SKILL FOCUS: Wound Care | DISCIPLINE: Nursing | LEVEL: 3

WOUND MANAGEMENT

Estimated Time: 30-45 minutes • Debriefing Time: 60 minutes

Patient Name: Clint D. Fullerton

SCENARIO OVERVIEW

Clint D. Fullerton is a 67 year old male who was admitted to the medical/surgical floor for treatment of a left ankle ulceration and is on contact precautions for CDiff. He has a past history of diabetes, hypertension, venous insufficiency and self-care deficits. He has a PICC line in the left brachial. His last Vancomycin dose was last night at 2000 so he is due for his morning dose. Peak Vancomycin levels were drawn after last night's dose, but the night RN has not seen the critically elevated results yet.

CURRICULUM MAPPING

WTCS NURSING PROGRAM OUTCOMES

- Demonstrate appropriate written, verbal, and nonverbal communication in a variety of clinical contexts
- Provide patient centered care by utilizing the nursing process across diverse populations and health care settings
- Minimize risk of harm to patients, members of the healthcare team and self through safe individual performance and participation in system effectiveness
- Integrate social, mathematical, and physical sciences, pharmacology, and pathophysiology in clinical decision making
- Lead the multidisciplinary health care team to provide effective patient care throughout the lifespan

BASIC SKILLS

- Provide wound care
- Administer medications via the enteral and parenteral routes
- Perform a basic physical assessment
- Manage intravenous therapy

NURSING FUNDAMENTALS

- Use appropriate communication techniques
- Use the nursing process
- Adapt nursing practice to meet the needs of diverse patients in a variety of settings
- Provide nursing care for patients with integumentary disorders
- Provide nursing care for patients with infection

PHARMACOLOGY

- Apply components of the nursing process to the administration of antimicrobial drugs

COMPLEX HEALTH ALTERATIONS

- Evaluate nursing care for patients with other alterations in the cardiovascular system
- Evaluate nursing care for patients with alterations in the endocrine system

ADVANCED SKILLS

- Manage central lines

LEARNING OBJECTIVES

1. Demonstrate proper infection control
2. Complete a head to toe assessment
3. Complete a focused wound assessment
4. Recognize and respond to abnormal findings
5. Safely administer medications: IV, central line
6. Safely draw from central line
7. Document accurately
8. Demonstrate appropriate therapeutic communication
9. Demonstrate appropriate interprofessional communication

QR CODE

Scan to begin

SIMULATION LEARNING ENVIRONMENT & SET-UP

ENVIRONMENT

Inside room: Patient lying in bed, IV pump
Inside or outside room: Contact Precautions cart and sink
Outside room: Computer or form(s) for documentation

PATIENT PROFILE

Name: Clint D. Fullerton
DOB: 02/26/19XX
Age: 67
MR#: 0508
Gender: Male
Ht: 68 inches
Wt: 143 lbs (65 kg)
Admitting Diagnosis: wound, open, ankle (S91.00)
Medical History: Diabetes Mellitus (E11.9), HTN (I87.33), Venous Insufficiency (I87.2)
Code Status: Unknown
Ethnicity: Caucasian
Allergies: None

EQUIPMENT/SUPPLIES/SETTINGS

Patient

- Hospital gown
- Pad, chux placed under patient or adult brief on
- No moulage
- ID band present with QR code
- IV in left hand
- Double PICC in left arm (set up for a blood draw and medication administration)

Monitor Settings

- Vitals: BP 124/72, P 112, RR 22, O2 91%, T 38.2C (100.8)

Supplies

- General
    - Phone
    - Modified or CDiff precaution door sign
    - Contact precaution cart/supplies
    - Various O2 delivery devices (Nasal cannula, non-rebreather, etc...)
    - I & O monitoring equipment/forms

- Medications
    - 40mg IV Lasix (available)

- IV Pump
    - 0.9% NaCl running at 75ml/hr 1000ml bag
    - IVPB Vancomycin 975 mg/500ml (available)

QR CODES

START

REPORT

PATIENT

PATIENT ID

LEG

IV SITE

CHEST

PICC

STATE 1—PREBRIEF, REPORT & PATIENT INTRODUCTION

- The facilitator should lead this portion of the simulation. The following steps will guide you through State 1.

- "Scan to Begin" using scenario start QR Code while students are in Prebrief.

- "Meet Your Patient" (on iPad) and explain how the iPad works in the simulated learning environment including the scanner/QR codes.

- Discuss the simulation "Learning Objective(s)" (on iPad) as well as any other Prebrief materials

- Get "Report" (on iPad)
    - Possible facilitator discussion questions
        - What is clinically significant in the shift-to-shift report?
        - What focused assessments do you plan to complete based on report?

- Play the "Patient" video (on iPad)
    - Possible facilitator discussion questions
        - How will you respond therapeutically to Mr. Fullerton's concerns?

- Advance to the "Patient Profile" screen (on iPad). This will act as a simulated patient chart.

- Students can view the tabbed content on the iPad (see below) prior to entering the patient's room and throughout the simulation as needed.

- Now, students can enter the room and begin the next state of the simulation.

HISTORY AND PHYSICAL

Name: Clint D. Fullerton

MR#: 0508
DOB: 02/26/19XX

DATE OF ADMISSION: 09/18/XX

CHIEF COMPLAINT: Ulceration Left Lower leg

HISTORY OF PRESENT ILLNESS: This is a 67-year-old male who resides at a local skilled nursing facility due to self-care deficits. He has a stage 2 ulceration on his left medial lower leg superior to ankle. He has been previously treated by Dr. Paulson who ordered multiple rounds of antibiotic treatment with no successful results. He is a brittle diabetic with his last HgbA1c being 9.2%.

PAST MEDICAL HISTORY: History of diabetes, HTN, venous insufficiency.

MEDICATIONS:

- Lisinopril 20mg PO daily
- Lantus insulin 0.2 units/kg/daily subcutaneously
- Novolin R insulin sliding scale subcutaneously with meals

ALLERGIES: None

SOCIAL HISTORY: Divorced; No children; Lived in LTC for 5 years. History of extensive alcohol use prior to LTC admission. Refuses to quantify current use but states LTC staff will take it away if they find it.

FAMILY HISTORY: Father - died in MVA at age 59. Mother – living, diabetic, age 91. Brothers – 2, status unknown.

REVIEW OF SYSTEMS:
Obtained From patient General: Current state of health described as fine.

Integument: Denies itching, dryness, rashes, pigmentation changes. Denies recent changes in birthmarks, moles, nails, or hair. Describes a sore above left ankle that has been present for several months. He has taken several antibiotics but it won't heal.

Lymph Nodes: Denies enlargement or tenderness

Head: Denies injury, change in level of consciousness, or headaches.

Eyes: Denies change in vision. Denies diplopia, eye pain, eye redness/inflammation. Denies glaucoma or cataracts. Wears glasses.

Ears: Denies hearing loss, change in acuity, tinnitis, vertigo, infection, or ear pain.

Nose: Denies sinusitis, nasal discharge or obstruction, post nasal drip, or epistaxis.

Mouth: Denies bleeding gums, mouth pain, oral cavity sores or growths, difficulty swallowing, sore throat, or hoarseness.

Respiratory: Denies excessive snoring, orthopnea, hemoptysis, productive cough, shortness of breath or wheezing. Denies history of pulmonary embolism, sleep apnea, bronchitis, pneumonia, recurrent infections or TB exposure. Denies occupational exposure to asbestosis or pneumoconiosis.

Cardiovascular: Denies chest pain or pressure. Denies palpitations or orthopnea. No history of murmur or valve disorder. History of hypertension for which he takes lisinopril.

Peripheral Vascular: Denies claudication, leg cramps, varicose veins, phlebitis, cramping. History of venous insufficiency and paresthesias in lower legs. States my legs get swollen every now and then, but it gets better when I sit in my recliner and put them up, and it used to feel like pins and needles in my feet but now I can't really feel my toes anymore.

Gastrointestinal: Denies change in appetite, weight gain/loss, abdominal pain, constipation, diarrhea, nausea or vomiting. Denies bloody or tarry stools. Denies change in bowel habits. Bowel movements occurring every 1-2 days. Denies history of colon polyps, hemorrhoids, liver problems, jaundice, or hepatitis. Denies symptoms of GERD.

Genitourinary: Denies dysuria, hematuria, hesitancy or change in stream. Denies history of infections or stone. Denies incontinence or nocturia.

Males: Denies history of hernias, testicular masses, prostatitis, STDs, or BPH. Denies current testicular pain, penile discharge/lesions or sexual dysfunction.

Musculoskeletal: Denies joint pain or stiffness. Normal ROM. Denies myalgias. No history of gout, osteopenia/ osteoporosis or osteoarthritis. Denies back pain. Denies history of compression fractures, broken bones, falls or amputations.

Hematopoietic: Denies easy bruising or bleeding. Denies anemia or prolonged bleeding. Denies history of previous transfusions or blood dyscrasias.

Endocrine: Denies polydipsia or polyuria. Denies heat or cold intolerance. Denies tremors. Denies history of thyroid disorder. History of diabetes for which he is taking Lantus and sliding scale regular insulin. Last HgbA1c was 9.2%.

Nervous System: Denies dizziness, syncope, vertigo, sensory or motor disturbances, tremor or weakness.

Psychiatric: Denies depression, anxiety, or panic attacks. Denies memory concerns. Denies history of mania. No recent personality changes. No history of previous psychiatric care.

LABORATORY AND DIAGNOSTIC STUDIES: Pending

ASSESSMENT: Ulceration, left lower leg.

RECOMMENDATIONS/PLAN: Admit to med/surg floor. Orders will include wound culture, wound nurse consult, and dietitian consult. I discussed with him the exact nature of the wound and his risk factors including diabetes management and personal hygiene. Patient will be continued on his medication regiment from long term care until his diabetic status can be reviewed. Wound treatment regimen will be determined once culture results are back. All questions were answered and he agreed with treatment plan.

Electronically Signed – Dr. Robert Bennett

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<tr><td>Yesterday</td><td>0800</td><td>Chem 7 STAT</td></tr>
<tr><td></td><td></td><td>Vancomycin 25 mg/kg IVPB over 1 hour x 1 dose STAT then</td></tr>
<tr><td></td><td></td><td>Vancomycin 15 mg/kg IVPB over 1 hour every 12 hours</td></tr>
<tr><td></td><td></td><td>PICC line</td></tr>
<tr><td></td><td></td><td>Heparin 100IU/mL flush 10mL IVP PRN</td></tr>
<tr><td></td><td></td><td>Peak Vancomycin levels x 1, trough Vancomycin levels daily</td></tr>
<tr><td></td><td></td><td>Contact precautions ---------Dr. Robert Bennett</td></tr>
</table>

MAR

Patient Name: Clint Fullerton
DOB:02/26/19XX Weight(kg):65
MR#: 0508
Provider: Dr. Robert Bennett
Allergies: None

Order	Sch. Time	Dose
Lisinopril 20mg PO daily	Last given 0730	20mg
Lantus insulin 13 units daily subcutaneously	Last given 0730	13 units
0.9% Normal Saline IV at 75 mL/hour	Last bag 0330	
0.9% Normal Saline IV at 75 mL/hour		
200 mg ibuprofen, 1-2 tablets Q4-6 PRN	Last given 0730	400mg
200 mg ibuprofen, 1-2 tablets Q4-6 PRN		
Saline lock flush 10mL IVP PRN		
Novolin R insulin Sliding Scale subcutaneously with meals: Fingerstick glucose level (mg/dL) / Novolin R (units) 150-200 / 4 201-250 / 8 251-300 / 12 301-350 / 16 351-400 / 20	Last given 0730	8 units
Novolin R insulin Sliding Scale subcutaneously with meals:		
Vancomycin 15 mg/kg IVPB over 1 hour Q12 hours	Given ystrdy 2030	975mg
Vancomycin 15 mg/kg IVPB over 1 hour Q12 hours		
Heparin 100 IU/mL flush, 10 mL IVP PRN	Given ystrdy 2140	10mL
Heparin 100 IU/mL flush, 10 mL IVP PRN		

VITALS

P 112
RR 22
BP 124/72
T 38.2C (100.8)
O2 91%
Pain: 2/10

PROGRESS NOTES

No reports available.

LAB/DIAGNOSTICS

Patient Name: Clint D. Fullerton

DOB: 02/26/19XX

MR#: 0508

Blood Glucose						
Date	Yesterday	Today			Units	Reference Range
Time	AM	AM				
Glucose	**210**	208			mg/dL	Fasting 70 - 105

Chem 7						
Date	Yesterday				Units	Reference Range
Time	AM					
Glucose	**210**				mg/dL	Fasting 70 - 105
BUN	**28**				mg/dL	10-25
Creatinine	**1.4**				mg/dL	F: 0.4-1.4/M: 0.5-1.5
Sodium	**156**				mEq/L	135-145
Potassium	**3.8**				mEq/L	3.5-5.3
Chloride	**98**				mEq/L	98-108
Carbon Dioxide	**26**				mEq/L	23-27

CBC with Differential					
Date / Time	Yesterday / AM			Units	Reference Range
WBC	**13.2**			x 10^3 uL	4.5-11.0
RBC	**3.9**			x 10^6 uL	F: 4.2-5.4/M: 4.6-6.2
HgB	**12.1**			g/dL	F: 13.0-15.0/M: 14.0-17.0
HCT	**38.1**			%	F: 38-47/M: 42-52
MCV	**85.3**			fL	80-90
MCH	**27.8**			pg	27-32
MCHC	**33.6**			g/dL	32-36
RDW	**13.2**			%	11.5-14.5
Platelet	**204**			x 10^9 uL	150-450
MPV	**7.8**			fL	6.0-12.0
Neutro	**74**			%	40-70
Lymph	**21.5**			%	22-40
Mono	**2.3**			%	1-10
Eos	**1.4**			%	1-7
Baso	**0.8**			%	0-2

Wound Culture						
Date / Time	Yesterday / AM	Today / AM			Units	Reference Range
Bacterial Growth	**0**	**0**				No growth

Stool Culture						
Date / Time	Yesterday / AM				Units	Reference Range
Clostridium difficile	**Positive**					Negative

IMAGING

No reports available.

LEVEL UP

Option not available yet.

SCANNER

Used for students to scan QR codes during simulation.

STATE 2 –PATIENT ASSESSMENT

- Patient Overview
  - Patient is sarcastic and gruff. It is apparent that he does not care for medical personnel or medical facilities, including the skilled nursing care facility where he currently resides. He is not feeling well and is short of breath this morning.

- Expected Student Behaviors
  - Perform appropriate infection control
  - Introduce themselves and verify patient
  - Communicate therapeutically
  - Perform general assessment: crackles (Scan Chest QR code)
  - Perform focused assessment: leg wound (Scan Leg QR code)
  - Analyze the lab/diagnostic results
  - Communicate with the provider using SBAR format

- Technician Prompts
  - Patient is a little short of breath and complains he doesn't feel well. He is gruff.
  - Patient responses can include:
    - "I hate hospitals. I came in here with a little scratch and now I'm sick."
    - "Will I ever feel well again? I can't quite catch my breath."
    - "Since I've been here, I keep getting sicker! Do you all even know what you're doing"
    - "I'm tired of answering questions. Just do what you have to do and get out."
- After the Crackles QR code is scanned, a critical peak Vancomycin level appears under the Labs tab. At this time, a phone call should be made to the students from the "lab" informing them of this critical value and that it was never entered into the database last night. "Lab" also states that an incident report is being generated.

- Facilitator Questions
  - What infection control meds are needed for Mr. Fullerton?
  - How do you plan on prioritizing the orders received? What is most important to do first and why?
  - Why do you think Vancomycin was ordered? (What types of infection will it treat)?
  - What is a peak/trough level and how does it affect your nursing management of administering Vancomycin?
  - Analyze the vital signs: do you have any concerns?

- Analyze your physical assessment findings: do you have any concerns?
- Analyze this wound's characteristics: does it appear to be a wound caused by arterial insufficiency or a venous stasis? Why?
- What are Mr. Fullerton's risk factors that contribute to poor wound healing?
- Based on the wound's characteristics, what type of dressings and treatment are optimal for this wound?
- Why do you think the wound culture shows "no growth" at this time?
- What is Cdiff? What causes it?
- How does the SBAR format facilitate interprofessional communication?

- Tabbed iPad content
  - After the student(s) scans the Crackles QR code, the tabbed iPad content will change as follows (students are not prompted to these changes):

LAB/DIAGNOSTICS

Patient Name: Clint D. Fullerton DOB: 02/26/19XX MR#: 0508

Blood Glucose

Date	Yesterday	Today			Units	Reference Range
Time	AM	AM				
Glucose	**210**	208			mg/dL	Fasting 70 - 105

Chem 7

Date	Yesterday				Units	Reference Range
Time	AM					
Glucose	**210**				mg/dL	Fasting 70 - 105
BUN	**28**				mg/dL	10-25
Creatinine	**1.4**				mg/dL	F: 0.4-1.4/M: 0.5-1.5
Sodium	**156**				mEq/L	135-145
Potassium	**3.8**				mEq/L	3.5-5.3
Chloride	**98**				mEq/L	98-108
Carbon Dioxide	**26**				mEq/L	23-27

CBC with Differential						
Date	Yesterday				Units	Reference Range
Time	AM					
WBC	**13.2**				x 10^3 uL	4.5-11.0
RBC	**3.9**				x 10^6 uL	F: 4.2-5.4/M: 4.6-6.2
HgB	**12.1**				g/dL	F: 13.0-15.0/M: 14.0-17.0
HCT	**38.1**				%	F: 38-47/M: 42-52
MCV	**85.3**				fL	80-90
MCH	**27.8**				pg	27-32
MCHC	**33.6**				g/dL	32-36
RDW	**13.2**				%	11.5-14.5
Platelet	**204**				x 10^9 uL	150-450
MPV	**7.8**				fL	6.0-12.0
Neutro	**74**				%	40-70
Lymph	**21.5**				%	22-40
Mono	**2.3**				%	1-10
Eos	**1.4**				%	1-7
Baso	**0.8**				%	0-2

Wound Culture							
Date	Yesterday	Today				Units	Reference Range
Time	AM	AM					
Bacterial Growth	**0**	**0**					No growth

Stool Culture							
Date	Yesterday					Units	Reference Range
Time	AM						
Clostridium difficile	**Positive**						Negative

Vancomycin Peak Level							
Date	Yesterday					Units	Reference Range
Time	2315						
Vancomycin	**76**					Mcg/mL	15-20

LEVEL UP

This tab is now active.

When selected, students are asked, “Have you called the provider?”

Once they have selected “yes,” then the iPad moves to State 3 content as below.

STATE 3 – INTERVENTIONS & REASSESSMENT

- Patient Overview
  - Patient continues to be somewhat sarcastic. He is not feeling well and is even more short of breath at this time.

- Expected Student Behaviors
  - Perform appropriate infection control
  - Communicate therapeutically
  - Reassess patient: change in vitals: Crackles (Scan Chest QR code)
  - Apply O2
  - Perform blood draw from central line: PICC line (Scan PICC QR code)
  - Administer meds: see MAR: IV site (Scan IV site QR code)
  - Initiate I&O monitoring
  - Communicate new orders/consults to appropriate departments

- Technician Prompts
  - At the beginning of this State, Vitals should be changed to: P 118, RR 26, BP 128/68, T 38.2C, O2 87%, Pain: 3/10
  - O2 sats should increase appropriately after O2 is applied.
  - Patient is short of breath and complains he doesn't feel well. He is gruff.
  - Patient responses can include:
    - "Didn't you already check my blood pressure and stuff?"
    - "I can't really seem to catch my breath."
    - "Why do I have to wear this (O2 device)?"
    - "Does anyone here know what they are doing?"

- Facilitator Questions
  - How will you prioritize the new orders you've received?
  - After reassessing the patient, do you have any concerns? If so, how will you address them?
  - How often should the patient be reassessed/monitored? Why?
  - How will you address Mr. Fullerton's concerns therapeutically?
  - Describe how you will maintain proper infection control during medication administration?
  - What will you assess at the IV site before giving the Lasix?
  - What will you assess at the PICC line site before drawing a blood sample?
  - Describe how you will explain I&O monitoring to your patient.
  - How will you communicate new orders/consults appropriately?

- Tabbed iPad content
    - After the student(s) calls the provider, the tabbed iPad content will change as follows (students are not prompted to these changes):

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<tr><td>Today</td><td>Now</td><td>CBC, Chem 7 & eGFR STAT</td></tr>
<tr><td></td><td></td><td>Consult Nephrology</td></tr>
<tr><td></td><td></td><td>Hold Vancomycin. Call with trough result.</td></tr>
<tr><td></td><td></td><td>Call Infectious Disease</td></tr>
<tr><td></td><td></td><td>Monitor I&O</td></tr>
<tr><td></td><td></td><td>Change NS IV to TKO</td></tr>
<tr><td></td><td></td><td>40mg Lasix IV STAT</td></tr>
<tr><td></td><td></td><td>O2 to keep Sat >90% & RT Consult --Dr. Robert Bennett</td></tr>
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MAR

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DOB:02/26/19XX Weight(kg):65
MR#: 0508
Provider: Dr. Robert Bennett
Allergies: None

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Novolin R insulin Sliding Scale subcutaneously with meals:		
Vancomycin 15 mg/kg IVPB over 1 hour Q12 hours	Given ystrdy 2030	975mg
Vancomycin 15 mg/kg IVPB over 1 hour Q12 hours	HOLD	
Heparin 100 IU/mL flush, 10 mL IVP PRN	Given ystrdy 2140	10mL
Heparin 100 IU/mL flush, 10 mL IVP PRN		
40mg Lasix IV STAT		

LEVEL UP

- There is an “end the scenario” option available now. At the end of the simulation, direct students here to end the iPad application.

STATE 4 – DEBRIEF

Nothing needed from the iPad.

DEBRIEFING QUESTIONS

1. How did you feel this scenario went?

2. What were the main issues you had to deal with Mr. Fullerton?

3. Review understanding of learning objective: demonstrate proper infection control.
    a. What infection control measures did you institute for Mr. Fullerton and why?

4. Review understanding of learning objective: complete a head to toe assessment.
    a. What did concerns did you find during your assessment that affect Mr. Fullerton's wound healing and health status?

5. Review understanding of learning objective: complete a focused wound assessment.
    a. What kind of wound does Mr. Fullerton have?
    b. What causes this type of wound?
    c. What dressings and treatments are required for healing of this type of wound?
    d. Why was Vancomycin ordered for Mr. Fullerton?

6. Review understanding of learning objective: recognize and respond to abnormal findings.
    a. What abnormal findings did you find in the vital signs, physical assessment or labs? How did you respond to these findings?

7. Review understanding of learning objective: safely administer medications IV, central line
    a. Did you have any concerns while administering medications? How did you respond?

8. Review understanding of learning objective: safely draw from central line.
    a. Did you have any concerns while using the PICC line? How did you respond?

9. Review understanding of learning objective: document accurately.
    a. What is important to document about your wound assessment and care?

10. Review understanding of learning objective: demonstrate appropriate therapeutic communication
    a. What "cues" did you notice that indicated therapeutic communication was needed with Mr. Fullerton?
    b. Describe communication techniques you used with Mr. Fullerton.
        i. Were your techniques effective?
        ii. Did any barriers occur?
        iii. If you could "do over," how would you change your therapeutic communication with Mr. Fullerton?

11. Review understanding of learning objective: demonstrate appropriate interprofessional communication
    a. Describe the information you used for SBAR communication with the provider.
        i. Was this communication effective? Why or Why not?
        ii. If you could change anything about this SBAR, what would it be and why?
    b. Did you use SBAR when communicating new order/consults to the appropriate departments/people? Why or Why not?

12. Tie the scenario back to the nursing process in a large group discussion. Concept mapping can be used to facilitate discussion.
    a. List 3 priority nursing problems you identified for Mr. Fullerton.
    b. Create a patient centered goal for each nursing problem you identified.
    c. Discuss focused assessments for each nursing problem.
    d. Discuss nursing interventions for each nursing diagnosis.
    e. Re-evaluate the simulation in terms of the nursing process; what was actually accomplished? What could be improved in the future?

13. Take away Points
    a. Ask each student to share one thing they learned from participating in this scenario that they will take with them into their nursing practice. (Each student must share something different from what the others' share.)

Note: Debriefing technique is based on INASCL Standard for Debriefing and NLN Theory-Based Debriefing by Dreifuerst.

SURVEY

Print this page and provide to students.

Students, please complete a brief (2-3 minute) survey regarding your experience with this ARISE simulation. There are two options:

1. Use QR Code: Survey
    a. Note: You will need to download a QR Code reader/scanner onto your own device (smartphone or tablet). There are multiple free scanner apps available for both Android and Apple devices from the app store.
    b. This QR Code will not work in the ARIS app.

SURVEY

2. Copy and paste the following survey link into your browser.
    a. https://ircvtc.co1.qualtrics.com/SE/?SID=SV_6Mwfv98ShBfRnBX

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