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Simulation based training to promote ability in dealing with aggression and violence in the healthcare setting

SimPRENA

Training manual for teachers

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1. Introduction

Definitions of violence are dependent on the group defining it, the purposes they serve, and how the definitions are subsequently applied. Violence in healthcare has been identified as a negative phenomenon related to the provision of nursing care. Violence in healthcare is a complex and dangerous risk, especially for general nurses and paramedics. Furthermore, there has been a persistent escalation in violence in recent years (Knor, Pekara et al., 2013). Healthcare delivery is one of the area's most likely to experience workplace violence (Pekara et al., 2017). Extensive research has demonstrated the significant impact of violence on the psychological and physical well-being of nursing staff (Weltens, 2021). The most significant cause of violence in healthcare, as will be discussed later, is escalated negative emotions, especially in non-psychiatric patients. However, this does not exclude psychiatric causes of violence that are not adequately addressed. When negative emotions are uncontrollable, they can lead to violent behaviour. In the context of health professional practice, it is imperative to acknowledge the potential for discordant intentions to emerge between the health professional and the patient or a patient's family member.

In the context of nursing practice, violence is defined as escalated aggressive behaviour arising from uncontrollable negative emotions and other associated factors, with elements of verbal or physical aggression that are no longer considered acceptable due to their direct threat to the interests and dignity of the individual targeted (Pekara, 2015). The definition also encompasses defensive behaviour that exceeds the nature of the attack in terms of its severity, and, in a given situation, the threat can be mitigated by a milder form of defence, such as communication. It is evident that violence in healthcare is perpetrated not only by patients themselves or their relatives against healthcare professionals but also, in certain situations, by health professionals against patients (Weltens et al., 2023) 2010).

It has been demonstrated that healthcare professionals can provoke potential aggressors to violence by behaving inappropriately or unprofessionally; however, this behaviour does not necessarily stem from any inherent malevolence on the part of the healthcare professional. Due to a lack of awareness regarding the patient's medical history, a healthcare professional may utilise inappropriate language or phrases, or their behaviour may elicit unpleasant emotions in the patient, which, in turn, may result in violence. These aggressive responses may be triggered by previous negative experiences with healthcare professionals. It is noteworthy that healthcare professionals may also provoke patients unknowingly (Bártlová et al., 2010).

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Agitation, restlessness and violence are not diagnostic categories. They are a type of behaviour in interpersonal interaction that is associated with various psychopathological symptoms. We understand terms related to violent behaviour as follows:

- Frustration - a psychological state that arises as a result of the avoidance of need satisfaction or goal attainment.
- Restlessness - a state of increased motor activity that ranges from mild forms (such as increased gesticulation, pacing, and stomping) to marked general restlessness, in which the individual runs aimlessly and actively interferes with the environment.
- Agitation - an escalated form of restlessness, accompanied by general motor activation. Both restlessness and agitation are accompanied by a sense of inner restlessness.
- Aggression (from Latin agressio = attack) is a behaviour that is directed towards the achievement of a set goal and is manifested by deliberately harming or restricting another person or thing. It is behaviour that has a conscious aim or purpose.
- Verbal aggression means threats and insults. They may or may not be accompanied by agitation.
- Violent behaviour is pathological aggression that is deliberately intended to harm someone. It involves physically aggressive behaviour such as hitting, kicking, pushing, throwing objects, using a weapon and threatening to use it. Violence against one's person, aggressive dreams, fantasies and plans are not included in this definition (Vevera et al., 2018).

Violence can be deconstructed into its component symptoms, as can any other psychiatric syndrome, and can be deconstructed into 3 major symptom domains: psychotic, impulsive, and predatory.

Psychotic violence is attributed to positive symptoms of psychosis, most commonly paranoid delusions of threat or persecution, command hallucinations, and grandiosity. Impulsive violence may reflect emotional hypersensitivity and exaggerated threat perception (sometimes is cause the rejection by staff - cigarettes, coffee or go home). Both impulsive and psychotic aggression can occur in patients with schizophrenia, although impulsive violence is common in many other disorders, including mood disorders, personality disorders, substance abuse, and many more. Predatory, or psychopathic, violence involves aggressive acts that are characterized by the planning of assaults, predatory gain, and lack of remorse (Stahl, 2014).

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2. Prevention of aggression and violence

Tools for predicting risk of violent behaviour

Given the lack of predictive validity of clinical interview assessment of risk of violent behaviour (first-generation assessment), tools are being introduced to make risk prediction more accurate (Páv, Pekara et al., 2024). Violence risk prediction tools can be divided into two main categories:

1. Statistical and clinically observational (second generation), OAS, MOAS, BVC

2. Structured expert assessment tools (third generation), which are a synthesis of the previous two categories of assessment (DASA)

Overt Aggression Scale (OAS)

It was developed to measure observable aggressive and violent behaviour in adults and children retrospectively. The OAS consists of two parts. The first part consists of four categories: (1) verbal aggression, (2) physical aggression, (3) physical aggression towards self, and (4) physical aggression towards others. The second part of the scale assesses staff interventions at the time of the incident. In addition to assessing the overall severity of aggression, the scale can be used to assess specific types of aggression. Within each category, aggressive behaviour is rated according to its severity. The start and end times of each episode are recorded; incidents that occur less than 30 minutes apart are counted as part of the same episode. The specific topography of aggression is reviewed in each situation, from mildly threatening forms of aggression, such as stamping feet, shouting or slamming doors, to the most severe forms that result in injury or unconsciousness (Hellings et al., 2005).

MOAS

This is a modified version of the OAS scale (Figure 2). Items are scored on a five-point scale. Scores range from 0 to 40, with higher scores indicating greater violence. The MOAS is one of the most widely used retrospective measures of violence and aggression. The scale was originally developed for use by clinicians in clinical settings but can also be used by parents to monitor their children's aggressive behaviour over time. It is particularly useful for assessing aggressive behaviour in patients with traumatic brain injury. It was originally developed to measure aggression in hospitalised psychiatric patients, particularly those with autism. The

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MOAS is administered individually. It is usually administered by nursing staff, although no special qualifications are required (Cohen et al., 2010).

Broset violence checklist (BVC)

The BVC is a six-item scale (Figure 3) that facilitates the prediction of violent behaviour from a 24-hour perspective. The scale is used throughout the health care complex (not only in psychiatry), in different departments (emergency department, ambulance, outpatient clinics). The BVC was originally developed by Linaker and Busch-Iversen in 1995 and further developed by Almvik & Woods in 2000. It is now used in more than 40 countries in several adaptations. The BVC is one of two instruments recommended by the National Institute for Clinical Excellence (NICE guidelines) in the UK, the Centre for Clinical Guidance in Denmark and the Health Directorate in Norway for monitoring violent and aggressive behaviour.42 Patients are assessed at an agreed time on each shift, usually three times a day. Items are scored on a dichotomous scale (violent element present = 1; absent = 0) and summed to give a total score. If the patient's behavioural profile is free of elements of abuse, non-cooperation, aggression or violence, the score is 0. If there is new confusion or worsening of confusion, the score is 1. The extended eight-item version, the East London Modified-Broset, is used as a tool to indicate restraint (or a room designated for safe movement) and is a specific tool that can be used in decision-making to indicate such restraint (Hvidhjelm et al., 2014)

Dynamic Appraisal of Situation Aggression (DASA)

The most widely used third-generation tool is the DASA-IV. It is based on the Structured Professional Violence Risk Assessment model and consists of seven items (Figure 2).44 The DASA is designed to assess the risk of violence within a time frame of a few hours to a maximum of two days in patients on acute psychiatric wards. A prediction for the next 24 hours is usually used. The instrument is a synthesis and development of previous instruments, e.g. items 1 and 7 are taken from the BVC (irritability and verbal threats), item 6 from the second-generation HCR-20 (impulsivity and negative attitudes). These items are supplemented with sensitivity to perceived threats, unwillingness to follow instructions, or being easily angered when a patient's request is denied.45 Similar to the BVC, the DASA-IV items are rated every 24 hours on a dichotomous scale (present = 1; absent = 0) and summed in a common scale. A score of 0-1 is considered low risk, a score of 2-3 is considered moderate risk, and a score of 3 or higher is considered high risk. The total score is to be assessed by the patient's contact nurse, and the assessment time is given as approximately five minutes (in our experience, it can be considerably shorter with good knowledge of the patient's clinical condition). Before data collection, it is recommended that nurses completing the tool attend a training workshop (e.g.

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two hours) on the rationale for using the Structured Short-Term Assessment of Violence Risk in patient care, how to use the DASA tool, how to involve patients in the DASA assessment process, and the nature of patient consent (Lantta, 2016).

The Safewards model and associated interventions have been highly effective in reducing conflict and containment and increasing a sense of safety and mutual support for staff and patients. Safewards is a model of practice improvement that has been used to promote a **therapeutic response to minimise conflict events in mental health in-patient settings**. This pilot project (Safewards ED) evaluated the impact of nine modified Safewards interventions in three emergency departments (EDs) within 2 health services in Victoria, Australia. Safewards' success was recognised in 2015 when it was recommended on the National Institute for Health and Care Excellence (NICE) Guideline NG10: 'Violence and aggression. Short-term management in mental health, health, and community settings. In this guideline, Safewards was identified as one of only two conflict and containment management interventions with good evidence to recommend their use. That same year, the Department for Health recommended that all healthcare providers should consider the implications of the Safewards interventions in their services. Safewards was also recommended by NHS England and the National Institute for Health Research. Additionally, the Care Quality Commission repeatedly endorsed it as a "good initiative to embrace a culture of safety" (Petr, Pekara, 2024).

Safewards interventions:

Get to know each other

Clarified mutual expectations

Positives and appreciation

Kind expressions

Circle of mutual help

Calming the situation

Mitigating the impact of bad news

Tools for calming down

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De-escalation

De-escalation model

Messages at dismissal

The Safeward model concept is useful not only for psychiatric wards, but the model also contains a lot of practical tips for no-psychiatry wards. Learn more here: https://www.stjoes.ca/violence-prevention/safewards/10-interventions

3. De-escalation

The professional who uses de-escalation in the management of acute psychiatric illness is less authoritarian, less confrontational and yet gains more control over the crisis situation. Staff who encounter acute psychiatric patients in daily practice must expect that the use of physical dominance over the patient or the use of restraints will reinforce the patient's idea that violence is necessary to resolve the conflict. Patients who are physically restrained or treated against their will have a longer average length of stay in the hospital. Medical facilities are also assessed in terms of their use of restraints. There is evidence that fewer accidents and injuries occur when there is no physical confrontation between staff and patients.

Everyone deals with stress or crisis situations individually. Each body reacts individually. The acute state in psychiatry is always evolving and is a continuum, from mild anxiety to increased anxiety to agitation, and can culminate in aggression. A person responds to an aggressive situation utilising the following methods:

1. "Fight": characterised by crying, readiness for physical aggression, tearing of hair, hands in fists, gnashing of teeth, growling, fighting in the eyes, fighting in the voice, readiness to stomp or kick, feelings of anger, rage, homicidal or suicidal thoughts, feelings of nausea in the stomach, use of words such as "bombs" or "erupting volcano" as metaphors to describe the feelings experienced.
2. "Flight": characterised by restlessness in the legs, numbness in the feet, anxiety, shallow breathing, big, frightened eyes, feeling trapped, tension, excessive movement, repetition of phrases such as 'I've got to get out of here, I've got to get out of here'.
3. "Freeze": stiffness in any part of the body, feeling cold, frostbite, numbness, pale skin, heavy, held breath or limited ability to breathe, feeling scared, palpitations, reduced heart rate.

The following 3-step algorithm is fundamental:

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1. Assess the situation
2. Establish communication
3. Negotiate tactically

1. Staff and patient safety first
2. Offer the patient the option to manage their emotions and distress and to maintain or regain control of their behaviour using the "De-escalation Decalogue".
3. Try not to use restraints if possible
4. Avoid coercive methods if possible

1. **Respect the patient's and staff's personal zone.** Maintain a minimum distance of two arm's lengths from the patient, a clear escape corridor. This distance not only provides space for both of you but also prevents an agitated patient from kicking or otherwise attacking you. Some will need even more distance for their safety. If the patient asks you not to immediately block their path, it is preferable to comply immediately and step back. The feeling of safety is also enhanced by neither party blocking the other's escape route. An appropriate level of privacy and a clear explanation of the situation is important so that the patient understands that sufficient staff and other resources are available to prevent unwanted behaviour. Certain situations may increase the escalation of challenging behaviour, e.g. if the patient is from the street, they will have difficulty handing over their personal belongings to staff. If the patient has a history of sexual abuse, changing into pyjamas in front of staff may be impossible or even humiliating.
2. **De-escalation and preventing unnecessary provocation**. Body language is essential, harmony between the verbal and the non-verbal. We do not belittle or threaten the patient, we offer support, understanding, and acceptable solutions. We emphasise that we want to keep everyone safe. A polite, calm demeanour is a necessary condition for success. The tone of our voice is important and should match what we are saying. We do not stare intently, we do not put our hands together, we do not cross our arms, it is preferable to stand at a slight angle rather than facing the patient, we do not turn away from the patient, arms should be lowered along the body with open palms, slightly bent knees are recommended. The expression must be natural, not acted, or the patient will recognise the feigned interest.
3. **Making verbal contact**. The first person to make verbal contact with the patient should try to de-escalate the situation. It is recommended that the person who initiates de-escalation should also complete it. If the first person is not trained in de-escalation, they should immediately pass the task to a person who is trained in de-escalation. Multiple people talking over each other will only escalate the tension. It is important to introduce oneself by name, to introduce the patient to the situation and help him to orientate himself, to ask how he would like to be addressed, to clarify one's role /"I am a doctor, a nurse, an orderly.../ and to emphasise that this role is to help him to regain his lost self-control.
4. **Brevity**. Agitated patients have difficulty understanding verbal information; use short, clear sentences and general language, avoid technical terms and listen actively. A sentence should be no more than 13 words, e.g. "You are in hospital. I am Nurse Judy. I will be taking care of you.

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I'm going to take your blood pressure first. It won't hurt, and the doctor will be here in 5 minutes. Repeat the key message until the patient hears it. Conversely, prolonged education or storytelling in a state of agitation is escalatory and confusing.

5. **Identify the patient's needs and feelings**. The patient may need to confide in an empathic listener or seek relief through medication. Anything from the patient's history, verbal or non-verbal expressions, can be used to identify the patient's needs (a sad person needs to feel hopeful, an anxious person wants to avoid further injury, etc.). Identifying the patient's need or desire can then be used to express a desire or willingness to help the patient fulfil that need, which greatly enhances the process of de-escalation and release of tension for the patient (e.g. writing a letter to an employer, talking to a loved one, partner, family). Suggestions such as "Even though I cannot meet the request at this time, I would like to get to know the request better and see how we can work on it together" can be helpful.
6. **Active listening.** Try to understand what the patient is saying, try to see the situation through their eyes. For example, if the person is agitated by a delusional belief that someone is trying to harm them and is able to share how they feel about this, it is possible to talk about why this is happening to them and who specifically is trying to harm them. Engaging in conversation and showing interest in the patient's problem helps to de-escalate. Active listening means trying to reflect back to the patient what they have just said. You can use the beginning of a sentence, e.g. "Tell me if I understood correctly...". This beginning of a sentence does not mean that you automatically agree with the patient; it just shows that you are listening to what they have to say.
7. **Expressing agreement or disagreement**. Expressing agreement with the patient greatly strengthens the therapeutic relationship. Of course, it is not possible to agree with everything the patient says, e.g. if he complains about the actions of the police in transporting him, it is possible to say "everyone should be treated with courtesy and respect", etc. Staff sometimes find themselves in a situation where they are expected to confirm what the patient says when it may be obvious that the patient is delusional. It is always possible to confirm that we hear what the patient is saying and feel their concern and anxiety, without necessarily agreeing with the content of what is being said.
8. **Set rules and clear boundaries**. It is important to teach the patient about acceptable behaviour. Assaulting others in any way is completely unacceptable, and the patient can be advised of the possible consequences of such behaviour, but this must be communicated as a fact and not as a threat. It can be openly communicated that aggressive behaviour is illegal and may result in the patient being arrested or prosecuted. Boundaries must be set respectfully. If the patient's actions are a cause for concern, feedback can be given that efforts to help the patient are being undermined by the actions. Respect and courtesy must be reciprocal, including on the part of the patient. Breaches of established rules by the patient must result in consequences that are clearly related to the behaviour in question and are appropriately and respectfully applied. Try to guide the patient to maintain self-control. It is appropriate to warn the patient if you feel uncomfortable with the situation, to tell them that we are afraid of their behaviour.

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9. **Offer choice and optimism.** For the patient who believes that they are left with a "fight or flight" choice, any other option may be welcome. Offering a choice is a way to stop the spiral of violence; offering the option of smoking, eating and drinking, being alone somewhere for a while, is also perceived as kindness by the patient. However, never promise what you cannot deliver (for example, that they will smoke if smoking is banned on the ward or cigarettes are not available). Raising the issue of medication is essential; the aim is not to sedate, but to calm and gain self-control; this can be communicated to the patient. It is appropriate to offer a choice (oral or injectable antipsychotic, even if administered against the patient's will) and to ask what the patient prefers and what helps. It may be helpful to appeal to the patient's pre-validated desire to remain calm and to offer several options: "Would you like a tablet, drops or an injection? Even in the case of injections, it is possible to give a choice of several options and emphasise that one option has significantly fewer side effects. Ask about the type of medication that helped the patient during previous hospitalisations. Do not rush to offer medication, but do not delay if it is needed. Always emphasise that medication is a means for the patient to gain self-control; emphasise that medication is necessary to protect the patient from harming themselves or others. Always express optimism that the patient will maintain self-control and that their condition will improve. If the patient insists on being discharged, reassure the patient that you have a common goal and ask what you can realistically do together to shorten the hospital stay.
10. **Debriefing for the patient and staff.** After the use of restraints, it is the responsibility of the person who ordered their use to re-establish a therapeutic relationship with the patient to reduce the possibility of traumatising the patient through their use and to reduce the likelihood of further violent behaviour. The aim is to gain the patient's perspective on his or her actions, to understand the situation and to show that the use of restraints was a last resort, that they were used for a minimum period, that the aim was to protect fellow patients and staff and not to humiliate the patient. Use the opportunity to increase the patient's motivation to take medication, which may limit further use of restraints.

Any use of restraint, where it has been used, should be discussed immediately with the staff who used it, and space should be provided for feedback, both positive and negative. Incidents should be discussed regularly at ward meetings, and any restraint should be monitored by the ward manager. Also, remember to ask the patient themselves, when things have calmed down, "What helps when they are as angry as they were today?", "What can help in the future to keep the behaviour under control?".

The De-escalation Decalogue also applies to children and young people. However, it is not true that a child is a young adult and therefore, communication needs to be adapted to the developmental stage of the minor.

When communicating with a minor, always keep the following in mind.

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1. Do not keep children/adolescents waiting for long periods of time (e.g. in a waiting room, for an interview, etc.).
2. Determine the appropriate greeting.
3. Young children - introductions (games, toys, pictures, etc.).
4. Breaking the ice - casual clothes, colours, a toy in your pocket - but don't overdo it, don't cheer up at all costs, and don't choose childish games for adolescents.
5. Horizontal posture - communicate at the child's eye level.
6. Use non-verbal communication.
7. Do not ignore the child's questions, respond appropriately for the child's age and always truthfully.
8. We never compare them to other children.
9. Praise and recognition are important.
10. Do not act as an authoritarian and always act with respect.
11. Parental presence is important (e.g. a young child needs to be on his or her mother's or father's lap).
12. In the presence of the parents, talk to the child, not to the parents.

De-escalation has a high potential to reduce aggressive or violent behaviour during the escalation of an individual's behavioural disturbance in acute psychiatry. De-escalation is a skill that requires ongoing training. De-escalation is an offer to the patient to get what they want, but without displays of agitation or aggression. However, de-escalation is not omnipotent; we will always be dealing with patients who, despite our best efforts, will try to test our limits and possibilities, and in the case of severe behavioural disorders, restraint is not entirely unavoidable in practice.

4. Simulation for health care professionals

"I hear and I forget. I see and I remember. I do and I understand." (Confucius)

This ancient Chinese quote is confirmed by modern learning methods, sometimes called "learning-by-doing", and has great application in simulation teaching. Simulation teaching makes it possible to test the behaviour of a simulated object without risk - for example, to try to negotiate with an aggressive patient (a standardised patient actor) or, in the case of medical simulators, to treat a virtual patient or to test the behaviour of individual physiological subsystems.

When we think about trying to mimic reality as closely as possible, we inevitably come to the concept of simulation. In this case, the ability to train in a safe environment is a huge

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advantage. The possibility of making mistakes that do not endanger anyone and, more importantly, do not harm anyone, is also a plus. Situations can be implemented in different ways - for example, simulations where real people use fictitious equipment in the real world or simulations where real people use simulated equipment in a simulated environment (SICE, 2015).

Medical simulators were originally designed to practice basic procedures such as administering injections, taking blood samples, and performing minor surgery. Today, simulators designed specifically for the medical field are increasingly used not only to teach medical and diagnostic procedures but also to simulate medical concepts, research agendas, and new treatment methods. Most mistakes in healthcare are due to the human factor. Most of them are preventable and rarely caused by a lack of knowledge. The inability to translate acquired theoretical knowledge into real working life is also a problem (www.uvn.cz, 2015).

Wherever it is possible or necessary to work in a team, collective or group, good communication is very important and a prerequisite for effective cooperation and good results. Both the health professional and the layperson are expected to be able to relate to a medical condition that they are encountering for the first and perhaps last time in their lives. Textbooks alone are simply not enough to teach; we also need to learn in real clinical settings that we can experience for real. Simulation teaching provides the opportunity to practice and rehearse knowledge and skills in a realistic environment that is safe for the learner, but most importantly, safe for the "patient". Reliable models allow the practice of individual practical skills, but above all, the possibility of modeling a "complex" clinical situation requiring the timing of individual therapeutic actions and collective cooperation. Moreover, all these activities can be planned without compromising human health (www.uvn.cz, 2015).

Educators agree that simulation-based teaching methods are one of the elements that contribute to breaking the usual teacher-student relationship (paternalistic relationship). They put the learner in the role assigned to him or, better still, chosen by him. The informal communication required by the students (partnership) is also essential. Simulation techniques are used especially in cases of familiarisation with new material, where this form promotes the learner's motivation towards the new material. At the same time, it helps the teacher to see what the students know about the material and how they perceive it. In some schools, the student simulates the work of the teacher and shows how he would teach a certain subject and what he would prepare for teaching (Hanuš, Chytilová, 2009).

Today, simulation is used in many areas, not only to replicate existing things, problems, or procedures but also to represent hypothetical situations, conditions, or processes.

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Simulations are used when it is not possible to use real equipment in a real environment, either for safety reasons or because of the significant financial costs involved. The field of simulation education has an indispensable place in modern society. It is already an integral part of the education and training of healthcare professionals. Doctors, nurses, and paramedics prepare for their future careers not only in real life during mandatory work placements in healthcare facilities but also through simulated situations that allow them to test their theoretical knowledge and verify the level of their newly acquired knowledge, all in the safe environment of a teaching facility. Simulation in healthcare training uses a 'learning from mistakes' approach, where mistakes are seen as an opportunity to motivate further learning and, unlike previous practical training, mistakes do not put the patient at risk. The most advanced medical simulators feature a life-size human body that actively responds to nursing or medical procedures. Some simulations used in healthcare are imaginary, using CT or MRI images. If we take patient safety as the most important criterion, simulations have the unquestionable advantage of allowing training in the fatal consequences of possible errors, as opposed to working with real patients. This approach is much more effective than passive teaching. It significantly increases patient safety, the effectiveness of the treatment provided, or the introduction of the most advanced methods into clinical practice. It is therefore essential that simulation teaching in the health sector should not only be used to practice real situations related to treatment, care processes or diagnosis, but also in the area of communication between health professionals and patients and their families (SICE, 2015).

There are several ways to understand simulation education. It can be about education that confronts participants with powerful experiences in activities that involve a degree of risk and adventure, about motivating young people to self-educate through unusual experiences, or about teaching them to be active in their leisure time and to overcome the stereotypes of everyday life. It can be about pushing participants beyond their physical and mental limits, about self-discovery, broadening horizons, creating space for social learning and gaining confidence in oneself and others. It is a special opportunity to gain collective experience in a group. Simulation learning is particularly effective in developing the emotional or performance side of the personality (Landriscina, 2013).

Incorporating purely cognitive elements, such as cognition and education in the narrower sense, is difficult but conceivable. There are also specialised programmes to build and develop work teams and their creative and performance potential in a targeted, deliberate and structured way. Simulations are carried out in the form of outdoor training and are very suitable for team building (Heaysman, Kramarski, 2021).

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Through adventure simulation programmes, several skills that are important for quality work can be practised and developed. These include the ability to communicate, cooperate, solve problems, take responsibility, etc. Clients have clearly defined learning objectives that are achieved through model situations in the form of group tasks and subsequent feedback and reflection (Landriscina, 2013).

Simulation could use team teaching or action learning, narrative dramas and several ways of learning.

There is a team of tutors on one side and a group of students or clients on the other. The collective interaction of tutors aims to achieve a higher level of performance than when one person trains alone. It allows the use of more difficult games, fillings and resources in training that are not feasible in normal teaching and life. Smaller groups of students allow for more interaction and two-way feedback. Team learning is a typical example of team building (Heaysman, Kramarski, 2021).

Participants are presented with clearly defined problem tasks, after which they organise their activities and form situational teams, bringing together individuals of different ages. The group itself produces its own structures and methods of social action, leading to the breaking down of generational barriers, the development of tolerance, the adoption of a possible role, more frequent social effectiveness and individual stimulation. In contradistinction to conventional teaching methods, which emphasise the transmission of knowledge and skills, this approach focuses on a past event to facilitate reflection, enhancement, and the acquisition of novel perspectives through group work techniques (Kramarski, Heaysman, 2021).

In contrast to the non-participatory reception of information from the teacher, the participants are encouraged to be active and engaged, where they have no opportunity to escape or adopt a non-participatory stance. The processes do this through defined tasks and assignments from the lecturers. This places clients in situations, events and processes in which they are encouraged to act. In the actual action and its retrospective awareness, a learning process occurs and takes place in which a particular knowledge, skill, role or experience is acquired (Kramarski, Heaysman, 2021).

This is the positive interdependence of clients in the pursuit of a goal. This happens in more complicated tasks and assignments where it is inconceivable for an individual to encompass the entire activity and draw all the attention to themselves. This naturally leads to task fragmentation and small group interaction. The emphasis is on personal responsibility and accountability for the benefit of the whole. The completion of successive tasks and skills is

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carried out according to the principle of gradation of difficulty, i.e. from easier to more complex. The completion of the task is guided by deep group reflection on the activity experienced (Kramarski, Heaysman, 2021).

Simulation training focuses not only on the actual training of realistic simulated situations but also on the problematic area of interpersonal communication. The model of simulation teaching is on the borderline between regular teaching and practice in a real environment. In this way, it allows a better link between theory and practice, especially thanks to the immediate feedback that the participant receives not only from the trainers (lecturer, teacher, health worker) but also from other people involved. The experience gained from simulation-based training allows the trainee to deepen their self-reflection so that they can consciously choose an appropriate communication strategy and avoid inappropriate reactions to protect themselves and other participants. It is always valuable for learners to process their emotions properly. It will enable them to identify what caused them and to try alternative courses of action.

- Introduction to the Simulation Block
- Simulation Session
- Repetition of simulation if necessary/requested
- Debriefing session
- End of simulation block

The introductory lecture aims to familiarise the participants with the objectives, form and content of the simulation training. The time required for the introductory lecture and discussion will depend on many factors, such as the participants' previous experience with this type of training, the level of trust and mutual support among the participants, and the trainer's ability to motivate the participants positively. Another important issue is the safety of the participants and the establishment of basic rules of trust, which prove to be essential for full and authentic engagement in the training. The most common reactions of participants in the initial phase of the training are worry, anxiety, shame and fear of embarrassment in front of colleagues. It is important to remember that these are natural feelings. For most of us, they occur in situations that are new to us and with which we have no previous experience. These feelings need to be considered. Talking freely about specific anxious feelings is an important part of the preparation for the lesson itself. Of course, the length of the discussion depends on the atmosphere in the group, the cohesion of the collective, the ability to support each other, and also on the trainer's ability to create an atmosphere of trust and safety in the group (no one is judged negatively, no one is shamed). The session is a source of information not only about the specific concerns of the participants (how long the simulation itself will take; who will see me;

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who will have access to the video recording of the training; what will I do if I can't think of anything to say in the simulated situation), but also about the much deeper insecurities we usually associate with performance-oriented situations (fear of failure). Answering specific questions related to the simulation learning process usually leads to a partial reduction in anxiety and fear.

Participants should be reassured that the aim of simulation training is not to deliver a perfect and flawless performance. It is through mistakes that you can learn and develop. It is important that they know that everyone can, will and, most importantly, should make mistakes!

The practice situation provides an opportunity to get to know oneself, one's particular way of communicating, one's communication limitations and then, in a safe environment, to better understand what affects us in difficult communication situations and how to behave in similar situations. It is important to stress that no one will be judging the participants negatively. The reaction to a simulated situation will not be described as good or bad. Rather, the aim is to identify the moments that facilitated communication with the patient and those that led to a problematic interaction.

In any case, we do not tell participants not to be afraid or ashamed. On the contrary, we respect their fears as a natural reaction to a new situation. We do not force anyone to work. We believe that a sufficiently safe and supportive environment will give some participants the courage to try new things, and they will then encourage others to do the same. Simply observing and giving feedback on someone else's work is not teaching in the true sense of the word, but it can help to take the fear out of participants and engage them in learning. It is necessary to respect and accept that in any group, there may be someone for whom performing in front of others is a huge burden. It is advisable to leave such a participant in the role of observer. The teaching itself could become unnecessarily traumatic for them. The experience of the authors of this text so far shows that most participants need at least basic information about the course to participate actively in the lesson.

During the first explanation, we keep asking them if they have enough information and if they are ready to start. Examples of questions:

- "Does this make sense to you? Is there anything else you need to know?"
- "Is there anyone here who would like to start? Is there anyone who is reluctant?"

We consider the so-called confidentiality rule to be important. At the beginning of the course, we ask participants not to talk about anything that happens during the course outside the

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classroom. The person sitting in the visiting room should also commit to this and avoid, for example, telling colleagues about the reactions of certain people during the training. It is, of course possible to talk about the teaching itself, its process but never about specific people, their performance and their reactions. Encounters with patients in front of the camera and the eyes of colleagues often lead not only to failures but also to emotional reactions for which the participant feels ashamed afterwards (e.g. crying when encountering an aggressive patient). If the lesson is to be archived in the form of a video recording, participants should know who will have access to the video recording and, if the recording is to be used for other purposes (e.g. a presentation in class), the participant should give written consent. Of course, they also have the right to refuse. In an age of ubiquitous mobile phone use and frequent misuse, we recommend that all participants be asked to switch off their mobile phones for their own safety.

Instructions to simulation trainees: Just before entering the room, which simulates a standard hospital room, the simulation trainee is familiarised with the task. For example: "Your task is to take a patient's history. Please take the situation very seriously and responsibly. Even though this is a training session, try to imagine that you are in a real situation. Do not interrupt the interview with the patient yourself; try to deal with the situation based on your own experience, knowledge, and skills. The trainer will end the exercise, but usually the simulated situation will last about eight to ten minutes."

The participant in the simulated training encounters a patient at the bedside and their objective is, for example, to obtain the necessary data for the medical history form (the specific situation is based on the scenario to be practised). The trainee is informed about the type of situation they will encounter in the room (aggressive, depressive, etc.). The aim is to establish the most effective communication with the patient. The semi-structured scenario allows the actor to react based on a pre-prepared scenario and to follow the instructions of the trainer, but it also leaves room for the actor's conception of the required role (here, the actor must be very well prepared to know when to de/escalate the situation). The recording of this situation is transmitted to an adjacent room where a group of other trainees, together with a psychologist, observe the action. The audio-visual recording also serves as a basis for feedback and can be used for further training of the participants. The trainees can rehearse the situation several times if necessary and try to apply the knowledge gained in the feedback.

The whole simulated situation is recorded on camera. The video recording is then used as a basis for feedback and to document interesting and instructive moments suitable for subsequent teaching. At the end of the simulation block, the recording is stored on an external disc and can be reused if necessary.

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5. Debriefing

Each practice situation is followed by a group discussion led by the trainer to provide the necessary feedback and suggestions to find new ways of communicating with the patient in certain situations. Feedback can be given not only by the trainer or actor but also by all the participants who have observed the event through the audio-visual training. However, none of them evaluate the other participants in the training. Specific reactions are not described as good or bad. Moments that facilitated communication and those that led to problematic interactions are sought. The practice situation gives the participants in the simulation training the opportunity to become aware of what influences communication, to clarify their communication limits and thus, in the safe environment of the simulation centre, to better understand how to behave in similar situations in the future.

The facilitator has familiarized him/herself with all aspects of the intended simulation-based experience. This includes being familiar with the prebriefing and preparatory resources, the healthcare simulation-based experience itself and methods for cueing, and the selected debriefing and evaluation methods. Facilitation methods before the healthcare simulation-based experience include preparatory activities and a prebriefing to prepare participants for the healthcare simulation-based experience. Facilitation methods before the healthcare simulation-based experience include preparatory activities and a prebriefing to prepare participants for the healthcare simulation-based experience. Hold a pre-briefing at a designated time before the healthcare simulation-based experience in which the amount of time may vary depending on the modality and complexity of the healthcare simulation-based experience. Minimally, the prebriefing should include:

- Discussion of the detail and expectations of the healthcare simulation-based experience.
- The level of detail revealed depends on the purpose, goal, and/or objectives of the healthcare simulation-based experience.
- Provide participants with the necessary background information about the healthcare simulation-based experience.
- An orientation of participants to the clinical simulation environment, modality for delivery of the clinical simulation, manikins, and the equipment that can be used or not used in the scenario.
- Provide clear descriptions of assigned roles for the scenario, whether as a direct care provider, as an observer, or as other assigned role characters.
- Discuss the process for participants to contact others (as needed) in the healthcare simulation and, if appropriate, ways to seek further information.
- As appropriate, provide time for participants to prepare before the start of the healthcare simulation experience.

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Procedure for giving feedback to students after a simulated encounter with a patient: After the simulated situation, we ask the learner what went well, what was difficult, what they found problematic, if they have any idea about the patient and their motives, or how they think they influenced the situation with the patient. We are not satisfied with one-word answers. We probe with open-ended questions and mirroring. We do not make our comments as immutable truths, interpretations, or evaluations, but as possibilities to which the participant can respond. This feedback phase aims to help the participant become more aware of the variables that played a significant role in the situation. The aim is to find out how the participant feels about themselves, how they perceive the situation, and what their options are for self-help. We do not judge, ridicule, or lecture the participants in any way - rather, we tell them how we saw the situation through our eyes. What needs to be changed is for the participant to decide.

- Each simulation should have the right objective, stop signals, simple content, and a trainer who knows they are not doing the simulation for themselves.
- It is better if the student comes up with the right solution.
- Common situations are best, NOT (!!) rarities.
- THE TRAINER HAS THE POWER to create a safe environment.
- Criticism, yes, BUT ONLY with accurate and respectful commentary.
- Have crisis scenarios for situations where the trainer makes the mistake (scenario set-up; equipment) and the participant makes the mistake.
- Humanity and empathy are most important in debriefing; even the trainer is learning.
- We observe behaviour, not performance.
- A good facilitator asks questions; an excellent one gets answers.
- The safer the environment, the more useful the debriefing.
- The simulation is very intense.
- Average students can learn more.
- Accept problems during the simulation.
- We don't focus on the personality or character of the participant.
- Mistakes during the simulation do not correspond to the real environment and practice.

“If you are not prepared to look at your pupils’ strengths, don’t touch their weaknesses.” Reuven Feuerstein

Debriefing in Healthcare Simulation is a period of time following an experiential learning activity during which learners/teams reflect, review, and discuss the activity to improve individual and team clinical skills and judgment. In the past, many healthcare disciplines relied on the apprenticeship model, which relied on learners encountering enough situations to ensure that they became competent. More recently, healthcare simulation has become extensively used as it provides scheduled, valuable learning experiences where learners not

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only put their knowledge into practice but also practice decision-making and communication skills.

Clinical Simulation scenarios range in complexity and/or clinical skill level. For example, medical simulation may be used for undergraduate nursing students to practice medication administration or for obstetrical residents practicing caring for a woman with postpartum haemorrhage. Following each clinical simulation scenario, a debrief is conducted by one or more people, such as a healthcare simulation facilitator who is considered a content expert about the scenario subject matter. Healthcare simulation educators who are content experts should also be highly skilled in debriefing. Many would argue that debriefing is the most important component of a healthcare simulation experience.

SHARP – Imperial College London:

SHARP contains the absolute basic principles of what to cover when conducting a debriefing. SHARP is an acronym that comprises five 'prompts' to guide trainers and trainees in providing/receiving a structured debrief. SHARP stands for Set learning objectives, How did it go, Address concerns, Review learning points, Plan ahead. It is a practical tool that can be used when there is not enough time to carry out a detailed debriefing using all the comprehensive information provided in the Objective Structured Assessment of Debriefing (OSAD) tool

- Five-step feedback and debriefing tool.
- Before cases.
    - Set learning objectives.
    - What would you like to get out of this case?
- After case
    - How did it go?
    - What went well? Why?
- Address concerns
    - What did not go so well? Why?
    - Review learning points
    - Were your learning objectives met for this case?
    - What did you learn about your clinical/technical skills?
    - What did you learn about your teamwork skills?
- Plan ahead
    - What actions can you take to improve your future practice

Gather, Analyze, Summarize Method (GAS): Debriefing is recognized as a best practice in simulation education but is only one of several methods of providing participant feedback. The

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purpose of a debriefing is to provide students with the opportunity for review of their simulation experience through facilitated dialogue, which leads to reflection, enhanced learning, and change in practice. In this chapter, the authors describe the development and use of a structured method for debriefing individuals and teams of providers.

Developed in collaboration with the American Heart Association, the "structured and supported method" includes three phases with associated goals, objectives, and time frames. Many simulation educators are busy, practicing professionals. Because of this, the primary development goal was to build a streamlined debriefing method that was both easy to learn and scalable. It was also important that the method drew on available literature and was validated by use at the Winter Institute for Simulation Education and Research (WISER).

Another aspect when considering the method includes the use of the gather, analyze, and summarize (GAS) debriefing tool. This tool allows even novice debriefers to gain skill in debriefing rapidly while remaining comfortable with the process. The ability to maintain a student-centric, safe environment where gaps in knowledge, skill, or performance are identified and addressed is central to the method.

- Gather data by actively listening to participants to understand their perspectives
- Analyze
    - Facilitate student reflection and analysis of their actions.
    - Identify positive aspects of team or individual behaviors that require change.
- Summarize
    - Facilitate identification and review of lessons learned.

PEARLS Framework

The PEARLS framework is a blended approach to healthcare simulation debriefing that can be applied flexibly in different environments (Eppich & Cheng, 2015; Bajaj et al, 2018). The PEARLS model of debrief features many of the other common segments of other healthcare simulation debrief modalities. The five phases of PEARLS healthcare simulation debrief are:

- Setting the Scene
- Reaction phase
- Description phase
- Analysis phase
- Summary phase

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Diamond Debriefing Method

The diamond debrief method is based on the debrief framework technique, which is made up of description, analysis, and application. Diamond debrief also consists of aspects of the advocacy-inquiry approach and of debrief with good judgment. Diamond debrief is designed to allow the exploration of non-technical elements of a healthcare simulation in debrief (Jaye, P., Thomas, L. & Reedy, G, 2015).

Summary of Medical Simulation Debriefing

Debriefing is not about the specific tool used or the debriefer/content expert but rather about the learners. Because debriefing provides an opportunity for learners to reflect and change future behaviors, it plays an important role in healthcare education and, ultimately, in the improvement of patient care and the prevention of errors.

The experience as a participant in clinical simulation allows people to learn through either difficult or successful clinical experiences that involve a patient as a team in a safe manner. In healthcare simulation, there is recognition and respect for the participant's prior life or clinical experiences that are brought into the clinical simulation scenario. In debriefing, participants are guided by conversation to process the applied experience through a range of emotions to hopefully land at a place of knowledge to bring into the next interactions with patients and improve bedside care and safety. The parallels between a growth mindset and clinical simulation are highly evident in many, if not all, layers of clinical simulation philosophy and practice.

Reframe Mistakes From Failure to Feedback

In safe clinical simulation, psychological safety should be one of the largest foundational pillars of a program. One of the aims of psychological safety is to make people feel safe to challenge the status quo and make mistakes without fear of reprimand. In a growth mindset, mistakes are an opportunity to learn and grow. Although the stakes are high in real-life clinical care to patients and families, healthcare simulation provides a safe container for healthcare workers to explore their mistakes and grow from them safely. Healthcare simulation should not be a shameful place to make mistakes. Healthcare simulation should be a place to see mistakes as an opportunity for growth and recognition of potential latent safety threats to patients. These may include environmental, policy, and equipment malfunctions that cause healthcare professionals to increase the chances of mistakes or errors.

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Communication skills, when used effectively, assist the debriefer in ensuring the clinical simulation is learner-centered. The concept of a psychologically safe educational environment as the foundation of a clinical simulation program is essential. A psychologically safe debrief environment allows clinical simulation participants to share and be vulnerable without fear of reprimand. The appropriate use of communication skills to guide the group's conversation will enable deep reflections and adaptations to practice. Communication skills encompass the act of talking, listening, empathizing, and making observations. With careful attention to communication skills, cognitive presence for the clinical simulation learner is more likely to be enabled.

Cognitive presence is incredibly important in a clinical simulation debrief. Cognitive presence is described as the ability of learners to find meaning in their experiences via reflection. As clinical simulation debriefers, an awareness of the desire to inspire cognitive presence in learners is essential. Effective communication skills make cognitive presence in debriefing for learners more possible.

Open communication is always important in a healthcare simulation debrief. Open communication means respecting all points of view that are shared within the clinical simulation environment. The removal of assumptions and allowance of a safe space for healthcare workers to reflect on their practice and understand their own and the team's behaviors is where the cognitive presence can happen in depth. Open communication creates a psychologically safe space in the healthcare simulation debrief for this to occur. Open communication is the permission of all topics and the respect of the individual in this vulnerable moment without shame or fear of any retribution. Open communication is where culture and clinical practices are challenged and refined.

Emotional intelligence is a critical skill for clinical simulation debriefers to enable and use communication skills best. Emotional intelligence is the ability to have awareness of our own emotions as well as of others. Emotional intelligence and communication skills do not always come naturally to everyone, and for many, there will be practice and awareness required to excel in this field. However, the skills that surround emotional intelligence can be acquired through a keen attitude to learn, reflection, and adaptations to communication skills next time. Emotionally intelligent people are not perfect but reflect continually on their communication skills and want to improve and learn new skills.

Empathy is an incredibly powerful skill to harness and utilize in all interactions in or out of the clinical simulation debrief circle. For healthcare workers, being truly empathetic to others is a superpower. To allow others to feel that those who surround them will walk alongside them

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and sit in their emotions rather than look down with sympathy and unintentional disempowerment is an incredibly powerful life skill. Empathy is linked with genuine curiosity and a lack of assumptions and judgment, key skills taught to clinical simulation debriefers. Empathy can be applied appropriately through close observation of clinical simulation participants. Observation and the process of noticing behaviours and the consideration of how to respond is also a communication skill essential for debriefers.

The ability to listen to participants in clinical simulation debriefing is one of the best gifts that can be given to a debriefer or facilitator. In most events in life, people want to be listened to, affirmed, and validated. Deep and skilled listening is essential as a clinical simulation debriefer. To achieve active listening, the debriefer must be fully present in the debriefing and not preoccupied with their responses to the participants or other concerns outside the simulation. Most people listen only to respond. However, listening to participants to allow them to reflect and process their performance will take the debrief of a clinical simulation to the next level. This is a fundamental communication skill, but many people, often even those in incredibly senior roles, can struggle with the ability to listen effectively.

To take turns listening as a clinical simulation debriefer is a skill that will allow participants to truly feel heard. The allowance of silence and pauses before engagement in conversations will allow clinical simulation participants to complete their reflections and to feel that their reflection has been completed. Trust in the learner to complete their reflection before a response enables more power in the facilitator/participant relationship.

Observation of body language to tailor communication skills to maximize impact is useful in the healthcare simulation debrief. For example, suppose a participant in a clinical simulation has a display of being closed off to interactions, such as crossed arms and legs. In that case, this is valuable information for a debriefer. These body language displays indicate that an event has occurred in the clinical simulation or the conversation at hand is closed off to this participant. As a clinical simulation debriefer, the act of noticing this unconscious body language and tailoring the debrief as appropriate to give the best opportunity of resolve for this person is a key skill.

As a debriefer in clinical simulation, be aware of facial expressions and the impact that this can have on participants' ability to be open and be vulnerable. Suppose the debriefer has a harsh facial expression and/or crossed arms and legs. In that case, this unconscious body language shows the participants that there isn't safety or vulnerability within this debrief circle. Intentional poses of arms by the side, uncrossed legs, and soft facial expressions will encourage participants to safely participate in conversations in debriefing.

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This article has discussed how to use communication skills to enhance a clinical simulation debrief. Topics discussed include cognitive presence, emotional intelligence, empathy, listening, and body language. Awareness of communication skills that can get the most out of a healthcare simulation debrief will take those in a debrief role to the next level. Awareness of often unconscious body actions as a faculty member and also of the participant group can assist in higher level educational outcomes and adapted clinical practice after the clinical simulation experience.

6. Scene preparation, scenarios

The preparation of scenarios for individual situations, so that the situation presented is realistic and in line with what the participants are exposed to at their workplace, is essential for the good running of simulation courses. As already mentioned, these should not be rare situations but rather common stories. The scenario itself has a structure, which is not categorically given, but it is useful if it is the same for all scenarios. Within this methodology, we present scenarios constructed from:

- A sequence number and a scene title,
- The distribution of roles among the actors,
- Input information for the participants,
- The formulation of the task or goal to be achieved,
- A description of the scene or setting,
- The script or a brief outline of the story,
- Instructions for the actors, or what escalates the situation and what calms it down,
- An inventory of the tools and props needed for the scene.

The sequence number and title of the scene should make it clear to the lecturers, actors, and the technician providing the audio-video transmission what is going to happen. *Example: Scene 18, WORKING WITH A CHILD/ADOLESCENT IN A SELF-HARM.*

The distribution of roles among the characters defines who will play what role in the story. *Example: Patient - Jane Smith (for this methodology, we give a fictitious name and surname).*

The input information is given to the participants by the trainer who leads the scene and then discusses it with the participants. The main point is to formulate the starting point from which the prepared story will develop. At this stage, it is necessary to think well about the task. The activities that the participants will carry out should be purposeful and realistic. In the example

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given, two nurses, a doctor, and an orderly from the same ward take part in the simulation course. It is advantageous if the participants do not know what will happen in the next few moments. *Example: In the observation room, there is a 16-year-old patient (Ms Jane Smith) with an unspecified behavioural disorder and an emotionally unstable personality structure. She had known since yesterday that she would be transferred to another hospital today. One nurse prepares the morning dose of medication, another nurse checks the expiry date of the medication, and the orderly takes the patient's drink to her room. The doctor is in the morning report room outside the nurses' office. The orderly enters the room and notices that something is wrong...*

The next piece of information given to the participants is the task or the goal to be achieved. The trainer must communicate the initial situation and the task, always leaving room for questions or other ambiguities. At this point, the importance and possibility of using the STOP signal will be reiterated. *Example: Proceed as in real life, using de-escalation approaches and appropriate team communication. Prioritise your response to the situation based on what you see. Anyone can always stop the situation by shouting "STOP!".*

To set the scene well, it is essential to give a basic description of the scene in the script, especially considering the scenery that may be needed for the story. The description of the scene is important for the preparation of the simulation but also as an input for the participants, although some information will not be revealed to the participants (in this case, for example, the hidden pen). *Example: There is a fully equipped nurses' station, including medication and dressing materials. The staff has the patient's medical records. A drink is provided for the patient. There is a working telephone and a number to contact a doctor. Restraint belts are also part of the ward's equipment. The patient is in a bed in the observation room. There is a bedside table beside the bed and a chair behind the bed. The patient is hiding a broken pen she has used to cut herself (artificial blood).*

The scenario itself serves as a basis for the participants and the lecturers, with the possibility of anticipating the possible development of the situation. However, we always have to consider the variability influenced by the decisions of the participants. We use the real names of the participants to avoid inaccuracies. The course of a scene is often emotionally charged. Using fictitious names can easily lead to confusion, especially in situations where several actors are working together. For this method, we will introduce a fictitious name. *Example: 16-year-old patient Jane Smith, diagnosed with unspecified behavioural disorder and emotionally unstable personality structure, was informed yesterday that she would be transferred to another hospital today. In her room, she cuts herself on her left forearm with a sharp shard from a broken pen. The patient was found by an orderly. She hides not only the pen but also her*

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bloodied left forearm under the blanket. Patient: "I'm not going anywhere. I told you I can't do it... Go away! Why are you all standing there? Don't touch me! Leave me alone! Go away!"

When rehearsing individual scenarios, the actors learn how to react to the possible development of the situation. Under the guidance of a lecturer or an experienced psychiatrist or psychiatric nurse, they learn what can escalate the situation in an undesirable direction and what should lead to a calming down. It is always necessary to keep in mind the possibility of the previously unexpected. *Example: What escalates the situation - Attempting to treat the bleeding before it is certain that a doctor will be called; inappropriate behaviour from staff (the actor determines by feeling what is uncomfortable for her); tendency to physically restrain the patient; reproachful or judgmental comments, shouting and uncertainty from staff; nervousness about waiting too long for a doctor. What calms the situation - showing concern and listening to what she is "crying out" for (she doesn't want to be transferred, she doesn't want anyone to stand there, to touch her); being treated as an adult (without moralising, reprimanding or infantilising); having a choice such as "show me the wound and then we'll decide if and how to treat it" or "when the others leave, can I stay here to see how serious the wound is?"; filling the time efficiently waiting for the doctor, e.g. by discussing the topic of "pets" (distracting, letting the patient talk about something else dear to her); calling the doctors themselves (nurses are sometimes set up to do everything themselves and not bother the doctor).*

A summary of the tools needed for a realistic simulation. *Example: a bed including bedding, pyjamas, medical uniforms, fictitious medical records with the patient's medical epicrisis, a broken pen, artificial blood (and detergent to quickly clean the artificial blood), dressing material, medicines, a working telephone (to call the doctor), a drink for the patient, restraint belts (they will only be available to give the impression that the situation can be handled in this undesirable way).*

Other types of communication scenarios may involve an angry family member, a disgruntled patient, or a refusal of care by a patient. With a focus on diversity, equity, and inclusion, healthcare simulation educators must provide an opportunity for learners to reflect on implicit biases when faced with uncomfortable or unfamiliar situations.

By incorporating these experiences into clinical simulation, the learner can practice difficult conversations in a safe environment. During these types of simulations, learners will also be allowed to call “time” if they are truly overwhelmed. This will end the scenario if necessary. During debrief, observers can then help brainstorm and discuss methods with the facilitators or faculty for handling such situations in clinical practice.

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Overall, high-quality clinical simulation in nursing education is increasingly valuable as clinical experience opportunities dwindle. Nursing simulation gives faculty and healthcare simulation educators a greater opportunity to control the quality of the clinical experience.

Clinical days in the hospital do not always provide an ideal learning environment. Learners may be told to "stand over there and watch" or can be ignored altogether by a nurse preceptor (who may be overwhelmed and inexperienced as well). The healthcare simulation setting thereby allows for evidence-based education to be presented and for the nursing learner to understand the rationale for the standard of care.

Nursing graduates will go on to practice in settings that may be very different from their clinical settings. Also common, local clinical sites may not mirror best practices or standards of care. In clinical simulation, learners experience a hands-on, realistic practice that they can draw on in these situations.

Critical thinking and communication skills cannot be expected to materialize without a deliberate opportunity to practice them during academic training. In conclusion, clinical simulation is a viable solution to bridge this graduate-to-professional nurse gap.

It is a good idea to work as a team (lecturers, actors) to outline the scene and the different ways it could develop. This can be done through discussion during rehearsals. A schematic outline of the scenes can also be helpful.

WORKING WITH A CHILD/ADOLESCENT WITH SELF-HARM - *Storyboard*:

In the observation room is a 16-year-old patient, Jane Smith, with a diagnosis of unspecified conduct disorder and an emotionally unstable personality structure. She had known since yesterday that she would be transferred to another hospital today. An orderly enters the room with the patient's drink. The nurses are busy with other tasks.

The orderly realises that something is wrong. The patient cries and shouts, "I told you I couldn't do it..." A nurse enters the room to find out what's causing the commotion.

The staff are shocked to discover that the patient has a cut on her forearm. The wound was caused by a broken pen she had obtained from an unknown source. A second nurse arrives. The tension escalates, and the patient screams, "Go away! Why are you all standing there? Don't touch me! Leave me alone! Go away!"

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The nurse calmed the situation by continuing to communicate with the patient and assessing the seriousness of the injury. The other nurse calls the doctor (this also reassures the patient). The orderly remains in the room, which is appropriate from a safety point of view. However, they are engaged in another activity. The patient does not feel under the weight of the attention of all the staff present.

The doctor consults the nurse and reads the patient's records. The orderly takes the equipment away. The other nurse is outside the observation room. Although someone is always present, no one is paying attention to the patient. This can be the trigger for further self-harm and escalation of tension.

The doctor sits down to align themselves with the patient at eye level. The other health professionals stand back and do not interrupt the patient's conversation with the doctor.

The outline of possible developments is a useful tool for both actors and lecturers. To some extent, it is possible to anticipate what the outcome will be and what the expectations are for the use of de-escalation techniques. As part of the subsequent analysis, participants can be more easily guided to identify key moments that help to calm the situation and those that, on the contrary, exacerbate it. We also anticipate and observe how the team works together, as this is also essential for a smooth course. The whole situation is recorded using audio-visual technology, which can be used for video analysis of selected moments. This is often the most valuable feedback for the participants.

Scene 16: WORKING WITH A PROBLEM FAMILY DURING THE VISIT

Role: Mother - Actor 1, e.g., Mary Jones (fictional name)

Father - Actor 2, e.g., Peter Jones (fictional name)

Patient, son - fictional role, e.g., David Jones (not in scene)

Entry information for participants: It is on Thursday at 15.00. 14-year-old David Jones is staying in a room with three beds. Next to David in the bedroom is a boy with autistic symptoms who has just defecated in the corner of the room and is now humming loudly, almost to the point of screaming. There are no vacancies anywhere else on the ward. David's parents are visiting. A nurse is checking the medication in the documentation, another nurse is preparing the hygiene equipment, the orderly is disinfecting and cleaning the medicine cups, and the doctor is in his office outside the nurses' station.

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Task / Goal: Proceed as in real life, using de-escalation approaches and appropriate team communication. Seek solutions under changing conditions and demands. Anyone can stop the situation at any time by announcing the "STOP!" signal.

Scene: There is a fully stocked nurses' station, including medication, bandages and hygiene products. Parents enter the office from the corridor. The doctor is outside the scene that is happening in the office.

Script: The parents of David, a 14-year-old patient being treated for his first psychotic episode, visit the ward. They enter the nurses' office unannounced, holding bedding and a bag containing David's personal belongings, and speak in a raised tone. Mother: "Hello, we would like to request that our son be moved to another room immediately. He tells us he is afraid of the dirty pig who is in there with him." Father: "Have you seen who he's in there with? Would you put your child in there with him?! We'll be taking him home right now..." This may be followed by an arrogant attempt to bribe the staff for an amenity room (e.g., during a conversation with the doctor called).

What makes the situation worse:

- Trying to discipline parents to behave,
- Eliminating the possibility of dealing with their request, e.g., "That's not possible!", "Where do you think you are?",
- False promises that can't be guaranteed, e.g., "As soon as you've finished your visit, we'll put David in a single room with his TV and PlayStation",
- Reluctance to call a doctor.

What calms the situation:

- The interest shown in the son (someone goes to see him),
- Trying to reorganise the room arrangements,
- Expressing concern for the parents and their fear for their son,
- Trying to reassure the parents that this is a temporary situation that can be dealt with (it is not a permanent condition),
- Call the doctor to deal with the discharge request (nurses are sometimes used to dealing with everything themselves and not bothering the doctor).

Equipment: bedding, a packed bag with son David's belongings, money to pay for the amenity bedroom, nurses' work desk (with keyboard, monitor, medical records, etc.), a working telephone (to call the doctor), health record sheets with medicine prescriptions, boxes of

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medicines, hygiene items, etc., equipment for the doctor's office (chairs, a coffee table with some flyers on it).

Storyboard:

David's parents enter the nurses' office unannounced, carrying bedding and a bag of personal belongings. The mother immediately says in a raised tone, "Hello, we would like to request that our son be moved to another room immediately. He tells us he is afraid of the dirty pig who is in there with him."

The parents demand an immediate solution to the situation. The father responds to the staff's refusal: "Have you seen who he's in there with? Would you put your child in there with him?! We'll be taking him home right now." One nurse continues to communicate with the parents, showing her willingness to help them in other ways. The other nurse called the doctor.

The arriving doctor tries to get his bearings. He politely declines the father's offer of money for the amenity bed. Together with the nurse, he urges the parents to sit down and discuss David's situation.

Now calmer, the parents discuss options with the doctor. One nurse remains present but does not get involved in the conversation. The other nurse goes to David's room to find out what's going on and address any problems that have arisen. Knowing that David is being cared for helps reduce the parents' anxiety.

Scene 05: CONFLICT BETWEEN ADOLESCENTS

Role: Patient a) - actor 1, e.g. Ava Williams (fictitious name)

Patient b) - actor 2, e.g., Nicole Brown (fictitious name)

Father of another patient - Actor 3 (the name is not important for the scene)

Entry information for participants: It's Thursday, at lunchtime. There are 2 female patients with eating disorders in the observation room, they have their meals here because they have to eat under staff supervision. One of the nurses is in charge of monitoring the patients, the other nurse is filling in the categories for the hospitalisation report for the insurance company, the orderly is outside the nurses' room (in the kitchen), and the doctor is interviewing the father of another patient in his office.

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Task / Goal: Use de-escalation approaches and appropriate team communication to manage the situation. Anyone can stop the situation at any time by announcing the "STOP!" signal.

Scene: The nurses' station is real, including space for other examinations. The patients are confined to a double observation room, visible from the nurses' station through a window. They're about to eat their lunch. The doctor is off-site, in his office.

Script: During lunch, Miss Eve suddenly smashes her cup on the floor while shouting at Miss Nicola: "You bitch! What the hell do you think you're doing?! You know very well that that bitch Monica is ratting me out!" Miss Nicole goes from defensive to offensive and openly threatens: "Try that on me again, and I'll pull your filthy hair out! You don't give a damn who I talk to, you understand?" A fight breaks out in the room, and a possible conflict arises out of pseudo-jealousy between the girls, with Eve angry at Nicole for talking to Monica, who revealed that Eve was cheating with food. The argument escalates into aggression when the patients start throwing various objects (plates, pillows, etc.) at each other. All of this is done with an initial disregard for the staff, who gradually arrive. At the same time, the father of another patient is in the doctor's room for an interview and insists that the doctor finish the interview.

What makes the situation worse:

- The directive handling of the situation by the staff (where the conflict can turn against the staff),
- Siding with one or the other patient, pointing out that one or the other is right,
- A tendency to discipline, threaten with sanctions, pass judgment, and assess who is to blame.

What calms the situation:

- The distribution of attention - someone looking after one patient, someone looking after another,
- Temporary separation, e.g., taking one of the girls to the nurses' station for another conversation (not as a punishment),
- Diverting attention to another topic in the acute phase of the conflict (after calming down, it is desirable to continue discussing the whole situation), clearly defining the rules for further discussion,
- Identification with the patients, e.g., "I understand that you are upset about this situation; I would probably be upset too".

Equipment: utensils for serving lunch, real lunch, nurses' work desk (with keyboard, monitor, medical records, etc.), equipment for the patients' examination (and ward) area, equipment for the double observation room, working telephone (to call the doctor), fictitious medical documentation of 2 patients with eating disorders.

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Storyboard:

There are 2 female patients with eating disorders in a room intended for the observation of patients who receive meals here because they must eat under staff supervision. One of the nurses is in charge of monitoring the patients, the other nurse is filling in the categories for the hospitalisation report for the insurance company. The orderly and the doctor are not present.

Eve smashes the cup on the floor and yells at Nicole, " You bitch! What the hell do you think you're doing?! You know very well that that bitch Monica is ratting me out!" Nikola goes from defensive to offensive and openly threatens: "Try that on me again, and I'll pull your filthy hair out! You don't give a damn who I talk to, you understand?" The staff begins to arrive.

At the same time, the father of a completely different patient is in the doctor's room for an interview and insists on finishing the consultation with the doctor, who is called in to resolve the problem between the girls.

Meanwhile, the nurses have separated the quarrelling patients. One nurse looks after each of them. They express understanding, do not moralise, do not judge, and do not try to find the guilty party. The arriving doctor is forced to orientate himself in the situation and, at the same time, to deal respectfully with the father of another patient, who continues to insist on finishing the conversation.

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