Nursing faculty teaching resource

INSTRUCTOR GUIDE

Run the escalation activity

Guided brief | 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: pages 1-2. Observer: pages 3-5. Give the update card on page 2 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 5). 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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