions

At 2:00 p.m.: rapid response requested at 1:58 p.m.; head of bed raised; oxygen increased to 4 L/min after equipment check under the standing emergency protocol; continuous oximetry. Charge nurse remains at bedside. Team including clinician and respiratory therapy is on its way. No post-adjustment findings are supplied; obtain current readings without delaying help.

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OBSERVER GUIDANCE

What to credit

If the patient worsens

If the patient worsens or help is delayed, immediately alert the charge nurse and response lead.

If the patient becomes unresponsive and is not breathing normally (including only gasping), call the code team (local emergency response) and start BLS as trained; return to SBAR only when immediate care is covered.

Acceptable response plans

Credit immediate assessment by an appropriate clinician: the covering clinician, or the rapid response clinician with covering-team coordination. Confirm who, timing, and the response to worsening or delayed help through the charge nurse/response lead. Do not require covering-clinician attendance.

Credit an uncertain concern about respiratory failure or sepsis tied to findings. Do not require a definitive diagnosis. A call confirms communication, not patient improvement.

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OBSERVER WORKSHEET

Observe the decision and call

Patient: Robert Hayes | Selected brief: _____ | Receiver: _____

Calling learner: _____ Observer: _____

O = observed as described; N = not yet demonstrated; N/A = no opportunity (explain). Note missing parts and prompts (Y/N). Use the reference. No total score.

Behavior	Attempt 1	Attempt 2
1. Initial decision: activates emergency help without waiting for the call.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
2. Initial decision: states immediate bedside support and continued observation.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
3. Identifies self, patient (name, MRN) and location; states the urgent problem before history.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
4. Reports trend, times, oxygen setting, breathing effort and mental status.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
5. States a supported clinical concern with appropriate uncertainty.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
6. Reports supplied actions without inventing a treatment response.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
7. Secures immediate assessment by an appropriate responder; addresses delay if raised.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
8. Confirms responder, timing and action for worsening or delayed help.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N

Attempt 1 evidence

Record words heard, missing parts and prompts. Refer to row numbers.

Attempt 2 evidence

What changed on the selected target? Note any remaining gaps.

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INSTRUCTOR GUIDE

Run the escalation activity

Select either brief | Guide illustrates the “initially unavailable” receiver. For final-semester students and new-graduate nurses with prior respiratory assessment and emergency-response teaching.

Learning objectives

- Recognize a concerning trend and verbalize immediate nursing support and escalation before the call.
- State a supported, uncertain clinical concern and request timely assessment.
- Confirm an appropriate response and contingency for worsening or delay; document the actual agreement.

Suggested timing: about 20 minutes

Time	Activity
3 minutes	Prebrief and observer calibration; allow longer on first use.
4 minutes	Caller reads chart; receiver and observer prepare separately.
3 minutes	Initial decision, update card, then SBAR call.
6 minutes	Communication note, reflection and debrief.
3 minutes	Same learner repeats both stages.
1 minute	Name an improvement and next target.

Distribution for 24 students in 8 groups

Provide 8 calling-nurse handouts, 8 sets of receiver/observer materials (5 pages per set; 40 single-sided sheets), and 1 guide per facilitator. Receiver: page 6 or page 7, plus page 8. Observer: pages 9-11. Give the update card on page 8 only after the initial decision.

Rotation

For three rotations: 24 calling handouts, 8 receiver cards and 8 update cards, 8 sets of observer reference/guidance pages, and 24 observer worksheets (page 11). The same learner makes both attempts before roles change. Later learners have heard the case; this is practice, not an unseen assessment.

The suggested timing is a starting point; adjust it for your group. Agree how to request faculty help, space groups so calls can be heard, and stagger rounds if needed.

Written for US practice settings; adapt terms and policies for your setting.

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FACILITATOR AND OBSERVER PREPARATION

Prebrief and observation

Read aloud: a short prebrief

“This is formative practice, not a graded assessment. We will discuss the words heard, then repeat the conversation with the same nurse learner. Equivalent wording is welcome.”

“Our goal is to recognize deterioration, summon help, and confirm an urgent response. Two chairs back to back represent the phone call.”

“The patient and chart are fictional. Work with the supplied facts as if they were real, and tell us if something prevents you from doing that. Everyone brings useful experience and is here to learn.”

“Treat one another respectfully. The receiver has a scripted role; resistance is part of the activity, not a judgment of the learner. Anyone may say pause. We will clarify the task, support the learner, and restart if needed. Keep identifiable comments within the learning group.”

“First state your immediate actions and how you would summon help. Then receive the update card and make the call. In real care, activate emergency help at once; the preparation time here is only for learning. Verbalize actions here; do not perform procedures or call emergency numbers.”

“If information is missing, say it is not provided and explain what you would check. Do not invent a new result, order, or patient response. The receiver should answer ‘That information is not provided.’ Faculty will clarify anything needed to continue.”

“The observer records all marks and prompts, using the reference to check facts and noting brief exact words. The receiver follows the role card and helps clarify what was said during debrief. Start with the learner’s view, then offer evidence and one useful next step.”

Observer only: calibrate privately before starting

Mark O when the behavior is observed and N when it is not yet demonstrated as described. Record any missing parts in the evidence notes; there is no partial category. Use N/A only when there was no scripted opportunity, and explain why. Mark a prompt when someone supplied a missing cue or suggested answer. A scripted challenge or request to repeat an unclear word is not a prompt. Do not total the marks or assign a pass score.

Focus detailed notes on one or two behaviors. For a row with several parts, mark N if a part is missing, then record what was present and what remains. Faculty resolve uncertain marks from the words heard. Binary marks keep feedback simple and consistent with the companion guide; this case checklist is not the validated SBAR-LA rubric.

Example

“Saturation fell from 96% to 89%” omits the oxygen setting and times: mark N and note “trend stated; setting and times missing.” Credit an appropriate response-team assessment even when the covering clinician cannot attend.

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MODEL RESPONSE AND RATIONALE

One possible escalation SBAR

> **First: one possible initial decision**
>
> "I would call for immediate help and activate rapid response now, stay with the patient, raise the head of the bed, and support oxygenation under the standing emergency protocol and monitor continuously. I would not wait for provider permission."

Use the supplied call update. Equivalent wording is welcome.

S Lead with the urgent problem

Dr. Jordan Patel, this is Lee Harmon, RN, on 3 East, calling about Robert Hayes, MRN 593824, room 318. The patient has acute breathing difficulty and low oxygen saturation. Rapid response is activated; an immediate bedside assessment is needed.

Why it works: Names the patient and the urgency before giving detail.

B Select the relevant context

The patient is 67, on hospital day 2 with pneumonia and receiving prescribed antibiotics, full code, with no known medication allergies. At 1:30 p.m., respirations were 18 and saturation was 96% on 2 L/min by nasal cannula. There is no chronic lung disease or home oxygen use.

Why it works: Provides the comparison and relevant background.

A Interpret without claiming certainty

At 1:58 p.m., respirations were 30 and saturation 89% on the same 2 L/min, despite a probe check. Heart rate rose from 88 to 118 and blood pressure fell from 126/74 to 104/64. The patient is awake and responding, with accessory-muscle use and short phrases; temperature is 100.8 °F. I am worried about acute respiratory failure and possible sepsis in this patient with pneumonia.

Why it works: Links findings to a working concern. Sepsis and respiratory failure remain unconfirmed.

R Make a clear request

The head of the bed is raised and oxygen has been increased to 4 L/min under the standing emergency protocol; 89% on 2 L/min is the latest documented saturation, and I will obtain the current reading from the charge nurse at the bedside. Rapid response, including its clinician and respiratory therapy, is on the way. I need you to assess the patient now. Can you come?

Why it works: Requests action now. If attendance is not possible, coordinate an immediate alternative; see the debrief.

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FACILITATION NOTES

Debrief and document

> **After an agreed alternative: confirm the plan**
>
> “The rapid response clinician will assess on arrival. You’re available by phone now; I’ll relay your contact request to the response lead. I’ll alert the charge nurse and response lead immediately if the patient worsens or help is delayed.”

Start with the initial decision

Which cues made this urgent? Review the decision before the supplied update. If the learner waited for permission, use a coached restart; the update does not earn retrospective credit.

Use the words heard

- Ask the observer for the concern, evidence, requested response, and confirmation. Ask the receiver what responsibility was understood.
- Credit “I am worried about sepsis” supported by the findings. “This is definitely sepsis” overstates what the case establishes. Pneumonia and sepsis are not alternatives.
- If a clinician is unavailable, distinguish coordinated assessment from an unconfirmed promise to review later.
- What would you communicate if the patient worsened before help arrived?
- Which sepsis screen or early-warning tool does your unit use? Apply only a supplied tool with available inputs; screening must not delay emergency help.

> **After the clinician cannot attend**
>
> I am concerned this cannot wait: saturation fell from 96% to 89% on the same oxygen, respirations are 30, and breathing effort is increasing. Since you cannot attend, please confirm the rapid response clinician will assess on arrival and that you are reachable now for an immediate update.

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DOCUMENTATION AND TRANSFER

Record the actual agreement

Clinical scope

The oxygen action is not a universal prescription. No new orders or later outcomes are simulated. Accept appropriate response-team assessment; the covering clinician does not have to attend.

Brief documentation practice

Write a short note during debrief: event/contact time, findings and concern, actions underway, whom you contacted, and the actual agreed response. Use the agreement reached in this attempt, not an assumed outcome. No new orders were given; plan confirmation is not order read-back.

Example: “2:00 p.m.: Called Dr. Jordan Patel, covering clinician, by phone. At 1:58 p.m.: RR 30 (18 at 1:30 p.m.), SpO2 89% on 2 L/min (96% on 2 L/min at 1:30 p.m.), HR 118, BP 104/64, temperature 100.8 °F; accessory muscles, short phrases, awake and responding. Concern for respiratory failure/possible sepsis. Rapid response requested 1:58 p.m.; head of bed raised, oxygen now 4 L/min under the standing emergency protocol, continuous oximetry, charge nurse at bedside. Agreed response-team clinician to assess on arrival and contact covering clinician, who is available by phone. Will alert charge nurse and response lead immediately if worsening or delay. Repeat SpO2 pending.”

Retry and transfer

Choose one target. Repeat both stages with the same learner and receiver behavior. Later roles have prior exposure. A different receiver adds a challenge, not an unseen clinical case. Use an unfamiliar case to explore transfer.

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FACULTY REFERENCE

Curriculum links

Suggested connections for lesson planning. These are limited mappings by the resource author, not endorsement, competency certification, or a validated scoring framework.

AACN Essentials

Domain 6, Interprofessional Partnerships, 6.1b: “Use various communication tools and techniques effectively.” Evidence here is the learner’s SBAR, clarification, and confirmation of responsibilities.

QSEN

Teamwork and Collaboration: explain the concern, clarify roles, and agree next steps. Safety: distinguish known findings from assumptions and communicate unresolved needs. Observe these behaviors; do not infer an entire competency from one exercise.

NCSBN Clinical Judgment Measurement Model

Recognize and analyze cues: compare the respiratory trend. Prioritize hypotheses: state an uncertain clinical concern. Generate solutions and take action: verbalize immediate help and escalation, then negotiate the response. Actions are verbalized, not physically demonstrated. No later patient outcomes are supplied, so this activity does not test evaluation of clinical outcomes.

A clearer second conversation demonstrates improvement on this familiar task. It does not by itself establish transfer to an unseen patient or completion of the clinical judgment cycle.

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SOURCES AND REUSE

Sources, review and reuse

Sources and related teaching resources

AACN Essentials: Domain 6: https://www.aacnnursing.org/essentials/tool-kit/domains-concepts/interprofessional-partnerships

QSEN: Prelicensure competencies: https://www.qsen.org/competencies-pre-licensure-ksas

NCSBN: Clinical Judgment Measurement Model: https://www.nclex.com/clinical-judgment-measurement-model.page

INACSL: Simulation standards and prebriefing: https://www.inacsl.org/healthcare-simulation-standards-of-best-practice-

AHRQ TeamSTEPPS: SBAR: https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html

AHRQ PSNet: Rapid Response Systems: https://psnet.ahrq.gov/primer/rapid-response-systems

SCCM: Surviving Sepsis Campaign 2026: https://www.sccm.org/clinical-resources/guidelines/guidelines/surviving-sepsis-campaign-international-guidelines-for-management-of-sepsis-and-septic-shock-2026

American Heart Association: Adult basic life support: https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-life-support

SBAR authoring guide: bedside report, critical results, orders and read-back: https://medical.linguacopilot.in/guides/sbar-simulation-scenario-builder

Before you teach

Written by the Lingua CoPilot Medical team from the sources listed. These cases have not been clinically reviewed. The model answer is one possible response, not a standard of care.

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