A CLINICAL INSTRUCTORS RESOURCE MANUAL: DEPRESSION SCENARIO

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Dedication

To my husband Daniel, for your support, patience, and encouragement always. To my

children, Chloe and Hayden who inspire me and make me want to do the best I can.

This accomplishment would not have been possible without your support.

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Abstract

I hear, I forget; I see, I remember; I do, I understand.

(Chinese proverb, n.d)

From a student perspective, there is opportunity for experiential learning to improve performance (Reilly & Spratt, 2007). Simulation is an experiential teaching strategy which can build clinical competence in nursing (Jeffries, 2005). Research suggests that nursing educators are inexperienced in simulation and consequently lack the capacity to utilize simulation as teaching strategy (Schiavenato, 2009). This need prompted the creation of a mental health clinical instructor resource manual of a depression scenario. The manual supports the application, pedagogy and process for simulation in nursing education. Multiple variations of a depression scenario were designed to promote simple to complex student learning. The scenario was enacted by a standardized patient and adapted for use in a high-fidelity simulation setting. Two test pilots of the simulation scenarios were conducted with undergraduate nursing students. Formative and summative evaluation strategies were administered to measure project objectives. This project was deemed a success with minor revisions made to improve fidelity and usability.

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Section one: Introduction

Traditionally, nursing students have developed clinical competency in mental health nursing by practicing nursing skills and interventions during scheduled clinical rotations. Clinical practice enables students to link and apply theory learned in the classroom to real world settings (Cederbaum & Klusaritz, 2009). However, learning in the clinical setting is becoming increasingly challenging to facilitate (Barette & Jackson, 2013). There are many challenges associated with providing clinical learning opportunities for nursing students in mental health such as a shortage of clinical sites, learner collision, shorter number of clinical hours, and student anxiety. These challenges can leave students unprepared for mental health nursing practice, as clinical learning is compromised by these extraneous factors. Not being adequately prepared for clinical experiences results in nursing students doubting their competence in the clinical setting (Brown, 2008; Cook, 2005). These challenges have led to the necessity of utilizing alternate teaching strategies such as simulation to assist students in developing clinical competency.

Simulation has been used to foster competencies that are fundamental to mental health nursing practice (Brown, 2008; Edwards, Herecelinsky, Warelow & Munro, 2007). Simulation has been described as the artificial representation of a phenomenon or activity that allows participants to experience a realistic situation without real-world risks (Jeffries, 2005, 2007, 2012; Tun, Alinier, Tang, & Kneebone, 2015). Simulation allows learners to function in an environment that is as close as possible to an actual clinical situation and provides them an opportunity to "think on their feet, not in their seat" (Rauen, 2001, p.93). Simulation based education (SBE) can be utilized as a complementary, adjunctive teaching strategy to build nursing competency (Handley & Dodge, 2013; Felton, & Wright, 2017; Jeffries, 2005). Experience helps the nurse develop capacity in handling familiar situations

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(Benner, Tanner & Chelsea, 2009). Furthermore, simulation provides learning opportunities in a safe environment where learners can practice skills they may be exposed to in the real-world clinical setting (Brown, 2015; Pike & O'Donnell, 2010), therefore allowing learners the needed time to progress from one level of proficiency to another (Benner, 2001). Simulation offers valuable learning opportunity for students to enhance their skills, allowing them to gain confidence and competencies within their nursing practice. This gives rise to the question of how simulation is being used, if at all to enhance students learning and supplement clinical teaching strategies.

Rationale for Project

According to Pravikoff, Tanner, and Pierce, (2005) several evidenced based teaching and learning strategies are underutilized in nursing education. Simulation has not been used to the same extent as other teaching strategies in preparing students for their mental health nursing practice (Brown, 2008; Felton, & Wright, 2017; Lehr & Kaplan, 2013). Nearly two decades have passed since faculty in the healthcare industry started facilitating learning with high-fidelity human patient simulation (Bradshaw & Hultquist, 2017), and still the utilization of high-fidelity simulation in mental health nursing is being under underutilized (Lehr & Kaplan, 2013). One reason for this may be the lack of understanding regarding the simulation process, which poses a barrier to nurse educators adopting simulation (Jeffries, 2008).

An assessment of SBE needs and resources completed in 2011 revealed that faculty development was the largest barrier to using simulation, even though it was regarded as the highest priority in the future use of simulation (Lemoine, Chauvin, Broussard, & Oberleitner, 2015). Unfortunately, simulation instruction does not come with a manual; therefore, many educators are left to guess how to utilize this learning strategy effectively (Seropian, Brown,

Gavilanes, & Driggers, 2004). As with any educational innovation, faculty development initiatives are critical to the successful design and implementation of simulation-based education (Lemoine, Chauvin, Broussard, & Oberleitner, 2015).

Nurses in many different healthcare settings will encounter patients with depression or those at risk of developing it (Skinner, 2014). Depression is a serious mental health illness linked with high rates of suicide (Oliffe and Phillips, 2008). Talking about suicide with patients is often a topic that nurses report as being very uncomfortable and anxiety provoking (Luebbert, & Popkess, 2015; Neville & Roan, 2013). Yet, suicide prevention is influenced by the health professionals' ability to accurately assess patients' suicide risk (Neville & Roan, 2013). There is a gap in suicide-specific intervention training in nursing education for mental health professionals (Lyons et al., 2005). Deficits in suicide prevention education in undergraduate nursing have left nursing students feeling unprepared to assess for suicide risk. Engaging nursing students in active learning through a simulated depression scenario has the potential to enhance student competency in working with depressed and suicidal patients. This is the reasoning why depression and suicide risk assessment were chosen for this simulation experience.

This final project paper will highlight a literature review, define the practice problem, and outline the process undertaken to design, implement and evaluate a simulation manual for mental health clinical instructors. Furthermore, a detailed description of the project deliverable, and the simulation resource will be discussed, including results from two pilot tests, recommendations for improvements and future use in nursing education.

<center>**Section two: Literature review**</center>

A systematic review of the literature was conducted. Databases searched include the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Proquest Nursing, Medline, Pubmed Cochrane Database of Systematic Reviews and hand searchers. Websites were also used to find information on the topic including Google Scholar, National League for Nursing (NLN), and International Nursing Association for Clinical Simulation and Learning [INACLS.] The key words used included mental health simulation, depression scenario, clinical competency, experiential learning through simulation, simulation instructional design, pedagogy of simulation, standards of practice simulation, simulation as a teaching tool, clinical teaching using standardized patient, and debriefing in simulation. This literature review included studies from 2000 to 2017 and was limited to simulation in nursing or educational related articles. Research on nursing students and simulation experiences is diverse ranging from those wishing to improve nursing education, to those wishing to improve aspects of students' performance, as well as those wanting to explore simulation as a teaching tool in general. Research also provided evidence as to why simulation experiences have not readily been adopted in nursing curriculum.

Benefits of Simulation to Nursing Education

Nursing literature supports the use of simulation as an adjunct to traditional educational practices (Brown, 2008; Gaba 2004). Many studies have found simulation to have a positive effect on nursing education and student learning (Blum, Borglund & Parcells, 2010; Schiavenato, 2009). In the literature, simulation experiences have been proposed to address the challenges of providing students with hands-on active learning experiences in nursing.

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Student learning. In a systematic review of 23 articles examining the effects of high fidelity simulations on student learning, investigator's findings supported researchers' hypothesis that using simulation as a teaching tool positively influences student learning compared to other more traditional learning methods (Harder, 2010). Most of the studies (n = 20) indicated an increase in assessment and clinical skills performance. In 91% (n = 21) of the studies, students evaluated their confidence levels and perceived competence was higher than those who did not participate in simulation (Harder, 2010). Kneebone (2005) focused on the idea that simulation-based learning offers the following benefits: sustained deliberate practice in a safe environment, access to expert tutors, reflection of real-life practice, and a supportive learner centred setting that is conducive to learning. Providing evidenced-based support for the use of simulation-based nursing education as an adjunct to traditional clinical teaching practices that can help build nursing competence.

Nursing competence. The College and Association of Registered Nurses of Alberta, (2013) maintains in their entry-to-practice competencies for the registered nursing profession, that new graduates should possess the "theoretical and practical knowledge of relational practice" (p.13). Knowledge generation is not linear, but rather shared from the contribution of theory and practice (Moran, Burson & Conrad, 2014). Scully (2011) identifies that connecting textbook descriptions of clinical situations with the reality of nursing practice is an ongoing problem faced by members of the nursing profession and is commonly referred to as the "theory-to-practice gap" (p.93). Nursing simulation is suggested in the literature to bridge this gap and build nursing competency (Jeffries, 2005, 2007; McCaughey & Traynor, 2010). Simulation allows for the praxis of these domains, as knowledge gained in the simulated learning environment can then be applied to real world practice to build nursing competency and assist in bridging the theory to practice gap. By practicing

competently, nurses can command pertinent knowledge and/or skills, and make suitable decisions and judgments (Pijl-Zieber, Barton, Konkin, Awosoga, & Caine, 2014; Tilley, 2008).

Literature notes that using simulation can build competency related to mental health nursing. Lilly, Hermanns, and Crawley (2012) evaluated a simulated attempted suicide scenario (wrist cutting) that was utilized by nursing faculty as a teaching modality to expose nursing students to critical events in mental health nursing practice. Many students reported that the experience was beneficial and gave them an insight into real-life critical events that could occur in mental health practice. Students felt that this exposure provided them with learning they would not have thought about in detail before the simulation experience. The researchers found simulation provided students with the ability to learn about crisis management and interventions in a nurturing environment (Lilly, Hermanns, and Crawley, 2012). It is also noteworthy to mention that simulation participants reported an enhanced appreciation for safety in the management of care of inpatient psychiatric patients following exposure to the simulation experience (Lilly, Hermanns, and Crawley, 2012). Indeed, if simulation as a teaching and learning strategy can improve nursing competence in relation to mental health practice, it can surely to be considered a solution to deal with some of the practice problems in educating nursing students in the mental health clinical environment.

Problems of Clinical Education for Nursing Students

Shortage of placements. Nurse educators are challenged to find suitable clinical placements that allow students to develop an understanding of the intricacies of mental health care. Tanner (2002) noted that changes in the current healthcare delivery systems have created a shortage of quality clinical placements and a shorter duration of clinical hours, which results in fewer opportunities for students to consolidate their practical skills.

Additionally, Kline and Hodges, (2006) acknowledge that the demand for clinical sites exceeds supply. Courtney-Pratt, Ford, and Marlow, (2015) concur, and identify, the demand for clinical practice sites; especially when several healthcare programs are within the same geographic area, can result in learner collision.

Based on personal experience, these findings are mirrored in the mental health clinical rotations within the University of Lethbridge, NESA program, as students are expected to commute to remote mental health practice settings due to the limited acute care settings within city limits. This demand increases the cognitive load placed on student learning due to the added strain of dealing with poor weather conditions, long driving times to and from clinical, and increased financial demands of getting to clinical.

Cognitive load refers to the effort being used in the working memory, which can create more of an extraneous load on the learner, which has the potential to negatively influence student learning (Plass, Moreno, & Brunken, 2010). Extraneous load is a result of unnecessary processes that do not directly contribute to learning (van Merrienboer, Jeroen, & Sweller, 2010). Oudshhorn and Sinclair (2015) maintain that simulation can replace inconsistent mental health hospital placements; further studies maintain this is because simulation allows students to engage in the similar clinical decision-making skills as in actual practice (Sinclar & Ferguson, 2009). Thereby, simulation offers a solution to the shortage of clinical sites, and learner collision, as students can develop their nursing skills in a manner that closely parallels active clinical practice. Additionally, simulation has the potential to lessen the cognitive load placed on nursing students as it can be utilized without having to travel to remote locations, as simulation scenarios can be adapted for use in various locations.

Lack of opportunity. Placements within a mental health setting can vary in their level of opportunity for student development (Happell, Gaskin, Byrne, Welch, & Gellion, 2015; Oudshoorn & Sinclair, 2015). Although students may be placed in real world professional practice settings, a facility has no way of guaranteeing exposure to diagnoses and the quality of learning opportunities. Research suggests that this makes it difficult for clinical nursing instructors to predict student-learning outcomes related to specific mental health diagnoses (Oudshoorn & Sinclair, 2015).

In mental health clinical situations, students are often discouraged from caring for patients who are acutely suicidal or who display self-harming behaviours. Therefore, simulation is particularly well suited to mental health nursing due to the occurrence and unpredictable nature of high risk events in a clinical setting (Brown, 2008). Simulation allows nursing students to have the opportunity to manage the high-risk events that they may not have the chance to experience in the clinical setting (Brown, 2008; Jack, Gerolamo, Frederck, Szjna & Muccitelli, 2004; Jeffries, & National League of Nursing 2012). Clinical nursing instructors can use simulations to replicate a multitude of diagnoses including depression, or suicide risk. Foster, Chaudhary, Murphy, Lok, Waller, and Buckley (2015), described healthcare students who have experienced suicide simulation in the form of virtual patient's, as being able to use what they have learned and experienced in simulation and apply it in the practice setting. This demonstrates that knowledge learned in simulation can be transferred to clinical practice, providing support for the creation of resources that promote the utilization of simulation in preparing students for mental health nursing practice.

Inadequate preparation contributes to anxiety. Literature acknowledges that educational institutions have placed little emphasis on preparing nursing students in relation to experiential learning (Anderson, 2009). Students experience a sense of uncertainty that

results from being inadequately prepared for clinical practice (Zupiria Gorostidi et al, 2007).

Many nursing students report being afraid of saying the wrong thing upon entering their

mental health clinical practice. If students are anxious about practicing in clinical

environments, then learning professional competencies can be jeopardized, as anxiety can

impair student learning (Abas, 2017; Melincavage, 2011).

GOH, Selvarajan, Chng, Tan, & Yobas, (2016) used a pre-and post-test, single group

quasi experimental design to explore the learning experiences of undergraduate nursing

students exposed to standardized patients while practicing their mental status examination

and suicide risk assessment skills in a mental health nursing module. Standardized patients

(SPs) are human actors who have been trained to respond in specific ways to student

clinicians (Jeffries, 2005). Investigators found the use of a standardized patient simulation

session significantly increased students' satisfaction and confidence level prior to entering the

clinical placement.

Results from this investigation are similar to a study conducted by Kameg, Szpak,

Cline and Mcdermott, (2014), that concluded that the use of simulation scenarios using a

standardized patient has the potential to be utilized in mental health nursing to decrease

undergraduate nursing student anxiety before attending clinical and interacting with a

mentally ill patient. Likewise, Lehr and Keplan (2013) point out that following simulation

experiences, the percentage of nursing students self-reporting high levels of anxiety in caring

for mental health patients decreased from 28% to 7%. These finding support the notion that

appropriately utilized simulated learning experiences can have the ability to provide a variety

of patient scenarios in a safe environment (Abas, 2017; Bland, Topping, & Wood, 2011).

Mental health simulation may be a solution to reduce student anxiety by enabling rehearsal of

clinical skills prior to real world patient engagement. Moreover, clinical nursing instructors

can create or adapt simulation scenarios to meet learner's needs and scaffold learning from the simple to the complex. This approach can reduce student anxiety, as they are able to gain mastery in simple tasks that build their confidence before being exposed to complex clinical situations.

Inexperienced clinical instructors. Despite the evidence identifying simulation as an effective teaching and learning strategy, many nursing programs and faculty members are hesitant about implementing simulation as a learning tool (Hanberg, 2009; Starkweather & Kardong-Edgren, 2008). The adoption and incorporation of simulation into curricula has been variable (Starkweather & Kardong-Edgren, 2008). The use of simulation used in nursing education seems to be disconnected and lacking a comprehensive process (Schiavenato, 2009).

An obstacle to implementation of simulation in nursing curriculum may come from the lack of consideration to faculty training, and time in preparation for simulation use (Jefferies, 2012). Smitten and Myrick (2010) conducted a qualitative grounded theory study in a single Canadian baccalaureate nursing degree program to investigate how nursing faculty are prepared to use high-fidelity simulation. This study found that continuing education for nursing faculty members was necessary to support the implementation of simulation in nursing education.

It is important to note that, however valuable simulation is in developing student nurse's competency, it cannot be fully utilized as a teaching and learning strategy without the support from clinical instructors. This lack of support may in fact be related to clinical instructors having little knowledge, training or experience with simulation. Mental health clinical instructors may be slow to adopt simulation into their clinical teaching practice, as many are inexperienced with simulation.

Consideration must to be given to the support and training needed to develop and implement simulation scenarios as a teaching modality (Akhtar-Danesh, Baxter, Valatis, Stanyon & Sproul, 2009). In a study examining nursing faculty perceptions of simulation where 104 statements were collected to determine what people say about the issue of simulation, it was evident that with correct support and training, many faculty members would embrace clinical simulation because of its ability to enhance nursing education (Akhtar-Danesh, et.al, 2009). This finding provides support for the belief that if clinical instructors become more experienced in simulation, they would be willing to incorporate it as a teaching and learning strategy. Therefore, a clinical nursing instructor resource manual has the potential to influence the utilization of simulation, as the manual is designed with the intent of building individual instructor capacity to run a simulation experience.

Conclusion

Simulation offers a response to the challenge of ensuring consistent learning in clinical practice (Feingold, Calaluce, & Kallen, 2004), and possibly a teaching strategy to enhance clinical competence (Murray, Grant, Howarth, & Leigh, 2008). It has the potential to lessen student's anticipatory anxiety about mental health practice, as students are first exposed to mental health issues in a safe learning environment (Jeffreis, 2005, 2007; Reedy, 2015). The use of simulation in clinical nursing education has potential benefits and challenges for its implementation as a teaching and learning strategy. For mental health clinical instructors to utilize simulation as a teaching strategy, they will need support, resources and training in relation to simulation. A clinical resource manual for a depression scenario may have the potential to build capacity for the use of simulation, as it exposes mental health clinical instructors to simulation based educational concepts.

<center>**Section three: Project description**</center>

For this Master of Nursing Project, a depression scenario was created for a Clinical Instructor Resource Manual.

Project Goals

For this project there are two goals:

1. To design a high-fidelity nursing simulation scenario related to depression that can be utilized by clinical instructors to build competence in mental health clinical practice.
2. To build capacity, transferability and sustainability for the use of simulation as a teaching and learning strategy in mental health clinical nursing practice, through the creation of a clinical instructor resource manual that is useful to the implementation of a depression scenario.

Meakim (2013), defined fidelity as the "believability, or the degree to which a simulated experience approaches reality" (p. 6). Whereas, utility is defined as "the state of being useful, profitable, or beneficial" (Merriam-Webster, 2018). Utility also refers to the usability of the project deliverable, which is "a measure of the quality of a user's experience when interacting with a product" (Hasen, 2016, p.180). Together these two definitions assist in adding clarity to the project goals.

Purposes of Deliverable

The first project deliverable will take the form of a clinical instructor resource manual for a depression simulation. This resource manual is needed, as currently there is limited guidance available for clinical mental health nursing instructors wishing to utilize simulation as a teaching strategy (Handley & Dodge, 2013). A user manual provides important information on 'how to use a product' to end-users (IAM consultants, Ltd., 2012). The user manual is akin to a teaching plan for a depression scenario.

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The second project deliverable is a high-fidelity nursing simulation scenario related to depression that provides an experiential learning opportunity for University of Lethbridge, Bachelor of Nursing (BN) undergraduate students during their 4510- mental health clinical rotation with the use of a standardized patient. The designed simulation scenario will focus on three components of caring for a depressed patient: 1). Mental health assessment of depression, 2). Suicide risk assessment, 3). Safety planning. The end goals for this project encapsulates the vision of being able to enhance student learning and understanding related to depression.

Ethical Considerations

For this project, A Project Ethics Community Consensus Initiative (ARECCI) assessment of risk for the participants was completed. ARECCI tools were used to measure the level of risk to participants. This project was determined to be minimal risk to participants (See Appendix: A for the ARRECI links). In addition to the ARECCI screening, there are ethical considerations for simulation to facilitate a safe and confidential learning environment for students. Consideration for the maintenance of psychological safety of all participants was reinforced in the design of the clinical instructor resource manual.

Theory of Change Statement

Two theory of change statements that aligned with the project goals were used to guide the implementation and evaluation phase of this project. 1). If clinical mental health nursing instructors are equipped with a clinical resource simulation manual of a depression scenario, then clinical instructor's capacity to utilize simulation as a sustainable teaching and learning strategy will increase. 2). If project goals are met, then the clinical instructor resource manual can become a transferable tool to build sustainability and increase utility of a depression simulation with undergraduate nursing students.

Theoretical Frameworks

Three theoretical frameworks guided this project: Kolb's (1984) Experiential Learning Theory, an Instructional Design Framework, and the National League of Nursing (NLN)/Jefferies Simulation Framework. There are two known beneficiaries for this project – mental health nursing students and mental health nursing clinical instructors. It is important to be aware of the needs of both groups of stakeholders as they each have unique requirements related to simulation based education. The aforementioned theoretical frameworks will inform the development of project deliverables related to each stakeholders needs.

Experiential Learning Model

Oliva (2009) observed that students learn when curricular goals and content were transformed into experiences. This view is supported by Kolb's (1984) Experiential Learning Model. From a student perspective, there is great opportunity for experiential learning to improve performance (Reilly & Spratt 2007), which ultimately leads to improved clinical competence (Jeffries, 2005). Experiential learning encompasses the cognitive, behavioural and affective domains of learning (Anderson, Krathwohl, Airasian, & Bloom, 2001). Likewise, simulation strategies can incorporate these three domains of learning to assist nursing students in practicing competently. Jefferies (2005), maintains that experiential learning is a theoretical concept that contributes to the understanding of the simulation process. Kolb (1984) notes that students cannot learn by being passive, rather they must be actively involved in the learning process. Kolb's (1984) cycle of learning can further be seen as paralleling the active learning component of this project and promotes the utilization of simulation as a teaching and learning tool, as the stages in Kolb's cycle of learning closely match the simulation process (see figure 1 below).
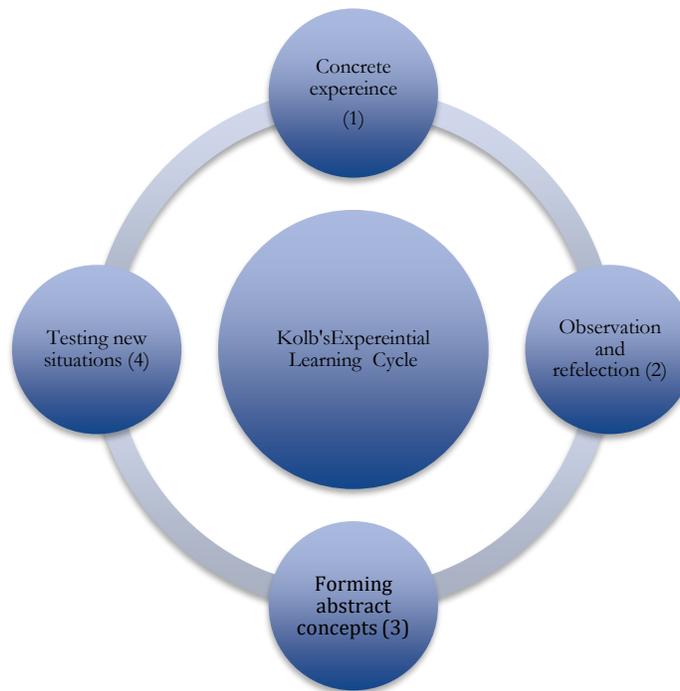
Figure 1. Experiential learning cycle. Four stages of learner construction. Adapted from *Experiential learning: Experience as the source of learning and development* (p.42), by D. A. Kolb, 1984, Prentice-Hall, Inc: Englewood Cliffs, N.J.

Through Kolb's (1984) experiential learning cycle, nursing students can embark on a course of discovery to gain insight, understanding, motivation and engagement in learning about depression. Learning experiences identified in Kolb's theory are related to the simulation process as follows:

- Concrete experience: student participation in a realistic scenario
- Reflective observation: debriefing process
- Abstract conceptualization: self-awareness from simulation experience
- Active experimentation: students try out learning in real world practice

Instructional Design Framework

Instructional design (ID) is a model that is used as a guide for developing and evaluating effective methods of instruction (Morrison, Ross, & Kemp, 2007). As this project is focused on developing effective methods of instruction for simulation, it is a useful model to guide this project development. To be successful in meeting project goals this clinical instructor resource manual applied instructional design principles, as purposeful simulation design promotes essential structure, process, and outcomes that are consistent with program goals (Burke, 2010). In this project, the instructional problem outlined in the ID framework began due to the need for students to gain experience in working with depressed patients, and progressed to the need for instructors to learn about simulation, in order to be able to enact a mental health scenario using a SP. It is through instructional design strategies that learning can become more efficient and teaching less difficult (Morrison, Ross & Kemp, 2007). Using the ID framework provided, a step-by-step guide to help organize the instructor's manual and ensured that all aspects of the project were covered along the way. Table one depicts nine steps found in the instructional design framework (see Table 1 below).

Table 1

Instructional design framework

Instructional Design Steps	Clinical Instructor Resource Manual
1. Instructional Problem	**Assessment** of instructional problem. What are the felt needs of clinical instructors. What are anticipated future needs of existing performance problems. Development of clinical instructor resource manual of depression simulation. **Assessment** of general characteristics of learners. Learning styles. Context of learning. Mental health clinical nursing instructors learning needs. i.e. pedagogy of simulation and process of simulation. Assess supports needed to implement simulation. i.e. simulation support staff, technological assistance. **Plan** & Create depression scenario, Utilization of subject matter experts to validate scenario Focus on goals of simulation. Select depression assessment tools. Determine content of scenario. Set learning objectives for instructors.
2. Learner	Use various types of fidelity to create the required perception of realism. **Plan** & Understand the three domains of learning: cognitive, psychomotor, affective domain. Ensure resources meet instructional objectives of utility, sustainability, and transferability. Construct measurable objectives. Sequence content according to INACSL, (2016) standards of best practice. Choose a theoretical and/or conceptual framework. Determine format of how to
3. Task Analysis	present information to increase utility of resource. Project deliverable to be
4. Instructional Objectives	reviewed by stakeholders. Test pilot to occur X2. Final clinical instructor
5. Content sequencing	resource manual to be emailed to key-stakeholders. The resource will then be
6. Instructional strategies	used for professional development and engagement of mental health 4510
7. Designing the message	mental health nursing students. **Implement** priority learning needs are identified and INACSL, (2016) standards of best practice simulation used as teaching tool to guide clinical mental health nursing instructors. **Evaluate** Gather formative feedback during simulation, direct observation of project lead, student exist slips, and feedback forms A final copy of clinical instructor resource manual will be provided to mental health 4510 clinical teaching team at the U of L. This resource may then be used for professional development of clinical instructors related to a depression simulation. Instructor feedback forms, a debrief SWOT analysis, Direct observation. Also, future evaluation methods such as evaluation of simulation facilitator could be considered to be included in manual
8. Development of instruction	
9. Evaluation Instruments	

The instructional design process focuses on what the learner needs to know, and avoids including nonessential content, and starts by focusing on an instructional problem (Morrison, Ross, & Kemp, 2007). Additionally, the structure in this framework helped to identify gaps within the content of the project deliverable and assisted in visualizing the end design of the clinical instructor resource manual. ID framework assisted in reaching the project goal of building capacity, transferability, and sustainability for the use of simulation as a teaching and learning strategy in mental health clinical nursing practice. The utility of the simulation manual was given consideration through-out the design process.

National League Nursing (NLN)/Jeffries Simulation Framework

The NLN/ Jeffries Simulation Framework was developed in 2007 by Jeffries and Rogers to guide simulation-based education (Jeffries. 2012). This framework identified five constructs: *student, teacher, educational practices, simulation design characteristics*, and *outcomes* (Jeffries,

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2012). These components help design, implement and evaluate simulation activities (Jeffries 2005, 2012). This framework has been used widely to guide the construction of the simulation scenarios and is integral to the project goal of designing a high-fidelity nursing simulation scenario related to depression. When simulation is conducted without the benefit of an organizing framework, educators have trouble determining the effectiveness of various practices (Jeffries, 2012) (see Table 2 below).

Table 2
NLN/Jeffries simulation framework

NLN/Jeffries simulation framework (2007)	Depression scenario
1. Facilitator 2. Student/Participant 3. Educational Practices 4. Simulation Design Characteristics 5. Expected Student Outcomes	Maintain a facilitative approach that is participant centered and driven by the objectives, consider participant's knowledge or level of experience, and the expected outcomes. Begin simulation-based experiences with a pre-briefing. Follow simulation-based experiences with a debriefing and/or feedback session. The designer and facilitator are responsible for ensuring that preparatory activities address the knowledge, skills, attitudes, and behaviours that will be expected of the participants during the simulation-based experience. Establish confines of confidentiality & psychological safety provide preparation materials and resources to promote participants' ability to meet expected outcomes of the simulation. Ensure fidelity of depression scenario. Pilot test simulation before full implementation. Design the scenario or case to include: A back-story to provide a realistic starting point. Script of a scenario that is developed for consistency and standardization to increase scenario repeatability/reliability. Design the simulation through attention to physical, conceptual, and psychological aspects of fidelity Ensure that participants are clear on purpose of experience.

Use of the NLN/ Jeffries simulation framework ensured that areas needing modification related to the design of the depression simulation were identified. For example, when specifically looking at construct number four, in the NLN/Jeffries framework related to simulation design characteristics; awareness for the need of fidelity within the depression scenario came to light. This identifies the need to give specific consideration for the realism of setting, prompts, and nuances of the simulation environment, assessment tools, and structure of the interview. The basic assertion of the NLN/Jeffries simulation framework is that student-learning outcomes are influenced by the constructs in this framework and therefore attention must be given to each construct when designing a scenario.

Linking Frameworks

Using both frameworks together was a back and forth process that increased the likelihood of providing a well thought out resource, which in turn increased the reliability of this project deliverable. By using the ID framework to guide the development of the clinical resource manual, the goal of developing a useful tool to ensure the implementation of a depression scenario and build capacity, transferability and sustainability for the use of simulation as a teaching and learning strategy was achieved. Utilizing and referencing the NLN/JSF in the design and implementation of the simulation scenario allowed for better standardization and reproducibility of the simulation process (Jeffries, 2005). Applying both theoretical frameworks simultaneously to build the project deliverable allowed, for various instructional strategies to be adapted to the simulation process, depression scenario and content of the clinical instructor resource manual (See Table 3 below).

Table 3

Comparison of frameworks

Instructional design steps (Morrison, Ross & Kemp, 2007)	NLN/Jeffries simulation framework (Jefferies, 2007)
1. Instructional Problem	1. Facilitator
2. Learner Characteristics	2. Student/Participant
3. Task Analysis	3. Educational Practices
4. Instructional Objectives	4. Simulation Design Characteristics
5. Content Sequencing	5. Expected Student Outcomes
6. Instructional Strategies	
7. Designing the Message	
8. Development of Instruction	
9. Evaluation Instruments	

It is intended that these two frameworks together ensure the designed clinical instructor resource manual creates an effective simulation-based educational experience.

Implementation Plan

International Nursing Association for Clinical Simulation and Learning [INACSL] Standards Committee (2016), standards of best practice support the use of a test pilot to meet the criteria of the simulation design. The test pilot is an initial small-scale implementation that is used to prove the viability of a project idea and comprise a risk mitigation strategy to reduce the chance of failure in a larger project (Fraser, Fahlman, Arscott, & Guillot, 2018). In other words, a test pilot facilitates decision-making and allows for a glimpse of how simulation would be implemented using the developed clinical instructor resource manual. Careful testing of the simulation scenario and standardized patient reduces the likelihood of unanticipated events during the educational session (Bradshaw & Hultquist, 2017). Thus, having an implementation plan allowed for recommendations and improvements to be factored into the project deliverable prior to it being distributed to key stakeholders.

Test Pilot

Two mental health clinical groups of seven (n=14) nursing students and two mental health clinical nursing instructors (n=2) volunteered to participate in the test piloting of the depression simulation scenario. The simulation experience took place at the University of Lethbridge simulation lab. Both clinical instructors were emailed the clinical instructor resource manual one week prior to the simulation experience. This allowed them to review the depression scenario, simulation processes, and the standardized patient scripts in preparation of the test pilots. Jones and Higge (2008) postulate that it is important that faculty members should be given enough time to be confident with the simulation scenario, setting, and debriefing methods before conducting a simulated scenario.

Test Pilot One

The first test pilot provided an opportunity to make incremental changes to the project deliverable through qualitative and quantitative data collection methods. In preparation for the simulation test pilot, one week prior to implementation, clinical instructors were emailed pre-readings related to depression to share with nursing students participating in the depression scenario.

Before nursing student's arrival at the simulation lab, the physical layout of the lab was made to resemble an acute care psychiatric hospital room, as per the instructions in the clinical instructor resource manual related to fidelity of the scenario. Scenario-based experiences that attempt to recreate clinical environments are a powerful learning experiences for students (Luctkar-Flude et al., 2012). All the scripted props and materials were applied to maintain environmental realism of the simulation experience. Using the clinical instructor's resource manual, the simulation scenario was executed. The clinical instructor resource manual was compartmentalized into three sections, which mirror the

simulation process recommended by the standards of best practice: simulation (INACSL Standards Committee, 2016) (See Figure 2. below).

Pre-briefing > Simulation > Debriefing

Figure 2. Simulation process of depression scenario for instructor use

Pre-briefing. During the pre-briefing, students were welcomed into the simulation lab and thanked for agreeing to participate and project ethics were reviewed. Students did not express having any questions related to assigned pre-readings. Following the scripted pre-briefing segment in the clinical instructor resource manual, psychological safety, purpose of the simulation, and confidentiality was established. All students signed a confidentiality agreement, then the simulation process was then explained to students and the instructor with an algorithm outlining the simulation experience (see Appendix: B).

Once students understood the simulation process, an informal pre-test on depression was administered to the nursing students. A pre-test can be used as a pre-instructional strategy. When used as pre-instructional strategy, a pre-test is designed to heighten the student's awareness of the content by serving as cues to the key points (Morrison, Ross, Kemp, 2007). These cues helped the nursing students identify and focus on the main idea of depression throughout the simulation experience. Students were given copies of the mental status assessment and suicide risk assessment forms they would be using during the simulation.

Running of the simulation. Moving from the pre-briefing to the actual simulation, the mental health clinical instructor became the SP and acted the role of a depressed patient. The SP was given three variations of a depression script to enact, based on simple to complex understanding of suicidal risk. The SP was provided with scripted responses to the mental health status assessment that would help accurately represent a person suffering from depression. This script was strategically located in the instructor's manual under resources for SP. This was intentionally added to the resource manual as it is possible that not all future individuals portraying the SP will be subject matter experts, thus creating greater sustainability for future enactments of the scenario if detailed scripts are provided.

The project lead assumed the role of simulation facilitator by utilizing the clinical instructor resource manual throughout the running of the scenario. Each student had 15 minutes to enact the depression scenario, while the remaining nursing students watched a live video feed of their peer's performance in the depression scenario. Each student was given a blank piece of paper to write down their personal reflections of what went well during simulation, and areas they found challenging. It was explained that this would be used to enhance the reflective learning process, and that they could choose to share or not share the content of their thoughts during the debriefing process. Additionally, each student was provided with a clinical skills observation form that acted as a prompt to help in the giving of feedback to peer nursing students participating in the simulation experience (See Appendix: C).

Debriefing. Debriefing occurred following each student's enactment of the simulation scenario. The project lead provided immediate feedback and students were provided with feedback from their peers that watched their performance on the live feed video screen. Following the enactment of the entire clinical group's simulation experience, it

was planned that reflective learning would take place in the form of a scheduled debriefing at the end after all students completed their simulation experience. The simulation facilitator was able to use the scripted responses and prompts outlined in Eppich and Chengs (2015) debriefing tool located in section three of the resource manual to streamline this process.

Test Pilot Two

The second test pilot followed the same implementation plan as the first test pilot; however, in the second test pilot strategic changes were made to the instructional design to improve the overall quality of the simulation design and process. Some of these changes included: adding more scripted scenario's, solidifying placement of debriefing, scheduling breaks for learners, and ensuring nursing students were shown the simulation lab prior to enactment of their scenario. For comparison purposes, feedback was held until the very end of the test pilot. Each student was asked to write down comments about their own performance as well as the performance of their peers and each student was provided with this feedback during a debriefing period at the very end once all students had completed their scenarios. This change was deemed very effective because it allowed the project lead to determine where to place debriefing in the design of a depression scenario to best facilitate reflective learning.

The SP was provided with additional scenarios to enact for the second test pilot. While the SP in test pilot one was given three depression scenarios to enact, the SP in test pilot two was provided with seven variations to add diversity to the scenarios. This incremental change allowed all seven students participating to experience a slightly different scenario, thus decreasing duplication. Students in test pilot two were provided with an education session one week prior to the simulation scenario which exposed them to the suicide risk assessment and safety planning forms. This education session included not only

exposure to the forms but also a detailed explanation of the forms and proper use of the forms. This change was instrumental in improving student performance from the first to the second pilot test.

Planned Evaluation

The project evaluation consisted of a mixed methods design where qualitative and quantitative measures were employed to better understand how the design of the overall simulation and clinical instructor resource manual could be improved. Planned evaluation helped in rendering judgement about the design of the scenario and the clinical instructor's manual, the running of the simulation, and ways to facilitate improvements to the project deliverable. The project evaluation included formative and summative data collection methods on two separate occasions one day apart. This project solicited feedback from participants following the completion of each test pilot. A total of 14 undergraduate nursing students who were in their mental health clinical nursing rotation (n=14) and their mental health clinical instructors (n=2) volunteered to give feedback using project evaluation tools. In addition, facilitator direct observation was employed throughout both test pilots to monitor adherence to the implementation plan and the instructor manual.

The combination of formative and summative planned project evaluation assisted in understanding whether the deliverable met proposed project goals. When these methods are used together they allow for a greater understanding of whether project goals have been reached.

The following data collection tools were used:

- Facilitator direct observation
- Student exit slips
- Informal debrief discussion with instructors SWOT analysis
- Student participation feedback form

- Instructor feedback form

Timing of feedback. Timing of nursing student feedback (exit slip and feedback form) occurred directly following the completion of the test pilots. This ensured that the immediacy and recall of the simulation experience was obtained from nursing students and instructors alike. First, the nursing students provided their feedback using the designed exit slips and student feedback forms. Following student's departure from the simulation lab, nursing instructors provided feedback using a SWOT analysis and instructor feedback form on the utility of the clinical instructor resource manual. Results from this mixed method plan were compiled and recorded by the project lead.

Summary of Findings

Part of developing a well thought out plan is being able to study results and make recommendations and adjustments accordingly for the project. The design, fidelity, utility of the simulation process and running of the simulation from the first test pilot to the second were reviewed to improve quality of the project deliverable.

There are several lessons learned from the evaluating this project and analyzing the results. For example, the importance of having subject matter experts or training in mental health related to the portrayal of a diagnosis, having scripted variations of the scenario related to patient presentation and determining placement of debriefing were important findings as knowing these elements promoted greater utility of the project deliverable. It was also discovered that strengths were already rooted within the nursing department at the University of Lethbridge for simulation, and that opportunities existed for the use of simulation within mental health clinical nursing practice.

Subject matter expert. It was noted through direct observation that it is essential that standardized patients (SP) have an understanding of the patient conditions that they are

to portray during the simulation. The clinical nursing instructors who acted as SP's demonstrated an ability to improvise in the scripted scenario and to realistically portray a depressed patient. The INASCL Standards Committee (2016) discuss that the simulation design should use a monologue to replicate features of patient situations. As a content expert aids in the development of realistic dialogue, behaviours consistent with the disease, and typical patient responses to common nursing actions (Bosek, Li, & Elicks, 2007). Because SME are keenly aware of the characteristics of depression, they can further adapt monologue spontaneously to learner's responses, providing a more realistic portrayal of a person suffering from depression. Mental health clinical instructor's ability to improvise in the scenarios provided enrichment in terms of fidelity in the portrayal of a depressed person. It is therefore recommended that SP be a SME, or have training related to the diagnosis they are portraying, as knowing the characteristics and presentation of the illness is important for student learning. It may not always be feasible or desirable that clinical instructors assume the role of the SP, however, through test piloting of the simulation, the importance of having someone who can realistically portray an accurate representation of patient diagnosis and presentation was confirmed.

Ideally, it may be beneficial to have someone who is not the designated clinical instructor for the nursing students participating in the simulation experience, but who can still accurately and reliably portray a depressed patient. Some literature has identified that having faculty in the simulation lab can be anxiety provoking for the students. Jeffries (2008) described the negative effects to students' critical thinking and problem-solving skills if nursing faculty are visible or interrupt students during the simulation process. Although, this did not directly speak to the role of clinical instructor acting as a SP, it does provide consideration for the impact of having a clinical instructor as part of the simulation

experience. Despite being reassured that simulation is for learning purposes only, nursing students may feel judged, believe their performance is being evaluated, or that their performance will affect their success in their clinical course if their clinical instructor is part of the simulation experience.

Variations in the scripted scenario. It was identified from direct observation during the first test pilot that the three scripted variations of the depression scenario were inadequate to meet nursing students learning objectives. When observing each student enacting the first three designed scenarios, it became clear that if the same three scenarios were to be performed again by the remaining students, learning would become repetitious, as nursing students watching the live feed were being exposed to the same learning objectives from peer enactment of the scenario.

Given that the simulation experience was only designed for a capacity of seven nursing students, it was achievable and valuable to student learning that each student be able to enact a unique variation of how a person suffering from depression could present in the real world. This was confirmed by feedback from students on the exit slips following the simulation experience (see Appendix D). When asked in the exit slips "What would have improved your learning experience?" responses from the first test pilot included "Maybe more scenarios would have been helpful" and "Practice that is close to some real-life variations of the situation and different scenarios of depression would improve learning". Additional scenarios were scripted and incorporated into test pilot two. These included scenario's that portrayed: low suicide risk, moderate suicide risk, high suicide risk, psycho-social needs to encourage a multidisciplinary approach, an agitated patient presentation, psychotic presentation and a scenario with no suicide risk.

Direct observation and comments from exit slips identified that these additional scenarios enhanced student learning for the second test pilot and annotations included: "The acting was different in different cases, giving us a variety of exposure to depression". Additional scenarios acted to enhance student learning related to depression, as it intentionally exposed students to various aspects of caring for a depressed patient.

Variations in the script scenarios reinforced that although individuals may share common characteristics within a diagnosis, they remain unique in their presentation of the illness itself. Handberg and Madden (2011) encourage individuals who are designing simulation scenarios to consider writing the scenario using a backwards design, beginning with the end and working toward the beginning. This premise further assisted in the creation of the additional scripted scenarios, as consideration was given to projected student learning outcomes related to each variation of the scenario. Having varied presentations of the depression scenario ensured the realism of the scripted scenarios and confirmed the design of the simulation had the ability to meet student learning outcomes. Quantitative data from the nursing student feedback form confirmed that students felt the simulation experience felt real for a depressed patient. As 86% of nursing students who participated in the depression simulation strongly agreed to the realism of depressed patient and that the depression scenario felt authentic (see Appendix E). Together the collected data suggests that the design of scenarios was effective in exposing students to a realistic representation of a depressed person.

It is therefore, recommended that a variety of scripted depression scenarios be purposefully included in the clinical instructor resource manual to ensure that no two students are exposed to the same scenario during the simulation. Additionally, variations of

the scenarios were observed to enrich the reflective learning in the debriefing process as students had more nursing considerations to reflect on.

Improved student confidence. Based on feedback from the exit slips, nursing students, overall, expressed an increased sense of confidence in their ability to assess a depressed patient. Samples of statements made by nursing students on the exit slips included: "I believe my confidence has increased to work with depressed patients"; "I feel confident to carry out a suicide risk assessment now"; "Went from a 1/10 to a 5/6 in confidence."; "Simulation has given me so much more confidence; I wish I could have done one prior to my mental health clinical experience". These statements made by nursing students support how rehearsing skills through simulated experiences can increase student confidence in assessing and caring for someone suffering from depression.

Direct observation supported data gathered from exit slips, as it was observed that students' overall confidence appeared to be progressively improved with each enactment of the scenario. This can be attributed to the cumulative learning, where one student is able to learn from the previous scenarios and mirror techniques and responses used to build rapport by mimicking therapeutic approaches, and imitating assessment styles based on other student's performances. While no literature was found to support this finding, students in these test pilots did overall report an increased sense of self-confidence following the simulation experience.

Placement of debriefing. Having debriefing of feedback immediately following simulation involvement is recommended by the INACSL (2016) Standards Best Practice: Simulation and NLN/Jeffries Simulation Framework (2007). Groom, Henderson and Sittner (2014) maintain that debriefing immediately after the simulation is recommended "so students' thoughts and feelings are not forgotten and are not distorted as time passes"

(Groom, Henderson, & Sittner, 2014. p.341). However, it is hard to determine from literature when the end of simulation is to take place. It does not explicitly indicate if "immediately after" means following each individual's performance or once all nursing students have completed the scenarios. Given the ambiguous nature of this detail in the literature, it was decided that each of the test pilots for this project would provide the debriefing at different times to ascertain what worked better for students learning needs. During test pilot number one, it was planned that debriefing would occur at the end of each individual scenario. For test pilot two, debriefing was held until all students had completed their scenarios.

It was identified through direct observation, exit slips, instructor debriefing discussion, and student and instructor feedback forms that having immediate feedback versus waiting until the completion of the nursing group was favoured by the majority of students. It was described by nursing students that having immediate feedback assisted in their recall of events, which helped them consider feedback in terms of what they had just experienced. Feedback from instructors during informal discussion/debriefing described the opportunity for immediate feedback regarding individual performance as a strength of the simulation experience (See Appendix F). Students in test pilot one expressed satisfaction and improved learning related to immediate feedback, while students in test pilot two identified the lack of immediate feedback as a weakness of the simulation and suggested that feedback be given immediately after each scenario.

A major lessoned was learned by observing two variants of the placement of debriefing. When simulation is utilized for learning purposes, immediate feedback gives subsequent participants the ability to adopt feedback or recommendations into their own enactment of the scenario, demonstrating how students can learn through active observation

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in the feedback process. This insight supports Kolb's experiential learning cycle where learners can assimilate new understanding through reflective observation. Although repetition of skills is declared a valuable tool in simulation, nearly half (47%) of the studies on learning in simulation report that feedback was the most important element, supporting the premise that debriefing during simulation affects learning (Mayville, 2011). This suggests that if debriefing is one of the most important elements of the simulation experience, then the simulation design must consider the timing of debriefing and ensure it is placed where it will most positively impact learning. It is therefore, recommended that when simulation is being utilized as a learning tool that mental health clinical instructors place debriefing following each nursing student's enactment of the scenario.

Preparation. Direct observation, exit slips, and instructor debrief discussion following test pilot one identified the need to have knowledge of the assessment forms prior to the simulation experience. This feedback provides support for the need to pay critical attention to detail when creating a simulation experience, as minor details can impact the running of the simulation scenario. This lack of attention to detail impacted student learning as students in test pilot one who had no prior exposure to the suicide risk and safety planning forms took extra time to get through the scenario and were not as adept at completing the assessments as compared to students in test pilot two who had prior exposure to these forms.

Students in test pilot number one provided feedback in the exit slip that commented "knowing ahead of time the form for suicide risk assessment" would have improved their learning experience. This potential weakness in the simulation design was rectified, the clinical instructor resource manual was updated to state that all assessment forms/tools should be sent out to nursing students and explained prior to the simulation experience. The

forms were also included in the student pre-reading section of the clinical resource manual, with a recommendation that clinical nursing instructors review assessment tools prior to enacting the simulation scenario. As students in test pilot number two did not identify any difficulties with this aspect of simulation, as they had prior exposure to assessment forms.

Current resources available. A strength of the simulation experience was described by mental health clinical instructors in the SWOT analysis as being that the University of Lethbridge already has a well-designed and equipped simulation lab reducing the cost of utilizing simulation and lessening issues of feasibility. Al-Ghareeb and Cooper (2016) report barriers to simulation relate specifically to the complex technologies and cost of lab equipment. Jefferies (2012) further maintains one of the greatest challenges of using simulation in nursing education is the expense. In addition to having access to a simulation lab, having faculty knowledgeable about simulation and willing to assist in the simulation process is invaluable. Young & Shellenbarger (2012) maintain faculty must work collaboratively with clinical laboratory staff because they can offer valuable assistance in executing the simulation.

However, this concern has been mitigated as the University of Lethbridge already has well-informed and hands on simulation coordinators who understand the pedagogy that supports simulation. In addition, the simulation staff expressed full support for this project and were available for current and future enactments of the mental health simulation scenarios. This was also directly observed during the running of both test pilots, as simulation staff displayed a willingness to assist mental health clinical instructors in all aspects of the experience. The universities simulation lab has the capacity for nursing students in their mental health rotation to take advantage of these already established resources.

Repository of mental health scenarios. Lack of mental health scenarios was
reported by instructors in the SWOT analysis to be a weakness related to the utilization of
simulation. They did however describe the clinical instructor resource manual as increasing
their confidence in the running of a depression scenario, and they reported seeing the
potential in increasing nursing student competency related to caring for a depressed patient.
However, instructors did express a concern that one scenario would not be adequate to build
overall nursing competency related to mental health nursing practice. Faculty members
recognize the need for time, practice, and the development of a repository of clinical
simulations to aid them in embracing simulation as a teaching tool (Gaberson, Oermann &
Shellenbarger, 2014). Mental health clinical instructors suggested that having a repository of
scenarios would allow them to more fully integrate simulation as a teaching and learning
strategy in mental health.

Building capacity. A major finding expressed by clinical instructors, was that having
the clinical resource manual presented an opportunity to build capacity within clinical mental
health instructors to enact a depression scenario with nursing students, as this tool facilitated
the running of the simulation and provided insight into best practices in simulation, and the
simulation process. Clinical instructors who were unfamiliar with the simulation process
expressed feeling they could run the simulation with the clinical instructor resource manual.
Furthermore, post-simulation quantitative data found in the instructor feedback form
depicted that 100% of the mental health clinical instructors who responded strongly agreed
that the utility of the clinical instructor resource manual would positively impact their ability
to run a depression scenario (see Appendix G).

Lack of formal training A threat to simulation was identified by clinical nursing
instructors as being a lack of formal training in teaching with simulation, particularly related

to the simulation process. Due to the growing demands of simulation, institutions are adopting this teaching methodology into their curriculum without structuring a training program (Seropian, et.al. 2004). A lack of understanding regarding the simulation process poses a barrier to nurse educators adopting simulation (Jeffries, 2008). Mental health nursing instructors reported during the informal discussions that they valued having guidelines to assist them in the reflective learning process, but felt more formal training would be beneficial to help facilitate this process. The INACSL Standards Committee (2016) recommends the use of facilitators in debriefing that have received formal training in debriefing techniques. Faculty members should receive preliminary training and be given enough time to be confident with the simulation setting, equipment, and debriefing methods before conducting a simulated scenario (Jones & Hegge, 2008). Effective simulation requires a considerable commitment of time from faculty, both in the planning and implementation of the simulations (Dreifuerst, 2012), seeing the amount of expertise, planning and training required in SBE has created interest among clinical instructors in learning more about simulation. This was deemed an opportunity in the SWOT analysis.

Gaining awareness regarding the expertise and knowledge needed to implement a simulation experience positions the two clinical instructors who volunteered for the test pilots to act as agents of change, as they now recognize the need for more training and education in relation to simulation. One clinical instructor reported "we are a practice-based profession and need the opportunity to practice skills the same way medicine/surgery clinical students would practice psychomotor skills, and yet little attention has been given to using simulation to prepare students for mental health practice". Instructors voiced a desire for additional training regarding simulation and felt this would then increase the sustainability of utilizing simulation in mental health.

The project deliverable has helped gain *buy in* for the use of simulation in educating nursing students for their mental health practice. Furthermore, three current mental health clinical instructors have asked to utilize the developed simulation scenario and instructor resource manual for future use, reinforcing the desire of instructors to utilize simulation to enhance their teaching and the necessity of this valuable resource to enhance student learning.

Project Limitations

A limitation of this project is that it only focuses on depression and for student nurses to truly become competent in the scope of their mental health practice, they will need to gain exposure to a plethora of patients with diverse diagnoses. However, small actions can have a vast effect in complex systems (Begun & White, 2008). Through the creation of one small simulation scenario, potential to develop a greater selection of scenarios based on a variety of mental health diagnoses for future learning purposes occurred. From here more scenarios can be developed which include diagnoses that go beyond depression and incorporate other facets of mental illness.

Another limitation of this project was that no external standardized patients were used for the enactment of the mental health simulation. Both clinical instructors identified that acting out seven scenarios was emotionally draining and by having more than one actor this could have been reduced, but this was not possible due to financial constraints. Having the funds to hire an actor/actress would alleviate this burden on instructors. Availability of funding acts as a significant roadblock to adopting simulation practices (Handberg, 2009). Involving simulated patients in healthcare education entails training individuals to accurately represent people diagnosed with specific health problems (Wakefield, Cocksedge, & Boggis, 2006). If not a subject matter expert, this may take additional time, planning and funding.

Lastly, the small student sample size of clinical groups to conduct test pilots was a limitation of this project. Due to the timing of the course project and completion of 4510 mental health nursing course no further test pilots were feasible. As well, only two nursing instructors were able to witness student learning in the simulated environment, leaving the potential for other mental health clinical instructors to not fully grasp the impact simulation based experiential learning can have on student learning. To have acceptance from nurse educators, it is important to allow an opportunity to observe a scenario in a nonthreatening environment and ask questions pertaining to the simulation pedagogy (Seropian et al., 2004).

Section four: Reflection

Implications for Nursing Education

      Nursing faculty have the challenge and responsibility to implement creative, innovative teaching and learning strategies to assist students in meeting professional competencies. These competencies ensure that nurses keep the patient at the center of decision making. Canadian Nurses Association (2008) maintains an Advanced Practice Nurse demonstrates leadership by identifying the learning needs of nurses or develop programs and resources to meet those needs. Specifically, advanced nursing practice includes the cultivated use of knowledge and skills (Daly & Carnwell, 2013). Within these parameters nurse leaders can advocate for change within nursing education. As a leader one does not need to be good at everything, but must be good at using others to complement their limitations (McBride, 2010). This project has allowed me to recognize my own strengths and limitations and to bring knowledge and expertise forward that can be utilized to improve nursing education and ultimately nursing practice.

      Clinical practice is the crucible of real world learning, however challenges related to educating students in the mental health clinical environment require alternative solutions to assist students with the development of competencies. Examining innovative teaching and learning strategies such as simulation to help expand nursing student's knowledge and practice is an essential component of being a leader in clinically instructing nursing students. This project has the potential to expand and inform clinical nursing instructors on the value of simulation as a teaching and learning tool, as they grapple with the realities of the clinical placement shortages, learner collision and student anxiety related to feeling unprepared for real world practice.

If experiential learning is valued in nursing and competency is an attribute for all nurses to strive for in relation to theory and practice, then perhaps simulation has the potential to act as an educational pedagogy that enhances active student learning. This project adds to clinical nursing knowledge and has value that goes beyond the project deliverable, as this project is a demonstration of how practicing clinical instructors can build new knowledge within their own nursing practice of educating students.

Major Lessons Learned About Simulation

The knowledge I have gained through working on this project and through the Master of Nursing program at the University of Lethbridge has changed how I view clinical nursing instruction, nursing education, how nursing can be taught, and the potential simulation has in facilitating student learning. This project outlined the need for on-going support to nursing instructors wanting to utilize simulation based educational practices in the development of nursing student's competence in mental health. It solidified that planning a simulation experience is time consuming, both in writing and in planning the simulated practice experience and requires an intentional design to meet learning outcomes. Implementation of simulation will require organizational support if clinical instructors are to utilize simulation as a tool to educate students in mental health nursing practice. In terms of sustainability, clinical nursing instructors need to become knowledgeable regarding evidence-based simulation practices, have a repository of validated scenarios, and the budget for standardized patient's.

Major Lessons Learned About Project Development

The Canadian Association of Schools of Nursing (CASN, 2015) reports a master's program prepares registered nurses for advanced roles in the profession. I have learned many lessons about project development such as how to formulate meaningful and intentional questions, examine and apply evidence, focus on student outcomes, and improve quality

clinical instructor nursing education, culminating in an evidenced based project. The voyage

through master's classes provided me with the opportunity to grow as much as the final

project itself. Each stage in the project development taught me something new and pushed

me to get involved and understand perspectives from various stakeholders' views. CASN

(2015) maintains that an essential component of a master's program is to prepare the student

to demonstrate "the ability to use a systematic approach to gather evidence, plan, implement

and evaluate solutions to nursing practice problems" (p.12). This has been evident

throughout my project development as I learned how to use, adopt, and implement

theoretical frameworks to formulate and support a project design, have recognized and

understood the importance of bringing new knowledge into practice, developed

relationships, leadership skills, enhanced my communication skills, collaborated with others

to bring change and improved learning strategies within the mental health clinical nursing

practice.

My passion for mental health clinical practice has been ignited while working on this

project. Discussion around the possibilities of utilizing simulation as an evidence-based

teaching and learning strategy has been contagious, as I have seen my colleagues become

excited by my work and the prospect of using these simulation experiences with their

students (see Appendix H).

Conclusion

The demands of providing clinical nursing education are increasingly complex. Nursing

students require higher levels of education and practice due to the acuity found in real world

practice. Educational needs are driving scholarship to develop practices and knowledge that

impacts learner outcomes and simulation is certainly a practice that can enhance learning.

The implementation of simulation-based education should ideally be part of an

organizational approach to quality improvement, building student competency and patient safety, where all approaches reinforce and nurture the other. By developing a simulation scenario to bridge the gap between mental health theory and practice related to depression a tangible deliverable has been generated from this project. Mental health clinical nursing instructors now have access to a sustainable project deliverable which they can utilize to enact a depression scenario with future generations of mental health nursing students to enhance their clinical experience.

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Appendix A
ARECCI LINKS

ARECCI Screening
Tool:http://www.aihealthsolutions.ca/arecci/screening/310049/23027ee724235501fc194cd
8b8351ce8

ARECCI Ethics Guidelines for Quality Improvement and Evaluation Projects:
http://www.aihealthsolutions.ca/arecci/guidelines/results/1502995/3716795530

Appendix B
Simulation Algorithm

Depression Algorithm   NURS 6002

Sequence of events in depression simulation and scope of material to be covered.

Algorithm:
Monday 0800
Sam Smith
Age: 21 DOB: Feb. 1, 1997
Allergies: NKA
Initial Settings:
T- 37,P- 88, R- 16
BP-120/70 O2 Sat 98%
Alert &Oriented x 3
No Significant mental
Health history
Form 1 Mental Health Act

Pedagogy of Simulation
1. Pre-briefing: All students and instructor together
2. Enactment of simulation scenario
3. (1 student at a time, remainder students watching live feed in separate room)
4. Debriefing

Low risk: Admits o suicidal ideation, reports being to being afraid to harm self
Moderate risk: No active intent or plan to harm herself.
Severe risk: Suicidal ideation with plan & intent to harm to self. 15 min break.
Then progress through scenario's 4-7.

Student 1: Phase 1: Conducts focused assessment to determine problem
Assess mental health status using ABSCATT MHSA tool
Recognizes signs of Depression
Approx. 7.5 minute

Phase 2: Expected Student Performance
Assesses risk and protective factors for suicide and safety plan: Student to rate patient as low, moderate, high risk & safety plan accordingly
Approx. 7.5 min
Student 1: then moves to interview room and Student #2,-6 repeat phase 1&2 until all students complete 15- 20 min dose of simulation

TOOLS for patient assessment
Phase I: ABSCATT
Phase 2: AHS Suicide Risk Assessment & Safety
Phase 3:Debriefing

Phase 3: Debriefing
All students and Instructor reconvene for debriefing
Debriefing dose 30- 45 minutes total duration
Student preference is for immediate feedback following their individual performance
(5-7 minutes each student)

If: suicide risk not completed
Patient deteriorates and refuses to talk with nurse any longer becomes guarded and disengages from conversation

Remaining students will watch through live stream video

Trenna Devoy MN NURS 6002 07/20/18

Debriefing of students

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Appendix C
Simulation Observer Form

Simulation Observer

Communication	Observers Comments
• Confidentiality assured • Introduce professional role • Establishes rapport and trust • Relaxed posture • Attentive to client comfort • Private location • Convey warmth and caring • Non-threatening tone of voice • Focused remained Primarily on patient's needs • Appropriate use of open ended questions • Able to listen to patient without interjecting personal bias or views • Active Listen: Clarifying, paraphrasing, silence, focusing, probing, validating, normalizing	
Situation Awareness	
• Knowledge and understanding of signs & symptoms of depression • Shares information with patient	
Decision Making	
• **Timely** • **Appropriate** • **Informs patient of rationale**	

Clinical Skills

	Achieved? Yes/No	Comments
Assessed patient **APPEARANCE**		
Assessed patients **BEHAVIOUR**		
Assessed patients **SPEECH**		
Assessed patients **COGNITION**		
Assessed Patients **AFFECT**		
Assessed Patients **THOUGHT PROCESS**		
Assessed Patients **THOUGHT CONTENT**		

Appendix D
Student Exit Slips

1. What would have improved your learning experience? Blue: Test Pilot #1 Red: Test Pilot #2	2. Do you think simulation would lessen your anxiety in engaging a patient in mental health?	3. Do you feel more confident in talking with a depressed patient and assessing for suicide risk?
"Knowing ahead of time the form for Suicide Risk Assessment. I enjoyed the having immediate feedback regarding my performance". "Just having some more of the handouts to go over beforehand like the suicide risk assessment form. Feedback after each scenario allowed everyone to apply feedback the running of their scenario". "Unsure I felt this was very helpful It was good. Maybe more scenarios, but not much else to improve" "Practice that is close to some real-life variations of situation and different scenarios of depression would have improved learning" "Maybe seeing the room before, debriefing after the first 3 scenarios to practice may have allowed more reflection and incorporating the skills we are learning as we go". Maybe more briefing into the situation, what should we focus on for our situation? Can we look through bag or not? Can we take time outs for questions"? "I found it was overall very helpful and having different scenarios was very beneficial to see what to do in different situation". "The feedback at the end was good because then we didn't have prompts or advantages in the next scenario. Very good and enjoyed it all! " "I would like immediate feedback after each scenario" It was hard to remember events when waiting until the end" "I think practicing a mental health status assessment and suicide risk assessment was extremely helpful"	"I do believe this simulation was very helpful" "Absolutely. I think a simulation class or two at the beginning of the semester would help a lot"." Yes. I believe my confidence has improved from a 2/10 to a 6/10. Big Shift!" "Yes, I think that sim would make me more confident in dealing with mental health" "Yes, I believe it was helpful and decreased my anxiety in a future encounter" "Yes, I believe it was helpful and decreased my anxiety in a future encounter" "Yes, for sure!! It was very helpful and makes me feel much more prepared for a situation like this in real life" "Absolutely. I feel as though practicing and preparation helps me feel more comfortable when engaging in almost everything mental health. It provides me the opportunity to know my strengths". "Yes, it's nice to have practice with suicide risk assessment and getting feedback before doing it in real life". "Yes, I feel this would be very helpful for students" "Just having some more practice with how to decide on a category (low, moderate, high risk). But overall, it was great learning experience. I liked how each patient was different."	"Yes, I believe my confidence has increased to work with depressed patients" "Yes, I feel more confident. Thank you for this learning opportunity" ""Yes. I felt that the simulation experience was very helpful. By simulating the experience first, I feel that I will be more comfortable and confident if I have to do a suicide risk assessment in a real patient". "Yes, I feel that it gives a you a good idea how to talk to depressed people and discuss difficult issue's Yes. I haven't had the opportunity to do previously. I feel confident to carry on a suicide risk assessment now. Went from a 1/10 to a 5/6 in confidence." "That simulation gave me a good feeling and that I am going to feel more confident in next possible simulation and practical experience". "Yes, for Sure! Thank you the was very helpful and makes me feel much more confident to deal with a real-life situation like this!" "I Do. I have feedback and learning strategies that I can take with me and use in the future". "Yes, and it was nice to get feedback about how to phrase questions and provide follow up" "Yes! I think this has boosted my confidence with speaking with a depressed patient and assessing for suicide risk. Thank you so much!" "Yes, it has given so much more confidence, I wish I could have done prior to my mental health clinical experience"

Appendix E
Student Feedback Form

Post Feedback for Mental Health simulation - Student
Thank you for participating in this mental health simulation pilot project. Your feedback will
help improve this simulation experience for future nursing students in eth NESA BN Program.
This is a **voluntary and anonymous feedback form** that will take 3 – 5 minutes to complete.
Results of this feedback will be shared with you in two weeks' time.
Using the scale below (1 = strongly agree and 5 = strongly disagree), please share *your personal
thoughts* on this mental health scenario and pilot project simulation experience.

Questions					
1. The simulation experience felt **realistic** for a depressed patient?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
2. The scenario felt **authentic** and believable?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
3. The scenario provided an **opportunity to practice communication skills** with a depressed patient?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
4. Overall, the simulation experience provided an **opportunity to assess and plan care** for a depressed and suicidal patient?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree

Strengths	**Weaknesses**
Specific Space for current student load Faculty commitment to developing critical thinking skills in mental health	No strategic plan to incorporate simulation into 4510 curricula
Existing Equipment in simulation lab @ University of Lethbridge	Lack of staff training in debriefing process
Existing technology i.e. video live stream capacity Simulation staff available for current and future learning opportunities	Growing staff to support students and faculty in simulation time consuming
Literature to support benefits of experiential learning to nursing competency	Not a plethora of developed mental health simulations for clinical use
Having resource manual to build capacity within NESA 4510 Mental Clinical practice to enact depression/suicide risk assessment	Tiresome for instructor to enact 7 scenarios
Buy in from 4510 theory and clinical teaching team	Standardized patient's may need monetary compensation
Students felt simulation experience increased their knowledge base and competency in engaging depressed/ suicidal individual	Simulation not counted as clinical time
Students described feeling less anxious about talking about suicide	Students fear of role playing and anxiety of being judged by peers and instructor regarding performance
Students appreciated individual feedback regarding performance and strategies to improve therapeutic outcomes for patients with depression or who may be suicidal Increased opportunity to collaborate with Simulation Coordinator to plan simulation scenarios Exposes students to high risk situations they may not have exposure to in clinical placement	Students had trouble with recall on events due to delayed feedback given during debriefing.
Able to enact care without learner Collison Students enjoyed immediacy of feedback and students who were next due to enact scenario applied recommendations to their learning	Training of standardized patient could be time consuming if no mental health back ground
Simulation could be utilized during orientation Students familiar with simulation due to exposure during first year at Lethbridge College Pre-test exposed and reinforced simple key expected learner outcomes Able to teach facts, principles, and concepts in an engaging manner Application of scenario opportunity to identify biases, anxieties during debriefing related to mental health issues Because of ability to create customized scenario's simulation can designed to meet particular student need	
Opportunities	**Threats**
An opportunity to facilitate learning on "snow days"	False belief that simulation can only be utilized to facilitate psychomotor skills Lack of imagination or motivation to incorporate simulation into current curriculum Possibility of faculty being "territorial" related to labs and resources Competition for resources from other areas clinical practice i.e. nursing 4750 and rural acute Potential budget constraints
Opportunities for student remediation	
Expose students to experiential learning in a safe environment Opportunity for evaluation of student's performance Increased student enrollment, lack of appropriate clinical sites possibility of simulation to be used as adjunct to clinical learning? Replacement of clinical hours? Increased opportunity to practice role of collaboration with various disciplines if incorporated into scenario Increased expectations for the level of competency in nursing graduates, which may in turn drive curriculum changes Opportunity to extend lesson beyond depression to cultural safety of Indigenous populations Students able to learn by modeling others therapeutic approaches Provides students opportunity to think outside the "box" and rehearse communication and assessment tools in environment without real world risks Realistic scenario increased student engagement and learning Students enjoyed participating in simulation as each scenario was unique Opportunity to improve clinical judgement without real world risk increased related to MHSA	If incorporated terms of curriculum. Strategic planning is viewed by most faculty as time consuming Ineffective marketing of advantages of simulation lab4510 Mental Health instructors have little background in simulation design4510 clinical instructors are not familiar with Standards of Best Practice in Simulation (International Nursing Association for Clinical Simulation and Learning) Scheduling students experience provided in sim

Appendix G
Instructor Feedback Form
Questionnaire Regarding Utility - Mental Health Clinical Instructors

Questions	1	2	3	4	5
1. There was enough information provided at the beginning of the simulation manual to provide direction for clinical instructor related to process of simulation	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
2. The resource manual is user friendly?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
2. The script for the standardized patient provides a typical treatment history of a depressed, and suicidal client? The scenario resembled a real-life situation?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
3. Overall, the simulation Scenario will provide students a realistic experience communicating with a depressed, and suicidal patient?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
4. I clearly understood the purpose and objectives of the simulation.	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
5. Simulation preparation assignments adequately prepares students to engage with depressed patient?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
6. The flow and organization of resource manual will assist instructor in recreating simulation exercise on their own?	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree
7. The flow and organization of resource manual will assist instructor in recreating s	1 Strongly Agree	2 Agree	3 Neither	4 Disagree	5 Strongly Disagree

Appendix H
Depression Scenario

Depression Simulation
2018

Who: University of Lethbridge undergraduate nursing students
What: Depression Simulation
Where: University of Lethbridge, Markin Hall Simulation Lab & Debriefing Room
When: Can be utilized by instructor t/o mental health clinical as post conference, plan for snow days, student remediation
Why: To enhance student's experiential learning in mental health practice and increase competency in mental health nursing practice related to assessing and caring for patient with depression
Scenario Title: Assessment Interview for a Patient with Major Depression
Target Audience: Mental Health undergraduate nursing students (Minimum 1 student to Maximum 7 students as to prototypical of maximum number of students allotted to clinical group).
Location of Simulation: University of Lethbridge, Markin Hall simulation center. Debriefing will occur outside simulation lab in conference room.
Expected Simulation Run Time: 15 minutes per student. Total simulation time 145-200 min.
Debriefing/Guided Reflection: 30 min-45 minutes. (Place debriefing following enact of each scenario approx. 5 min/student). Following simulation have students write down own reflections firs on blank paper. As feedback is constructive this provides student opportunity to acknowledge their own performance.
Prerequisite knowledge: Learners should have basic knowledge of depression, including signs & symptoms, suicide risk factors and warning signs, the ability to conduct a mental health status assessment, and utilize therapeutic communication skills.
Scenario Description: Person suffering from depression presents to ER department and is admitted to acute care psychiatry where RN will complete a mental health status assessment, perform suicide risk assessment and safety plan.
Room set-up: Traditional interview room or hospital room, with vital sign assessment tools, and some patient's belongings i.e. duffle or suitcase (include in b, razor blade, belt, medication bottle (Tylenol), and plastic bag containing food and clothing. Fidelity of psychiatric environment should be maintained.

Running of Scenario: Prior to running the scenario, the human actor playing the standardized patient (SP) will be given patient's background, including medical and psychiatric history, work and school history, current stressors and behavioral patterns. Instruct actor to give minimal information until prompted by student. Beneficial to have subject matter expert or train standardized to present authentically as depressed patient.

Each student can independently move through simulation exercise, and the remainder of the student clinical group will congregate together in debriefing room and rotate one at time through simulation. All students returning together with instructor for debriefing. Student not engaging in enactment of scenario can watch via video steam.

Instructor's Role: When simulations are used as a teaching-learning process, the instruction is student centered because the teacher's role becomes that of a facilitator versus that of an evaluator. Students need instructor's role and purpose of simulation to be transparent from start of simulation. The clinical instructor can assume the role of a standardized patient (SP) or solicit a pre-arranged actor. The SP does not have any actual pathology (i.e. depression) but portrays the symptoms accurately through verbal and emotional cues (Tun, Alinier, Tang, & Kneebone, 2015). When using actors to support the psychological aspect of fidelity, there is a potential that poor acting this can diminish the credibility and reliability of the simulated environment (Sedgwick, Dersch, & Grigg, 2014). Therefore, instructors may wish to solicit actors who are subject matter experts or have experience in dramatization.
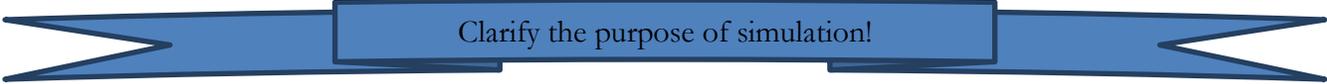
> Clarify the purpose of simulation!

I.   Simulation Purpose:

This simulation is appropriate for undergraduate mental health nursing students. It can be placed after students have had theoretical introduction to clinical depression, suicide risk assessment and safety planning. Pre-reading resources on depression can be given to develop learner's knowledge related to depression prior to simulation experience. A pre-test can also be utilize to develop learner knowledge related to depression.

II.   Pedagogy of Simulation:

Kolb's (1984) Experiential Learn Theory:

Experiential learning is based on the premise of learning is best achieved by experience (Conlan, Grabowski, & Smith, 2003). Kolb's theory emphasizes the central role that experience plays in the learning process Kolb's (1984) theory that maintains "learning is the process whereby knowledge is created through the transformation of experience" (p.38). Kolb's cycle emphasizes learning like simulation requires the use of a variety of learning modalities and appears to be a valid and useful model for instructional design in nursing simulation. According to Kolb (1984), experiences are grasped through apprehension or comprehension. Apprehension is viewed as participation in the actual experience, whereas comprehension occurs outside the actual experience through abstract conceptualization paralleling the actual practice component of simulation and debriefing segment.

III.   Process of Simulation:

Pre-Briefing → Simualtion → Debriefing
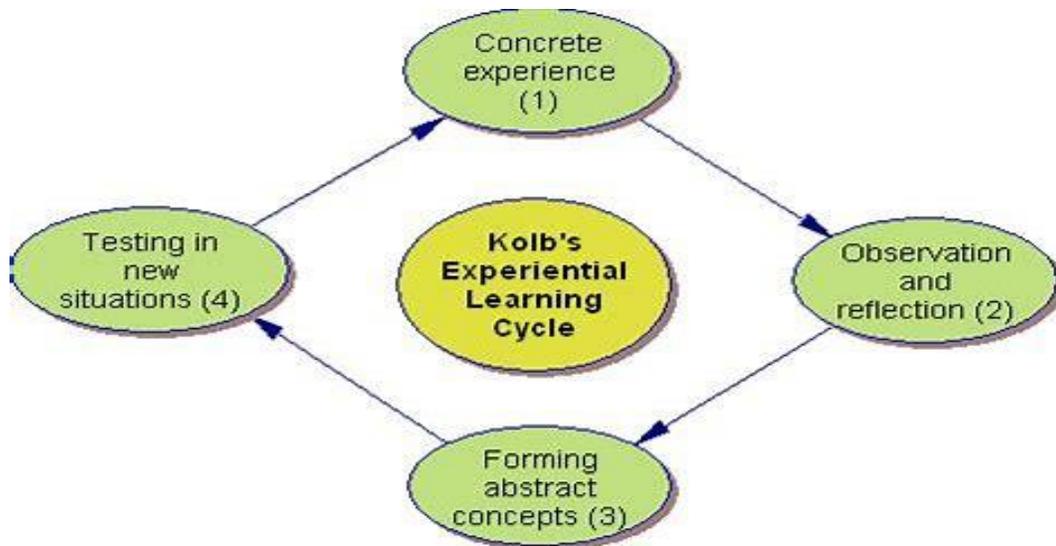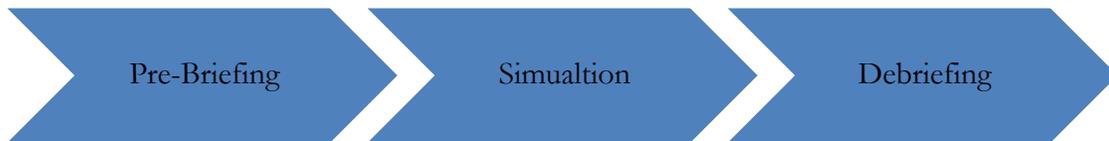
The learner will engage in 3 tasks related to process of simulation:

1. Assume the role of RN in assessing the patient for signs and symptoms of depression by conducting a MHSA.
2. Utilize the nursing process to demonstrate the ability to assess, plan and implement care based on mental health status assessment of depressed patient in terms of suicide assessment and safety planning.
3. Reflect on one's own practice to ensure actions are professional, ethical, responsible, and accountable in their interactions with depressed patient.

V. Type of Scenario: Standardized patient/High fidelity mannequin to enact depressed patient
      Student to enact role of Registered Nurse
      Nursing Instructor to act as scenario facilitator or Subject Matter Expert/Actor
      Simulation coordinator: technical support
      Students not participating can observe via live stream TV and complete observational checklist. Observational location can be adjusted by instructor.

VI. Scenario Materials Required:
- Client interview space, or patient room and one room for remaining students not engaging in simulation (room should have capacity for 8)
- 2 chairs in interview room
- One table

- Clip board for RN to take notes
- Admission forms on client's chart, with History of Present Illness & reason for admission
- Vital signs machine
- Pt suitcase filled with a razor, belt, medication bottle, gown, cannabis, cell phone, electrical device with extension cord
- Patient chart, admission form, doctors' order, form I, Mental health act brochures, lab values
- Phone in room so RN can call for help during agitated patient scenario
- TV with live stream capacity for student viewing
- Pens for students to write with during scenario

VII. Background for Scenario:

The briefly outlined scenarios provide an opportunity for students to explore and develop understanding of emotional, intellectual and behavioral realities of people suffering major depression and possible suicidal ideation.

Patient Description (Major Depression): Background for Scenario:

The patient presentation for this scenario is consistent with Depression; to keep students engaged each scenario presents slightly different. Instructor can progress from low to moderate, to high risk of suicide, so as to increase student's confidence in different stages of acuity. Additionally, variations of scenario include agitated depression, psychotic depression, patient needing psych-social support and multidisciplinary approach and patient who is actively seeking help and no suicide risk.

Patient Description (Major Depression):

Sam is a 21 year old post-secondary student to be admitted to inpatient psychiatric unit for further assessment under the Mental Health Act. Sam is waiting on a bed in acute care in-patient psychiatry. On the nurse's initial approach the patients head is downcast, they are teary. Patient is dressed in baggy sweat shirt and loose fitting jogging pants. Their hair is messy and they have a strong smell of body odor detected. Sam is normally good student but has recently been missing classes over the last 2 weeks and grades have started to decline. Sam is avoiding all social activities and isolating self in dormitory. Sam reports "I just want to give up and die". Upon assessment patient tells nurse that they broke up with partner. Sam describes being embarrassed regarding being admitted to the "psych ward". Admits that their mother suffers from depression. Sam reports to nurse feeling sad, empty and hopeless. Sam is experiencing trouble concentrating and having little interest in school or friends. Sam does admit to wanting to fall asleep and not wake up, and admits to thinking of dying often but describes "feeling too scared to do anything". Sam the discussed the loss of father due to cancer 5 years. Had seen family doctor and was prescribed Zoloft 50mg po. OD.

1. **Low suicide risk:** Suicidal thoughts, no plan or intent to harm self. Reports I would much rather go to sleep and not wake up but would never take measures to end own life, that is against my faith.
2. **Moderate suicide risk variation:** Wants to give up and die, has been thinking of overdosing on pills and has thought of stockpiling medication. Denies any intent as worried impact their death would have on mother as she has already lost her husband.
3. **High suicide risk variation:** Wants to give up and die, has been stockpiling medications, plans on taking pills as soon as people leave residence so they will not be interrupted or

saved. Reports one way or another they will find a way to die. "I just want to die, it's my right and you can't stop me.

<p align="center">**Coffee Break 15 minutes**</p>

4. **Variation to encourage multidisciplinary approach:** Risk remains moderate. Reports rent is due, and has no finances, reports having little food at home and no medication coverage and can't afford their prescription of Zoloft (encourage student to suggest SW referral if they do not determine this themselves* hint is there anyone I can talk to about my finances. I feel that if I could just pay for my medications I could feel better.

5. **Agitated Scenario**: During MHSA Sam becomes increasingly agitated. Asks why they can't leave says that they came into hospital voluntarily and do not need to be hospitalize. Pt tells nurse "I am leaving" and swipes material on desk to floor in an aggressive manner. RN should use call bell or phone to get assistance in room.

6. **Psychotic Depression** A bout of **severe depression** or mania may trigger some psychotic symptoms. According to the National Alliance on Mental Illness (NAMI), an estimated 20 percent of people who have major depression also have psychotic symptoms. This combination is known as depressive psychosis. Thoughts are disorganized and reports "I want to have a sandwich, I have not been able to eat anything for days because someone is poisoning my food". "I want a big mac, apple pie, where's my dog, look at the person they keep laughing at me". When asked questions by nurse responds in non-sensical and illogical manner. Patient talks in circles, repeat words that nurse is saying to you. Patient presents as a poor historian and is unable to give concrete answers. Nurse may wish to speak with a family member to gain more accurate history. In safety planning nurse may seek to give patient PRN for hallucinations, delusions and psychotic features. May suggest moving patient to PICU to decrease stimulation. Likely this scenario will be cut short d/t patient presentation which can lead to great discussion regarding safety planning and nursing priorities.

7. **Variation no suicide risk:** very cooperative and thankful for being able to talk about depression, feels like they have no one to talk to and is fearful of being judged. Tired of feeling depressed and wanting to learn more about positive coping skills as feels stuck. Very appreciative and receptive to nurse. Has no thoughts of suicide and reports would never harm self. Able to article well their experience with depression. Willing to stay in hospital. Wanting to know when they can go for smokes?

<p align="center">63</p>

VIII. Algorithm of Simulation: Expected Student Performance

Student 1: Phase 1: Student conducts focused assessment to determine problem
Assess mental health status using **ABSCATT MHSA** tool. Recognizes signs & symptoms of depression

Student 1: Phase 2
Student assesses risk and protective factors for suicide and safety plan: Student to rate patient as low, moderate, high risk & safety plan accordingly (Student 1: then moves to live video feed room and Student #2,-6 repeat phase 1&2 until all students complete dose of 15of simulation. **AHS SUCIDE ASSESSMENT TOOL & SAFETY PLANNING TOOL.**

Phase 3: Debriefing
All students and Instructor reconvene for debriefing. **Debriefing dose 30 minutes** (Literature supports that debriefing process should be double the time of actual simulation experience

Example timeframe used for test pilot.
Pre-Briefing: 30 minutes all students & Instructor 0900-0930
Running simulation from 0930-11:15
Debriefing from 11:15-12:00

Sam

Debriefing 30-45 minutes all students & instructor. Cheng and Eppich (2015) maintain debriefing should be double running time of simulation

Student 1
15 minutes
5 min debriefing

Student 2
15 minutes
5 min debriefing

Student 3
15 minutes
5 min debriefing

15 min break after third scenario to maintain positive cognitive load

Repeat process for students 4-7

Moves to simualtion viewing room

Moves to simualtion viewing room

Moves to simualtion viewing room

Moves to simualtion viewing room

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