Colorado Center for Nursing Excellence

Clinical Scholar Didactic Course
March 2011
Tentative Schedule
Day 1, Monday, March 14, 2011

Time	Objective	Presenter
8:00 – 9:40	Introductions, formulation of objectives, class agreements, introduction to logbooks Pages 4 – 7	Karren Kowalski
9:40 – 10:00	Break	
10:00 – 11:00	Discuss the definition of Clinical Scholar, motivation to become a Clinical Scholar, values in a variety of contexts. Discuss the emerging / evolving professionalism, role modeling and the importance of a mentor	Marianne Horner
11:00 – 12:00	QSEN	Gail Armstrong
12:00 – 12:45	Lunch	
12:45 – 1:00	More in depth explanation of logbooks	Karren Kowalski
1:00 – 2:00	Describe the general role of the clinical scholar – Jeopardy game	Marianne Horner & Deb Center
2:00 – 2:10	Break	
2:10 – 2:40	Discuss the importance of relationships in getting things done	Karren Kowalski
2:40 – 3:30	Discuss lateral violence and incivility in the workplace and its impact on students	Deb Center
3:30 – 4:40	Identify principles & aspects of interaction and learning style - DISC	Karren Kowalski
4:40 – 5:00	Logbook time and sharing Pages 8 – 19, & p. 25, questions 1 & 2	Karren Kowalski

The Clinical Scholar Colorado 2010

Colorado Center for Nursing Excellence

Why
Who
What
How

- **Originally developed as a strategy to soften the impact of the faculty shortage and…..**
- Personal motivation

Why would a person want to be a Clinical Scholar?

2

- Difference between Clinical Scholar and other clinical educators
- Qualifications
- Attributes and qualities

Who is a Clinical Scholar?

3

- Clinical expertise
- Educational requirements
- Previous teaching

What are the qualifications for a Clinical Scholar?

4

- Clinical nurse
  - Competent
  - Expert
- Clinical Scholar
  - New role
  - Novice

Ability to combine two roles

5

Do you remember what it is like to be a novice?

6

- Some examples…..

Patricia Benner: Skill Acquisition: Novice to Expert

7

- Clinical organization's culture and values
- Culture and values of nursing education
  - Schools of nursing
  - Students

Ability to Blend Two Distinct Cultures

8

- Role model clinical competency and professionalism
- Assess learning needs
- Plan learning activities including making patient care assignments
- Teach according to the agency and school of nursing guidelines

What does a Clinical Scholar Do?

9

- Supervise and teach for knowledge and skill development
- Evaluate clinical performance
- Facilitate clinical conferences
- Socialize into the nursing profession

What does a Clinical Scholar Do?

10

- Preparation
  - Didactic course
  - Formal academic education
- Role development from Novice → Expert
- Ongoing mentoring
- Deliberate reflection

How do you Become a Clinical Scholar?

11

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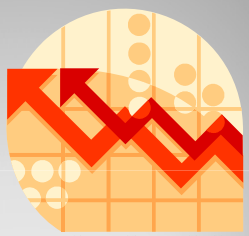
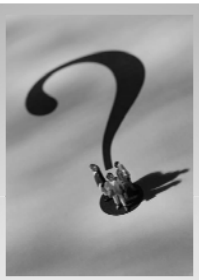
Faculty Development Initiative Project
Summary Results for Clinical Scholars



Data Obtained from Evaluations Following Student Rotations & Scholar Survey



What Did We Learn?

- **65%** of the Clinical Scholar course participants have taught one or more clinical rotations
- Of the remainder, the majority of them are either precepting and / or involved in unit level teaching
- Of those who have left their positions, more than half are still using the skill set

- Having Clinical Scholars on the unit provides a higher quality experience for students – **94%**
- Having a Clinical Scholar who is a staff member allows higher quality nursing care to be delivered to patients – **93%**
- Would welcome Clinical Scholar back – **97%**

What Do Agencies Say?

- Quality of the clinical experience provided by Clinical Scholars was high – **97%**
- Clinical Scholar was knowledgeable clinically – **100%**

What Do Schools Say?

- Regarding all of the additional questions posed, there was at least a positive response of **80%**

What Do Schools Say?

- **On all measures the responses were strongly positive**
- Demonstration of expert knowledge – **97%**

What Do Students Say?

- Regarding questions surrounding positive attributes of the Scholar – **95%**
- Regarding questions surrounding quality of clinical experience provided by the Clinical Scholar – **92%**
- Regarding questions about quality of evaluation – **93%**

What Do Students Say?

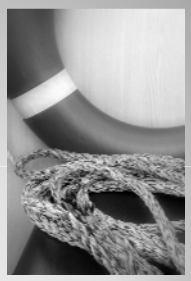
- Increased job satisfaction – **79%**
- Increased enthusiasm for the profession – **93%**
- Enhanced commitment to their agency – **77%**

What Do Clinical Scholars Say?

- Comparing attitudes re: seeking an additional degree: there was a **10%** change between the beginning and end of the course
- Of those, **50%** have taken specific actions to pursue that goal

What Do Scholars Say?

- Believed that patient **safety was enhanced**, even by those who were not personally leading student rotations – **91%**



What Do Scholars Say?

- For student nurses
- For schools of nursing
- For agencies
- For YOU!

Clinical Scholar Model is a "Win-Win" for all!

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Benner's Five Stages of Skill Acquisition

- Novice
  - Learns well with concrete and objective information
  - Beginners with little or no experience
  - Perform best with **rules** to guide activities
  - Needs **lists** / cookbook approach / **memorization** heavily relied on
- Advanced Beginner
  - Focus is on bits and pieces
  - Has coped with some experiences and knows recurrent meaningful components
  - Still has difficulty sort out what is most important
  - Still trying to remember things
  - Most details are treated equally
  - Need help in prioritizing from mentors / teachers
- Competent
  - Sees actions in terms of long range goals or plans
  - Plan for teaching is based on analysis and thought
  - Still lacks speed and flexibility in accomplishing tasks
  - Feeling of mastery and the ability to cope with and manage a clinical assignment
  - Works in a conscious, deliberate manner that helps achieve a level of organization
- Proficient
  - Continues to enhance skills
  - Performance is guided by experience
  - Can recognize when the expected normal picture does not happen
  - Decision making is less labored – knows what is important
  - Best taught by the use of case studies of particular situations
- Expert
  - No longer relies on guidelines or rules to perform the role
  - Has enormous background and experience
  - Has an intuitive grasp of the situation
  - Can zero in on the solution to problems without hesitation
  - Operates from a deep understanding of the situation
  - Have a hard time telling all that they know as it is so ingrained
  - Has highly skilled analytical ability to apply in new situations
  - Can transfer knowledge and skills and apply knowledge to solve problems in a new situation

Adapted from Sara Jarrett "Clinical Scholar Colorado 2008"

Evaluation of Individual Presenter by Student
Clinical Scholar

Presenter: Marianne Horner	Topic: Clinical Scholar	Date: March 14, 2011

Regarding the Presenter:	Scale					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	No Opinion / N/A
1. The speaker was knowledgeable regarding the content presented	○	○	○	○	○	○
2. The presentation was stimulating and interesting	○	○	○	○	○	○
3. The content presented will be useful to me in my role as a Clinical Scholar	○	○	○	○	○	○
4. Appropriate reference materials were provided	○	○	○	○	○	○
5. Handouts or other materials are clear	○	○	○	○	○	○
6. The presenter was responsive to questions from the audience	○	○	○	○	○	○
7. The content was at an appropriate level, not too elementary, not too complex	○	○	○	○	○	○
8. The content was covered satisfactorily and completely	○	○	○	○	○	○
9. The speaker's selected teaching strategy (lecture, discussion, small groups, etc.) maximized my learning	○	○	○	○	○	○

Comments:

What is QSEN and Why Should I Care About it??

Colorado Center For Nursing Excellence
Clinical Scholar Workshop
Amy Barton, PhD, RN
Gail Armstrong, DNP, ACNS-BC, CNE
Kathy Foss, MS, RN

Quality and Safety Education for Nurses Project is supported by The Colorado Trust, a grantmaking foundation dedicated to achieving access to health for all Coloradans

Introductory definition….

- Quality and Safety Education for Nurses (QSEN) is a Robert Wood Johnson funded national initiative that is providing leadership for all nursing programs in looking at how updated definitions of quality and safety are being integrated into nursing curricula.

National Context of IOM's work

- To Err is Human: Building A Safer Health System (1999)
- Crossing the Quality Chasm: A New Health System for the 21st Century (2001)
- Health Professions Education: A Bridge to Quality (2003)
- Keeping Patients Safe: Transforming the Work Environment of Nurses (2004)
- Preventing Medication Errors: Quality Chasm Series (2006)

Institute of Medicine

The number of people who die each year from medical errors…

… is equivalent to 3 jumbo jet crashes every 2 days.

Leape LL. Error in Medicine. *JAMA* 1994. Dec 21;272(23):1851-7

To Err is Human

- Establishing a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety.
- Identifying and learning from errors by developing a nationwide public mandatory reporting system and by encouraging health care organizations and practitioners to develop and participate in voluntary reporting systems.
- Raising performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of health care.
- Implementing safety systems in health care organizations to ensure safe practices at the delivery level.

Crossing the Quality Chasm

- *Safe*: avoiding injuries to patients from the care that is intended to help them.
- *Effective*: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- *Patient-centered*: providing care that is respectful of and responsive to in dividual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- *Timely*: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*: avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Health Professions Education

- Delivering patient-centered care,
- Working as part of interdisciplinary teams,
- Practicing evidence-based medicine,
- Focusing on quality improvement and
- Using information technology.

The Common Call to Health Professions Education

IOM HP Education	QSEN
Patient Centered Care	Patient Centered Care
Teamwork & Collaboration	Teamwork & Collaboration
EBP	EBP
Quality Improvement	Quality Improvement
Informatics	Informatics
	Safety

Keeping Patients Safe

Governing Boards That Focus on Safety
- Are knowledgeable about the link between management practices and patient safety.
- Emphasize patient safety to the same extent as financial and productivity goals.

Leadership and Evidence-Based Management Structures and Processes
- Provide ongoing vigilance in balancing efficiency and patient safety.
- Demonstrate and promote trust in and by nursing staff.
- Actively manage the process of change.
- Engage nursing staff in nonhierarchical decision making and work design.
- Establish the organization as a "learning organization."

Effective Nursing Leadership
- Participates in executive decision making.
- Represents nursing staff to management.
- Achieves effective communication between nurses and other clinical leadership.
- Facilitates input from direct-care nursing staff into decision making.
- Commands organizational resources for nursing knowledge acquisition and clinical decision making.

Adequate Staffing
- Is established by sound methodologies as determined by nursing staff.
- Provides mechanisms to accommodate unplanned variations in patient care workload.
- Enables nursing staff to regulate nursing unit work flow.
- Is consistent with best available evidence on safe staffing thresholds.

Keeping Patients Safe, con't

Organizational Support for Ongoing Learning and Decision Support
- Uses preceptors for novice nurses.
- Provides ongoing educational support and resources to nursing staff.
- Provides training in new technology.
- Provides decision support at the point of care.

Mechanisms That Promote Interdisciplinary Collaboration
- Use interdisciplinary practice mechanisms, such as interdisciplinary patient care rounds.
- Provide formal education and training in interdisciplinary collaboration for all health care providers.

Work Design That Promotes Safety
- Defends against fatigue and unsafe and inefficient work design.
- Tackles medication administration, handwashing, documentation, and other high-priority practices.

Organizational Culture That Continuously Strengthens Patient Safety
- Regularly reviews organizational success in achieving formally specified safety objectives.
- Fosters a fair and just error-reporting, analysis, and feedback system.
- Trains and rewards workers for safety.

Preventing Medication Errors

- **Specific measures should be instituted to strengthen patients' capacities for sound medication self-management.**
- **Government agencies (i.e., the Agency for Healthcare Research and Quality [AHRQ], the Centers for Medicare and Medicaid Services [CMS], the Food and Drug Administration [FDA], and the National Library of Medicine [NLM]) should enhance the resource base for consumer-oriented drug information and medication self-management support.**
- **All health care organizations should immediately make complete patient-information and decision-support tools available to clinicians and patients. Health care systems should capture information on medication safety and use this information to improve the safety of their care delivery systems.**
- **Reducing errors requires improved methods for labeling drug products and communicating medication information to providers and consumers**.

QSEN: A Useful Framework for Innovation and Collaboration

- Robert Wood Johnson funded project seeks to redefine quality and safety competencies and reform clinical nursing education
- QSEN addresses challenges of preparing nurses with competencies to continuously improve the quality and safety of care in systems in which they work

Bridging the Gap

QSEN Phase I: October 2005 – March 2007

- Develop Knowledge, Skills and Attitudes (KSAs) to provide operational definitions for each competency
- Seek feedback to build consensus for inclusion in pre-licensure curricula
- Develop teaching strategies for classroom, group work, simulation, clinical site teaching, and interprofessional learning

Professional Nursing Identity and Accountability

- "What quality and safety competencies describe what it means to be a respected nurse?"
- "What teaching and learning strategies will prepared graduates with the knowledge, skills, and attitudes (KSAs) to continuously improve the quality and safety of the health care systems in which they work?"

Cronenwett, L. & Sherwood, G. (2007). Quality and safety education for nurses. *Leader to Leader*, National Council of State Boards of Nursing, p. 1.

Phase I of QSEN

Smith, E.L., Cronenewett, L., & Sherwood, G. (2007). Current assessments of quality and safety education in nursing. *Nursing Outlook* 55(3): 132-137.

To assess the extent to which educators believed content related to the 6 competencies were already integrated in pre-licensure curricula, the authors surveyed program leaders from a national sample of programs (pg132)

- 1. Does your pre-licensure curriculum contain content/experiences aimed at the development of the following competencies?
- 2. What pedagogical strategies are being used to teach content related to each competency?
- 3. What is the level of satisfaction with student competency development for each domain?
- 4. What is the perceived level of faculty preparedness to teach each competency?
- 5. To what extent would faculty value various approaches (website, teaching manual, conferences, DVD) for provision of curricular resources for quality and safety education?

Phase I Results

Smith, E.L., Cronenewett, L., & Sherwood, G. (2007). Current assessments of quality and safety education in nursing. *Nursing Outlook* 55(3): 132-137.

- 195 of 629 sample schools returned surveys (31%)
- Majority of respondents (>95%) reported that they included content related to each competency in their programs. (pg134)
- Mean scores for satisfaction with student competency development were between neutral and very satisfied (3.3-4.7) (pg 135)
- More than 75% respondents rated faculty as expert/very comfortable in teaching patient centered care, safety and teamwork & collaboration. Just over half rated faculty as intermediate/somewhat comfortable in teaching EBP, informatics and QI. (pg 135)

Phase I focus group results

Smith, E.L., Cronenewett, L., & Sherwood, G. (2007). Current assessments of quality and safety education in nursing. *Nursing Outlook* 55(3): 132-137.

- Although the faculty agreed that they *should* be teaching these competencies and, in fact, had thought they *were*, focus groups of faculty did not understand fundamentals concepts related to the competencies and could not identify pedagogical strategies in use for teaching KSAs. An advisory board member led a focus group of new graduates. Not only did these nurses report that they did not have learning experiences related to the KSAs, they did not believe their faculties had the expertise to teach the content. (pg 136)

Phase I Conclusions

Smith, E.L., Cronenewett, L., & Sherwood, G. (2007). Current assessments of quality and safety education in nursing. *Nursing Outlook* 55(3): 132-137.

- Nursing has always valued safety, teamwork and patient-centered care and content on these topics *are* included in curricula – but the content doesn't match the new competency definitions or KSAs.
- Program leaders, such as deans, directors and chairs may be too far away from the actual "curriculum in use" to accurately respond to the survey
- Educators often lack exposure to the realities of practice, and, thus, might not have had a way to know that their students were not achieving the competencies and KSAs. (pg 136)

Challenges for Nursing Education

- Recharging nursing curricula with relevance and rigor
- Rethinking teaching-learning strategies
- Redefining clinical nursing education practices and environments

Reframing the Focus of Clinical Nursing Education

- Professional knowledge
- Individual learning
- Individual consequences for error
- Disciplinary focus
- Systems knowledge
- Team/group learning
- Learning from error
- Interprofessional/ patient-centered focus

Patient-Centered Care

Cronenwett, Sherwood, Barnsteiner et al, 2007

Traditional Concept	*QSEN Update*
Listening to the patient, and demonstrating respect and compassion	Recognizing the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs

Patient Centered Care

Familiar Concepts	Progressive Concepts
Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care	Recognize that patient expectations influence outcomes in management of pain or suffering (PCC-A) Examine how safety, quality and cost-effectiveness of health care can be improved through the active involvement of patients and families (PCC-K) Examine common barriers to active involvement of patients in their own health care processes (PCC-K)

Teamwork and Collaboration

Cronenwett, Sherwood, Barnsteiner et al, 2007

Traditional Concept	*QSEN Update*
Working side by side other health care professionals and performing nursing skills	Functioning effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care

Teamwork & Collaboration

Familiar Concepts	Progressive Concepts
Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities	Choose communication styles that diminish the risks associated with authority gradients among team members (T& C – S) Appreciate the risks associated with handoffs among providers and across transitions in care (T&C-A) Identify system barriers and facilitators of effective team functioning (T & C – K)

Evidence Based Practice

Cronenwett, Sherwood, Barnsteiner et al, 2007

Traditional Concept	*QSEN Focus*
Standardizing skills execution, following and updating internal policies	Integrating best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care

Evidence Based Practice

Familiar Concepts

- Value the concept of EBP as integral to determining best clinical practice
- Question rationale for routine approaches to care that result in less-than-desired outcomes or adverse events

Progressive Concepts

- Discriminate between valid and invalid reasons for modifying evidence-based clinical practice based on clinical expertise or patient/family preferences (EBP – K)
- Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices (EBP-A)

Quality Improvement

Cronenwett, Sherwood, Barnsteiner et al, 2007

Traditional Concept	*QSEN Focus*
Administering medications using the 5 rights	Using data to monitor the outcomes of care processes and using improvement methods to design and test changes to continuously improve the quality and safety of health care systems

Quality Improvement

Familiar Concepts

- Use tools (such as flow charts, cause-effect diagrams) to make processes of care explicit
- Participate in a root cause analysis of a sentinel event

Progressive Concepts

- Value measurement and its role in good patient care (QI-A)
- Give examples of the tension between professional autonomy and system functioning (QI – K)
- Value local change (in individual practice or team practice on a unit) and its role in creating joy in work (QI – A)

Safety

Cronenwett, Sherwood, Barnsteiner et al, 2007

Traditional Concept	*QSEN Focus*
Using bed rails properly; "being sure that my patient does not fall during my shift"	Minimize risk of harm to patients and provides through both system effectiveness and individual performance

Safety

Familiar Concepts

- Demonstrate effective use of strategies to reduce harm to self or others

Progressive Concepts

- Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as work arounds, and dangerous abbreviations) (S-K)
- Appreciate the cognitive and physical limits of human performance (S-A)

Informatics

Cronenwett, Sherwood, Barnsteiner et al, 2007

Traditional Concept	*QSEN Focus*
Timely and accurate charting	Use information and technology to communicate, manage knowledge, mitigate error and support decision making

Informatics

Familiar Concepts

- Identify essential information that must be available in a common database to support patient care
- Navigate the electronic health record

Progressive Concepts

- Value technologies that support clinical decision-making, error prevention and care coordination (I-A)
- Use information management tools to monitor outcomes of care processes (I-S)
- Recognize the time, effort and skill required for computers, databases and other technologies to become reliable and effective tools for patient care (I-K)

Phase II Pilot Schools

- Augustana College-Sioux Falls, SD
- Catholic University of America-Washington, DC
- Charleston Southern University-Mt. Pleasant, SC
- Curry College-Milton, MA
- Emory University Nell Hodgson Woodruff School of Nursing-Atlanta, GA
- LaSalle University-Philadelphia, PA
- St. Johns College of Nursing of Southwest Baptist University-Springfield, MO
- University of Colorado Denver, School of Nursing-Denver, CO
- University of Massachusetts, Boston College of Nursing & Health Sciences-Boston, MA
- University of Nebraska Medical Center-Omaha, NE
- University of South Dakota, Department of Nursing-Sioux Falls, SD
- University of Tennessee, Health Science Center-Memphis, TN
- University of Wisconsin, Madison-Madison, WI
- UPMC Shadyside School of Nursing-Pittsburgh, PA
- Wright State University-Dayton, OH

QSEN Phase III (Feb 2009 – Feb 2012)

Goals:

- Promote continued innovation in the development and evaluation of methods to elicit and assess student learning of knowledge, skills and attitudes of the six IOM/QSEN competencies and the widespread sharing of these innovations.
- Develop the faculty expertise necessary to assist the learning and assessment of achievement of quality and safety competencies in all types of nursing programs.
- Create mechanisms to sustain the will to change among all programs through the content of textbooks, accreditation and certification standards, licensure exams and continued competence requirements.

Phase III – Collaboration with AACN

QSEN – UNC

- Development of a Facilitator's Bureau
- Two QSEN National Forums (#1: May 2010 – Denver Colorado!!)
- Develop CE materials
- Web based faculty development modules
- Support of publishers/authors of nursing texts to create new options
- Support professional organizations

AACN

- Train-the-trainer faculty development at 10 regional conferences
- Develop resources, tools, CDs and other materials for regional conferences
- Follow-up tracking of impact of regional conferences
- Evaluation and dissemination of new teaching resources to alumni of regional conferences

QSEN's Goal

"To alter nursing's professional identity so that when we think of what it means to be a respected nurse, we think not only of caring, knowledge, honesty and integrity…. But also, that it means that we value, possess, and collectively support the development of quality and safety competencies"

Cronenwett, L. (2007). Emory Jowers Lecture on "Quality and Safety Education for Nurses" available at http://qsen.org. Slide 10.

Current Relevance?

The Essentials of Baccalaureate Education for Professional Nursing Practice

American Association of Colleges of Nursing – October 2008

Essential II: Basic Organizational and Systems Leadership for Patient Safety and Quality Care

Knowledge and skills in leadership, quality improvement and patient safety are necessary to provide high quality health care

Overview of Essential II

- All references to safety and quality are based on IOM recommendations of the last 10 years
- Research supports that nurses more than any other healthcare professional are able to recognize, interrupt, evaluate and correct healthcare errors, thus contributing to patient safety.
- High quality patient care outcomes are directly connected to organizational and systems leadership in safety and quality improvement (QI)
- Basic nursing leadership includes awareness of complex systems, politics, policy, regulatory guidelines
- New clinicians need to use QI processes, and be able to initiate basic quality and safety investigations, assist in development of QI action plans, participate in rapid cycle change projects.

AACN Outcome Competencies in Safety and QI

- Participate effectively in interprofessional healthcare teams, being accountable for care delivery in a variety of settings
- Demonstrate leadership and communication skills to effectively implement patient safety and QI initiatives
- Awareness of complex organizational systems
- Apply concepts of QI and safe systems to identify clinical questions and describe the process of changing current practice
- Promote achievement of safe and quality outcomes for diverse populations
- Initiate and execute change processes for both microsystems and/or system-wide practice improvements

What kind of curricular content will contribute to these outcomes?

- Leadership styles, theory, & behaviors
- Change theory and complexity science
- Communication
- Healthcare systems (micro and macro levels)
- Operations research
- Teamwork skills
- Patient safety principles – facility focused and national initiatives
- Quality improvement, CQI models, benchmarking processes, tools, regulatory requirements
- Statistics, root cause analyses, Failure Mode Effects Analysis

Examples of Integrative Learning Strategies for Essential II

- Provide opportunities for students to:
  - Develop quality improvement project that spans several courses
  - Engage in quality improvement/patient safety activities to promote an understanding of the organizational process, unit application and evaluation process
  - Participate in interprofessional performance improvement team currently working on implementation/evaluation of national patient safety goals
  - As students examine various microsystem committees, identify one for more in-depth exploration

The Context of National Practice Initiatives

- National Patient Safety Goals – Joint Commission
- 5 Million Lives Campaign – Institute for Healthcare Improvement
- 30 Safe Practices for Better Health Care – Agency for Healthcare Research and Quality (AHRQ)
- Nursing Sensitive Indicators/Outcomes – National Quality Forum, American Nurses' Association, AHRQ

Nurse Sensitive Indicators (AHRQ, ANA, NQF)

- ***Decub ulcers**
- ***Failure to rescue**
- UTI
- Central line infx
- Surgical wound infx
- Septicemia
- Hospital acquired pneumonia
- VAP
- Patient falls
- Restraint prevalence
- Postoperative PE or DVT
- Nurse staff satisfaction
- Total nursing care hours provided/pt day

Evidence Guiding Systems

- Hand hygiene
- Falls (restraints/bedrails)
- Failure to rescue
- UTI prevention
- Surgical wound infections
- Septacemia
- Hospital acquired pneumonia
- Use of restraints
- DVT prevention
- Verbal orders
- Oral care
- Medication administration (look alike/sound alike meds, high alert medications, anticoagulants, medicat reconciliation)
- Decubitus ulcer prevention
- Contact precautions (MRSA prevention)
- Charting/abbreviations

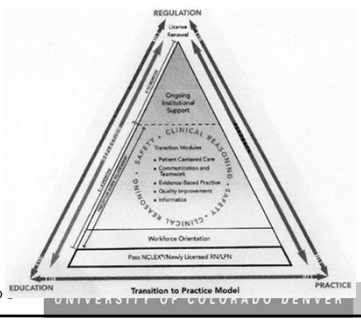
Teaching skills in the context of IOM

Nsg Intervention Week One	NQF Safe Practices for Better Healthcare	IHI 5 Million Lives Campaign	NSO/NSI	National Patient Safety Goals
Oral Care	#23 Care of the Ventilated patient	Ventilator Associated Pneumonia	Ventilator Associated Pneumonia	
Decub Ulcer Prevention	#27 Decub ulcer prevention	Decub ulcer prevention	Decub ulcer prevention	#14 Decub ulcer prevention
Falls/Mobility/ Restraints	#28 DVT prevent #33 Fall prevent		DVT prevention Fall prevention	#9 Reduce the risk of patient harm resulting from falls
Infection Control	#19 Hand Hygiene #24 Multi Drug Resistant Org Prev #25 UTI prevent	Central Line Infx Prevention of MRSA	UTI prevention CL infection Hospital acquired pneumonia	#7 Reduce the risk of health care-associated infections a. Hand hygiene b. Sentinel events r/t hygiene c. Prevent multi drug resist organ d. CL infx

Working with 162 KSAs

- How to work with QSEN's 162 KSAs?
- Barton, Armstrong, Preheim, Gelmer. (2009). A national delphi study to level QSEN's KSAs. *Nursing Outlook*, 57: 313-322.

NCSBN Transition to Practice Model



Catching up with Practice….

- Ultimately QSEN is working to update nursing educational models so that they are more congruent with demands of practice.
- What are your thoughts about this?

Evaluation of Individual Presenter by Student
Clinical Scholar

Presenter: Gail Armstrong	Topic: QSEN	Date: March 14, 2011

Regarding the Presenter:	Scale					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	No Opinion / N/A
1. The speaker was knowledgeable regarding the content presented	○	○	○	○	○	○
2. The presentation was stimulating and interesting	○	○	○	○	○	○
3. The content presented will be useful to me in my role as a Clinical Scholar	○	○	○	○	○	○
4. Appropriate reference materials were provided	○	○	○	○	○	○
5. Handouts or other materials are clear	○	○	○	○	○	○
6. The presenter was responsive to questions from the audience	○	○	○	○	○	○
7. The content was at an appropriate level, not too elementary, not too complex	○	○	○	○	○	○
8. The content was covered satisfactorily and completely	○	○	○	○	○	○
9. The speaker's selected teaching strategy (lecture, discussion, small groups, etc.) maximized my learning	○	○	○	○	○	○

Comments:

CLINICAL SCHOLAR REFERENCE SHEET

Clinical Scholar: Staff nurse trained to facilitate clinical experience for nursing students. The nurse is an expert in clinical skills and is assigned to a group of students from a specific school of nursing. The clinical rotations are typically taught at the hospital where the nurse is employed. The workload for the Clinical Scholar remains the same as the usual agreed upon hours. Therefore, the nurse will be released from usual clinical responsibilities on the unit for the number of hours that he/she teaches for the school and will work the balance of the hours on the unit, as usual. The nurse is paid by the hospital and the hospital is then reimbursed by the schools of nursing as stipulated in a legal contract. This ensures that the Clinical Scholar serves in a collaborative manner with the school of nursing. The Clinical Scholar is responsible for patient assignments, oversight, supervision, and facilitation of nursing students.

Clinical Instructor (Adjunct /Affiliate Faculty): A nurse who is employed by a school of nursing. They may teach clinical rotations at any facility as assigned by the school of nursing. The school of nursing pays the Clinical Instructor.

Clinical Preceptor: A nurse who works at a hospital and is assigned a student or new hire to orient and mentor. The ratio of student to preceptor is 1:1. Responsibilities include introducing students and new nursing staff to the policies and procedures, customs, and norms of the workplace. A Clinical Preceptor who works with nursing students is also responsible for communicating and collaborating with schools of nursing to facilitate the learning experience for the nursing student. The hospital is responsible for preparing clinical preceptors to work with students to facilitate learning. Some examples of rotations that a student must complete prior to graduation that are supervised by a preceptor are: Integrated Practicum, Senior Practicum, Externship, and Preceptorship. Depending on the nursing program, the student must complete between 120-180 hours.

ANIP- Associate Nursing Instructional Personnel: A nurse working under the direction and supervision of a Masters' prepared faculty member from the school of nursing who may teach students in a laboratory and/or clinical setting.

Staff Nurse: A nurse who is responsible for patient care on a unit in the hospital. The nurse is often a mentor to nursing students in their clinical rotations. The staff nurse is ultimately responsible for the patient not the student.

Education Requirements

A Clinical Scholar should possess a Masters degree, however, shortages have made it necessary to employ nurses with a Bachelor of Science in Nursing. A Masters prepared nurse may teach BSN nursing students. It is customary that a Clinical Scholar should teach nursing students in a program that is a level below the degree the Clinical Scholar holds.

Colorado Department of Labor Grant

The Faculty Development grant, for one million dollars, was to support nursing education in the community and to help increase nursing faculty. The initial grant was for two years. It was extended to four years with a skeletal budget. The Colorado Center for Nursing Excellence (CCNE) oversees the grant.

www.e-colorado.org is a website that allowed you to register for this seminar. It will also be available for you to explore throughout this course and after. It allows you to chat with other Clinical Scholars throughout Colorado to seek guidance, support, and advice. You will be able to post bulletins as well. Additional information and resources will also be posted on this site from Colorado Center for Nursing Excellence**.**

Evaluation of Individual Presenter by Student
Clinical Scholar

Presenter: Deb Center & Marianne Horner	Topic: Jeopardy	Date: March 14, 2011

Regarding the Presenter:	Scale					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	No Opinion / N/A
1. The speaker was knowledgeable regarding the content presented	○	○	○	○	○	○
2. The presentation was stimulating and interesting	○	○	○	○	○	○
3. The content presented will be useful to me in my role as a Clinical Scholar	○	○	○	○	○	○
4. Appropriate reference materials were provided	○	○	○	○	○	○
5. Handouts or other materials are clear	○	○	○	○	○	○
6. The presenter was responsive to questions from the audience	○	○	○	○	○	○
7. The content was at an appropriate level, not too elementary, not too complex	○	○	○	○	○	○
8. The content was covered satisfactorily and completely	○	○	○	○	○	○
9. The speaker's selected teaching strategy (lecture, discussion, small groups, etc.) maximized my learning	○	○	○	○	○	○

Comments:

Interpersonal Relationships:

Karren Kowalski, PhD, RN, FAAN

COLORADO CENTER FOR NURSING EXCELLENCE

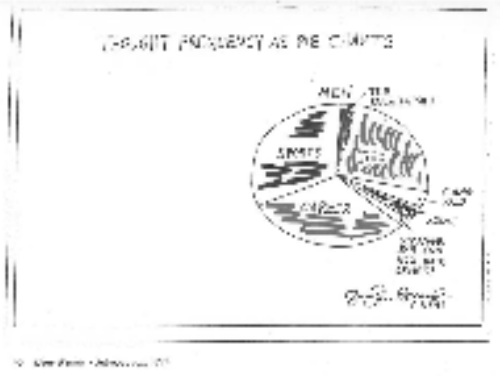
●How Do You Think Things Get Done?

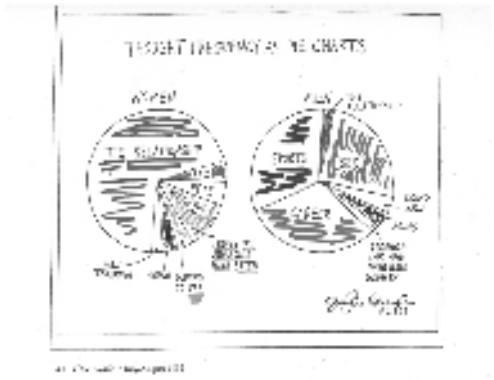
Building Relationships

- **Build trusting, collaborative relationships**
- **Provide feedback in ways that can be heard**
- **Follow through**
- **Care about people as individuals**
- **Are persuasive and celebrative**
- **Non-threatening and non-judgmental**

Relationships are based on:

- **Common Beliefs and Values**
- **Common Vision or Goals**
- **Common Interests**





DIFFERENCES

- **Background**
- **Beliefs and values**
- **Vision and goals**

- **THE GENERATION GAP**

STEPS in Building Relationships

- **Creating the right positive mind set**
- **Collecting information about the person**
  - **Discover common ground**
  - **Common interests, values, mutual friends**

- **Demonstrate knowledge, caring, thoughtfulness:**
  - **Unexpected, inexpensive, thoughtful acts**

Behaviors Promoting Relationships

- **1. Active Listening**
- **2. Ask More Questions**
- **3. Frequency of Interaction (over time)**
- **4. Follow Through**
- **5. Competence**
- **6. Reciprocity**

THANK YOU!!!

- **KARREN KOWALSKI**
- **303-715-0343**
- **karren.kowalski@worldnet.att.net**

Evaluation of Individual Presenter by Student
Clinical Scholar

Presenter: Karren Kowalski	Topic: Interpersonal Relationships	Date: March 14, 2011

Regarding the Presenter:	Scale					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	No Opinion / N/A
1. The speaker was knowledgeable regarding the content presented	○	○	○	○	○	○
2. The presentation was stimulating and interesting	○	○	○	○	○	○
3. The content presented will be useful to me in my role as a Clinical Scholar	○	○	○	○	○	○
4. Appropriate reference materials were provided	○	○	○	○	○	○
5. Handouts or other materials are clear	○	○	○	○	○	○
6. The presenter was responsive to questions from the audience	○	○	○	○	○	○
7. The content was at an appropriate level, not too elementary, not too complex	○	○	○	○	○	○
8. The content was covered satisfactorily and completely	○	○	○	○	○	○
9. The speaker's selected teaching strategy (lecture, discussion, small groups, etc.) maximized my learning	○	○	○	○	○	○

Comments:

Healthy Work Environments & Creating a Climate of "Civility"
A Leadership and Nursing Retention Strategy for Nursing Educators

Objectives:

- Review current evidence related to creating a healthy work environment.
- Define the impact of lateral violence, incivility & bullying within nursing and nursing education.
- Identify four strategies for creating a culture of civility with students and staff nurses.

Content:	**Note Taking and Quotes:**
INTRODUCTION TO CIVLITY: *"Before we can change things, we must call them by their real name." Confucius* **Exercise: "*A Penny for your Thoughts*"** ❖ **Name It** ❖ **Feel It** ❖ **Acknowledge It** ❖ **Learn from It** **Definitions:** **<u>Horizontal Hostility and Lateral Violence:</u>** *"A consistent (hidden) pattern of behavior designed to control, diminish, or devalue another peer (or group) that creates a risk to health and/or safety*" **<u>Incivility:</u>** *"Form of psychological harassment and emotional aggression that violates the ideal workplace/classroom norm of mutual respect."* **<u>Bullying</u>**: *"is when a person is picked on over and over again by an individual or group with more power, either in terms of physical strength or social standing."* **<u>Signs:</u>** **Overt Signs:** name-calling, sarcasm, bickering, fault-finding, back-stabbing, criticism, intimidation, gossip and spreading rumors, shouting, blaming, put-downs, raising eyebrows, trivializing, judgment, accusations, etc. **Covert Signs:** unfair assignments, eye-rolling, ignoring, making faces (behind someone's back), refusal to help, sighing, whining, sarcasm, refusal to work with someone, sabotage, isolation, exclusion, fabrication, withholding information, undermining, discounting, etc. **Other Forms:** Verbal, non-verbal, physical, public, private, email, text-message, telephone, written **To *thrive** hostility and incivility <u>needs</u>:** *Secrecy; Shame; and Silent Witness*	"*You are today where your thoughts have brought you; you will be tomorrow where your thoughts <u>take</u> you.*" James Allen Watch your thoughts, for they become words; Watch your words, for they become actions; Watch your actions, for they become character; *Watch your character, for it becomes destiny.* *How does this impact your students? Your patient outcomes? Your organization?*

How frequent does this occur? ***Evidence – National Workforce Data***

- The first reported publication promoting civility was written in 1405
- 80% of workers in US believe incivility is a problem.
- 96% have experienced incivility at work.
- 60% report experiencing significant stress due to incivility at work.
- 48% believe they are treated uncivilly at least once per week.
- 3 out of 4 employees are dissatisfied with how incivility is handled in their company
- More than 50% say they would have a career problem if they reported the incivility.
- Only 9% have reported to HR or their EAP – *silent witness*
- 12% left their job because of incivility

Who are the Victims/Targets? _____

Who are the Perpetrators/Oppressors? _____

- 60% of the time – *the offender has a higher job status than the target – "impact of power and the downward flow of anger"*
- 20% of the time *there is lateral violence – across peers*
- 20% of the time *there is an upward flow from lower-level offenders to higher-level targets → more covert/subtle sabotage*
- Gender: Men are twice as likely as women to be offenders. When women are uncivil, they can be *more* significant.
- Age: Offenders are on average, about a half a dozen years older than their targets.
- The percentage of workers treated uncivilly who:
  - 94% get even with their offender
  - 88% get even with their organization

Who are the Silent Witnesses/By-Stander? _____

A Silent Witness is an Accomplice" Bartholomew

- *"Incivility has the power to intimidate people into silence. It isolates the targets and makes them feel ashamed and responsible. Angry words lead to physical avoidance."*
- *"Memory of incivility can linger for years." → PTSD has been diagnosed as a result of incivility in the workplace.*

Why does this exist in Nursing?

Oppression Theory: *Whenever there are two groups and one has more power than the other, oppression occurs when the values of the subordinate culture are repressed.*

What happens when I am the target or a witness to incivility? Neuroscience → Amygdala Hijacking

- "I had to defend myself and I yelled back." (*FIGHT*)
- "I just want to get away from the guy." (*FLIGHT*)
- "I couldn't focus and didn't even hear what they were saying." (*FREEZE)*
- "I was so taken off guard I could not speak." (*FREEZE*)

<u>THE COST OF INCIVILITY</u>:

According to Pearson and Porath, $300 BILLION is spent annually in the United States due to Bad Behavior in the workplace.
Considerations: *What is the impact on…*

- Students, Faculty and Nursing Education
- Staff - Team and Morale and Engagement Level of Team
- Quality and Safety: Patient Care and Outcomes
- Turnover – Survival of Nurses
- Employee and Patient Satisfaction
- Continuity of Care between Providers/Health Systems and relationships with referring and discharging agencies
- Other areas _____

How MUCH does your organization spend annually related to this?

"60% of newly registered nurses <u>leave</u> their first position within 6 months because of some form of lateral violence perpetrated against them" → from their peers or managers – Griffin, 2004

What is the **cost to the individual** nurse, student, faculty member or you?

What is the **cost to the reputation** of the organization or school? When incivility is witness by your patients, students, faculty, staff etc:

- Nearly 80% of customers who witnessed **NO** employee-to-employee incivility said they would use the company's service again while ***only 20% of those that witnessed incivility agreed to do so.***
- Nearly 2⁄3's of people who witnessed incivility reported they would ***feel anxious dealing with any employee*** in that company. (Large % regarded the entire organization as uncivil even if witnessed only two employees.)
- 9 out of 10 customers attitudes changed negatively toward the organization as a result of witnessing incivility. Quote, "Did she (the rude employee) think I wouldn't notice? Think again!"

What is the ***cost to the patient*** → outcomes of care, hospital re-admissions, loss of continuity of care etc. → Who pays for this?

While we may want to believe incivility in healthcare organizations is only between employees, the Joint Commission Sentinel Event ALERTS – provides clear evidence to the contrary – ***patients are victims/targets of incivility from healthcare workers.***

COST – *Considerations when calculating the cost*:

- How does incivility wreck performance?
- How our brain responds to incivility?
- How does incivility create stress and burnout?
- What is the price of incivility to the team?
- What is the cost when valuable employees leave due to incivility?
- What is the cost to reputation of the organization?
- What is the cost to the offender?

Examples from Pearson and Porath:

1. Hospital Organization Total Cost**:** Gross income -- $999,856,000.

- LOST REVENUE and EXPENSES: Grand total estimated cost caused by incivility = **$70,911,390.55** which is a little under 8% of their total income.
- Calculations include time that *can be estimated* – and does *not* include all factors of disengagement, lost attention/focus, reduced productivity, etc

What do you think healthcare and nursing education could do if we didn't spend this on incivility? What are the possibilities?

2. One Uncivil Email by a VP of a Technology Company:

- Lost time for VP, Target, HR Director - in salary alone for the time spent resolving the impact of the email (does not impact reputation, lost revenue due to time spent on this or impact of future work due to relationship impact etc) = **$1,513 for one uncivil email**.

3. One uncivil episode by a habitual instigator/offender in a hospital: based on the calculation of lost work time, legal fees **= $25,832** (does not include the cost of the consultant and work to clean up the mess after with the team.)

National Workforce Data

- Average Price to replace each employee = $50,000 (***1.5-2.5 times the annual salary.)***
- Amount of time Fortune 1000 executives spend resolving employee conflicts = ***7 weeks per year***

<u>What is the cost if this on our patients?</u> Clinical Reports:

- Institute of Medicine's (IOM)– Report on Safety and Quality
- American Association of Critical Care Nurses (AACN) – Silence Kills Project www.silencekills.com
- Joint Commission – three sentinel event alerts – 2008, 2009, 2010

Findings:

- 60% of medication errors are caused by mistakes in interpersonal communication.
- 84% of MD's have seen coworkers taking shortcuts that could be dangerous to patients
- More than 50% of healthcare workers have witnessed coworkers break the rules, make mistakes, fail to support, demonstrate incompetence, show poor teamwork, disrespect them and micromanage.
- 23% of Nurses said they considered leaving their units because of these concerns.
- 195,000 deaths in US Hospitals because of medical mistakes
- 78% said it was difficult or impossible to confront a person directly if there was witnessed incompetent care
- Fewer than 10% of MD's and RN's and clinical staff directly confront their colleagues about concerns

<u>Seven Crucial Conversations in Healthcare</u>

Conversations that are difficult & essential to master:

1. Broken Rules – shortcuts, not following procedures
2. Mistakes – poor clinical judgment, inadequate assessments
3. Lack of Support – refusing to help or share information
4. Incompetence – lack of knowledge and skills
5. Poor Teamwork – cliques, upstaging
6. Disrespect – condescending, dismissive tone
7. Micromanagement – misuse of authority

Can your organization AFFORD to be silent about incivility any longer? Can YOU as a clinical scholar?

<u>Outcomes</u>:

- Joint Commission Sentinel Event – *Leadership Standard (2008)*
  - *Requires a Policy about Bullying*
  - *Requires a separate Medical Staff Policy r/t Physicians*
  - *Requires a protection for employees who report incidents*
  - *Requires monitoring, evaluation and process improvement*
- AACN → Position Statement & Zero Tolerance Policy
- Center for American Nurses → Position Statement & Sample Policy
- ANA → Recommendations and Code of Ethics

Nursing Education: Types of Incivility within Education

- Student → Faculty
- Faculty → Student
- Faculty → Faculty
- Faculty → Administration
- Administration → Faculty

Three great references:

- Clark, C. (2010) The Sweet Spot of Civility: My Story. *Reflections on Nursing Leadership, Sigma Theta Tau International Honor Society of Nursing,* 36(1). (Article 1 in three part series)
- Clark, C. (2010) Why Civility Matters. *Reflections on Nursing Leadership, Sigma Theta Tau International Honor Society of Nursing,* 36(1). (Article 2 in three part series)
- Clark, C. (2010) What Educators Can Do To Promote Civility. *Reflections on Nursing Leadership, Sigma Theta Tau International Honor Society of Nursing,* 36(2). (Article 3 in three part series)

Curtis J (2007) **You have no credibility: nursing students' experiences of horizontal violence; *Nurse Education in Practice***, May; 7 (3): 156-63

- *Bullying By Students, the Clinical/Class Group, Faculty, and other nurses*
- Research Study questioned 152 → 2nd/3rd year nursing student's r/t experience of horizontal violence (either directly experienced or witnessed)
- Analysis identified five major themes:
  - humiliation & lack of respect
  - powerlessness & becoming invisible
  - hierarchical nature of horizontal violence
  - coping strategies
  - impact on future employment choices
- **More than 1/2** experienced or witnessed horizontal violence
- **51%** - indicated it "impacts on their future employment choices"
- Strategies discussed to reduce the effect of horizontal violence:
- Giving a higher priority to debriefing within a supportive environment
- Teaching assertiveness & conflict resolution skills

Susan Luparell PhD, **Faculty encounters with uncivil nursing students**: an overview. *Journal of Professional Nursing*, Volume 20 , Issue 1 , Pages 59 - 67

- Study by Lashely & deMeneses, n=409
  - 67% initial response rate from direct mailing
  - **People want to speak out*!
  - Nearly 100% had experience with lateness, talking in class, inattention in class
  - 52.8% had been yelled at in the classroom
  - 42.8% had been yelled at in the clinical setting
  - 24.8% reported objectionable physical contact by a student

What does this mean to you? What does this mean to how you will support your students?

Luparell, S. (2007) **The effects of student incivility on nursing faculty.** *Journal of Nursing Education*, 46 (1): 15-9

- **Types of Uncivil Behaviors - Classroom & Clinical**
  - Annoyances
  - Students often unaware of effect
  - Aggregate impact
  - Classroom Terrorism
  - Direct interference with instruction
  - Intimidation
  - Threats to bring social or political pressure
  - Actual or threatened violence
  - Attacks on Instructor/Student *Psyche or Capability*

Kolanko KM; (2006) Academic dishonesty, bullying, incivility, and violence: difficult challenges facing nurse educators. *Nursing Education Perspectives*, Jan/Feb; 27 (1): 34-43

- **Most Common Uncivil Behaviors by Students → *reported by faculty***
  - Making disapproving groans
  - Making sarcastic remarks or gestures
  - Not paying attention in class
  - Dominating class discussions
  - Using cell phones during class
  - Cheating on examinations

- **Most Common Students Perceptions of Faculty Incivility**
  - Canceling class without warning
  - Being unprepared for class
  - Disallowing open discussion
  - Being inflexible
  - Being disinterested or cold
  - Belittling or taunting students
  - Delivering fast-paced lectures
  - Not being available outside of class
  - ***"Beyond uncivil" = when faculty undermine other faculty credibility***

Heinrich, K. T. (2007) Joy Stealing: Ten mean games faculty play and how to stop the gaming. *Nurse Educator*. 32(1), 34-8.

Faculty-to-Faculty Incivility - *"Heinrich's Ten Joy-Stealing Games"*

1.	The Set-Up Game	1.	Leave hung out to dry
2.	The Devalue and Distort Game	2.	Twist assets into liabilities
3.	The Misrepresent/Lie Game	3.	Tell untruths that handicap them
4.	The Shame Game	4.	Bully in public, private, or cyber-bullying
5.	The Betrayal/***Mobbing*** Game	5.	Involve 3rd party or group to gang up
6.	The Broken Boundary Game	6.	Steal credit for scholarship etc.
7.	The Splitting Game	7.	Separate nurses into we/they
8.	The Mandate Game	8.	Pressure, command, demand→ never ask
9.	The Blame Game	9.	Accuse first, ask questions later
10.	The Exclusion Game	10.	Silence, leaves them out

How will you use this information when working with students and other faculty?

How will you prepare students for clinical?

How will you prepare yourself for clinical with students?

THE SOLUTION: *Create a Healthy Work Environment Culture based on Civility and the 3 Principles of Mutuality:*

- Mutual Respect
- Mutual Learning
- Mutual Accountability

"Everyday, in every interaction, we either approve of the old script or write a new one." Bartholomew

How can I help stop lateral violence and incivility? *What is my role as a Clinical Scholar?*

"Coming together is a beginning. Keeping together is progress. Working together is a success." Henry Ford

Pearson and Porath: ***The Top 10 Things to Create a Civil Workplace***

1. Set Zero-tolerance Expectations
2. Look in the Mirror (*assess the entire Team, including the leadership*)
3. Weed Out Trouble BEFORE It Enters (screening & interview for civility)
4. TEACH Civility
5. Train Employees & Managers How to Recognize & ***Respond*** to Signals
6. Put Your Ear To The Ground & Listen Carefully
7. When Incivility Occurs, Hammer It!
8. Take ALL Complaints Seriously
9. Don't Make Excuses for Powerful Instigators
10. Invest in Post-departure Interviews

Six Steps YOU can Take as a Clinical Scholar:

Step 1: Self-Awareness → *Visible Commitment*

- Begin with yourself - Learn about Violence & Incivility
- Recognize it & Assess for it
- Understand it
- Take action to stop it & Take action to heal it

"Say what you mean and mean what you say without being mean when you say it." Meryl Runion

Step 2: Assess & Address within your Clinical Group

- Agreements – set the tone
- Check-in with students individually and in post-conference.

Step 3: Institute "Zero Tolerance" Policy

- Reference: by Kathleen Kerfoot "*What YOU Permit YOU Promote*"
- Agreements should include behavioral standards with clear ramifications for violations → *for accountability*
- *Protects those that report from retaliation or discipline*

Step 4: Provide Education → *Empowerment*

- Reflective Practice
- Assertiveness & Authentic/Crucial Conversation training
  - ***I feel, I think, I want***
  - **DESC** – *Describe, Explain, State Outcome, Consequence*
  - **SBAR** – *Situation, Background, Assessment, Recommendation*
  - **CUS** - *I am concerned; I am uncomfortable; It is a matter of safety*
- Conflict management
- Increase skills & knowledge around healthy workplace

Cognitive Rehearsal - Educating new nurses/nurses about horizontal hostility allows them to "***depersonalize it, thus allowing them to ask questions and continue to learn***." (Griffin, 2004)

- Retention of new nurses who were taught these skills increased to over 90%

- **How do I respond when an incident occurs?**
  - ✓ Recognize the incident
  - ✓ **Pause** → Take a deep breath! And give permission for time-out to deescalate/think
  - ✓ **Ensure "right people are involved"** (*Nothing without me about me)*
  - ✓ **Compassion** → Share what was heard/observed to ensure clarity and understanding
  - ✓ **Ask – what was the intention**?
  - ✓ **Listen**
  - ✓ **Ask** – How can we avoid this in the future? How do we write a new script? How do we make new choices?
  - ✓ **If unable to agree** → *Agree to disagree and not hold each other hostage until there is agreement*
  - ✓ **Gratitude** → *sincere appreciation for attention and proactive solution building*

"*Don't wait for a light to appear at the end of the tunnel, stride right down there and light the bloody thing yourself!"* Sara Henderson

Step 5: Create a Safe Environment

- Establish Ground Rules – "*Respect"*
- *Culture of Learning: MLE's – Major Learning Experiences*
- Provide Mediator and Create Privacy
- Use → Coaching Skills – "*Coaching-in-the-Moment*" → Cognitive rehearsal for challenging topics

What is ONE thing you are going to do differently tomorrow as a result of this discussion?

Step 6: Be Patient

- Persistent → Remember: "*What you permit you promote*"
- Consistent → *fair and just*
- Compassionate

Civility Made Easy – the 1-2-3... of Creating a Climate of Civility

One – Make an individual *CHOICE* and commitment to learn, create, maintain and improve "civility"

Two Requirements – Ensure conversations are held with the ***right people*** present in a ***safe & private*** location. ***Remember***: *"Nothing about me without me" and "always deliver the message to the right address!"*

Three Principles of Mutuality are Guiding Principles - These are foundational for collaboration & consensus building: 1.) Mutual Respect 2.) Mutual Learning 3.) Mutual Accountability

The Five Agreements to Live By – The following information has been adapted from *The Fifth Agreement, A Practical Guide to Self-Mastery* by Don Migule Ruiz and son, Don Jose Ruiz. These few statements, if really imbedded into your life, can radically change your life, your team and your students! They seem so simple, yet they can be hard to actualize. Use them in your daily practices or for reflective practice and you will be amazed by how simple they become. Place them in places to help your remember and please feel free to share them with others in your life!

1. **Be impeccable with your word.**

Speak with integrity. Say only what you mean. Avoid using words to speak against yourself or to gossip about others. Use the power of your word in a proactive direction from a place of truth and compassion. If you make a mistake, as humans do, be accountable to you and others, apologize and take steps to move forward and learn from the experience.

2. **Don't take anything personally.**

Nothing others do is because of you. What others say and do is a projection of their own reality, their own dreams and their reaction from past experiences. When you are immune to the opinions and actions of others, you won't be the victim of needless suffering. Forgive and move on.

3. **Don't make assumptions.**

Find the courage to ask questions and to express what you really want. Think about and ask questions to clarify cultural, language, generational differences and written words. Pay attention to non-verbal cues and clarify when verbal communication is inconsistent. When you communicate with others, be clear to avoid misunderstanding, judgment, sadness and drama. Be sure to follow-up by validating the other individual's understanding matches your intention. Remind yourself of this one frequently!

4. **Always do your best.**

Your best is going to change from moment to moment; it will be different when you are healthy as opposed to sick. Under any circumstance, simply do your best, and you will avoid self-judgment, self-abuse and regret. As life-long learners our best can get better!

5. **Be skeptical. But, learn to listen.**

Don't believe everything you hear or see. Don't believe yourself or anybody else, rather ask questions to find the truth. Use the power of doubt to question everything you hear: Is it really the truth? Are you asking the right person? Always listen to the intent behind words and you will understand the meaning.

Quotes of the Day*:*

"Never underestimate the capacity of another human being to have exactly the same shortcomings you have." *Leigh Steinberg*

"Never underestimate the power of your actions. With one small gesture you can change a person's life. For better or for worse." *David P. Brown*

"Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around." *Leo Buscaglia*

"Penny for Your Thoughts" Exercise
Confidential Exercise

The following questions will help provide your nursing education team with some baseline information related to the topic of "incivility and horizontal violence and bullying" within the Nursing Program. All the information shared will be held in the strictest of confidence. Completed forms should be placed in the envelope provided. Once all of the faculty have completed the exercise the envelope will be sealed. _____ will be the only person to see the completed forms and will compile all the responses into a summary for the team to use in further developing this topic.

All forms will be shredded upon completion of the summary to protect the anonymity of the individual faculty member. Please do not add your name to the form. Please complete both pages.

I have experienced hostility, incivility or bullying while part of this faculty/staff. Yes – No

If yes, please answer the following three questions. If no, go to the next page.

- ☐ **In the space provided, please briefly describe the experience:**

- ☐ **Please write a "few words" to describe how this incident made you feel:**

- ☐ **I think the priority focus for changing the climate towards civility should be:**

Please respond to the following questions. All answers will be anonymous and provided back to the unit in a collated manner.

1 = Strongly Agree / 2 = Agree / 3 = Neutral / 4 = Disagree / 5 = Strongly Disagree

I am respected by my peers.	1	2	3	4	5
I feel supported by my peers.	1	2	3	4	5
My work group is a safe environment in which I can express my opinions.	1	2	3	4	5
If I have a problem with any member of this group, I feel good about talking to that person directly.	1	2	3	4	5
My peers respect my opinion.	1	2	3	4	5
I have a good working relationship with all team members.	1	2	3	4	5
In the past month, I have not participated in any discussion about a team member who is not present.	1	2	3	4	5
I receive constructive feedback from my peers that help me to improve my performance.	1	2	3	4	5

What I like most about this team is:

What I need more from this group is:

Thank you for your input.

Questions adapted from Bartholomew (2006) Ending Nurse-to-Nurse Hostility, p. 125

Commitment to Coworkers

Adapted from: Bartholomew (2006) *Ending Nurse-to-Nurse Hostility*

"It is much easier to build a good relationship than to struggle with a bad one."

A healthy work environment can be achieved when all the individuals on the team are committed to the same goals and guidelines. This document outlines the expectations for all members of our team.

School of Nursing: _____ Date: _____

I, _____ agree with the following statements and by signing below I am making a commitment to my coworkers and nursing program to abide by these commitments.

- We will maintain a supportive attitude with colleagues, creating a positive team environment by recognizing our colleagues for performance that exceeds expectations. We will hold each other accountable for our behavior and performance, recognizing that the actions of one speak for the entire team.
- We recognize that each of us plays a vital role in the school's operations and treat each other accordingly.
- Rudeness is never tolerated.
- There is no blaming, finger pointing, or undermining of fellow faculty, students and administration.
- We are on time for our classes and meetings and when returning from breaks.
- We treat each other as professionals with courtesy, honesty, and respect.
- We welcome and nurture newcomers.
- We recognize that many hands make light work and offer to help each other.
- We show appreciation and support to staff that come from other departments.
- We don't call in sick unless we are sick.
- We recognize that we all have strengths and weaknesses and that it takes many diverse personalities to make a team.
- We respect cultural, spiritual, and educational differences in one another.
- We praise each other in public and criticize in private.
- We do not gossip. We protect the privacy and feelings of our fellow employees.
- We profess that "There is no 'I' in TEAM."
- Our actions & attitudes make our fellow employees and students feel appreciated, included, and valued.
- We share ideas and openly communicate with each other.
- We respect each other's time and avoid urgent requests.
- We have fun and keep a sense of humor at work.

I expect, if at any time, I do not comply with the above statements, my peers and the administration will have a confidential conversation with me directly and hold me accountable for the above commitments.

I agree to hold my peers and the administration accountable to the above commitments and I will have confidential conversations directly with any individual that does not follow this agreement in an effort to promote a healthy work environment.

I agree to hold my students accountable to the above commitments and I will have confidential conversations directly with any individual that does not follow this agreement in an effort to promote a healthy learning environment.

Signature: _____ Date: _____

Cognitive Rehearsal – Cueing Ideas to Improve Civility

Adapted from Griffin, M. (2004) Teaching Cognitive Rehearsal as a Shield for Lateral Violence: An Intervention for Newly Licensed Nurses. *The Journal of Continuing Education,* 35(6), p. 260.

To increase the civility of our conversations, it is important to remember the following:

- Begin Eye-to-Eye! (*Both sit or stand.)*
- Slow-down and really ***LISTEN*** to each other!
- Pause and ***THINK*** before responding. Take a few deep breaths! Oxygen is good for your brain and your emotions!!
- You make the ***CHOICE*** to React – Respond – or Clarify.
- Use "I" statements!
- Repeat as necessary!
- **AVOID**: "***You***" statements blame; "***But***" statements may imply excuses and undermine words; and "***Why"*** questions can lead to intimidation.

I feel, I think, I want…	DESC Model	SBAR Model
I FEEL – (*Accountability*) – Identifies what you feel with the situation – ONE WORD **I THINK** – (*Compassion*) – what it is about **I WANT** – (*Respect*) – What you want for yourself – not what you want from the other person.	D – **DESCRIBE** the behavior E – **EXPLAIN** the impact of the behavior S – **STATE** the desired outcome C – **CONSEQUENCE** what happens if the behavior continues	**S** - Situation: What is happening at the present time? **B** - Background: What are the circumstances leading up to this situation? **A** - Assessment: What do I think the problem is? **R** - Recommendation: What should we do to correct the problem?

Expected Communication Behaviors for Professionals:

- Accept one's fair share of the workload.
- Respect the privacy of others and hold conversations in private locations. Never criticize publicly.
- Be cooperative with regard to the shared physical work-space.
- Be willing to help when requested and be willing to request and accept help when needed.
- Keep confidences. Don't engage in conversations about another coworker.
- Work cooperatively despite feelings of dislike.
- Don't denigrate superiors or co-workers by speaking negatively about them. Address them by their proper name.
- Look coworkers in the eye when having conversations.
- Do repay debts, favors, and compliments, no matter how small.
- Stand-up for the "absent member" in a conversations when he or she is not present and ensure the conversations are directed to the right individuals.

Carefronting is "Caring enough to confront is the key to effective relationships – both parties must be willing and able to state how they feel and what they value. Carefronting disrespectful behavior comprises negotiating differences in clear, respectful and truthful ways."

Ausburger

Cues for Conversations The following are situations where you may need to respond. Each situation has a specific statement you can use to respond for to clarify the situation:

Nonverbal Innuendo (raising of eyebrows or face-making)

- I sense (I see from your expression) that there may be something you wanted to say to me. It's okay to speak directly to me.
- I noticed you rolled your eyes. Can you help me understand what you intended to communicate to me?

Verbal Affront (covert or overt, snide remarks, lack of openness, abrupt responses.)

- The individuals I learn the most from are clearer in their directions and feedback. Is there some way we can structure this type of situation?
- I just heard you say _____. Can you help me understand what your intention was with that statement?

Undermining activities (turning away, not available)

- When something happens that is "different: or "Contrary" to what I thought or understood, it leaves me with questions. Help me understand how this situation may have happened.
- When I see you turn away (or other behavior) I feel we are not communicating effectively. I think it is important for us to be able to communicate and understand each other. I want to be able to work with you. Can you help me understand this?

Withholding information (practice or patient)

- It is my understanding that there was (is) more information available regarding this situation and I believe if I had known that (more), it would (will) affect how I learn or need to know.
- I feel confused. I think there is more information I need from you. I want to be able to do the best job and need for you to feel confident in sharing information with me. How can we improve this?

Sabotage (deliberately setting up a negative situation)

- There is more to this situation than meets the eye. Could you and I meet privately and explore what happened?
- I feel set-up. I think there is more to this than I understand. I want us to be able to work together. Can we discuss this?

Infighting (bickering with peers). Nothing is more unprofessional than a contentious discussion in a non-private setting. ALWAYS avoid.

- This is not the time or place for this. Please stop (physically walk away or move to a neutral spot.)
- We need to take this discussion to a private locations. Please come with me so we can finish this discussion.

Scapegoating (attributing all that goes wrong to one individual.) Rarely is one individual, one incident, or one situation the cause for all that goes wrong. Scapegoating is an easy route to travel, and rarely solves the problems.

- I don't think that's the right connection.
- I feel I am being blamed. I think we need to look at this situation together. I want to get to the source of the problem.

Backstabbing (complaining to others about an individual and not speaking directly to that individual.)

- I don't feel right talking about him/her/this situation when I wasn't there and don't know the facts. Have you spoken to him/her?
- This is a conversation that needs to include ____. I feel we need to stop this conversation until ___ can be present.

Failure to respect privacy.

- It bothers me to talk about that without his/her/their permission.
- I cannot speak for anyone other than myself. That information should not be repeated.

Broken confidences.

- Was that information said in confidence?
- That sounds like information that should remain confidential.
- He/She asked me to keep that confidential.

Practice Scenarios – to create your own Cognitive Rehearsal

#1 Scenario: ***"You are receiving a hand-off report from a member of staff from another department. During this interaction, they roll their eyes when you ask questions & tell you that 'the information is in the chart, just look it up!'" OR "You are a student receiving shift report …"***	**#2 Scenario:** ***"You are a staff member talking to your manager about your assignment. You think it is unfair."*** **OR –** ***"You are a student talking to your instructor about feedback on your assignment..."***	**#3 Scenario:** ***"You witness a peer make an error."***
#4 Scenario: ***"Another staff member comes up to you and begins to tell you a story about how/what another staff person said or did." OR "You are a student and…"***	**#5 Scenario:** ***"You overhear two individuals in the hall having a disagreement."***	

Evaluation of Individual Presenter by Student
Clinical Scholar

Presenter: Deb Center	Topic: Incivility	Date: March 14, 2011

Regarding the Presenter:	Scale					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	No Opinion / N/A
1. The speaker was knowledgeable regarding the content presented	○	○	○	○	○	○
2. The presentation was stimulating and interesting	○	○	○	○	○	○
3. The content presented will be useful to me in my role as a Clinical Scholar	○	○	○	○	○	○
4. Appropriate reference materials were provided	○	○	○	○	○	○
5. Handouts or other materials are clear	○	○	○	○	○	○
6. The presenter was responsive to questions from the audience	○	○	○	○	○	○
7. The content was at an appropriate level, not too elementary, not too complex	○	○	○	○	○	○
8. The content was covered satisfactorily and completely	○	○	○	○	○	○
9. The speaker's selected teaching strategy (lecture, discussion, small groups, etc.) maximized my learning	○	○	○	○	○	○

Comments:

National League for Nursing

CORE COMPETENCIES OF NURSE EDUCATORS ©
WITH TASK STATEMENTS

Competency 1 – Facilitate Learning

Nurse educators are responsible for creating an environment in classroom, laboratory, and clinical settings that facilitates student learning and the achievement of desired cognitive, affective, and psychomotor outcomes. To facilitate learning effectively, the nurse educator:

- Implements a variety of teaching strategies appropriate to learner needs, desired learner outcomes, content, and context
- Grounds teaching strategies in educational theory and evidence-based teaching practices
- Recognizes multicultural, gender, and experiential influences on teaching and learning
- Engages in self-reflection and continued learning to improve teaching practices that facilitate learning
- Uses information technologies skillfully to support the teaching-learning process
- Practices skilled oral, written, and electronic communication that reflects an awareness of self and others, along with an ability to convey ideas in a variety of contexts
- Models critical and reflective thinking
- Creates opportunities for learners to develop their critical thinking and critical reasoning skills
- Shows enthusiasm for teaching, learning, and nursing that inspires and motivates students
- Demonstrates interest in and respect for learners
- Uses personal attributes (e.g., caring, confidence, patience, integrity and flexibility) that facilitate learning
- Develops collegial working relationships with students, faculty colleagues, and clinical agency personnel to promote positive learning environments
- Maintains the professional practice knowledge base needed to help learners prepare for contemporary nursing practice
- Serves as a role model of professional nursing

Competency 2 – Facilitate Learner Development and Socialization

Nurse educators recognize their responsibility for helping students develop as nurses and integrate the values and behaviors expected of those who fulfill that role. To facilitate learner development and socialization effectively, the nurse educator:

- Identifies individual learning styles and unique learning needs of international, adult, multicultural, educationally disadvantaged, physically challenged, at-risk, and second degree learners
- Provides resources to diverse learners that help meet their individual learning needs
- Engages in effective advisement and counseling strategies that help learners meet their professional goals
- Creates learning environments that are focused on socialization to the role of the nurse and facilitate learners' self-reflection and personal goal setting
- Fosters the cognitive, psychomotor, and affective development of learners
- Recognizes the influence of teaching styles and interpersonal interactions on learner outcomes
- Assists learners to develop the ability to engage in thoughtful and constructive self and peer evaluation
- Models professional behaviors for learners including, but not limited to, involvement in professional organizations, engagement in lifelong learning activities, dissemination of information through publications and presentations, and advocacy

Competency 3 – Use Assessment and Evaluation Strategies

Nurse educators use a variety of strategies to assess and evaluate student learning in classroom, laboratory and clinical settings, as well as in all domains of learning. To use assessment and evaluation strategies effectively, the nurse educator:

- Uses extant literature to develop evidence-based assessment and evaluation practices
- Uses a variety of strategies to assess and evaluate learning in the cognitive, psychomotor, and affective domains
- Implements evidence-based assessment and evaluation strategies that are appropriate to the learner and to learning goals
- Uses assessment and evaluation data to enhance the teaching-learning process
- Provides timely, constructive, and thoughtful feedback to learners
- Demonstrates skill in the design and use of tools for assessing clinical practice

Competency 4 – Participate in Curriculum Design and Evaluation of Program Outcomes

Nurse educators are responsible for formulating program outcomes and designing curricula that reflect contemporary health care trends and prepare graduates to function effectively in the health care environment. To participate effectively in curriculum design and evaluation of program outcomes, the nurse educator:

- Ensures that the curriculum reflects institutional philosophy and mission, current nursing and health care trends, and community and societal needs so as to prepare graduates for practice in a complex, dynamic, multicultural health care environment

- Demonstrates knowledge of curriculum development including identifying program outcomes, developing competency statements, writing learning objectives, and selecting appropriate learning activities and evaluation strategies

- Bases curriculum design and implementation decisions on sound educational principles, theory, and research

- Revises the curriculum based on assessment of program outcomes, learner needs, and societal and health care trends

- Implements curricular revisions using appropriate change theories and strategies

- Creates and maintains community and clinical partnerships that support educational goals

- Collaborates with external constituencies throughout the process of curriculum revision

- Designs and implements program assessment models that promote continuous quality improvement of all aspects of the program

Competency 5 - Function as a Change Agent and Leader

Nurse educators function as change agents and leaders to create a preferred future for nursing education and nursing practice. To function effectively as a change agent and leader, the nurse educator:

- Models cultural sensitivity when advocating for change
- Integrates a long-term, innovative, and creative perspective into the nurse educator role
- Participates in interdisciplinary efforts to address health care and educational needs locally, regionally, nationally, or internationally
- Evaluates organizational effectiveness in nursing education
- Implements strategies for organizational change
- Provides leadership in the parent institution as well as in the nursing program to enhance the visibility of nursing and its contributions to the academic community
- Promotes innovative practices in educational environments
- Develops leadership skills to shape and implement change

Competency 6 - Pursue Continuous Quality Improvement in the Nurse Educator Role

Nurse educators recognize that their role is multidimensional and that an ongoing commitment to develop and maintain competence in the role is essential. To pursue continuous quality improvement in the nurse educator role, the individual:

- Demonstrates a commitment to life-long learning
- Recognizes that career enhancement needs and activities change as experience is gained in the role
- Participates in professional development opportunities that increase one's effectiveness in the role
- Balances the teaching, scholarship, and service demands inherent in the role of educator and member of an academic institution
- Uses feedback gained from self, peer, student, and administrative evaluation to improve role effectiveness
- Engages in activities that promote one's socialization to the role
- Uses knowledge of legal and ethical issues relevant to higher education and nursing education as a basis for influencing, designing, and implementing policies and procedures related to students, faculty, and the educational environment
- Mentors and supports faculty colleagues

Competency 7 – Engage in Scholarship

Nurse educators acknowledge that scholarship is an integral component of the faculty role, and that teaching itself is a scholarly activity. To engage effectively in scholarship, the nurse educator:

- Draws on extant literature to design evidence-based teaching and evaluation practices
- Exhibits a spirit of inquiry about teaching and learning, student development, evaluation methods, and other aspects of the role
- Designs and implements scholarly activities in an established area of expertise
- Disseminates nursing and teaching knowledge to a variety of audiences through various means
- Demonstrates skill in proposal writing for initiatives that include, but are not limited to, research, resource acquisition, program development, and policy development
- Demonstrates qualities of a scholar: integrity, courage, perseverance, vitality, and creativity

Competency 8 – Function within the Educational Environment

Nurse educators are knowledgeable about the educational environment within which they practice and recognize how political, institutional, social and economic forces impact their role. To function as a good "citizen of the academy," the nurse educator:

- Uses knowledge of history and current trends and issues in higher education as a basis for making recommendations and decisions on educational issues
- Identifies how social, economic, political, and institutional forces influence higher education in general and nursing education in particular
- Develops networks, collaborations, and partnerships to enhance nursing's influence within the academic community
- Determines own professional goals within the context of academic nursing and the mission of the parent institution and nursing program
- Integrates the values of respect, collegiality, professionalism, and caring to build an organizational climate that fosters the development of students and teachers
- Incorporates the goals of the nursing program and the mission of the parent institution when proposing change or managing issues
- Assumes a leadership role in various levels of institutional governance
- Advocates for nursing and nursing education in the political arena

These competencies were developed by the NLN's Task Group on Nurse Educator Competencies

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Evaluation of Individual Presenter by Student
Clinical Scholar

Presenter: Karren Kowalski	Topic: All Topics	Date: October 18, 2010

Regarding the Presenter:	Scale					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	No Opinion / N/A
1. The speaker was knowledgeable regarding the content presented	○	○	○	○	○	○
2. The presentation was stimulating and interesting	○	○	○	○	○	○
3. The content presented will be useful to me in my role as a Clinical Scholar	○	○	○	○	○	○
4. Appropriate reference materials were provided	○	○	○	○	○	○
5. Handouts or other materials are clear	○	○	○	○	○	○
6. The presenter was responsive to questions from the audience	○	○	○	○	○	○
7. The content was at an appropriate level, not too elementary, not too complex	○	○	○	○	○	○
8. The content was covered satisfactorily and completely	○	○	○	○	○	○
9. The speaker's selected teaching strategy (lecture, discussion, small groups, etc.) maximized my learning	○	○	○	○	○	○

Comments: