Nursing faculty teaching resource

EDUCATOR MASTER CONTENTS

Choose and distribute the pages

SBAR shift handoff 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 care plan 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.
- 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	Assumes improvement receiver card
8-9	Observer references and worksheet
10-15	Instructor guide

The guide illustrates the “assumes improvement” receiver. Both cards use the same facts and care plan. Accept equivalent wording; keep the chosen receiver behavior consistent across retries.

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

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GUIDED LEARNER | OUTGOING NURSE CASE BRIEF

A shift handoff

It is 7:00 p.m. on 5 West. You are Casey Nolan, RN, giving report to Dana Whitfield, RN, at the nurses' station. An item of care is still due after your shift ends.

> **Your task**
>
> Use the chart excerpt to give an SBAR handoff. Identify what is still due and agree who will do it and when. You may refer to these notes.

Patient	Diane Foster, 68 years; fictional MRN 730516
Location	5 West, room 521
Admission	Postoperative day 1 after laparoscopic cholecystectomy for acute cholecystitis. Observation continues after nausea and limited oral intake; discharge awaits intake and mobility review.
History / status	Hypertension; no known medication allergies; full code
Latest assessment	At 6:15 p.m.: alert, oriented, no nausea or dizziness; incisions clean and dry. Pre-dose pain 4/10 at the incision with movement; patient goal 3/10 or less.
Recent medication	Acetaminophen 650 mg orally at 6:15 p.m., administered under the existing order.
Mobility / intake	Tolerating oral fluids. Fall precautions and one-person assistance for walking under the current care plan.

Observation	Recorded at 6:15 p.m.
Blood pressure	128/76 mmHg
Heart rate	82/min
Respiratory rate	16/min
Oxygen saturation	97% on room air
Temperature	98.6 °F (37.0 °C)

Reassess pain at 7:15 p.m., one hour after the oral dose. Assist with toileting when requested; check pain and dizziness before standing and provide one-person assistance. If pain remains above the goal, reassess and contact the covering surgical clinician for review of the pain plan. Promptly report new or increasing abdominal pain, fever, vomiting or changed vital signs; use the emergency pathway for deterioration.

The patient requests help to the bathroom when needed. A daughter asked about visiting tomorrow. This excerpt is not the complete medication record.

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GUIDED LEARNER | SBAR PREPARATION & REFLECTION

Prepare your handoff

Outgoing nurse: Casey Nolan, RN | Receiving nurse: Dana Whitfield, RN | Patient: Diane Foster

S - Situation

What does the receiving nurse need to know first?

B - Background

Which details matter to care during the next shift?

A - Assessment

What is the current status? What has and has not been reassessed?

R - Recommendation / plan

What needs to happen next? Who will do it, and by when?

After your attempt

Record the agreed task, responsible nurse, and time. What would you change in your next attempt?

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

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UNGUIDED LEARNER | OUTGOING NURSE CASE BRIEF

A shift handoff

It is 7:00 p.m. on 5 West. You are Casey Nolan, RN, giving report to Dana Whitfield, RN, at the nurses' station.

> **Your task**
>
> Use the chart excerpt to give a focused SBAR handoff. Agree responsibility and timing for continuing care, and confirm the plan with the receiving nurse. You may refer to these notes.

Patient	Diane Foster, 68 years; fictional MRN 730516
Location	5 West, room 521
Admission	Postoperative day 1 after laparoscopic cholecystectomy for acute cholecystitis. Observation continues after nausea and limited oral intake; discharge awaits intake and mobility review.
History / status	Hypertension; no known medication allergies; full code
Latest assessment	At 6:15 p.m.: alert, oriented, no nausea or dizziness; incisions clean and dry. Pre-dose pain 4/10 at the incision with movement; patient goal 3/10 or less.
Recent medication	Acetaminophen 650 mg orally at 6:15 p.m., administered under the existing order.
Mobility / intake	Tolerating oral fluids. Fall precautions and one-person assistance for walking under the current care plan.

Observation	Recorded at 6:15 p.m.
Blood pressure	128/76 mmHg
Heart rate	82/min
Respiratory rate	16/min
Oxygen saturation	97% on room air
Temperature	98.6 °F (37.0 °C)

Reassess pain at 7:15 p.m., one hour after the oral dose. Assist with toileting when requested; check pain and dizziness before standing and provide one-person assistance. If pain remains above the goal, reassess and contact the covering surgical clinician for review of the pain plan. Promptly report new or increasing abdominal pain, fever, vomiting or changed vital signs; use the emergency pathway for deterioration.

The patient requests help to the bathroom when needed. A daughter asked about visiting tomorrow. This excerpt is not the complete medication record.

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UNGUIDED LEARNER | SBAR PREPARATION & REFLECTION

Prepare your handoff

Outgoing nurse: Casey Nolan, RN | Receiving nurse: Dana Whitfield, RN | Patient: Diane Foster

S - Situation

Your notes:

B - Background

Your notes:

A - Assessment

Your notes:

R - Recommendation / plan

Your notes:

After your attempt

Record the agreed task, responsible nurse, and time. What would you change in your next attempt?

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COOPERATIVE RECEIVER | RECEIVER ROLE CARD

Play the receiving nurse

You are Dana Whitfield, RN, receiving report on Diane Foster from Casey Nolan, RN. Receiver: cooperative.

Opening

"I am ready for report." Listen without interrupting.

Let the learner finish

Allow the learner to select the information and propose a plan. Do not reveal the pending task while they are preparing or speaking.

Clarify if needed

After the report, if the plan is unclear, ask: "What am I responsible for next, and when?" The observer records whether the learner supplied this before or after your question.

Close the handoff

Once action, owner, and time are clear, summarize the agreed plan. If essential information is still missing after one clarification, take it to the debrief.

> **Example confirmation, after agreement**
>
> I'll reassess pain at 7:15 p.m. and document the response. I'll provide one-person assistance to the bathroom when requested, checking pain and dizziness first. If pain remains above the goal of 3/10, I'll reassess and contact the covering surgical clinician; I'll report new concerning symptoms promptly and use the emergency pathway for deterioration.

Keep the case consistent

- Do not invent a new vital sign, medication, order, or change in condition. If asked for missing information, say it is not provided.
- Accept equivalent wording. The learner may introduce the patient or lead with the pending task.
- Do not supply the model answer if the learner gets stuck. One clarification is enough; discuss remaining gaps afterward.

The learner uses the selected guided or unguided brief. Keep this role card separate during preparation.

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ASSUMES IMPROVEMENT RECEIVER | RECEIVER ROLE CARD

Play the receiving nurse

You are Dana Whitfield, RN, receiving report on Diane Foster from Casey Nolan, RN. Receiver: assumes improvement.

Opening

"I am ready for report." Listen until the learner mentions the medication, or until the report ends if it is omitted.

Test the assumption once

If the response is still unclear, ask: "So the pain's better now?" If the learner has already clearly said it has not been reassessed, skip the question and acknowledge that uncertainty.

Respond to the learner

Accept an evidence-based correction: "Understood; we do not know the response yet." If the learner claims improvement without evidence, ask once: "What reassessment supports that?" The observer records whether correction was spontaneous or prompted.

Close the handoff

Once action, owner, and time are clear, summarize the agreed plan. If uncertainty remains after one clarification, end the attempt and take it to the debrief; do not invent findings.

> **Example confirmation, after agreement**
>
> I'll reassess pain at 7:15 p.m. and document the response. I'll provide one-person assistance to the bathroom when requested, checking pain and dizziness first. If pain remains above the goal of 3/10, I'll reassess and contact the covering surgical clinician; I'll report new concerning symptoms promptly and use the emergency pathway for deterioration.

Keep the case consistent

- Do not invent a new vital sign, medication, order, or change in condition. If asked for missing information, say it is not provided.
- Accept equivalent wording. The learner may introduce the patient or lead with the pending task.
- Do not supply the model answer if the learner gets stuck. One clarification is enough; discuss remaining gaps afterward.

The learner uses the selected guided or unguided brief. Keep this role card separate during preparation.

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OBSERVER REFERENCE

Facts for the observer

Keep this page beside the observer worksheet. Check the words heard against these facts without giving the outgoing learner the model answer.

Patient	Diane Foster, 68 years; fictional MRN 730516
Location	5 West, room 521
Admission	Postoperative day 1 after laparoscopic cholecystectomy for acute cholecystitis. Observation continues after nausea and limited oral intake; discharge awaits intake and mobility review.
History / status	Hypertension; no known medication allergies; full code
Latest assessment	At 6:15 p.m.: alert, oriented, no nausea or dizziness; incisions clean and dry. Pre-dose pain 4/10 at the incision with movement; patient goal 3/10 or less.
Recent medication	Acetaminophen 650 mg orally at 6:15 p.m., administered under the existing order.
Mobility / intake	Tolerating oral fluids. Fall precautions and one-person assistance for walking under the current care plan.
Vitals at 6:15 p.m.	Blood pressure: 128/76 mmHg; Heart rate: 82/min; Respiratory rate: 16/min; Oxygen saturation: 97% on room air; Temperature: 98.6 °F (37.0 °C)

Plan and uncertainty

Reassess pain at 7:15 p.m., one hour after the oral dose. Assist with toileting when requested; check pain and dizziness before standing and provide one-person assistance. If pain remains above the goal, reassess and contact the covering surgical clinician for review of the pain plan. Promptly report new or increasing abdominal pain, fever, vomiting or changed vital signs; use the emergency pathway for deterioration.

The response to the recent acetaminophen dose is not known. The patient requests help to the bathroom; provide one-person assistance. A correct handoff identifies this uncertainty and transfers the reassessment to a named nurse at the supplied time.

Credit equivalent wording and an appropriate interpretation. Do not credit an invented improvement or a reassessment described as already completed.

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

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OBSERVER WORKSHEET

Observe the handoff

Patient: Diane Foster | Selected brief: _____ | Receiver: _____

Outgoing 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. Identifies the patient using name and MRN.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
2. Communicates the pending task and one-person mobility assistance.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
3. Includes the recent medication and administration time.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
4. States the unknown medication response; corrects an assumption if raised.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
5. Gives the reassessment time (7:15 p.m.).	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
6. Establishes who will take the pending task.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
7. Communicates the supplied contingency.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N
8. Invites clarification and obtains receiver confirmation.	O / N / N/A Prompt: Y / N	O / N / N/A Prompt: Y / N

Attempt 1: words heard

Note missing parts and prompts using row numbers. Choose one target.

Attempt 2: words heard

What changed? Note remaining gaps and a next target.

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INSTRUCTOR GUIDE

Run the activity

Select either brief | Guide illustrates the “assumes improvement” receiver. Handoff at 7:00 p.m.

> **Teaching focus**
>
> Transfer a pending task with an owner and time. Introductory practice for learners with basic postoperative assessment knowledge; use the nurses' station setting.

Choose guided support with hints and worksheet prompts, or unguided practice using the same chart and care plan.

Learning objectives

- Select relevant information and distinguish findings from assumptions.
- Communicate the pending action, owner, time, and supplied contingency.
- Correct an unsupported assumption about improvement, if raised, and confirm the agreed plan.

Suggested timing: about 20 minutes

Time	Activity
3 minutes	Prebrief and calibration; allow longer on first use.
4 minutes	Nurse reads chart; receiver and observer prepare separately.
3 minutes	First handoff.
6 minutes	Reflection, evidence, documentation and debrief.
3 minutes	Same learner repeats the same version.
1 minute	Name an improvement and next target.

Print for your session

For 24 students in 8 groups: 8 outgoing handouts, 8 sets of receiver/observer materials (3 pages per set; 24 single-sided sheets), and 1 guide per facilitator. Receiver: page 6 or page 7. Observer: pages 8-9. Three rotations need 24 nurse handouts and 24 observer worksheets (page 9); reuse the cards and references.

Facilitation

The suggested timing is a starting point; adjust it for your group. Space groups so reports can be heard and agree how to request faculty help; stagger rounds if needed. Review the facts before teaching and keep answers with faculty. For bedside report, use the companion guide.

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 a focused handoff that keeps care safe across the shift change. Two chairs represent the nurses’ station.”

“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.”

“This is a focused report at the nurses’ station, not a complete bedside report. Use the supplied chart and care plan.”

“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

“Dana Whitfield will reassess” establishes an owner but no time: mark the owner row O and timing row N. Note “owner named; time missing.” “The pain is better” has no supporting reassessment.

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MODEL RESPONSE AND RATIONALE

One possible SBAR

One acceptable response, not a script to memorize. Equivalent wording and a different sensible order are acceptable when meaning and responsibility remain clear.

S Establish the patient and the task

Dana Whitfield, this is Casey Nolan, RN, giving report on Diane Foster, MRN 730516, in room 521. This is postoperative day 1 after a laparoscopic cholecystectomy. The next item due is a pain reassessment at 7:15 p.m.

Why it works: Uses two patient identifiers and leads with a priority that crosses the shift change.

B Select relevant background

The patient remains for observation after postoperative nausea and limited intake. There is a history of hypertension, no known medication allergies, and full-code status. Acetaminophen 650 mg orally was given at 6:15 p.m. under the existing order.

Why it works: Includes the medication and timing so the receiving nurse knows its effect still needs evaluation.

A Separate observation from assumption

At 6:15 p.m., the patient was alert, with no nausea or dizziness, clean dry incisions and reassuring recorded vital signs. Pain was 4 out of 10 with movement. Relief after acetaminophen has not been confirmed. Reassess pain and check safe mobility rather than assume improvement.

Why it works: Interprets the earlier findings and the remaining uncertainty without inventing a medication response.

R Transfer an actionable plan

Can you reassess pain at 7:15 p.m. and document the response? The goal is 3/10 or less. Provide one-person assistance to the bathroom when requested, checking pain and dizziness before standing. If pain remains above goal, reassess and contact the covering surgical clinician to review the plan. Promptly report new or increasing abdominal pain, fever, vomiting or changed vital signs; use the emergency pathway for deterioration. Please confirm the plan and timing. What questions do you have?

Why it works: Connects action, owner, time, mobility safety, and the supplied contingency; acceptance must be confirmed.

> **Receiver confirmation**
>
> I'll reassess pain at 7:15 p.m. and document the response. I'll provide one-person assistance to the bathroom when requested, checking pain and dizziness first. If pain remains above the goal of 3/10, I'll reassess and contact the covering surgical clinician; I'll report new concerning symptoms promptly and use the emergency pathway for deterioration.

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FACILITATION NOTES

Debrief and try again

> **If asked: "So the pain's better now?"**
>
> The dose was given at 6:15 p.m.; relief has not been reassessed. Last pain was 4/10; reassessment is due at 7:15 p.m.

Start with the learner

- What was the handoff priority?
- Which chart information or prompt helped you organize the handoff? What would you change next time?
- What did you leave out, and why?

Ask for evidence

- Observer: quote the owner and timing, noting any prompts.
- Receiver: what did you understand you were responsible for?
- How did the learner clarify the unknown response? Quote the words.

> **Discuss the assumption**
>
> Medication administration does not establish its effect. Discuss how the learner acknowledged the unknown response and returned to a clear plan.

Documentation practice

Record the agreed task, owner, time and contingency. This confirms the handoff plan, not a completed reassessment or medication-order read-back.

Second attempt

Repeat with the same learner and options. Choose one target and record the retry in the second observer column.

Common difficulties

What you hear	What to explore
"The pain is better now."	Which reassessment supports that claim?
"Recheck it later."	Which time and which nurse?
"Okay" without confirmation	What did the receiver actually accept?

Later learners have prior exposure. Use an unfamiliar case to explore transfer; this retry is practice on a known task.

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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: distinguish the earlier pain score from the unknown medication response. Generate solutions and take action are represented only by communicating an existing care plan and transferring responsibility. This is limited clinical judgment practice; it does not test independent treatment selection or evaluation of the patient’s subsequent response.

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: Handoff: https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/handoff.html

OpenStax: Pain assessment and reassessment: https://openstax.org/books/medical-surgical-nursing/pages/7-2-pain-assessment

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.

Lingua CoPilot Medical | Version 1.0 | Revised November 4, 2026.

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