COLORADOCENTER
for Nursing Excellence

Continuing Nursing Education Disclosure Form

Title of Event: Clinical Scholar July 2015

Date and Location of Event: July 20-24, 2015 at Good Samaritan Hospital

The objectives for this event are:

1. Participants will be able to discuss the role of the Clinical Scholar identifying personal attributes of self that may be utilized to enhance the student experience.
2. Participants will be able to demonstrate creative and individualized approaches to employ in working with a variety of learners.
3. Participants will be able to employ a variety of communication techniques to enhance teamwork and effective interactions in practice situations in the classroom.
4. Participants will be able to identify and discuss at least three separate subject areas that are directly involved in implementation of the clinical scholar role.
5. Participants will be able to utilize the NLN Competencies for Nurse Educators to identify specific skills that I now possess to begin to function in the clinical educator role.

- 38.8 contact hours will be awarded. To receive contact hours the participants must remain for the entire presentation. No partial contact hours will be awarded.
- No conflicts of interest have been disclosed by any speaker.
- No conflicts of interest have been disclosed by any planner.

The Colorado Center for Nursing Excellence is an approved provider of continuing nursing education by the Colorado Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

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Clinical Scholar Workshop Guidelines and Expectations

By signing below I agree to the following:

Administrative Rules

- I understand that promptness is expected. I will be on time for the beginning of all classes and will return from breaks and meals promptly.
- Further, I understand that I have committed to be present for all scheduled workshop hours
- I will return phone calls or text messages only during scheduled breaks. I will be certain that if my cell phone is not turned off, it is in the vibrate-only mode during class.
- If I am using a computer during the workshop, I will refrain from internet use and I will save the workbook content to my device. During the workshop I will only use my computer for viewing the workbook content and/or taking notes.

Exploration, Discovery and Growth Rules

- I agree that all information shared by other participants will remain confidential. I will not repeat or discuss what is shared with anyone.
- I agree that I will ***not*** engage in "side-bar" discussions.
- I agree that I will direct my comments to whomever has the floor, whether it is faculty in the front of the room or a participant who commented last.
- I agree to participate verbally in discussions and exercises appropriately. It is my responsibility to weigh my fair share of contribution, speaking neither too often nor too little.
- I agree to be open to new ideas and experiences.
- I agree to take risks and step outside of my comfort zone.
- I agree to maintain a positive attitude.
- I agree to give supportive feedback and make corrections without invalidating anyone.
- I agree to suspend judgment and be responsible for my actions.
- I agree to be responsible for learning as much as I can from this experience. I also agree to ask for what I need from my facilitators and my fellow participants.
- I agree to get better acquainted with my fellow participants so we can all identify ways to support one another, to work together as a team and to develop professionally.

Project Expectations

- I understand that I have assumed an obligation when I registered for this workshop.

Biographical Sketches of Course Faculty

Victoria (Tori) Baker, an academic clinician, has spent most of her career in agencies serving culturally diverse populations. She has studied health services research, nurse-midwifery and public health. Since 1988, she has taught and designed courses in health promotion, public health, social justice, cultural humility, advanced assessment, and obstetrics, in English and in Spanish, including clinical, on site, and online settings. Currently she teaches masters and doctor of nursing practice students in a distance nursing school, the Frontier Nursing University. She consults in health and educational projects for Baker's Dozen Consulting. In addition, she has worked as a Certified Nurse-Midwife, director of a university-based midwifery practice, and representative of a non-profit organization in Central America. Website: https://sites.google.com/a/wildblue.net/malinche/Home/coltt-2011.

Amy Boatright, **RN, MSN, CNM,** joined the Colorado Center for Nursing Excellence in August 2011. She currently serves as consultant and guest faculty member for the Center. She helped to develop the curriculum for the HRSA-funded Leadership for Directors of Nursing in Long Term Care project funded in July 2011. Amy has been involved in revising and updating the Center's Clinical Scholar course materials, as well as serving as a resource to the participants in the 2011 Advancing Quality Initiatives course as they completed their capstone projects. She recently returned to nursing after taking a few years to be at home with her two young sons. Prior to this, Amy enjoyed practicing full-scope midwifery in the Denver metro area. Her educational background includes undergraduate degrees from Brown University and Columbia University, as well as a Master's degree in nursing from Case Western Reserve University and a certificate in Nurse-Midwifery from the Frontier School of Midwifery and Family Nursing. She has enjoyed working with nursing and midwifery students in the clinical setting as a staff nurse in Labor and Delivery, as a Certified Nurse-Midwife and as adjunct faculty.

Monica Brock MS, RN, CPAN, is the inpatient Perianesthesia Clinical Nurse Educator at the University of Colorado Hospital. She obtained her BSN from Boise State University in 2005, and began her career as a graduate nurse at University Hospital. In 2010, after several years as a Certified Post-Anesthesia Nurse and preceptor, she returned to school to pursue her Master's degree. In 2012, she graduated from Regis University with a Leadership in Healthcare Systems Degree with a certificate in Healthcare Education. In 2012, she also began her role as a Clinical Scholar with a dual appointment between the University of Colorado College of Nursing and University Hospital. After 2 years of teaching students in the clinical setting, she returned to UCH Perioperative Services, accepting the Clinical Nurse Educator position in July 2014. Monica maintains a passion for Evidence Based Practice and Quality Improvement Projects. Over the course of her career, Monica has presented both locally and nationally, including podium and poster presentations at the Rocky Mountain Research and EBP Symposium and AORN, ASPAN, ANA and Magnet National Conferences.

Biographical Sketches of Course Faculty

Deborah L. Center, RN, MSN, CNS (Deb@ColoradoNursingCenter.org), is currently a Project Director at the Colorado Center for Nursing Excellence where she facilitates the Home Health Care Innovations Project. She has been the past Project Director for the Clinical Placement Clearinghouse, the Nursing Faculty Recruitment and Retention Program and the Adam's County Clinical Connections Projects.

She has held many positions within clinical practice settings and nursing education. These include: staff nurse; preceptor; coordinator for staff development; clinical instructor; nursing faculty and program coordinator; legal consultant; case manager; and nursing administration, from assistant manager to VP of Patient Care Services. With each position, her expertise and passion led her to be seen as a change agent, facilitator, coach and mentor.

She believes in empowering others first through awareness and a clear understanding related to choice. The content she teaches is based on a solid foundation of evidence and supports developmental learning. She has presented educational programs within each organization where she has been employed and at local/national conferences. Deborah's clinical expertise is in the areas of cardiology, critical care, and advanced medical-surgical nursing. She has participated in and developed orientation programs for new staff and faculty in all of the educational programs with which she has been associated.

She completed her Bachelor's Degree at Xavier University in Cincinnati, Ohio and her Master's of Science in Nursing with a Clinical Specialty in Adult Critical Care at Wright State University in Dayton, Ohio. She is a 2008 Fellow from the Bighorn Leadership Program focused on Rural Health. She completed the certified coaches program with Coaches Training Alliance (CTA) and is an experienced coach for individuals, groups and teams. She has been an author/co-author on several publications related to nursing and nursing education.

She has spent the majority of her career learning and attempting to fully understand the issue of incivility in nursing, healthcare and society. Along the way, she has learned a few lessons and now has a few strategies to share related to creating and sustaining a healthy work environment.

As a coach, she strives to establish an individual relationship based on trust, safety, transparency and compassion. Her goal is to help those working with her gain a new level of self-awareness in order to break patterns of the past and create a new future. Her non-judgmental approach to reframing situations has been described as "insightful" and "intuitive," allowing clients a new perspective into their situation. She believes there is amazing human potential inside each of us often forgotten or lost in the chaos of our world. She looks forward to helping you find yours again!

Biographical Sketches of Course Faculty

Teresa Connolly, RN, PhD After earning her Bachelor of Science in nursing at Villanova University, Teresa Connolly moved from Philadelphia to Boston to work as a nurse at Massachusetts General Hospital on a neuroscience floor for almost seven years. She completed her Master's at Boston College and is in the final stages of completing her PhD in nursing from Boston College. Her area of focus is adult post-stroke survivors. She has also been a clinical instructor for undergraduate nurses and taught the graduate-level neuroscience pathophysiology. She is currently employed by the College of Nursing Anschutz Medical Campus as a senior instructor teaching undergraduate nurses.

Katherine Foss, RN, MSN (katherine.foss@UCdenver.edu) has been focusing her nursing career on education since 1996. Her focus has been on teaching staff and patients in a variety of acute and sub-acute care environments. Since 2000, Kathy has been working exclusively with student nurses in clinical practice. In 2009, Kathy was asked to co-facilitate implementation of an IHI/Josiah Macy foundation grant to provide inter-professional education experiences in the clinical setting for medical and nursing students at the University of Colorado Hospital. She currently contributes the University of Colorado, Anschutz Medical Campus, Inter-professional Education Steering Committee which oversees the development of the inter-professional education curriculum for health professions students. Realizing the need for instructors in the clinical environment, she co-developed and taught in the first clinical instructor development course in the Denver metro area.

Elizabeth "Beth" Hendrick, BSN, RN, holds the position of RN Educator, Student Placement Coordinator in the Performance Services Department at Littleton Adventist Hospital. Beth earned her BSN from Walla Walla College (now University) in 1978. She focused her clinical career in OB, L&D specifically. Beth worked 28 years in OB, in a variety of settings in the states of Washington , Michigan and Colorado, including staff nurse, charge nurse, and clinical coordinator, which was basically a manager, at that time.

Beth moved into the Performance Services Department at Littleton Adventist Hospital in 2006. Since that time, Beth has grown student placements from less than 100 students per year, to over 600 nursing students per year and has regulatory oversight of all allied health students. In an effort to streamline processes, Beth lead an initiative for a web based student placement program with the ACE (Alliance for Clinical Education) members which many clinical facilities and academic institutions are now using in Colorado, myClinicalExchange.

Biographical Sketches of Course Faculty

Marianne Horner, CNM, RN, MS (Marianne@coloradonursingcenter.org), is a Project Director at the Colorado Center for Nursing Excellence where she has been employed since 2005. Her initial involvement was with the Faculty Development Initiative Project (Clinical Scholar, Preceptor and Powerful Presentations) and she has more recently become involved in other grants, including the Advanced Leadership for Quality project, Colorado Community Health Network leadership training, Nurse Faculty Recruitment & Retention, the Colorado Nursing Student Clearinghouse, Transition to Practice and Preceptor training. Nursing education is a theme that has been woven throughout her career, having taught, mostly clinically, ADN, BSN, ND, NP and Nurse Midwifery students. Educational preparation includes an MS in Parent Child Nursing from the University of Colorado Health Sciences Center. A decade later she completed a post Masters degree certification in Nurse-Midwifery and practiced full scope nurse midwifery and women's health care for a number of years as an Advanced Practice Nurse and Certified Nurse-Midwife. She has been intimately involved in all aspects of several grants at The Center, including curriculum development, writing, collaborative endeavors and actual teaching. Out of the first grant there were six published articles where she was an author that aided in the dissemination of this successful model. Creating a very unique lifestyle Marianne and her husband live part-time in Costa Rica where they enjoy frequent visits from their three children, five grandchildren and numerous friends.

Sara L. Jarrett, RN, EdD (sjarrett@regis.edu), is currently a professor and chair of accelerated nursing at Regis University. As program chair, she is responsible for orienting and evaluating the effectiveness of clinical faculty. Sara is also responsible for hiring new clinical faculty and scholars. She also participates in planning clinical experiences for pre-licensure students. She has worked in these roles in both the academic and practice setting.

Ingrid Johnson RN, BSN, MPP (Ingrid@coloradonursingcenter.org), is the assistant project director for the HRSA funded Long-Term Care Nurse Leadership program provided by the Colorado Center for Nursing Excellence. Prior to working at the Center, Ingrid was the Director of Content Management for the American Association of Nurse Assessment Coordination (AANAC) where she was responsible for keeping LTC nurses up to date on the ever-changing CMS regulations. She co-wrote *The MDS 101 – An Introduction to the RAI Process* following the launch of the MDS 3.0 and has been published in multiple long-term care and geriatric nursing periodicals.

Prior to working in long-term care, Ingrid was certified in the provision of chemotherapy and bone marrow re-infusion, worked in hospice, and was a certified rehabilitation registered nurse. Ingrid worked as a consultant in Colorado with the Concord Coalition for the presidentially appointed non-partisan National Commission on Fiscal Responsibility and Reform. She also served as the President of the Illinois chapter of the Case

Management Society of America.

Ingrid is an alumnus of the 2008 Rural Healthcare Bighorn Leadership Development Conference and provided expert testimony to a congressional house subcommittee on the provision and funding of care to head injury patients in rehabilitation facilities. She holds a BSN from DePauw University in Greencastle, Indiana and a Master's of Public Policy from the University of Denver.

Gail Katz earned her BSN in 1980 from Idaho State University in Pocatello, Idaho, her MSN and CNS from the University of Colorado Health Science Center in 1987 and her DNP from the College of Nursing at Anschutz in 2007. She has practiced in med-surg, rehabilitation nursing and case management. Most of her career in the private sector was in Risk Management, Claims Management, Loss Prevention and Patient Safety and Compliance. In 2007 she designed and developed the Simulation program at the University of Colorado at the Anschutz CON. She has been a legal nurse expert in many states and has testified many times. She also has presented nationally on topics such as Documentation, Liability Claims Management and Risk Management. Since 2008 she has been an Assistant Professor of Nursing at the CON at the Colorado Springs Campus in the Graduate Department.

Karren Kowalski, PhD, RN, NEA-BC, FAAN (karren.kowalski@worldnet.att.net), is the President and CEO of the Colorado Center for Nursing Excellence. She has served as Project Director for three HRSA Grants on Leadership Development and for the Colorado Trust grant on Frontline Leaders Leading a Quality Initiative. She was project director for the Clinical Scholars project funded by the Colorado Department of Labor and Employment. She is a Professor at Texas Tech University Anita Thigpen Perry School of Nursing and teaches part time in the DNP program in Nursing Administration. She previously served as Assistant Vice President and Administrator of Women and Children's Services and Chairperson of the Department of Maternal Child Nursing at Rush-Presbyterian-St. Luke's Medical Center and Rush University in Chicago.

She completed her doctoral work in Sociology at the University of Colorado, Boulder, where her major areas of study were Leadership, Women's studies and the Family. She received her BS from Indiana University and her MSN from the University of Colorado. She has held multiple leadership positions from the head nurse to director and administrator. She has served as Project director on seven major state and federal grants totalling more than $6.4 million. In all these positions, she has developed innovative and creative approaches to problem solving. She has authored numerous articles and co-edited five advanced textbooks, including *Beyond Leading and Managing, Nursing Administration for the Future,* and *Fast Facts for the Classroom Nursing Instructor,* both of which she co-authored with Dr. Patricia Yoder-Wise.

Dr. Kowalski is the recipient of numerous awards and honors including state and national awards for leadership. Among these is the 2010 Florence Nightingale recipient, Distinguished Alumnae of the University of Colorado, School of Nursing, selected as one of the Ten Outstanding Young Women of America, and is a charter member of the Colorado Nurses Association Hall of Fame. She is a past president of CNA. She was elected to the American Academy of Nursing in 1981. She speaks nationally and is known for her strong presentation style and teaching skills.

Dianne McCallister, MD, MBA (diannemccallister@centura.org), is the Chief Medical Officer at Porter Adventist Hospital since 2005. She is a Board Certified internist and the Chief Medical Officer Safety and Vice President for Patient Safety and Quality Systems for Porter Adventist Hospital. Her areas of interest include using quality as a focus for improving relationships with physicians, hospital efforts to support the physician community and process improvement.

Dr. McCallister's previous experience includes being the physician on the team that opened Parker Adventist Hospital where she served as their first Medical Director and President of the Medical Staff. She has practiced in both Aurora and Wheatridge as a partner in large Internal Medicine Practices. She attended CU Medical School and trained at Presbyterian/St. Luke's, where she served one year as Chief Medical Resident and has served as an Instructor in Internal Medicine. She is a graduate of the Executive MBA program at Daniels College of Business. She now serves as an Editor for the Journal of Healthcare Communication and has served as Director of Medical Education for Rocky Vista Medical School for Centura and now as Administrative Liaison to the school from Centura. She has been married for 25 years to Tom, and they have three children. Her interests outside of work include family, reading, writing, gardening, exercise, and enjoying this beautiful state.

Susan Moyer, RN MS CNSPH (susan@coloradonursingcenter.org), is currently an Assistant Project Director at the Colorado Center for Nursing Excellence where she currently is involved in several grant projects, including the Long Term Care Leadership Project, Future of Nursing: Colorado State Implementation Program and Nurse Education Practice Quality and Retention Project.

She has held many positions within clinical practice settings and public health. These include: staff nurse; preceptor; clinical scholar; public health nurse and public health nurse supervisor. The content she teaches is based on a solid foundation of evidence and supports developmental learning. She has presented at the national, state and local levels. Susan's clinical expertise is in the areas of cardiology, critical care, and public health nursing. She completed her Bachelor's Degree at Mesa State College in Grand Junction, Colorado and her Masters of Science with a Specialty in Public Health Nursing at University of Colorado.

Biographical Sketches of Course Faculty

Bari Platter, RN, MSN (bari.platter@UCDenver.edu), is a Psychiatric Clinical Nurse Specialist and Educator at the University of Colorado Hospital in Denver, Colorado. She specializes in the areas of transcultural nursing, interpersonal communication, solution focused therapy. In addition to working as the Educator for the University of Colorado Hospital's Psychiatric Service and CeDAR program, Bari is also a Clinical Instructor at the University of Colorado Health Sciences Center School of Nursing and Regis University School of Nursing. She is a member of the Friendship Bridge Nursing Project- an international organization that provides nursing education in Vietnam.

Linda Stroup, RN, MSN, PhD (c) (lstroup@mscd.edu), has held many roles in nursing from staff, clinical instructor, nursing faculty, and nursing education administrator, including her current position as Associate Chair of the Department of Nursing at Metropolitan State College of Denver. Linda is currently a doctoral student in a PhD program at Colorado State University in the School of Education with an emphasis in College and University Leadership. Linda's clinical expertise is in the areas of cardiology and medical/surgical nursing.

She has held a variety of leadership positions in nursing, including treasurer of the Colorado Council on Nursing Education and treasurer of District 20 of the Colorado Nurses Association. Linda is committed to quality professional nursing education and strengthening partnerships between education and service.

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Clinical Scholars
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❑ 1. Teaching Adults: Motivators & Barriers

Notes:

Presented by: Monica Brock MS, RN, CPAN

Content by:

Kari Waterman MS, RNC-NIC, CNS

Manager of Clinical Education & Professional Resources

and

JoAnn DelMonte RN, MSN

Coordinator of the Graduate Nurse Residency Program, University of Colorado Hospital

❑ 2. Objectives

- Apply effective adult & clinical teaching principles into practice.
- Describe motivators and barriers to learning for adults.
- Discuss difficult student behaviors and strategies to employ.

❑ 3. Reflection…how did you learn?

❑ 4. Adult Learners

Notes:

- Personal Benefit
- Self-directed
- Life experiences that can be resource for learning
- Want to learn things that can be applied immediately
- Learning Styles

❑ 5. Effective Clinical Learning

- Identifying what the student needs to learn
- Creating a "safe" environment
- Create opportunities to reflect and relate learning
- Learning by doing
- Immediacy of learning
- Skill acquisition =
  - ◊ Cognitive (knowledge/ ideas)
  - ◊ Affective (feelings)
  - ◊ Psychomotor (actions)

❑ 6. Clinical Teaching

Notes:

- Then...
- Now...

❑ 7. Research tells us after 2 weeks we tend to remember…

- 10% of what we read
- 20% of what we hear
- 30% of what we see
- 50% of what we see + hear
- 70% of what we say
- 90% of what we say + do (Active Learning)

❑ 8. Motivators to Learning

- Personal interest & goals
- External expectations
- Knowledge
- Social interaction
- Social welfare

❑ 9. Barriers to Learning

❑ 10. Barriers to Learning

Notes:

- Geographic
- Demographic
- Socioeconomic Conditions
- Cultural
- Transportation
- Childcare
- Fatigue
- Confidence
- Ill-prepared
- Theory-Practice gap
- Instructor, Nurse Preceptor

❑ 11. An Ounce of Prevention is Worth a Pound of Cure

- Clear & concise communication
- Provide early & regular feedback
- Discuss expectations
- Involve students in discussions & ask for examples
- Mutual respect

❑ 12. Difficult Student Behaviors

Notes:

- Invisible Student
  - ◊ Lacks confidence
  - ◊ Shy
  - ◊ Quiet
- Strategies
  - ◊ Seek this student out
  - ◊ Ask direct questions
  - ◊ Reinforce contributions
  - ◊ Utilize written progress reports

❑ 13. Difficult Student Behaviors

- Know-It-All Student
  - ◊ Need for attention
  - ◊ Ill-prepared
  - ◊ Lack confidence
- Strategies
  - ◊ Redirect comments to the group
  - ◊ Talk to student privately
  - ◊ Don't allow student to monopolize discussions
  - ◊ Admit you don't have all the answers

❑ 14. Difficult Student Behaviors

Notes:

- Rambler Student
  - ◊ Nervous
  - ◊ Ill-prepared

- Strategies
  - ◊ Redirect
  - ◊ Ask them to summarize
  - ◊ Let's hear from some others in the group
  - ◊ Assign "timer" in post conference

❑ 15. Student Learning is…

- Significantly related to teacher behaviors:
- Clinically competent
- Knows how to teach
- Collegial relationships with students
- Friendly
- Supportive
- Patient

❑ 16. References

Notes:

- Billings, D.M. & Halstead, J.A. (1998). Teaching in Nursing. A Guide for Faculty. Philadelphia, PA: W.B. Saunders Company.

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- O'Shea, K.L. (2002). Staff Development Nursing Secrets. Questions and Answers Reveal the Secrets to Successful Staff Development. Philadelphia, PA: Hanley & Belfus Inc.

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Notes:

❑ 1. Nursing Education

Notes:

Professional Engagement

Sara L Jarrett, EdD, MS, CNS, RN, CNE

❑ 2. Objectives

- Explore professional engagement as a framework for a paradigm change in role development for the 21st century nurse.
- Relate professional engagement to the future of nursing education and health are delivery.

❑ 3. Engagement

- PROFESSIONAL ENGAGEMENT

  – ACCOUNTABILITY FOR PRACTICE AND COMPETENCE

  – CITIZENSHIP

  – STEWARDSHIP

  – ADVOCACY

❑ 4. Competence

Notes:

- DETERMINANTS OF COMPETENCE
- ACCOUNTABILITY

  – PERSONAL

  – PROFESSIONAL

  – INSTITUTIONAL

  – PUBLIC POLICY

❑ 5. Citizenship

- SOCIAL CONTRACT THEORY – PROFESSIONAL RIGHTS AND RESPONSIBILITIES
- BETTERMENT OF THE PROFESSION
- DEFINING IDENTITY OF THE PROFESSION

❑ 6. Stewardship

- TIME , TALENT, TREASURE
- SELF, PROFESSION, HEALTH CARE SYSTEM
- ENGAGING OTHERS IN ACTION AND SOLUTIONS

❑ 7. Advocacy

Notes:

- INDIVIDUAL
- PRACTICE
- POLICY

  – INSTITUTIONAL

  – PUBLIC

❑ 8. Paradigm Shift

- ENVISIONING THE FUTURE
- FORECASTS AND TRENDS

❑ 9. Looking to the Future Health Care System

- COMPLEXITY OF PATIENT CARE
- HEALTH CARE FINANCING
- STAFFING ISSUES
- CONTINUUM OF CARE

❑ 10. Looking to the Future of Nursing Education

Notes:

- CHANGES IN EDUCATIONAL PREPARATION (DEGREES)
- CHANGES IN CRITERIA FOR PROGRAMS
- TECHNOLOGY
- PUBLIC POLICY ISSUES

❑ 11. Summary and Discussion

- WHAT SHOULD BE NURSING'S NEXT STEPS?
- HOW DO WE ASSURE A PREFERRED FUTURE FOR NURSING ROLES AND NURSING EDUCATION?

❑ 12. Website Resources

- http://www.aacn.nche.edu/
- http://www.aacn.nche.edu/publications/baccalaureate-toolkit
- http://www.aacn.nche.edu/publications/position-statements
- http://www.aacn.nche.edu/publications/brochures/GradStudentsBrochure.

❑ 13. Website Resources

Notes:

- http://www.aacn.nche.edu/Media/FactSheets/nursfact.htm
- http://bhpr.hrsa.gov/healthworkforce
- http://stats.bls.gov/oco/ocos083.htm
- http://www.bls.gov/news.release/ecopro.toc.htm
- http://www.nurses-co.org/default.asp

❑ 14. Website Resources

- http://www.bls.gov/news.release/ecopro.toc.htm
- http://www.aacn.nche.edu/Media/NewsReleases/2008/BaccEssentials.html
- http://www.nln.org/newsreleases/data_release_03032008.htm
- http://www.nln.org/

Notes:

❑ 1. Nursing Education

Notes:

- Trends and Issues
- Changing Faculty Roles

❑ 2. Objectives

- Discuss the nature of nursing education today.
- Reflect about the relationship of nursing's history to contemporary issues.
- Identify current professional nursing issues related to nursing education.

❑ 3. Yesterday and Today

- HISTORICAL PERSPECTIVES
- TODAY'S REALITIES

❑ 4. Current Issues—Shifts in Nursing Education

- THE LEARNER
- THE FACULTY
- THE LOCATION
- THE INFORMATION
- THE EDUCATIONAL PROCESS

❑ 5. Health Care System Issues and Nursing Education

Notes:

- COMPLEXITY OF PATIENT CARE
- HEALTH CARE FINANCING
- STAFFING ISSUES
- CONTINUUM OF CARE

❑ 6. The Changing Paradigm

- EDUCATIONAL PREPARATION – EDUCATING NURSES: A CALL FOR RADICAL TRANSFORMATION (2009)
- INSTITUTE OF MEDICINE REPORT – FUTURE OF NURSING (2010)
- EDUCATION INSTITUTIONS
- SHORTAGES

Notes:

Notes:

Notes:

Notes:

❑ 1. Clinical Scholar Why—Who— What— How

Notes:

Marianne D. Horner, MS, RN, CNM

❑ 2. Why would a person want to be a Clinical Scholar?

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

❑ 3. Who is a Clinical Scholar?

- Difference between Clinical Scholar and other clinical educators
- Qualifications - http://www.dora.state.co.us/nursing/rules/ChapterII.pdf

❑ 4. Where does your paycheck come from?

- Will you be directly teaching rotations of nursing students?

❑ 5. Categories

Notes:

- Paycheck from:
  - ◊ clinical agency + teaching rotations of students = Clinical Scholar
  - ◊ clinical agency + charged with education for staff in your agency = Clinical Educator
  - ◊ a school – clinical teacher = Adjunct Faculty or Clinical Faculty
  - ◊ a school – classroom teacher (may also teach clinically) = Academic Faculty
  - ◊ No immediate teaching responsibilities or other

❑ 6. What are the qualifications for a Clinical Scholar?

- Clinical expertise
- Educational requirements
- Previous teaching

❑ 7. Ability to combine two roles

Notes:

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

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

- Novice
  1.
  2.
  3.
  4.
  5.
  6.

❑ 9. Patricia Benner: Skill Acquisition: Novice to Expert

Notes:

- Expert

1.

2.

3.

❑ 10. Ability to Blend Two Distinct Cultures

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

❑ 11. What does a Clinical Scholar Do?

Notes:

1.

2.

3.

4.

5.

6.

7.

8.

9.

❑ 12. How do you Become a Clinical Scholar?

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

- ❑ **13. Meet our Clinical Group!**

Benner's Stages of Clinical Competence

Based on in-depth interviews with nurses, Patricia Benner adapted the Dreyfus model of skills acquisition to define comparable stages in the development of clinical competence in nursing:

Novice	Beginners have had no or very limited experience of the situations in which they are expected to perform. • Taught rules to help them perform. Lists, "recipes" are useful. Memorization is heavily utilized. • The rules are context-free and independent of specific cases; hence the rules tend to be applied universally. • The rule-governed behavior is extremely limited and *inflexible*. • Little situational perception • Unable to use discretionary judgment • Focuses on pieces vs. the whole • As such, novices have no "life experience" in the application of rules. • "Just tell me what I need to do and I'll do it."
Advanced Beginner	Advanced beginners are those who can demonstrate marginally acceptable performance. • Those who have coped with enough real situations to note, or to have pointed out to them by a mentor, the recurring meaningful situational components. • These components require prior experience in actual situations for recognition. • Principles to guide actions begin to be formulated. The principles are based on experience. Guidelines based on attributes or aspects • Situational perception still limited • Notices change but cannot cope with it • All attributes and aspect are treated separately and given equal importance • Needs help setting priorities • Unable to see entirely of a new situation
Competent	Competence, typified by the nurse who has been on the job in the same or similar situations two or three years. • Develops when the nurse begins to see long-range goals or plans of which he or she is consciously aware. • A plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem. • The conscious, deliberate planning that is characteristic of this skill level helps achieve *efficiency and organization*. • Lacks the speed and flexibility of the proficient nurse but does have a feeling of *mastery* and the ability to cope with and manage the many contingencies of clinical nursing. • Does not yet have enough experience to recognize a situation in terms of an overall picture or in terms of which aspects are most salient, most important. • Aware of all of the relevant aspects of a situation • Able to set priorities • Critical thinking skills are developing

Benner's Stages of Clinical Competence

Based on in-depth interviews with nurses, Patricia Benner adapted the Dreyfus model of skills acquisition to define comparable stages in the development of clinical competence in nursing:

Proficient	The proficient performer *perceives situations as wholes* rather than in terms of chopped up parts or aspects, and performance is *guided by maxims* (definition: general truth). • Can now recognize when the expected normal picture does not materialize. This *holistic* understanding improves decision making. • Decision making becomes less labored because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones. • Uses maxims as guides, which reflect what would appear to the competent or novice performer as unintelligible nuances of the situation, they can mean one thing at one time and quite another thing later. Once one has a deep understanding of the situation overall, however, the maxim provides direction as to what must be taken into account. Maxims reflect nuances of the situation. • Able to see what is most important in a given situation • Perceives deviation from the normal pattern
Expert	The expert nurse no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. • With an enormous background of experience, now has an *intuitive grasp* of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. • Operates from a deep understanding of the total situation. • The performer is no longer aware of features and rules; his/her performance becomes fluid and flexible and highly proficient. • This is not to say that the expert never uses analytic tools. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience. Analytic tools are also necessary for those times when the expert gets a wrong grasp of the situation and then finds that events and behaviors are not occurring as expected. • Has a vision of what is possible.

Communication

Definition:

The one thing humans do more than communicate:

_____

We can not NOT _____

Communication consists of

_____

_____

_____

Humans Communicate

_____

_____

_____

_____

_____

Once the message is sent, it

_____

It can be amended <u>AND</u> the first impression is

_____

This is often unconscious.

How we communicate determines what kind of relationships we make.

Self-regard is a major influence in all communication.

Stress results when self-regard is threatened.

Communication is learned from

_____

Poor Communication leads to:

_____

_____

_____

_____

_____

Little focus is placed on communication in the work place. Yet it is

_____

to smoothly functioning teams.

Guidelines for Communication

1. Approach each interaction as though the other person has no knowledge of effective communication. Assume responsibility for creating the sender-receiver rhythm.

2. Share your thoughts and feelings. Be self-revealing.

3. Casual conversation or "small talk" can be important to relationships, particularly when it is light and humorous. It balances the deep meaningful talk.

4. Acknowledging, praising, and encouraging the other person is supportive and brings life and energy to the relationship.

5. Present messages in a way that the other person can receive them.

6. When you have a problem or issue with another, take responsibility for the problem and speak about it as your problem also.

7. Use language of equality even when position titles are not of the same level.

Communication Patterns

Pattern	Interaction	Source	Example
Attribution of blame	Sender blames receiver	Fault-finder dictator acts superior as camouflage for fear and low self-esteem	Mostly "you" messages; for example, "You really blew it!"
Placation	Sender placates receiver	Sender's low self-worth: puts herself/himself down	"I was wrong. I'm sorry. It's all my fault."
Constrained cool headedness	Sender is correct and very reasonable without feeling or emotion	Feelings of vulnerability covered by cool analytical thinking	"Studies have shown that in 75% of cases the patient is correct. I decided to use research data in coming to a solution."
Irrelevant	Sender is avoiding the issue, ignoring own feelings and feelings of the receiver	Fear, loneliness, and purposeless-ness	"Wait a minute. Let me tell you about…" (changes the subject)
Congruence	Sender's words and actions are congruent; inner feelings match the message	Any tension is decreased and self-worth is at a high level	"For now, I feel concerned about the anger and hostility exhibited by Dr. X. I'm wondering what approach would de-escalate him."

Remember ERIC:

Emotional

Reaction

Impedes

Communication

Communication Pitfalls

1. Advice Giving

It is so tempting to give advice when a co-worker comes with an issue or problem. *Don't!* Most often what the person wants is to work through the issue by talking out loud. Just listen.

2. Making others wrong

When telling others "our" story of distress, the adversary is always "wrong." The telling of the story to a third party only reinforces how right "I" am and how wrong, bad, or terrible the other person is. If you have an issue or problem, take the problem to the person with whom you are upset. "Take the mail to the correct address." Don't gossip!

3. Defensiveness

Defensiveness occurs when you do not listen, are hostile or aggressive, or respond as if attacked when there was no attack. Look for a physiological signal in your body so that you can identify your own distress. Stop. Breathe. Acknowledge that the message did not come out the way you intended and begin again.

Also, defensiveness can occur when met with hostile, aggressive behavior from another. Rather than choose an emotional response or react to the attack, know that the other person's behavior has nothing to do with you personally but is the response chosen by that person in a moment of stress. Any one of a dozen other responses could have been chosen. Understand the person is motivated by fear or hurt.

4. Judging the other person

Evaluating another person as "good" or "bad," as someone you like or don't like, or judging their actions or behavior as "stupid" or "crazy" or "inappropriate" is a reflection of how you judge yourself. Who is the hardest person on you? Of course, you are. Know that you can have feelings about situations or behaviors without judging the other person in a negative way. Rather, you can feel compassion for their stress and fear, which often drives behavior. This is true particularly when a supervisor or physician is reprimanding you.

5. Patronizing

Speaking to another as if they are less than human or in need of custodial care fails to honor them as a human being. You do not have to be condescending or seek to humiliate in an overly sweet voice. These are merely other versions of judging or making the person wrong. Another approach is to question what is at issue for them in the moment.

6. Giving False Reassurance

One of the great temptations of nurses is to "fix" things and make them better, to rescue the situation or the person involved. To accomplish this goal, sometimes we reassure inappropriately. Know that you do not have to fix every situation. You can support people to work through the situation themselves.

7. Asking Why Questions

When working in a team, refrain from asking why questions. These tend to create a defensive response in the other person. Instead, ask, "What makes you think…"

8. Blaming Others

Saying things such as "You make me so angry" is blaming the other person for your feelings, which you choose at any given time. In nearly every situation, the responsibility for communication breakdown is a joint responsibility. You can always choose your response, even if that response is to say, "I can't discuss this with you now. I would like to talk about this later when I am calmer."

Triangulation

Fun Game

- You can enter the game at any door

_____

- Your preferred position is

_____

- If I'm a victim

_____

- After I've been "persecuted"

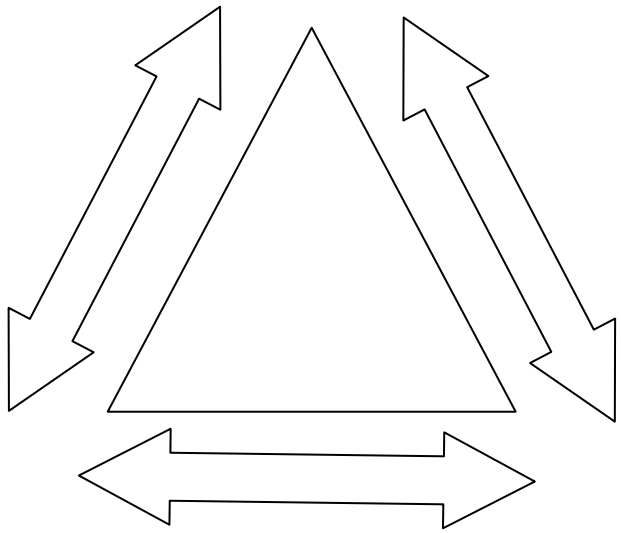
_____

- Rescuer goes to Persecutor

_____

- In this game we can take any role

_____



Gossip

Definition — Talking about someone that is not present.

Good Gossip – Talk that enhances another's view of the person being talked about.

Bad Gossip – Talk that will cause someone harm, pain, confusion or shame. It is character assignation.

Organizational Gossip – changes that are coming, or are feared to be coming relating to organizational changes, as opposed to being directed against an individual. Most likely to occur during times of rapid change and uncertainty, people become fearful about possible negative effects on their own jobs and careers.

Gossip Test

Is it true?

Is it fair?

Will it bring goodwill and better relationships for all concerned?

Self-Awareness

Why am I gossiping?

What need am I filling?

Would I say this directly?

There is a relationship between gossip and wanting to belong. Social bonding.

Before you text, type or speak, THINK first.

T is it _____

H is it _____

I is it _____

N is it _____

K is it _____

Dealing with Difficult People

Definitions:

Relationship - the state of being related or connected or bonded together

Conflict – competitive or opposing action of incompatibles: antagonistic state or action opposing needs, drives, wishes or demands

Confront – to face especially in challenge; meet or bring face to face

Levels of Accountability

8.

7.

6.

5.

4.

3.

2.

1.

Differentiation/Awareness Model

1. Introduction

- Difficult person
- Difficult situation

Empowerment in a conflict situation is defined as:

_____

_____

2. Stimuli for upset or reaction:

- Trigger is Outside
- The responding Feeling is Inside

"You Make me Feel so ….."

3. What are Responses?

- Stress or Fear

4. Automatic Reactions?

- Unconscious – fight or flight

Physiological Responses?

- **Create list of responses / reactions**

_____

_____

_____

_____

_____

_____

_____

- **Patterns:**

  Raised adrenalin leads to:

  Assumptions

  Examples:

_____

_____

_____

- **We go through life reacting to**

External World

Vs.

Responding Creatively

Internal

1. **Feelings** _____
2. **Thoughts** _____
3. **Wants** _____

Which is most difficult for you to identify?

Exercise:

_____

_____

In the unclear areas – this is where automatic responses have an opportunity to arise / grow.

How does that look for you?

If we get fused / one in reaction at our internal level

_____

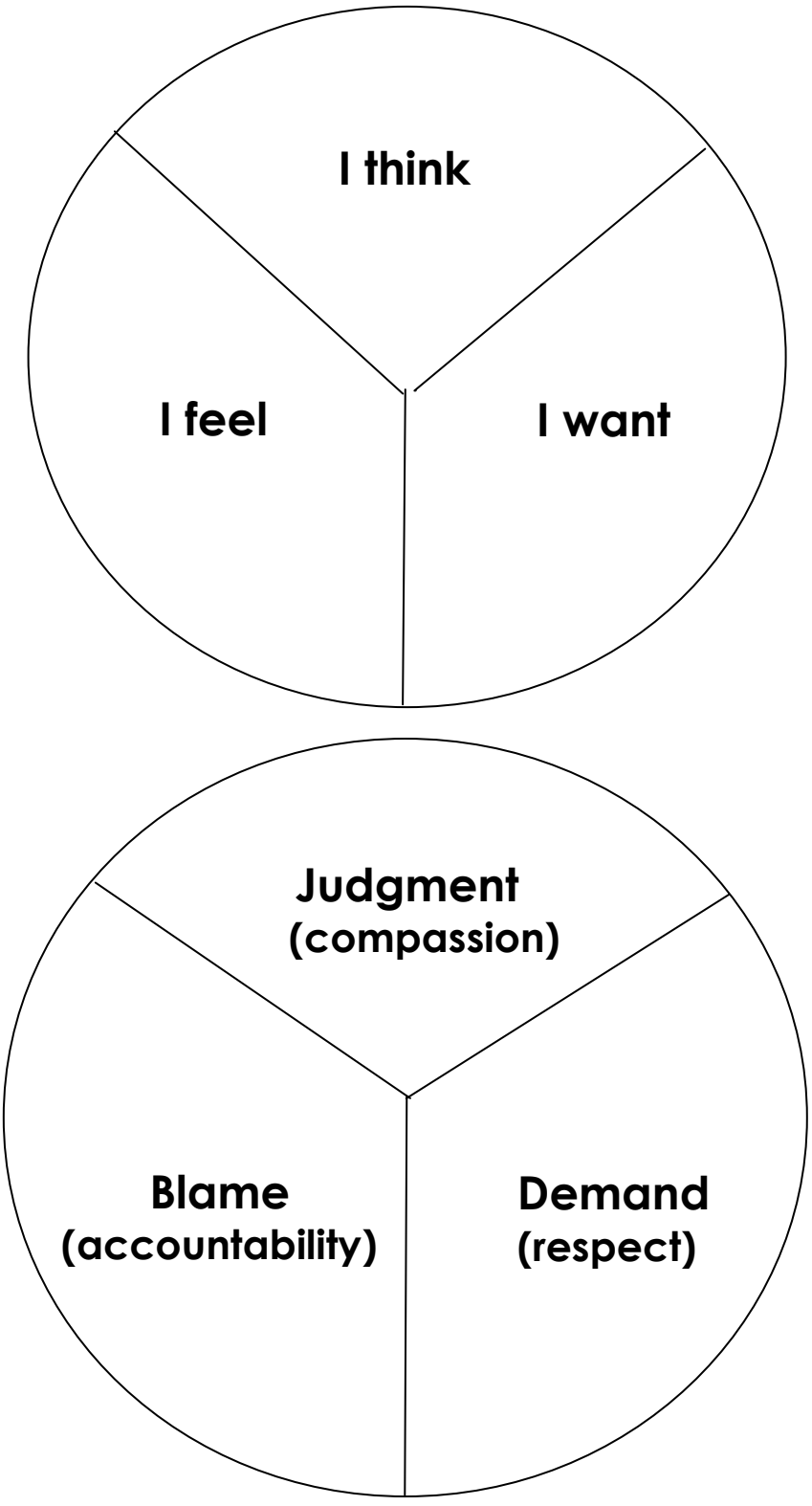
examples

Feel ⇒ _____ _____

Think ⇒ _____ _____

Want ⇒ _____ _____

Differentiation: Clarifying Internal Drivers



Communication Practice Session

identify feelings or sensations
I'm feeling

_____

_____

_____

_____

refer to your perspective of the situation, check assumptions
I think

_____

_____

_____

_____

_____

identify what you want from the relationship or situation
I want

_____

_____

_____

_____

How I'd like to work together is

_____

_____

_____

_____

_____

Communication Practice Session

identify feelings or sensations
I'm feeling

_____

_____

_____

_____

refer to your perspective of the situation, check assumptions
I think

_____

_____

_____

_____

_____

identify what you want from the relationship or situation
I want

_____

_____

_____

_____

How I'd like to work together is

_____

_____

_____

_____

_____

Feeling Descriptions

afraid
agitated
aggravated
alarmed
alienated
alone
angry
anxious
apathetic
appreciated
ashamed
attacked
awkward
bewildered
blamed
blamey
blank
burned-out
calm
caring
closed
cold
comfortable
committed
compassionate
competent
complete
concerned
confident
conflicted
confused
connected
considered
contented
controlled
creative
curious
cut-off
cynical
touchy
trusting
unappreciated
uncomfortable
unconsidered
understood
unresponsive
unsure
defeated
defensive
dejected
dependent
depressed
deprived
desperate
disappointed
disrespected
doubtful
eager
easy
embarrassed
engaged
envious
evasive
excited
excluded
exhilarated
fearful
foggy
friendly
frustrated
full
furious
generous
genuine
gentle
glad
grateful
guilty
helpless
hopeful
hopeless
hostile
humiliated
hurried
hurt
ignored
uptight
useless
victimized
vindictive
violent
washed-up
wishy washy
worn out
immobilized
impatient
inadequate
incompetent
indecisive
ineffective
inhibited
insecure
involved
isolated
jealous
judgmental
left out
lonely
lost
mean
misunderstood
nervous
numb
open
optimistic
overwhelmed
out of control
pain
paralyzed
paranoid
passionate
peaceful
persecuted
pessimistic
playful
pleased possessive
preoccupied
pressed
pressured
protective
proud
pushed
pushed-out
quiet
regretful
rejected
relieved
remorseful
repelled
repulsed
resentful
resentment
resigned
respected
restrained
rigid
sad
scared scattered
secure
set-up
self-reliant
shy
silly
sincere
sleepy
sluggish
sorry
stiff
stubborn
stupid
supported
supportive
suspicious
sympathetic
tender
terrified
threatened
tired
torn
worried

Confrontation Skills Worksheet

Set the Climate and State Your Case

What will you say in this step?

- _____
- _____
- _____
- _____

Listen for Understanding

What are you likely to hear from the other person? Topics, tone, emotion.

- _____
- _____
- _____
- _____

Negotiate and Make Agreements

What is the new behaviors you want form the other person? What are some options for agreements between the two of you?

- _____
- _____
- _____
- _____

How to Confront Effectively

Definition of Confrontation

1. Direct Communication
2. Face to face communication
3. Focus on a specific problem.
4. Confrontation can be high intensity or low intensity.
5. Two-part goal for successful confrontation:
   a. Produce the desired behavior change.
   b. Maintain productive relationship.

Guidelines for When Confrontation is Appropriate

Don't Confront:

Who: External Customers

When: You are angry or out of control.

The personal risk is too high.

Do Confront:

Who: Colleagues and personal relationships

When: Quality of work is the issue.

Relationship will be damaged if not confronted.

Personal quirks – less important but still legitimate.

Confrontation Steps

Set the Climate and State Your Case

Ask for time.

State your intentions.

State your concerns or reservations.

Own your responsibility.

Describe the behavior being confronted.

State the impact of the behavior (thoughts and feelings).

Listen for Understanding

Give 100% attention.

Demonstrate understanding.

Negotiate and Make Agreements

Make specific personal requests.

Offer help in the change.

Describe the positive/negative consequences.

State the agreements reached.

Establish a follow-up.

Share the appreciation.

More Tips on Handling Angry People

The behaviors suggested below are additional ideas for how to handle an angry person who is yelling, threatening, or having a full blown temper tantrum. There is no one right way to handle these situations. It depends on the situation, your own personality, and the personality of the other person. Look over this list and pick out the ideas that might work for you.

1. Stay matter of fact and neutral in tone. Never respond to hostile comments with a hostile remark of your own.

2. Responding to hostile comments:

Apologize to the person. Not a personal apology such as "It's all my fault." A more neutral, ***professional apology***, "I'm sorry we're having difficulty agreeing on this issue" or "I'm sorry you're upset."

3. Do not focus on their wrongness. Focus on a solution or an agreed understanding of the problem. Give the other person a way to save face.

4. Keep the discussion tentative.

- Raise questions
- Mention other possibilities
- Suggest ways to give both of you time to think

5. Avoid your own dogmatic statements. Stay flexible. Try temporary arrangements, especially if the problem is temporary.

- Yelling, screaming, and physical gestures. The words often contain threats and are not always coherent or logical.
- This tactic is usually unpredictable even to the person who uses it.

6. Let the other person run down for a while. How long you have often depends on the situation and how much time you have.

7. Get the other person's attention. Speak loudly, but do not use an angry tone. Use phrases such as:

"Stop, stop" "Hold on"

"Wait a minute" "Slow down"

"Ok, I understand"

8. State your intention to solve the problem. "I can see this is important to you and I'm willing to discuss it. But not this way."

9. Be prepared to repeat yourself*, but do not use an angry tone in the repetition.*

10. Take a break. Give the other person a chance to calm down. Move to a different location.

11. If you continue talking, *keep pulling the conversation back to specific, current issues.* Move the focus away from "never" and "always" statements and concentrate on what actually happened today.

12. Take the other person's either/or statement and turn it into multiple choice options. Try to come up with several options that might at least be partially acceptable to the other party. Make one of the options totally unacceptable to them.

13. Walk out. Only do this if you are in physical danger or are losing control of yourself. It is usually not a powerful move to make.

14. Respond with calm silence. This kind of silence equates with power in our culture. Offer to postpone the conversation until the other person calms down.

Notes:

Notes:

Notes:

Notes:

❑ 1. Diversity in the Clinical Group

Notes:

- Victoria Baker, PhD, CNM, CPH*
  *Certified in Public Health

❑ 2. SESSION PLAN

- Diversity's Value
- Campinha-Bacote's model
- Using the Model in Patient Care
- Using the Model in Clinical Groups
- Final Questions

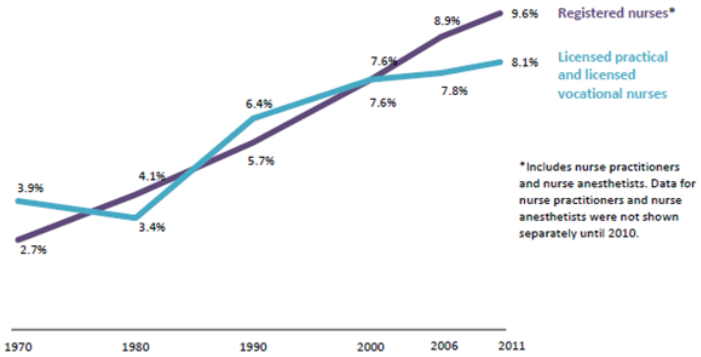
❑ 3. DIVERSITY'S VALUE

- National Context
  - ◊ Changing population demographics
  - ◊ Lag in nursing workforce demographics
- National Need for More Diversity in Nursing
- Think globally. Act locally.
- Broad concept

❑ 4. MEN IN NURSING

Notes:

Figure 1. Percentage of Nurses Who Are Men From 1970 to 2011



Source: U.S. Census Bureau, 1970 Decennial Census, 1980, 1990, and 2000 Equal Employment Opportunity Tabulation, and 2006 and 2011 American Community Survey

Figure 2. Male Median Earnings by Percent Male in Nursing Occupations: 2011

Source: U.S. Census Bureau, 2011 1-year American Community Survey
Note: Nurse midwives are excluded due to a small number of sample observations.

❑ 5. CULTURAL COMPETENCE vs. Cultural Humility

Notes:

- (Tervalon & Murray-García, 1998)

❑ 6. MODEL: PROCESS OF CULTURAL COMPETENCE IN THE DELIVERY OF HEALTHCARE SERVICES

- Cultural Desire
- Cultural Awareness
- Cultural Knowledge
- Cultural Skill
- Cultural Encounter

(Campinha-Bacote, 2002)

❑ 7. TEACHING CULTURAL DESIRE

Notes:

- *Activites*
  - ◊ Personal Stories
  - ◊ Social Determinants of Health
  - ◊ Health equity
  - ◊ Racism
- *Modeling*
  - ◊ Stories
  - ◊ Self Reflection
- *Structure*
  - ◊ Credit

❑ 8. TEACHING CULTURAL AWARENESS

- *Activites*
  - ◊ Cultural Assessments
  - ◊ Discussions of case scenarios
  - ◊ Journals
- *Modeling*
  - ◊ Self Reflection
- *Structure*
  - ◊ Cases
  - ◊ Evaluations
  - ◊ Safety

❑ 9. TEACHING CULTURAL AWARENESS

Notes:

- Example: To a Non-Muslim Woman

❑ 10. TEACHING CULTURAL KNOWLEDGE

- *Activites*
  - ◊ Alternative healing practices
  - ◊ Community Events
  - ◊ Cases
- *Modeling*
  - ◊ Cultural Implications
  - ◊ Demeanor re: differences
- *Structure*
  - ◊ Evalutaion
  - ◊ Safety

❑ 11. TEACHING CULTURAL SKILL

Notes:

- *Activites*
  - ◊ Protocols and care plans
  - ◊ Cultural assessments
  - ◊ Practice with interpreters
  - ◊ Finding resources
  - ◊ Cases
- *Modeling*
  - ◊ Know these skills yourself
- *Structure*
  - ◊ Evaluation

.

❑ 12. TEACHING CULTURAL SKILL

Cultural Assessment Exercise

1. Use a toll to assess a classmate.
2. Answer these questions.
   - ◊ Could this be administered on your unit?
   - ◊ Does it get you the information you want?

❑ 13. APPLYING IT TO CULTURAL ENCOUNTERS

Notes:

- Post clinical debriefs
- Cases
- And all the other examples

❑ 14. USING THE MODEL TO TEACH: MODELING

- Stories
- Demeanor
- Values
- Science

❑ 15. USING THE MODEL TO TEACH: STRUCTURING THE GROUP

- Expectations
- Assess Your Students
- Discussions
- Evaluation
- Conflict

❑ 16. CLINICAL GROUP MANAGEMENT: CONFLICT

Notes:

- Accommodation (bosses)
- Avoidance (bar room brawl)
- Collaboration (team projects)
- Competition (debates)
- Compromise (legislation)

(Cavenaugh, 1991)

❑ 17. LESSONS LEARNED

- Address the topic directly
- Apply the model & cultural humility to interactions with both patients and students
- Teach it consistently, in every case, and in many ways.
- Model what you want to see
- Structure the groups carefully

❑ 18. MORE QUESTIONS

Victoria Baker, PhD, CNM, CPH*
Baker's Dozen Consulting
Frontier Nursing University
303-704-2168
malinche@wildblue.net
*Certified in Public Health

❑ 1. Early & Often

Notes:

Documenting Student Progress

Marianne Horner, MS, RN, CNM

Colorado Center of Nursing Excellence

❑ 2. This is a discipline/ skill to develop— observation

❑ 3. Student achievement is judged against specific standards or criteria

- Apply the same standards to all students

❑ 4. Key Point in documenting student progress

- Be attentive
- Observe and record completion of tasks
- Remember, there is so much more to attend to!

Notes:

- [ ] **5. When briefing & de-briefing tasks...**

  - What are the safety concerns?
  - How did the patient perceive what was happening?
    - ◊ Was it painful?
    - ◊ Were they frightened?
    - ◊ Did they feel better because of the intervention?

- [ ] **6. Document interactions that demonstrate emerging clinical judgment**

  - Keep brief notes during the day to allow accurate recording later
  - Build in time to make your notes AND do it as soon as possible after the clinical experience

- [ ] **7. JUST DO IT!**

Notes:

❑ 8. Anecdotal Notes are Formative Evaluation

- Always record date / time
- Contextual information
- Possessing clarity

❑ 9. Objectivity is Critical

- Write only what you are willing to have the student read
- Other parties may have occasion to examine your note

❑ 10. As Sergeant Friday would say...

❑ 11. When shall we begin?.

Notes:

❑ 12. Let's practice...

- Remember our clinical group?.

❑ 13. Practice...

- Here is Emily Day….
- You are her Clinical Scholar observing this interaction
- Write an anecdotal note

❑ 14. Guard Confidentiality

- How?

❑ 15. What to do with notes at the end of the rotation?

- Recommendation is to turn them in with your completed evaluation forms

- ❑ **16. Anecdotal Note + Anecdotal Note + Anecdotal Note = Compilation into Summative Evaluation Tool**

Notes:

- ❑ **17. No Surprises!**

- ❑ **18. A+**

Notes:

❑ 1. Grading Written Assignments: The Challenge for New Clinical Faculty

Notes:

Marianne Horner MS, RN, CNM

Colorado Center for Nursing Excellence

❑ 2. Grading a Care Plan

- Why do we do care plans?

❑ 3. Care Maps/Mind-Mapping

- A visual of critical thinking
- Beyond the "linear", traditional care plans
- Students have to explain their map
- Cannot "grade" mind maps
- Do need to include the nursing process
- Interactive dialogue with student
- (see handout)

.

❑ 4. Mini Map Example

- (see handout)

❑ 5. Grading a Paper

Notes:

- 6th edition APA manual
- http://www.apastyle.org

❑ 6. Process for Grading Written Assignments

- Review guidelines and rubric with students at orientation
- Focus on PURPOSE of assignment
- De-identify papers, read in random order

❑ 7. Process, continued

- First reading:

  – Scan for common strengths / concerns

  – Adjust expectations if needed

  – Keep preliminary marking to a minimum

❑ 8. Process, continued

Notes:

- Second reading

  – Apply rubric

  – Provide comments / feedback

  – Identify strengths, offer encouragement

  – Be specific re. point deductions

❑ 9. Additional Considerations

- Interrater Reliability – trade papers to grade
- Seek input from course coordinator
- Have second blind reading for a paper of concern

❑ 10. Additional Considerations

- What about plagiarism?

  – Turnitin.com

  – Plagiarsm.org

- Color of writing instrument
- Okay to submit for early reading?

❑ 11. Technology Support

Notes:

- iAnnotate app to "hand grade"

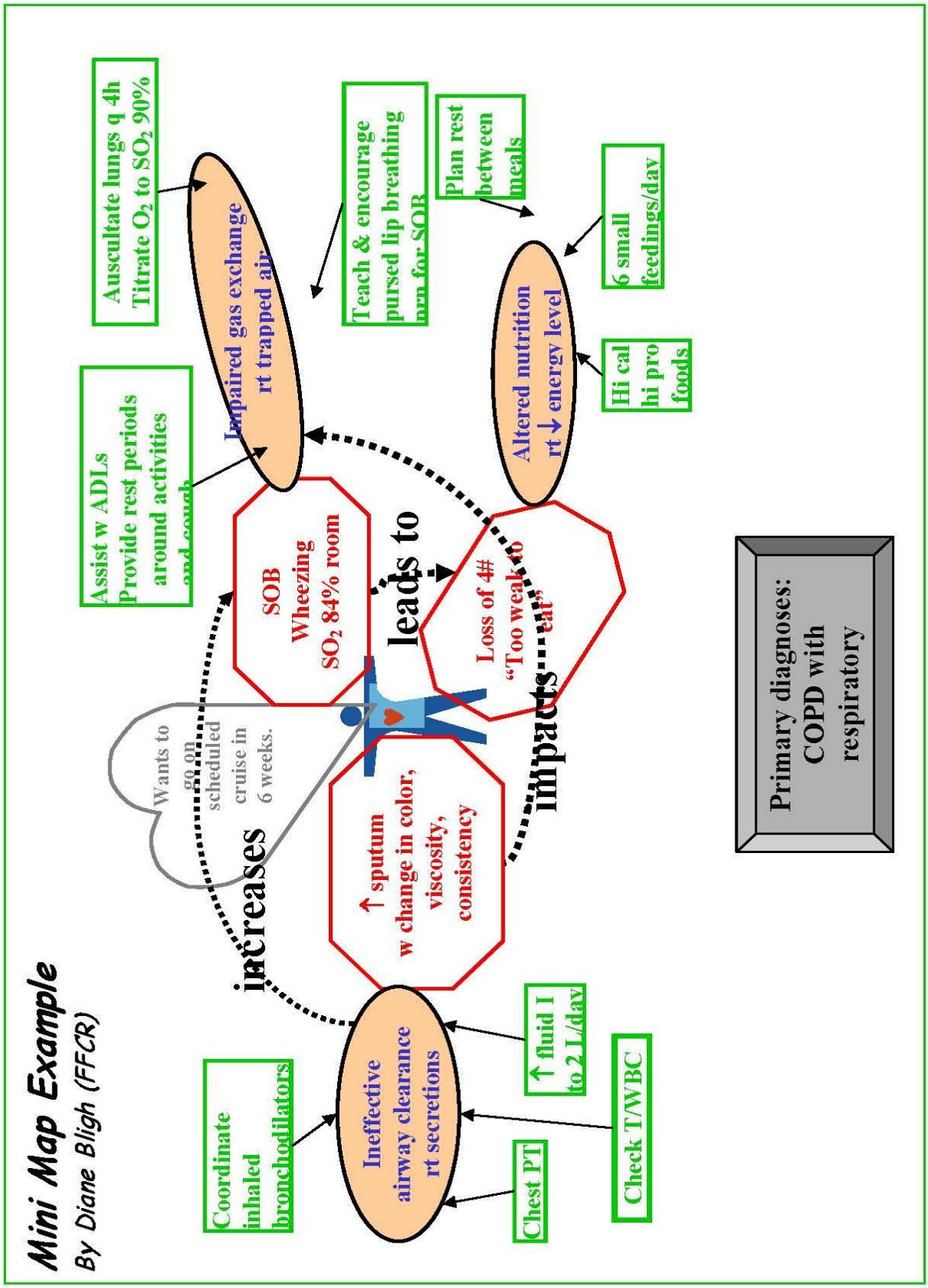
  – iAnnotate for grading papers - http://www.youtube.com/watch?v=sxOP9s7ZcZY

  – Branchfire.com/iannotate/

❑ 12. Technology Support

- Quickoffice Pro for papers and clinical evaluations

- Also university electronic platform such as Blackboard; Ecollege, etc.


Mini Map Example
By Diane Bligh (FFCR)
Primary diagnoses: COPD with respiratory
Impaired gas exchange rt trapped air
Auscultate lungs q 4h
Titrate O2 to SO2 90%
Assist w ADLs
Provide rest periods
around activities
and cough
Teach & encourage
pursed lip breathing
hen for SOB
Plan rest
between
meals
Altered nutrition
rt ↓ energy level
6 small
feedings/day
Hi cal
hi pro
foods
SOB
Wheezing
SO2 84% room
leads to
Loss of 4#
"Too weak to
eat"
impacts
Wants to
go on
scheduled
cruise in
6 weeks.
increases
↑ sputum
w change in color,
viscosity,
consistency
Ineffective
airway clearance
rt secretions
Coordinate
inhaled
bronchodilators
↑ fluid I
to 2 L/day
Chest PT
Check T/WBC

Evaluating or Creating Learning? MIND MAPPING/CARE MAPPING
By Diane Bligh (FRCC)

- Can't use previous methods: taking home and marking with red ink
- Must understand student's thinking.
- Interactive dialogue MUST occur between the instructor and the student.

Questions to ask: These are questions used to determine if the care plan includes all of the required elements

- Does it include ALL pieces of the nursing process?
- Is patient at center?
- Is assessment data present? Accurate?
- Do nursing diagnoses relate to Sx?
- Are your nursing goals clear?
- Is the patient's goal included?
- Are nursing actions appropriate?
  - —How will they impact the nursing Dx?
  - —What effect will they have on the goals?
- What teaching did you include?
  - —Discharge planning?
- Were you able to evaluate your interventions?
- Are there interconnections between problems? What was your thinking in making your interconnections?
- What have you gained from writing this map?

Shared Learning... Having students share their maps and explain them to their peers is SO powerful in terms of individual and group learning.

- Students share mind maps in pre or post-conference.
- Students explain rationale for their thinking.
- Faculty ask if classmates could give appropriate patient care by following map.
- Fellow classmates:
  - —make comments, ask questions
  - —explain how they might make different connections
  - —give positive feedback and support

Notes:

❑ 1. Innovations in Nursing Education

Marianne Druva Horner, MS, RN, CNM

Colorado Center for Nursing Excellence

❑ 2. Mr. Holland's Opus

❑ 3. "Did You Know" + nursing education as we know it = ???

❑ 4. Let's look at our history….

- Why?
- Why?
- Why?

❑ 5. Photo Slide

❑ 6. How is health care changing?

Notes:

❑ 7. Carnegie Foundation for the Advancement of Teaching

- Educating Nurses: A Call for Radical Transformation
- Patricia Benner, et al.

❑ 8. Photo Slide

- From Lisa Mikluch, Gonzaga University
- RMNE Conference 2012

❑ 9. Patient Safety and Quality

- We say that we've always been concerned about safety, but what is the reality?

❑ 10. Photo Slide

❑ 11. Paradigm shift: What can we do?

Notes:

1. Incorporate QSEN throughout
2. From pathology / medical model
3. From heavy emphasis on acute care to more community based
4. Use unfolding case studies
5. Tie content together – demonstrate connections between concepts and facts

- A Work in Progress...

❑ 12. How To Vote via Texting

1. Standard texting rates only (worst case US $0.20)
2. We have no access to your phone number
3. Capitalization doesn't matter, but spaces and spelling do

❑ 13. Poll Results

❑ 14. Other Resources

Notes:

- http://prezi.com
- http://www.pecha-kucha.org/what (wordless PP)
- http://www.pixton (30 day free trial – comics)
- http://www.polleverywhere.com (free)
- http://pbwiki.com or http://wikispaces.com
- http://www.xtranormal.com (free to make animated movies)
- From Morris, K (2012) Living Lectures: Alternatives to Power Points webinar

❑ 15. What is Team Based Learning?

- Larry Michaelsen
- http://www.teambasedlearning.org/vid

❑ 1. Interprofessional Communication: Clarity and Teamwork— The Key to Patient Safety

Notes:

Diann McCallister, MD, MBA

Chief Medical Officer,

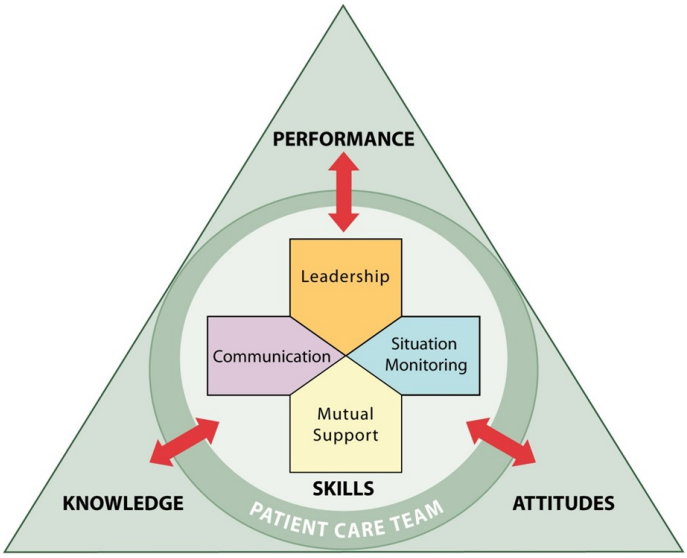
The Medical Center of Aurora

Marianne Horner, MS, RN, CNM

Project Director

Colorado Center for Nursing Excellence

❑ 2. Team Strategies & Tools to Enhance Performance and Patient Safety



❑ 3. Communication & Teamwork

Notes:

- 90-98% of errors in the hospital have communication as a major causal factor
- The airline industry has reduced crew caused errors to 0 by use of communication/ teamwork training
- JCAHO now considers communication failures a sentinel event – rude style AND/ OR failing to speak up

❑ 4. Communication Overload and Assumptions

- Does this seem familiar?

❑ 5. Video Clip

Notes:

- ❑ **6. How much can one mind hold?**

  - The law of 7s.

- ❑ **7. Video Clip**

- ❑ **8. Olny srmat poelpe can raed tihs. I cdnuolt blveiee taht I cluod aula-clty uesdnatnrd waht I was rdanieg. The phaonmneal pweor of the hmuan mnid, aoccdrnig to a rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, the olny iprmoatnt tihng is taht the frist and lsat ltteer be in the rghit pclae. The rset can be a taotl mses and you can sitll raed it wouthit a porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe. Amzanig huh? yaeh and I awlyas tghuhot slpeling was ipmorantt!**

- ❑ **9. Human Factors: How Our Brain's Wiring Can Contribute to Errors**

  - Physician's Differential Diagnosis— can create a knowledge-based error

  - This type of logic has

    —30% chance of error

    — 30% chance of not detecting an error was made

Notes:

❑ 10. Medical Training Addresses These Errors

- Tactics utilized to minimize errors in diagnosis
- Structured problem solving – same information in same order every time – (might look rigid to others)
- Identify all possibilities and then identify the right answer based on facts

❑ 11. Let's Talk about SBAR...

❑ 12. Sue Sheridan

Notes:

Notes:

❑ 1. Auditory, Visual and Kinesthetic Learning

Notes:

❑ 2. Learning preferences

- One or two of these receiving styles is normally dominant. This dominant style defines the preferred way for a person to learn new information

❑ 3. Auditory Learners

- Process new information best when it is spoken
- Lectures
- Discussions
- "I hear you"

❑ 4. Visual Learners

- Process new information best when it is visually illustrated or demonstrated
  See things in pictures
- Graphics
- Images
- Illustrations
- Demonstrations
- "I see what you are saying"

❑ 5. Kinesthetic Learners

Notes:

- Process new information best when it can be touched or manipulated
- Written assignments
- Taking notes
- Examination of objects
- Interactive
- "I feel you"

❑ 6. Blended Learning

❑ 1. Clinical Scholar Workshop: Legal and Ethical Issues in Nursing Education

Notes:

Linda Stroup, PhD, RN

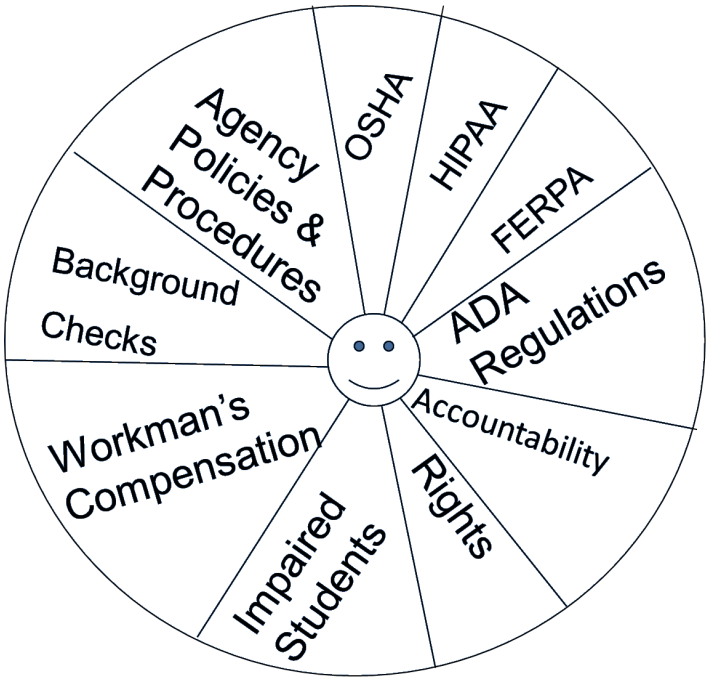
Chair, Department of Nursing

Metropolitan State University of Denver

❑ 2. Objectives

- Discuss selected legal information that guides the clinical scholar role.
- Discuss selected ethical issues that can occur in the clinical setting with nursing students.
- Identify at least three resources that are available to clinical scholars related to legal and ethical issues in the clinical setting.

❑ 3.

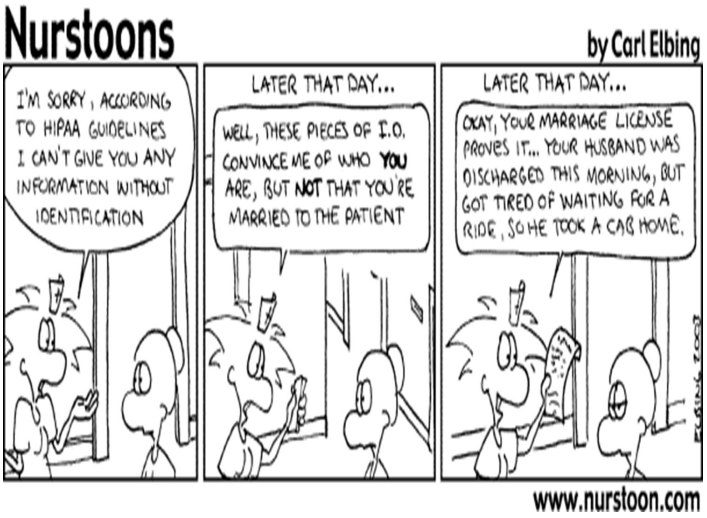


Notes:

❑ 4. HIPAA Humor

- Knock, knock
- Who's there?
- HIPAA
- HIPAA who?
- Sorry, I'm not allowed to disclose that information.

❑ 5.



❑ 6. HIPAA

- Health Insurance Portability and Accountability Act
- Alliance for Clinical Education (ACE) approved test
- Agency specific
- What issues do you see related to HIPAA and nursing students?

❑ 7. OSHA

Notes:

- Schools responsible for education and testing
- Alliance for Clinical Education protocols
- Agencies may have additional requirements

❑ 8. Background Checks

- In compliance with Joint Commission requirements, all students are required to have background checks
- Responsibility of nursing schools
- On file prior to clinical rotations

❑ 9. Family Educational Rights and Privacy Act (FERPA)

- The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education
- Enacted in 1974

❑ 10. FERPA

Notes:

- FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."

❑ 11. FERPA

- Provide parent/eligible student an opportunity to seek correction of records he/she believes to be inaccurate or misleading

- Parent or eligible students have the right to inspect and review the student's education records maintained by the school

❑ 12. FERPA

- Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):

- School officials with legitimate educational interest;

- Other schools to which a student is transferring;

- Specified officials for audit or evaluation purposes

❑ 13. FERPA

Notes:

- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.

❑ 14. FERPA

- The following items are not considered educational records under FERPA:
  - ◊ Private notes of individual staff or faculty, (NOT kept in students' advising folders)
  - ◊ Campus police records
  - ◊ Medical Records
  - ◊ Statistical data compilations that contain no mention of personally identifiable information about any specific student

❑ 15. Written Consent

Notes:

- Required before agency can disclose non-directory information
- Specify records to be disclosed
- Purpose of disclosure
- Identify party records to whom records disclosed
- Date and signature of student whose record is being shared

❑ 16. Title II of the Americans with Disabilities Act of 1990

- Prohibits discrimination by any school that receives federal funds (Section 504 of the Rehabilitation Act)
- Learner has the primary responsibility for identifying and documenting disability and requesting specific supports, services, and other accommodations to meet needs

❑ 17. ADA

Notes:

- Offices for Students with Disabilities processes requests for accommodations
- School may ask for reasonable medical documentation
- Learner is very stable on medication, or is using a prosthetic, and is not currently substantially limited in a major life activity, that person is not "disabled" under the ADA or Section 504

❑ 18. ADA

- Qualified students with disabilities may also obtain reasonable accommodations so that they can participate in school programs –may not be unduly costly or disruptive for the school, or be for the learner's personal use only

❑ 19. ADA

- Some key points:

Any accommodations should be arranged before a student comes to the clinical setting – shouldn't be a surprise to clinical scholar/faculty

If a student self-discloses, immediately refer back to school

Minimum functional abilities

❑ 20. Student Handbooks

Notes:

- Each college has a student handbook containing specific information related to:

  Workman's compensation

  Needle stick injuries

  Impaired students

  Grievances

❑ 21. Workman's Compensation

- Students are usually covered by the college in the clinical area
- College has specific agencies, clinics, providers that must be used
- Established time lines very important
- Needle stick or other injury usually covered here

❑ 22. Impaired Students

- Identify source for college and agency policy
- Notify course facilitator/school immediately

❑ 23. Grievances

Notes:

- School policy defines policy and procedure

❑ 24. Colorado Nurse Practice Act

The Board of Nursing has been working to empower Colorado nurses to determine their own scope of practice. The Board's mission is the regulation of nursing practice in Colorado; this regulation does not mean dictating how individual nurses should carry out that practice, but whether or not the practice meets the standards established by the Nurse Practice Act.

❑ 25. Student Scope of Practice

- What must be considered ??
- If the RN scope is based on what was included in the completed nursing education program and additional knowledge/training

❑ 26. Student Scope of Practice

Notes:

- Begin by asking the following question: Is this task within my scope of practice?

- Basic Nursing Education Preparation

  –Has the skill/task been taught in the nursing program?

  –Is the skill/task in the course guidelines or previous course guidelines?

  –Is it allowable in <u>THIS</u> clinical setting by policy/procedure?

❑ 27. Clinical Agency Policies and Procedures

- Clinical scholars and students must follow agency policy

  –Example– Students may have been taught to administer meds via PICC line (which means it is in the scope of student practice) but the agency has a policy that prohibits this skill by students.

❑ 28. Patient Rights

Notes:

- Right to privacy
- Right of refusal

  –Care

  –Procedures

❑ 29. ANA Code of Ethics with Interpretive Statements

- Establishes the ethical standard for nursing profession
- Revised in Spring 2015
- Nine provisions:

  - First three describe fundamental values and commitments of the nurse

  -Next three address boundaries of duty and loyalty

  -Last three address aspects of duties beyond individual patient encounters

❑ 30. ANA Code of Ethics

Notes:

- Protection of patient rights and confidentiality
- Protection of patient health and safety by acting on questionable practice
- Patient protection and impaired practice

❑ 31. Selected Resources

- Colorado Nurse Practice Act
- ANA Standards of Practice
- ANA Code of Ethics
- Agency policy and procedures
- Student Scope of Practice
- Student Handbook

NCLEX Exam: Test Your Knowledge

1. The NCLEX is created by:
    a. The local State Board of Nursing
    b. The American Association of Colleges of Nursing (AACN)
    c. The National League for Nursing (NLN)
    d. The National Council of State Boards of Nursing (NCSBN)

2. A candidate's eligibility to take the NCLEX exam is determined by:
    a. The student's college or university
    b. The local State Board of Nursing
    c. AACN
    d. NCSBN

3. The cost of the NCLEX exam is:
    a. $120.00
    b. $150.00
    c. $200.00
    d. $250.00

4. Which of the following best describes the format of the NCLEX:
    a. It is a variable length adaptive test given by computer
    b. It is a 265 item computer exam
    c. It is a 75 item computer exam
    d. It is given by computer, orally or in paper and pencil format, depending on the student's learning needs.

5. The NCLEX exam must be completed within:
    a. 3 hours
    b. 4 hours
    c. 5 hours
    d. 6 hours

6. If a student fails the NCLEX on the first try, he/she is likely to get extra help and pass on the second attempt.
    a. True
    b. False

7. NCLEX questions are in a multiple choice format.
    a. True
    b. False

8. Results are received
    a. Immediately upon completion of the exam at the testing center
    b. By mail within two weeks of the exam
    c. By mail within 4-6 weeks of taking the exam
    d. By phone within a few days of testing

9. What percentage of US born BS-prepared nurses pass NCLEX on their first attempt?
    a. 58%
    b. 78%
    c. 86%
    d. 98%

10. The most important component in determining likelihood of success on the NCLEX exam is:
    a. Knowledge of pathophysiology
    b. Quality clinical experience in medical/surgical nursing
    c. Knowledge of nursing process
    d. Critical thinking ability

Notes:

❑ 1. Helping Students Prepare for NCLEX-RN Exam

Marianne Horner, MS, RN, CNM
Project Director
Colorado Center for Nursing Excellence

Teresa Connolly, RN, PhD

❑ 2.

❑ 3. Why is NCLEX content included in the Clinical Scholar content?

❑ 4. Why?

- License to practice dependent on passing NCLEX
- Great way to assess student's thought processes/ critical thinking.
- Good review of content relevant to patient prior to student caring for given client.
- Help student develop NCLEX practice patterns

❑ 5. Objective

Notes:

- Discuss clinical and it's relationship to NCLEX

  –Adult Learners like clear applicability

  –Opportunities for NCLEX utilization

  –About the test…

❑ 6. The NCLEX is created by:

- National Council of State Boards of Nursing in order to:

  –Determine if a student is ready to be a safe and effective nurse.

  –Safeguard the public.

  –Test for minimum competency.

- Questions are based on the knowledge and activities of an ***entry level nurse***

❑ 7. A candidate's eligibility to take the NCLEX exam is determined by:

- After the state board of nursing declares a candidate eligible, they will receive an Authorization to Test

- Security at the test site by Palm Vein Technology and digital fingerprinting

Notes:

❑ 8. The cost of the NCLEX exam is:

- $200 each attempt
- Only 3 attempts allowed
- And there is a 45 day waiting period between attempts

❑ 9. Which of the following best describes the format of the NCLEX:

- It is a variable length, adaptive test, given by computer
- Computer adaptive test

  –Variable number of questions

  - 75 - 265

  –Can't go back and change an answer

  –Can't skip questions

  –Up to 6 hours to complete

❑ 10. Types of questions

- Multiple choice
- Multiple response
- Drag and Drop
- Hot spot
- Sequencing/Prioritization
- Auditory (breath sounds, heart sounds)
- Video
- Graphic item (graphic choices as answers)

❑ 11. Types of Questions

Notes:

- Chart/exhibit questions

  –Display a client's chart showing 3 tabs that the candidate would need to click on and read the information in order to answer the question.

  –Tabs could include any of the following:

  - prescriptions,
  - history and physical,
  - lab results,
  - miscellaneous reports,
  - imaging results (e.g. chest x-ray, etc.),
  - flow sheets,
  - medication administration record,
  - progress notes,
  - vital signs

❑ 12. Passing the Exam

- The NCSBN Board of Directors determined that

  –safe and effective entry-level RN practice requires a greater level of knowledge, skills, and abilities than was required in 2007, when NCSBN implemented the current standard.

  –The new passing standard is 0 logits on the NCLEX-RN logistic scale, 0.16 logits higher than the previous standard of -0.16.

  –The new passing standard took effect on April 1, 2013, and is the standard until 2016

Notes:

❑ 13. Pass Rates:

- First time: 83% (US Born)
- Repeat takers: 48% (US Born)
- And….it doesn't necessarily mean that if a student fails the NCLEX on the first try, he/she is likely to get extra help and pass on the second attempt.

❑ 14. Pass Rates

- Data is posted on the State of Colorado Board of Nursing website regarding pass rates categorized by school & by year
- http://www.dora.state.co.us/nursing/education/RN-PassRates.pdf

❑ 15. Results are received:

- By mail within 4-6 weeks of taking the exam
- Or non-official e-mail notification with nominal fee

❑ 16. The most important component in determining likelihood of success on the NCLEX exam is:

- Students who perform well on critical thinking assessments, do well on NCLEX and visa versa.
- (Giddens, J. (2002). The relationship of critical thinking to performance on the NCLEX-RN. Doctoral dissertation, Colorado State University.)

❑ 17. How Do I Teach Critical Thinking?

Notes:

- This all goes back to your skills in asking the right questions!

- Am I designing my instruction so that students have to think through the purpose of what they are doing?

❑ 18. How Do I Teach Critical Thinking?

- Am I designing instruction so that students are knowledgeable about accessing the information they need to learn?

  –Am I holding them responsible for prerequisite information?

  –Am I encouraging them to use sources other than the textbook?

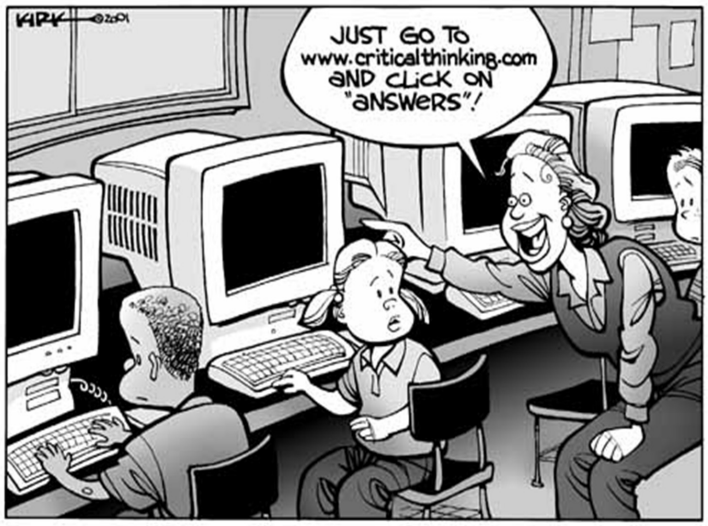
❑ 19. How Do I Teach Critical Thinking?

- Am I designing my instruction so that students learn the criteria they need to assess their own thinking?

- Am I helping students to apply knowledge gained in one clinical experience to other situations?

❑ **20.**

Notes:



❑ **21. Topics**

- Client Needs

  –Safe and Effective Care Environment

  •Management of Care 17-23%

  •Safety and Infection Control 9-15%

  –Health Promotion and Maintenance 6-12%

  –Psychosocial Integrity 6-12%

  –Physiological Integrity

  •Basic Care and Comfort 6-12%

  •Pharmacological and Parenteral Therapies 12-18%

  •Reduction of Risk Potential 9-15%

  •Physiologic Adaptation 11-17%

❑ 22. Topics — But wait, there's more!

Notes:

- Integrated Processes: integrated throughout the Client Needs categories and subcategories

  –Nursing Process

  – Caring

  –Communication and

  –Teaching/Learning

❑ 23. Whew!

- And we wonder why students are anxious about this process?

NCLEX Review—Pediatrics

1. A 4-day old newborn infant is receiving phototherapy at home for a bilirubin level of 14 mg/dL. The nurse should plan to include which of the following in the plan of care during the home visit to the mother of the newborn infant?

   a. Having minimal contact with the newborn infant to prevent stimulation.
   b. Advising the mother to limit newborn infant oral intake during phototherapy
   c. Applying lotions to exposed newborn infant's skin
   d. Assessing skin integrity and fluid and electrolyte status of the newborn infant.

2. A nurse is caring for a post-term, small for gestational age newborn infant immediately after admission to the nursery. The priority nursing action would be to monitor the results of what serum laboratory study?
   a. _____

3. The mother of a 4-year old child calls the clinic nurse and expresses concern because the child has been masturbating. The most appropriate response by the nurse is which of the following?

   a. "The child is very young to begin this behavior and should be brought to the clinic."
   b. "This is not normal behavior, and the child should be seen by the physician."
   c. "This is a normal behavior at this age."
   d. "Children usually begin this behavior at age 8 years."

4. A clinic nurse provides information to the mother of a toddler regarding toilet training. Which statement, if made by the mother, indicates a need for further information regarding the toilet training?

   a. "The child will not be ready to toilet train until the age of about 18 to 24 months."
   b. "Bladder control usually is achieved before bowel control."
   c. "The child should not be forced to sit on the potty for long periods."
   d. "The ability of the child to remove clothing is a sign of physical readiness."

5. A nurse is preparing to care for a child after a tonsillectomy. The nurse documents on the plan of care to place the child in which most appropriate position?

   a. Supine
   b. Trendelenburg's
   c. Side lying
   d. High Fowler's

6. An emergency room nurse is caring for a child diagnosed with epiglottitis. Assessing the child, the nurse monitors for which indication that the child may be experiencing airway obstruction?

   a. The child is leaning backward, supporting himself with the hands and arms
   b. The child has a low-grade fever and complains of a sore throat
   c. The child is leaning forward with the chin thrust out
   d. The child exhibits nasal flaring and bradycardia.

7. A nurse is reviewing the physician's orders for a child who was just admitted to the hospital with a diagnosis of Kawasaki disease. The nurse expects to note an order for which of the following as a part of the treatment plan?

   a. Morphine sulfate
   b. Immune globulin
   c. Heparin infusion
   d. Digoxin (Lanoxin)

8. A clinic nurse reviews the record of a 3-week-old infant and notes that the physician has documented a diagnosis of suspected Hirschsprung's disease. The nurse reviews the assessment findings documented in the record, knowing that which symptom most likely led the mother to seek health care for the infant?

   a. Diarrhea
   b. Projectile vomiting
   c. Regurgitation of feedings
   d. Foul-smelling ribbonlike stools

9. A physician orders intravenously administered potassium for a child with hypertonic dehydration. A nurse performs which priority assessment before administering the potassium?

   a. Taking the temperature
   b. Taking the blood pressure
   c. Obtaining a weight
   d. Checking the amount of urine output

10. A clinic nurse reviews the record of a child just seen by a physician. The physician has documented a diagnosis of suspected aortic stenosis. The nurse expects to note documentation of which of the following clinical manifestations specifically found in this disorder?
    a. Hyperactivity
    b. Exercise intolerance
    c. Pallor
    d. Gastrointestinal disturbances

D, glucose, c, b, c, c, b, d, d, b

NCLEX Review: Women's Health

1. A nurse in a health care clinic is instructing a pregnant woman in how to perform "kick counts". Which statement by the woman indicates a need for further instructions?

    a. "I should place my hands on the largest part of my abdomen and concentrate on the fetal movements to count the kicks."
    b. "I will record the number of movements or kicks."
    c. "I need to lie flat on my back to perform the procedure."
    d. "A count of fewer than 10 kicks in a 12-hour period indicates the need to contact the physician."

2. A physician has prescribed transvaginal ultrasonography for a woman in the first trimester of pregnancy and the woman asks the nurse about the procedure. The nurse accurately provides which of the following information to the client?

    a. The procedure takes about 2 hours
    b. Transmission gel is spread over the abdomen, and a transducer will be moved over the abdomen to obtain the picture.
    c. It will be necessary to drink 1 to 2 quarts of water before the examination
    d. The transvaginal probe encased in a disposable cover and coated with gel is inserted into the vagina.

3. A nurse in a maternity unit is reviewing the records of the clients on the unit. Which of the clients would the nurse identify as being at most risk for developing disseminated intravascular coagulation (DIC)?

    a. A gravida IV who delivered 8 hours ago and has lost 500 mL of blood
    b. A gravida II who has just been diagnosed with dead fetus syndrome
    c. A primigravida with mild preeclampsia
    d. A primigravida who delivered a 10-lb baby 3 hours ago

4. A pregnant woman reports to a health care clinic, complaining of loss of appetite, weight loss, and fatigue. Following assessment of the woman, tuberculosis is suspected. A sputum culture is obtained and identifies Mycobacterium tuberculosis. The nurse provides instructions to the mother regarding therapeutic management of the tuberculosis. The nurse tells the client that

    a. Medication will not be started until after delivery of the fetus.
    b. Isoniazid (INH) plus rifampin (Rifadin) will be required for a total of 9 months.
    c. The newborn infant will need to receive medication therapy immediately after birth.
    d. Therapeutic abortion is required.

5. A home care nurse is monitoring a pregnant client with pregnancy induced hypertension (PIH) who is at risk for preeclampsia. At each home care visit, the nurse assesses the client for which three classic signs of preeclampsia? _____

6. A nurse implements a teaching plan for a pregnant client who is newly diagnosed with gestational diabetes mellitus. Which statement, if made by the client, indicates a need for further education?

   a. "I need to stay on the diabetic diet."
   b. "I will need to perform glucose monitoring at home."
   c. "I need to avoid exercise because of the negative effects on insulin production."
   d. "I need to be aware of any infections and report signs of infection immediately to my health care provider."

7. A nurse assists in the vaginal delivery of a newborn infant. After the delivery, the nurse observes the umbilical cord lengthen and a spurt of blood from the vagina. The nurse documents these observations as signs of

   a. Hematoma
   b. Placenta previa
   c. Uterine atony
   d. Placental separation

8. A nurse is monitoring a client in labor who is receiving oxytocin (Pitocin) and notes that the client is experiencing hypertonic uterine contractions. List in order of priority the actions that the nurse takes. (Number 1 is the first action)

   _____Stop the oxytocin infusion
   _____Perform a vaginal examination
   _____Reposition the client
   ____Check the client's blood pressure and heart rate
   ____Administer oxygen by face mask at 8 to 10 L/min

9. A nurse is monitoring a new mother in the postpartum period for signs of hemorrhage. Which of the following signs, if noted in the mother, would be an early sign of excessive blood loss?
   a. A temperature of 100.4 degrees F.
   b. An increase in the pulse rate from 88 to 102 beats per minute
   c. An increase in the respiratory rate from 18 to 22 breaths/minute
   d. A blood pressure change from 130/88 to 124/80

10. A nurse is caring for a pregnant client with severe preeclampsia who is receiving magnesium sulfate intravenously. The nurse ensures that what medication, the antidote to magnesium sulfate, is in the client's room?
    a. _____

C, d, b, b, hypertension, proteinuria and generalized edema; c; d; 1,4,2,5,3; b, calcium gluconate

NCLEX Review—Medical Surgical Nursing

1. A nurse is reviewing laboratory results and notes that a client's serum sodium level is 150 mEq/L. The nurse reports the serum sodium level to the physician, and the physician prescribes dietary instructions based on the sodium level. Which food item does the nurse instruct the client to avoid?
   a. Low-fat yogurt
   b. Cauliflower
   c. Processed oat cereals
   d. Peas

2. A nurse is reviewing a client's laboratory reports and notes that the serum calcium level is 4.0 mg/dL. The nurse understands that which condition most likely caused this serum calcium level?
   a. Prolonged bed rest
   b. Excessive administration of vitamin D
   c. Renal insufficiency
   d. Hyperparathyroidism

3. A nurse plans care for a client with chronic obstructive pulmonary disease, knowing that the client is most likely to experience what type of acid-base imbalance?
   a. Respiratory acidosis
   b. Respiratory alkalosis
   c. Metabolic acidosis
   d. Metabolic alkalosis

4. A nurse is caring for a group of adult clients on an acute care medical-surgical nursing unit. The nurse understands that which of the following clients would be the least likely candidate for total parenteral nutrition (TPN)?
   a. A 66-year-old client with extensive burns
   b. A 42-year old client who had an open cholecystectomy
   c. A 35 year-old client with persistent nausea and vomiting from chemotherapy
   d. A 27 year-old client with severe exacerbation of regional enteritis (Crohn's disease)

5. A client with a spinal cord injury suddenly experiences an episode of autonomic dysreflexia. After checking the client's vital signs, list in order of priority, the nurse's actions. (Number 1 is first priority and #5 is last priority).
   a. _____Check for bladder distention
   b. _____Raise the head of the bed
   c. _____Contact the physician
   d. _____Loosen tight clothing on the client
   e. _____Administer an antihypertensive medication

6. A nurse is completing a time tape for a 1000-mL IV bag that is scheduled to infuse over 8 hours. The nurse has just placed the 11:00am marking at the 500 mL level. The nurse would place the mark for noon at which numerical level (mL) on the time tape.

---

7. The nurse is caring for a client experiencing hematologic toxicity as a result of chemotherapy. The nurse develops a plan of care for the client. The nurse plans to
   a. Restrict all visitors
   b. Restrict fluid intake
   c. Insert an indwelling urinary catheter to prevent skin breakdown
   d. Restrict fresh fruits and vegetables in the diet.

8. Megestrol acetate (Megace), an antineoplastic medication, is prescribed for the client with metastatic endometrial carcinoma. The nurse reviews the client's history and contacts the physician if which of the following is documented in the client's history?
   a. Asthma
   b. Myocardial infarction
   c. Thrombophlebitis
   d. Gout

9. A nurse is monitoring a client with diabetes insipitus. Desmopressin (DDAVP, Stimate) has been prescribed for the client. Which of the following outcomes reflects a therapeutic effect of this medication?
   a. Serum osmolality greater than 320 mOsm/kg
   b. Increased blood pressure
   c. Decreased urine output
   d. Urine osmoloality less than 100 mOsm/kg

10. The family of a bedridden client with diabetes mellitus calls a nurse to report the following symptoms: blood glucose of 400 mg/dL (by fingerstick), polydipsia, and increased lethargy. To determine a possible diagnosis, the nurse asks the family which most important question?
    a. "Has there been any change in the dietary intake?"
    b. "Have there been any ketones in the urine?"
    c. "Has there been any fever?"
    d. "Have you increased the amount of fluids provided?"

C, a, a, b,; 3,1,4,2,5; 375 mL, d, c, c, b

NCLEX Review-- Psychiatric Nursing

1. The nurse is working with a client who has sought counseling after trying to rescue a neighbor involved in a house fire. In spite of the client's efforts, the neighbor died. Which action does the nurse engage in with the client during the working phase of the nurse-client relationship?

   a. Exploring the client's potential for self-harm
   b. Exploring the client's ability to function
   c. Inquiring about the client's perception or appraisal of the neighbor's death
   d. Inquiring about and examining the client's feelings that may block adaptive coping

2. A client is admitted to a mental health unit for treatment of psychotic behavior. The client is at the locked exit door and is shouting, "Let me out. There's nothing wrong with me. I don't belong here." The nurse analyzes this behavior as

   a. Projection
   b. Denial
   c. Regression
   d. Rationalization

3. An 18-year-old woman is admitted to an inpatient unit with the diagnosis of anorexia nervosa. A cognitive behavioral approach is used as part of her treatment plan. The nurse understands that the purpose of this approach is to

   a. Help the client identify and examine dysfunctional thoughts and beliefs
   b. Emphasize social interaction with clients who withdraw
   c. Provide a supportive environment
   d. Examine intrapsychic conflicts and past issues

4. The nurse is providing information to a client about the use of disulfiram (Antabuse) for the treatment of alcohol abuse. The nurse understands that this form of treatment works on the principle of which therapy?

   _____

5. A client who is delusional says to the nurse, "The federal guards were sent to kill me." The nurse's best response is

   a. "The guards are not out to kill you."
   b. "I don't believe this is true."
   c. "I don't know anything about the guards. Do you feel afraid that people are trying to hurt you?"
   d. "What makes you think the guards were sent to hurt you?"

6. The nurse is planning activities for a client who has bipolar disorder with aggressive social behavior. Which of the following activities would be most appropriate for this client?
   a. Ping pong
   b. Writing
   c. Chess
   d. Basketball

7. Select all nursing interventions for a hospitalized client with mania who is exhibiting manipulative behavior.
   _____Communicate expected behaviors to the client
   _____Enforce rules and inform the client that he or she will not be allowed to attend therapy groups
   _____Ensure that the client knows that he or she is not in charge of the nursing unit
   _____Be clear with the client regarding the consequences of exceeding limits set regarding behavior
   _____Assist the client in testing out alternative behaviors for obtaining needs.

8. A nurse is conducting a group therapy session. During the session, a client with mania consistently talks and dominates the group session and her behavior is disrupting group interactions. The nurse would initially
   a. Ask the client to leave the group session
   b. Tell the client that she will not be able to attend any future group sessions
   c. Tell the client that she needs to allow other clients in the group time to talk
   d. Ask another nurse to escort the client out of the group session

9. A client who has been drinking alcohol regularly admits to having a "problem". The client is asking for assistance with the problem. The nurse would support the client to attend which self-help community groups? _____

10. The nurse is planning care for a client being admitted to the nursing unit who attempted suicide. Which of the following priority nursing interventions will the nurse include in the plan of care?

    a. Check whereabouts of the client every 15 minutes
    b. Suicide precautions with 30 minute checks
    c. One-to-one suicide precautions
    d. Ask the client to report suicidal thoughts immediately

D, b, a, aversion therapy, c, b, #7-a, d,e; c, Alcoholics Anonymous, c

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 – 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
Judith A. Halstead, DNS, RN (Chair), Wanda Bonnel, PhD, RN,
Barbara Chamberlain, MSN, RN, CNS, C, CCRN, Pauline M. Green, PhD, RN, Karolyn R. Hanna, PhD, RN,
Carol Heinrich, PhD, RN, Barbara Patterson, PhD, RN, Helen Speziale, EdD, RN, Elizabeth Stokes, EdD, RN,
Jane Sumner, PhD, RN, Cesarina Thompson, PhD, RN, Diane M. Tomasic, EdD, RN,
Patricia Young, PhD, RN, Mary Anne Rizzolo, EdD, RN, FAAN, (NLN Staff Liaison)

❑ 1. Principles for Planning the Clinical Day

Notes:

Kathy Foss, MS, RN
Supervisor, Clinical Entry Programs
Professional Resources

❑ 2. Getting Started….

Objectives:

- Examine the influences on creating a safe learning environment for students
- Identify the areas of performance evaluation in the clinical setting
- Discuss strategies to improve clinical performance

❑ 3. Foundations.... What's my Style?

- Models and best practices
- Learning and teaching styles
- Essential Skills
- Challenges and rewards

❑ 4. Philosophy of Teaching

Notes:

- Clinical teaching is:
  - ◊ Just as important as classroom teaching
  - ◊ A climate of mutual trust & respect
  - ◊ Focuses on essential knowledge, skills & attitudes
  - ◊ A nursing student is a learner not a nurse
  - ◊ Nursing students do not perform at the same level
  - ◊ Sufficient time is needed before performance evaluation
- Adapted from Gaberson & Oermann, 1999

❑ 5. Foundations... What do I need to get started?

- Academic Mission and Hierarchy
- Type of Position
- Faculty Responsibilities
- Educational Policies
- Course Syllabus and Evaluation Tool
- Resources

❑ 6. In the Beginning…

Notes:

- Pre-Clinical Contact
  - ◊ myClinicalExchange
  - ◊ phone or email?
- Student Orientation
  - ◊ what, where, when, and who?
- Clinical Preparation
- "The Ground Rules"

❑ 7. Strategies for Assignments

- Goal: Identify the student's ability to **consistently** provide **safe** care with **confidence.**
- Factors to include:
  - ◊ Level of and number of students
  - ◊ Clinical course focus and objectives
  - ◊ Practice or Care setting
  - ◊ Census
  - ◊ Available resources
  - ◊ Individual student learning needs and skill level

❑ 8. Assignment Responsibility

Notes:

Who is Responsible?

- Instructor
- Student
- Agency Leadership
- Collaborative Effort

❑ 9. Approach to Assignments

- Single Assignment
- Dual Assignment
- Team Assignment
- Peer Assisted Learning/Teaching

❑ 10. Instructor Priorities

- Is there a student not meeting performance criteria?
- Is there a student performing below ability?
- Which student needs more opportunities to perform skills?
- What feedback have you received about a student?

❑ 11. How Do You Know Students are Prepared?

Notes:

- Preparatory work
- Ask student to identify priorities
- Have student give "report"
- Student can describe level of care or scope of practice
- Student safety

❑ 12. How do I Evaluate Student Performance?

❑ 13. Definitions:

- Struggle

To make strenuous or violent efforts in the face of difficulties or opposition. To proceed with difficulty or with great effort.

- Failure

Omission of occurrence or performance: a failing to perform a duty or expected action. Lack of success.

- Success

To attain a desired objective or end. Favorable or desired outcome. The attainment of wealth, favor or eminence.

- Merriam-Webster's Collegiate Dictionary, www.websters.com

❑ 14. What is Clinical Evaluation?

Notes:

- The nature of clinical evaluation involves assessing and evaluating students in areas of critical thinking, therapeutic interventions, communication, teaching, research, leadership and management, professionalism, and adherence to standards of practice.

- Smith, M., et al (2001). Legal issues related to dismissing students for clinical deficiencies. *Nurse Educator*, (26)1: 33-38

❑ 15. Why is Clinical Evaluation Important?

- A primary goal of nursing education is to prepare safe, competent nurses who can be held accountable for their own actions.

Smith, M., et al (2001). Legal issues related to dismissing student for clinical deficiencies. *Nurse Educator*, (26)1: 33-38.

- Accurate performance assessments are particularly vital when they underpin licensure or registration intended to protect the public from incompetent, unsafe or unscrupulous practitioners.

Horbsky, P. (2002). Preceptors' perceptions of clinical performance failure. *Journal of Nursing Education*, (41)12: 550-553

- Teachers lead, direct and make things happen; teachers are experts present to impart information and knowledge; teachers are authority figures who can be blamed if things go wrong.

Barber, P. (1986). A process-centered approach to education. *Nurse Educator*, (11)2: 40.

Notes:

❑ 16. Challenges...How can I help students to be successful?

- Structure of Clinical Rotation
  - ◊ Short clinical rotation periods
  - ◊ High patient acuity
  - ◊ Competency vs. proficiency
  - ◊ Disparity in evaluation
  - ◊ Time

❑ 17. Challenges... How can I help students to be successful?

- Changing characteristics of students
  - ◊ 2nd career, older, nontraditional students
  - ◊ Competing time demands
  - ◊ Disabilities
  - ◊ English as a second language
  - ◊ Gender and culture

❑ 18. Challenges...How can I help students to be successful?

Notes:

- Clinical Instructor Issues
  - ◊ Fear of legal action
  - ◊ "Was it me?"
  - ◊ "When I was new... or when I was in nursing school..."
  - ◊ Failure is viewed as uncaring
  - ◊ Marginalized or unsupported
  - ◊ Time

❑ 19. Clinical Practice: Safe versus Unsafe

Safe:

- Application of knowledge, skills and adherence to standards of practice.
- Demonstration and progression to meet clinical performance competencies.
- Demonstration of effective communication and professional conduct.

Unsafe:

- Unsafe clinical practice is behavior that places the patient,, family or staff in either physical or emotional jeopardy.
- Unsafe clinical practice is an occurrence or pattern of behavior involving unacceptable risk.

Scanlan, J. et al (2001). Dealing with the unsafe student in clinical practice. Nurse Educator, (26)1: 23-27.

❑ **20.**

Notes:

❑ 21. Room for Debate

- How many incidents equal unsafe clinical practice?
- Is one incident sufficient to claim unsafe clinical practice, or should there be a pattern of unsafe practice?
- What type of incident is unsafe, compared with practice that constitutes a failure?

❑ 22. Behaviors of Impaired Performance

- Absenteeism
- On-the-job absenteeism
- Inconsistent work pattern
- Physical or emotional problems
- Symptoms of intoxication or withdrawal
- Panic with resulting inability to think or act
- Threats to harm
- Poor judgment

❑ 23. Struggling "Looks Like"

Notes:

- Poor eye contact
- Shuffling paperwork
- Easily distracted
- Disengaged body language
- Habits of nervousness
- Makes excuses

❑ 24. Struggling "Sounds Likes"

- Echolalia
- Common phrases used:
  - ◊ I'm not sure what you mean
  - ◊ I didn't have time to…
  - ◊ I couldn't find…
  - ◊ I had no idea I was to know...
  - ◊ I wasn't taught…
  - ◊ I'm sorry….
  - ◊ I need more time…

❑ 25. Elephant in the Room

Notes:

- Who knows it?

❑ 26. Strategies to Improve Clinical Performance

- Identify, discuss and document EARLY and OFTEN
- Explore other influences on performance
- Actively listen to the student's self assessment of performance
- Assess and discuss learning needs

❑ 27. Strategies to Improve Clinical Performance

- Place responsibility on the student
- Redirect efforts back to necessary knowledge or skill
- Be descriptive about improvement strategies
- Ensure that the student has heard and understood feedback
- Reinforce success

❑ 28. Anticipate a Response

Notes:

- "You're hovering."
- "You're expecting too much."
- "You're being unfair."
- "I'm failing because you're not here to help me."
- How would you know that I'm failing? You're not around enough."
- "I don't know…."

❑ 29. Moving forward...

- Care of the Clinical Instructor
- Record Keeping
- End of Clinical Rotation Duties
- What do you do when...

❑ 30. Online Resources

- www.qsen.org
- http://nursing.unm.edu/resources/teaching-and-learning-strategies.html
- http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol132008/No3Sept08/NursingPracticetoNursingEducation.aspx

❑ 1. Creating a Culture of Inquiry

Notes:

- Karren Kowalski, PhD, RN, FAAN
- Marianne Horner, MS, RN, CNM

❑ 2. Definitions

- Culture:
  - ◊ Set of shared attitudes, values, goals & practices
- Inquiry:
  - ◊ Examination into facts or principles
  - ◊ A request for information
  - ◊ Systematic investigation

❑ 3. Questions are the _____ of the mind.

❑ 4. Categories

- Questions asked _____
- Questions asked _____

❑ 5. Reasons to Ask Questions

Notes:

- Stimulate the brain
- Create an exchange
- Discover knowledge and issues
- Allows you to listen
- Provides opportunity to acknowledge
- Lead another through a process of discovery

❑ 6. Guidelines for Asking Questions

- Know Your Purpose
  - ◊ What is to be gained?
  - ◊ Put yourself in their shoes
  - ◊ Phrase as win-win

❑ 7. The Delivery

- Speak clearly, calmly & directly
- Be positive
- No underlying negativity or disapproval
- Don't bury the question
- Display interest in the answer

❑ 8. The Response

Notes:

- Active listening...

❑ 9. Additional Active Listening Tips

- Can you paraphrase the response?
- Are follow up questions, clear, easy?

❑ 10. The Evaluation

- As you listen, evaluate the response
- Clarifying questions may be needed
- Be prepared to question until issue reaches completion

❑ 11. The Payoff

- Act on the information attained
- If something improves or something changes, acknowledge

❑ 12. When to use questions

Notes:

Based on Teaching Tips homework:

- What are some questions you came up with?
- In which category?

❑ 13. Misconceptions

- Questions are what you use when you don't know the answer in order to cover your ignorance.
- Using questions all of the time feels deceptive and will make people impatient with me

❑ 14. Smart Questions

- What has to be done?
- Please tell me more about the process.
- How do you feel about it?
- Can you explain that further?
- What can I do to help you?

❑ 15. More Smart Questions

Notes:

- From what perspective are you asking?
- What are some of the reasons this didn't work as well as you had hoped?
- What can be done to make this work better?
- What key results are we looking for?
- How do you plan to proceed?

❑ 16. "Why" Questions

- A dangerous approach!
  - ◊ Creates defensiveness
  - ◊ Closes communication
- Rephrase to
  - ◊ What….
  - ◊ How….
  - ◊ Could….

❑ **17. Questions… Leading another through the Process of Discovery**

Notes:

❑ **18. How to scaffold questions to "Lead"**

❑ **19. Write down 2 clinically based questions a student might pose**

- Trade questions with your partner who will ask the question. Take turns until time is up. Get feedback from your partner about your skill
- DO NOT ANSWER or go to explanation, **lead** through questions...

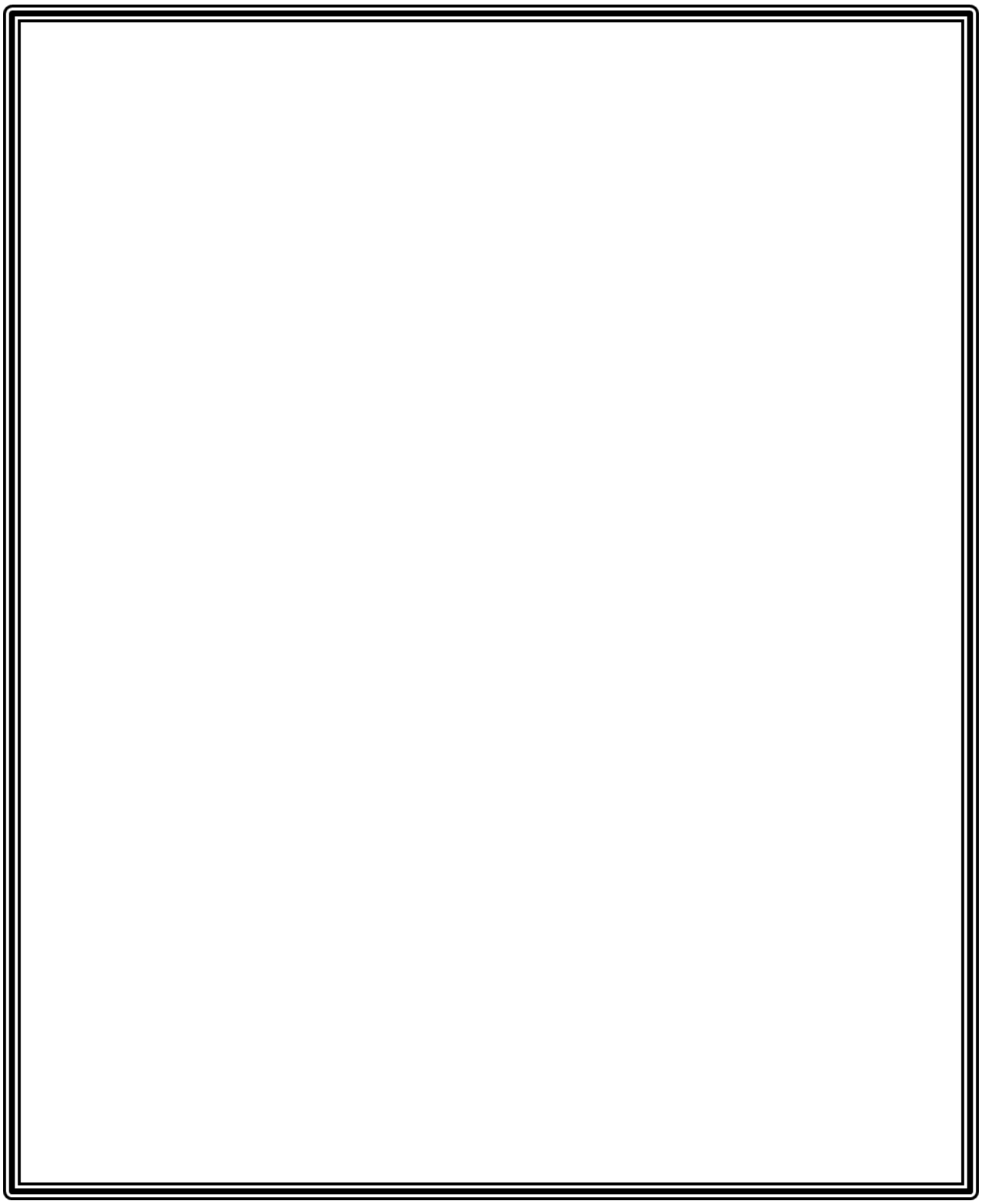
❑ **20. How did that work?**

- What are the advantages?
- What are the barriers?

Notes:

Notes:

Reflective Practice

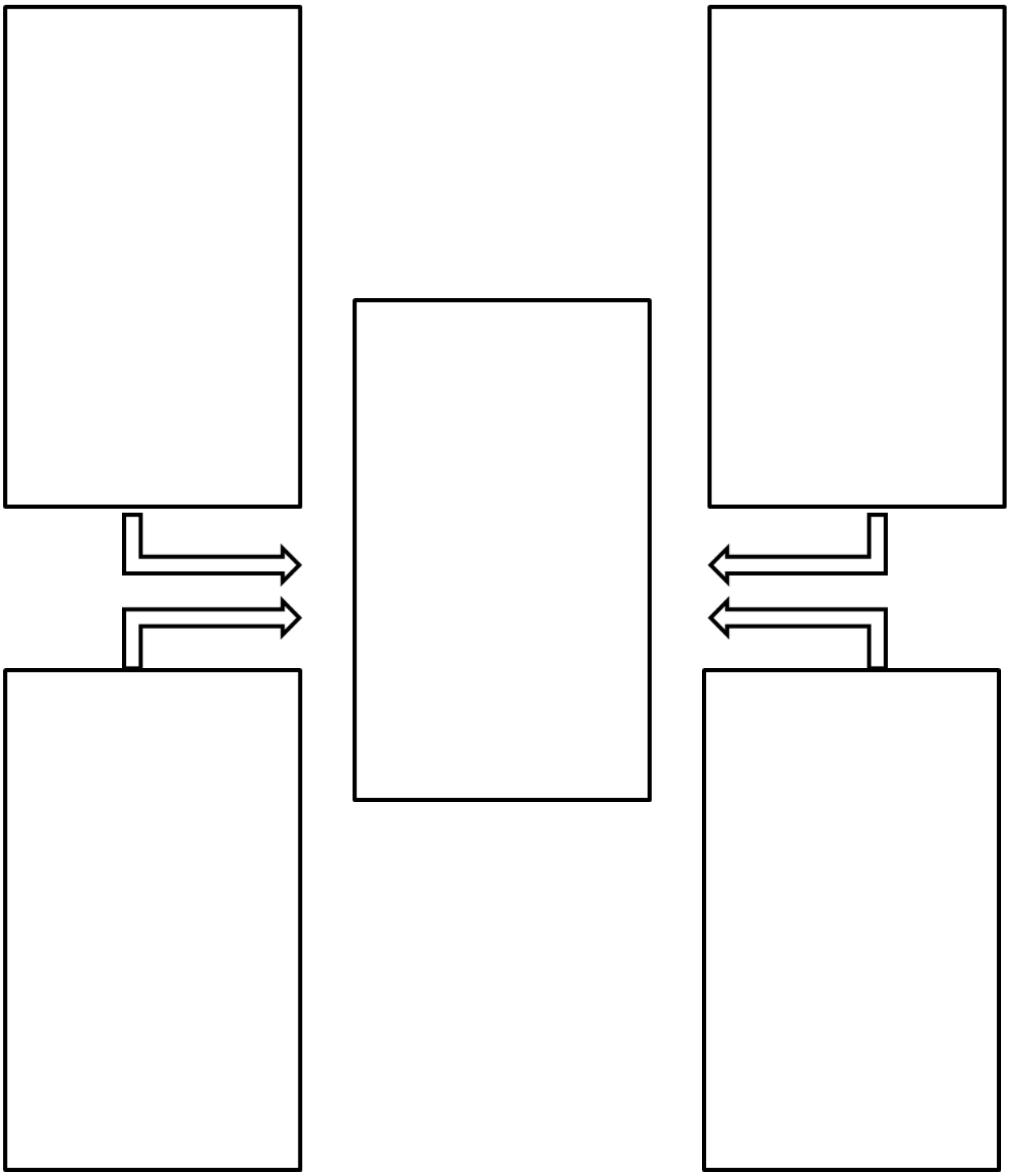


Perceptions:

Barriers:

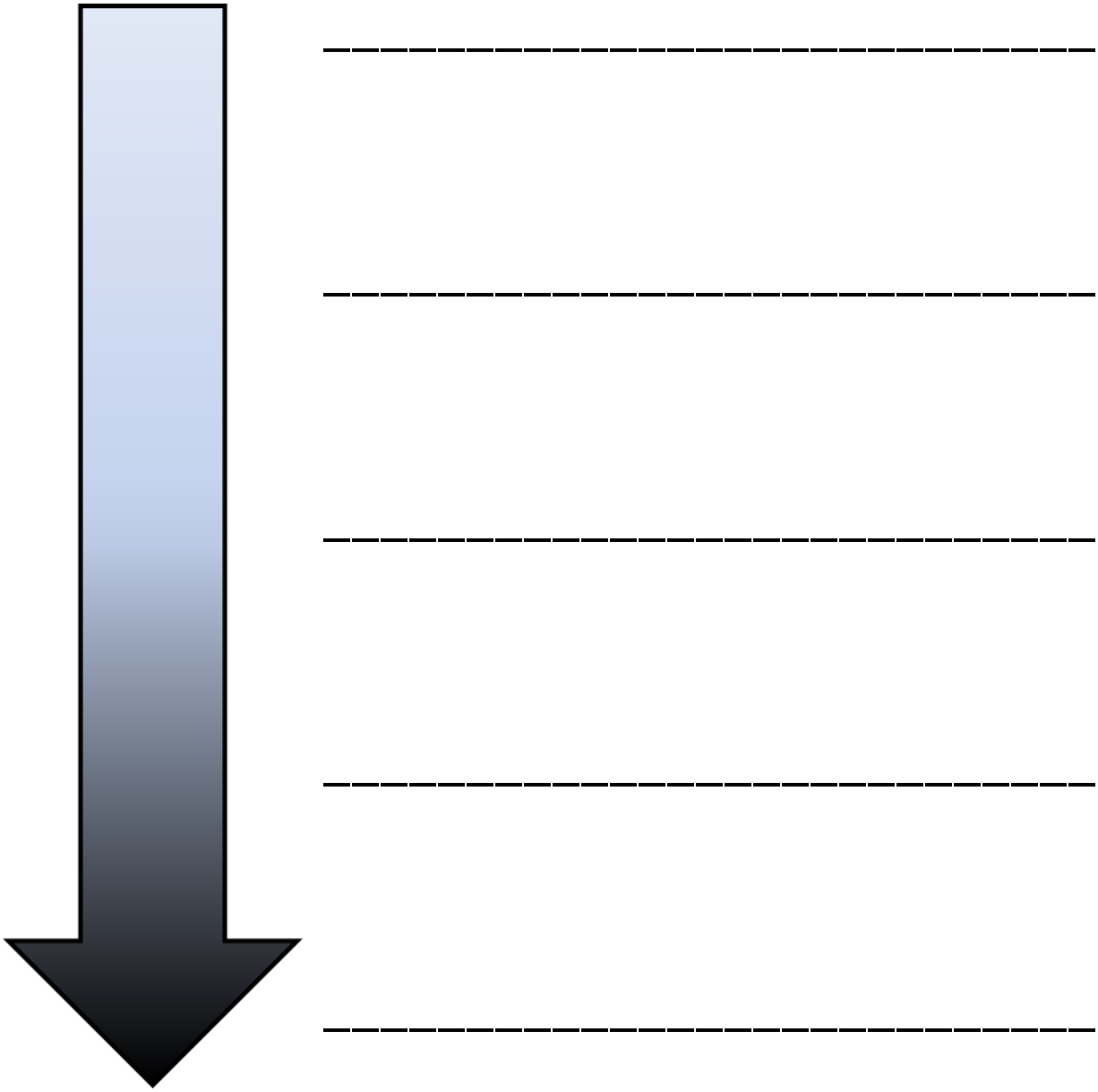
A Model for Structured Reflection

(Johns, 2005)



A Continuum of Reflective Practice

(Johns, 2005)



Reflective Practice Action Plan

Methods that appeal to me:

___ Answering questions
___ Asking questions
___ Talking
___ Journaling
___ Doodling, drawing, painting
___ Making lists or flowcharts
___ Stream of consciousness writing
___ Exercising
___ A hobby, like gardening, knitting, fishing
___ Music, playing or listening
___ Reading more on a given subject
___ Meditating
___ Other ideas:

Times I can make available for reflection:

___ First thing in the morning
___ During my work day
___ After exercising
___ Setting a reminder on my phone/computer
___ During my commute
___ At lunch
___ Before bed
___ Posting a reminder note where I will see it

Amount of time I will commit per day/per week: _____

Reflective questions that would be especially helpful for me:

Notes:

❑ **1. Clinical Instructors, Legal Liability & Risk Management**

Notes:

Gail B. Katz, DNP, CNS, RN
Assistant Professor of Nursing
University of Colorado, Colorado Springs

❑ **2. Adapted from presentation by:**

Melissa Lowry, MS, APRN, and
Laura Kozarek, RN, BSN
University of Colorado
Professional Risk Management

❑ **3.**

❑ 4. Responsible for Safety of the Public

Notes:

- By monitoring student's knowledge and ability
- Supporting the student's learning
- Documenting the student's progress
- Communication concerns to the didactic faculty for the course
- Working with the faculty to develop a plan of action for the student's success

❑ 5. Protect against Harm, Breach of Privacy or other potential Liability

- "It's not enough that we do our best; Sometimes we have to do what is required."

  — Sir Winston Churchill

❑ 6. Common Issues for Scholars

- Failure to supervise
- Negligent supervision
- Failure to intervene, counsel and support student success
- Failure to communicate concerns to the faculty of record, College and possibly, the hospital

❑ 7. Jury Verdicts All States

Notes:

- #1 Medication Errors
- #2 Lack of informed consent
- #3 Treatment Errors
- #4 Negligent Surgery
- #5 Negligent Supervision

❑ 8. St. Elsewhere, New York vs Smith

- 58 yo ♀ s/p CABG, arrhythmia on POD #2. Student Nurse (SN) asked Staff RN what to do. Staff RN notified cardiologist, .25 Digoxin ordered. Staff RN told SN that MD order 1.25 mg. 1.25 mg *called* to pharmacy by Staff RN.
- No written order
- Staff RN believed pt deteriorating. Told SN to give Digoxin from unit stock, not to wait for pharmacy. SN, acting alone without supervision, obtained three .5 mg vials and administered 1.25 mg IVP to pt. No 'rights' checked.
- After med given, pharmacist phoned the SN to question amount of Digoxin. Supervising RN realized SN pushed 5x amount actually ordered.
- Digibind, pt arrested, successful resuscitation. Hypoxic damage to brain, intestines and extremities, removal of portion of intestines and right leg amputation.

Notes:

❑ 9. Staff Nurse (7 months nursing experience) at fault for:

1. Not questioning the 1.25 mg order
2. Telling the SN to take med from unit stock and give it alone, because it was a potentially dangerous drug
3. Supervising nurse should be in the room when the SN was giving a med she had never administered before. Ask SN if she was able to give IV med.s
4. Calling Clinical Scholar to supervise SN

❑ 10. Student Nurse admitted:

1. She knew Digoxin could stop a heart
2. Had never given the drug herself
3. She made no effort to consult/educate herself prior to administering
4. Knew she was not authorized to give meds IV without supervision

❑ 11. Clinical Scholar should have:

1. Explained to staff RN that she was responsible for close supervision of the SN and "not simply make herself available in the event the SN decided to ask questions." And to call Scholar at any time.
2. Been available to supervise student nurse in her tasks

❑ 12. What should the Clinical Scholar do now?

Notes:

❑ 13. Supervision

- Failure to monitor performance
- Failure to appropriately assign
- Failure to intervene, report and support

❑ 14. Negligence/Liability

- An act or failure to act that is below the standard of care.
- **Causation:** This act, or failure to act, results in a permanent body or monetary injury to the patient.

❑ 15. The Four Legal Principles

- Reasonable and Prudent Under the Circumstances
- Due Diligence
- Best Interests of the Patient
- Good Faith

❑ 16. Legal Responsibilities

Notes:

- To be a "reasonable & prudent" clinical scholar and clinical educator/supervisor
- To follow P&P of institution
- Report concerns clearly and timely

❑ 17. Plaintiff Attorney's Toolbox

- Negligence
- Invasion of Privacy
- Breach of confidentiality
- Defamation
- Damages
  - ◊ Infliction of emotional harm- intentional or negligent
  - ◊ Permanent Monetary damages

❑ 18. Punitive damages 2.5 MIL

- "Every nurse has responsibility to know dosing parameters and side effects of medications."
- "A nurse is expected to wonder why it would take 3 containers of a prepackaged IV med to achieve a dose."

❑ 19. High Risk Activities

Notes:

- Monitoring and Observing
- Treatments
- Medication Administration
- Teaching
- Communication
- Supervising and Assessing

❑ 20. Communication

- Failure to document– anecdotal
- Failure to notify faculty
- Failure to counsel student

❑ 21. Medication

- Failure to administer medication correctly, IE, the "rights"
- Failure to check for allergies
- Failure to look up medication

❑ 22. Medical Legal View of Records

Notes:

- Presumed to be true
- Attorney's chief source of information
- Formal documentary evidence
- Jury solves dispute of viewing records

❑ 23. Monitoring & Observing

- Failure to gather and document information
- Failure to recognize significance of certain information

❑ 24. Treatment

- Failure to implement interventions
- Failure to respond to alarms
- Failure to safely use equipment

❑ 25. Patient/Family Teaching

Notes:

- Any instruction on care to pt or family

  Medication prescribed

  Treatments

  Dietary requirements

  Referral information

- Discharge instructions!

  In writing & signed by patient or responsible family

❑ 26. History of incident

- 74 year old post op for a vaginal vault suspension for urinary incontinence.
- MD ordered for a Foley catheter post op.
- The SN obtained the supplies and once ready, under the supervision of her precepting nurse, successfully placed the Foley.
- How is this a Risk Management case?

❑ 27. Issues

Notes:

- Documented Latex allergy and the student nurse placed a latex catheter vs. a non-latex catheter.
- Delayed discharge by one day due to complications and additional treatment necessary
- How does this fall under Supervision?

❑ 28. What else went wrong?

- Supervising nurse failed to monitor performance
- Student nurse failed to follow the six rights

❑ 29. Avoiding Lawsuits

- DEVELOP STRONG TRUST RELATIONSHIP Often avoids law suits. If lawsuits, jury favor caring nurse. Juries love nurses!
- Complete, legible, promptly composed medical record
- Educate patient to be informed
- Omit blame/jousting from behavior repertoire

❑ 30. Common Sense Touchstones

Notes:

- Your care and treatment should be what you expect for your family, or for you
- With support from hospital resources, apologize early
- Every encounter is an opportunity to ":right" a possible error
- Seek consultation and support from your resources (Risk Management or Legal)

❑ 31. Distinguishing Roles and Scholar's Legal Responsibility For Student Incident

❑ 32. Who can be liable for student error in a lawsuit?

- Hospital
- Precepting Nurse
- Student
- Clinical Instructor
- School or College of Nursing

❑ 33. When is a Clinical Scholar potentially liable?

Notes:

- Their own actions
- Occurrences under their direct supervision
- Nursing actions for which a student is not deemed competent or prepared to do
- Failure to report to the hospital, College, faculty

❑ 34. When is a Hospital Liable?

- Failure to follow their own policy and procedure
- Failure to have P & Ps meet EBP
- Failure to act as a prudent institution
- Failure to provide reasonable safety measures

❑ 35. When is a Precepting Nurse Liable?

- Failure to follow hospital policy and procedures
- Their own actions
- Failure to reasonably supervise nursing care

❑ 36. Avoiding Risk/Loss Prevention and Mitigation of Damages

Notes:

- Documentation of student competency
- Prompt notification to student, and to school/ didactic faculty of concerns or problems

❑ 37. When is a School Liable?

- Failure to follow their own policies and protocols
- Failure to provide a disciplinary process
- Failure to enact a disciplinary process

❑ 38. Documentation of Competency/ Concerns

- Anecdotal notes of Clinical Instructor

  Objective

  Kept on All Students

  Regular intervals

  Provided to School at the end of the rotation

- College/Scholar documentation of mastered skills

❑ 39. Prompt Notification

Notes:

- In writing
- Objective
- Specific examples with dates
- Recommendations/Plan of action, shared with student when appropriate, shared with faculty/ College

❑ 40. Special liability for schools and clinical scholars

- "Nor shall any State deprive any person of life, liberty, or property without due process of law."

  Procedural Due Process

  Substantial Due Process

❑ 41. Procedural Due Process

- Was the student given notice of concerns and an opportunity to be heard?

❑ 42. Substantive Due Process

- How was the academic decision reached?
- Was the decision arbitrary or capricious?
- Courts defer to expertise & professional judgment

❑ 43. Malpractice Insurance Yes or No?

Notes:

- This is a personal decision
- Depends on role/job duties, course and scope
- Not expensive
- May provide peace of mind
- Know what your policy provides: other insurance clause

❑ 44. Employer vs. Individual Insurance Policy

- Importance of an "Umbrella" – what happens in court & why employer insurance could be your best decision
- Downsides of relying on employer insurance
  - ◊ Respondeat Superior "let the master respond"
  - ◊ Theory of Contribution
  - ◊ Your consent for settlement is not required
- Why you may need to have supplemental private insurance: how do you practice?
- Resolution of a legal case- why you have little power, consent clause?
- National Practitioner Database Bank: report

❑ 45. What is never covered by insurance

Notes:

- Intentional Acts
- Outside course and scope
- Criminal Acts

❑ 46. New Challenges of Medicine and Nursing

❑ 47. A Word About Social Media

- 2 Wisconsin nurses fired for posting a picture of a patient's x-ray on Facebook
- RN fired for posting on Facebook at the same time as medications were being passed. Court supported termination stating the RN compromised patient safety by being distracted with personal cell phone use during medication administration.
- Lessons Learned- If you don't want your employer to see your posting, or if your grandma would be offended by it, DON'T POST IT

❑ **48.**

Notes:

❑ 49. Criticisms of Copy/Paste

- Inconsistent or redundant notes
- Propagation of inaccurate/outdated information
- Inability to support or defend codes for billing
- Clinical plagiarism
- Inability to identify author/date

❑ 50. ELECTRONIC MEDICAL RECORD

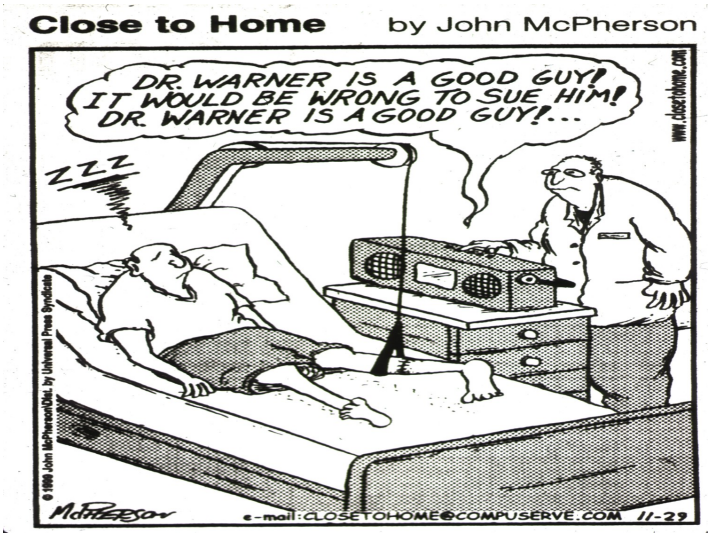
Remember!

Metadata (data about data) reveals how, when, and by whom clinical information was accessed, deleted, or modified.

Can all be tracked

❑ **51.**

Notes:



❑ **52. Thank You**

Questions?

Notes:

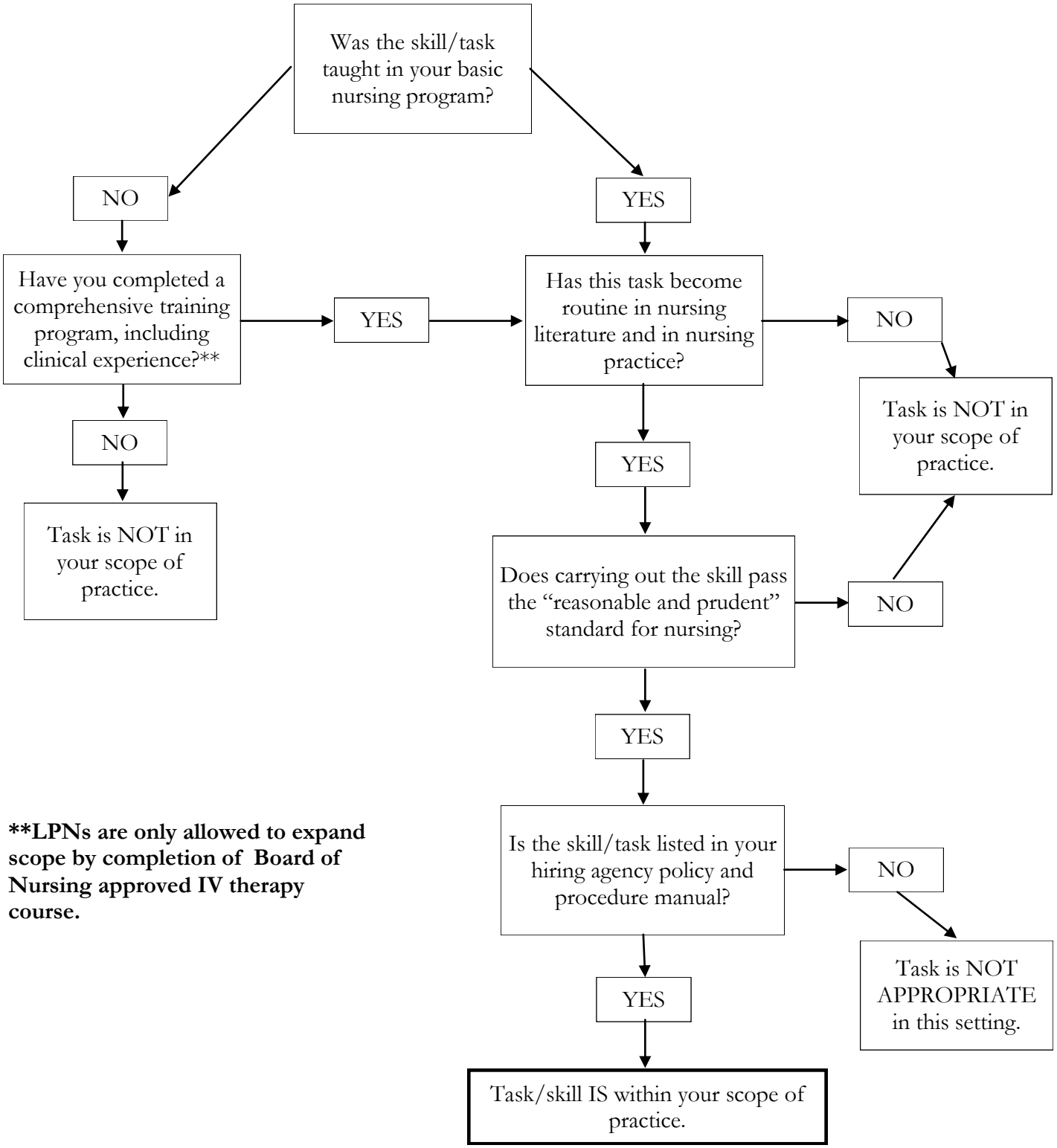
Notes:

Nursing Student Skills and Tasks Worksheet

Directions: Use the list below and select the items that must be supervised and those items that do not require supervision.

	SKILL OR TASK	U= Unsupervised	S= Supervised	COMMENTS
1	Prepares room and assembles necessary equipment			
2	Identifies patient verbally by name by checking ID bracelet			
3	Documents valuables			
4	Escorts patient to another department for a diagnostic test			
5	Completes discharge paperwork			
6	Assist patients with baths/hygiene			
7	Assess the skin for breakdown			
8	Assist patient with elimination (bedpan, urinal, and commode)			
9	Perform range of motion (ROM)			
10	Assess for any redness, swelling, pain or signs of infection to IV site			
11	Turn and reposition patient within prescribed activity limitations			
12	Assist with post-mortem care			
13	Empty and record NG, J/ P,Ostomy Drainage, Urine Output			
14	Management of the many alarms (i.e. IV pump, feeding pump)			
15	Manage tube feedings			
16	Record body weight using standing scale, bed scale and sling			
17	Administer 100% Oxygen			
18	Sterile Dressing Change			

Is This Task Within My Scope of Practice?



****LPNs are only allowed to expand scope by completion of Board of Nursing approved IV therapy course.**

❑ 1. Feedback... What's Feedback?

Notes:

Bari K. Platter, MS, RN, PMHCNS-BC
Clinical Nurse Specialist
CeDAR (Center for Dependency, Addiction and Rehabilitation)

❑ 2. Objectives

- Examine components of communication to foster providing effective feedback
- Discuss two methods of feedback
- Apply feedback concepts as they relate to the narratives

❑ 3. The Five "W's" of Effective Feedback

- Why
- Who
- What
- Where
- When

Additional 3 "W's"

- Wait
- Will
- Worry

❑ 4. Solution Focused Therapy

Notes:

- Strengths-based model
- Assumes that students are doing their best
- Is an adult: :adult model

❑ 5. Solution Focused Feedback Formula

- Acknowledge or compliment
- Bridge or rationale
- Feedback

❑ 6. Examples

- I know that you aren't going to be working in psychiatry after you graduate; you want to work in critical care. (Acknowledge)
- Because it is important to effectively communicate with patients and families, no matter the clinical area (Bridge)
- I'd like you to pay more attention to your process recordings and the responses you give to patients. You appear to be impatient- give examples (Feedback)

❑ 7. Examples

Notes:

- I enjoy it when you share your perceptions in post conference (Compliment)

- It's important to develop good working relationships with your peers; this is something that continues to be important after you graduate (Rationale)

- So I'd like to give you some feedback about a couple of times when you have been joking with the group; people have started to feel uncomfortable and begin to shut down. I'd like you to think about how your comments are being interpreted by your peers. (Feedback)

❑ 8. Examples

- I think it is wonderful that you feel confident in this clinical area (Compliment)

- I know you want to work at this hospital when you graduate (Rationale)

- So I'd like to talk with you about your interactions with the staff; I have received some feedback that they think you are a "know it all". I'd like to give you some suggestions to work more effectively with the staff . (Feedback)

❑ 9. Crucial Conversations

Notes:

- A communication program developed to help people communicate effectively when the stakes are high

- Three elements of a crucial conversation:

  ◊ Strong emotions

  ◊ Opposing opinions

  ◊ High stakes

❑ 10. Contrasting Statements

- A ***don't/do*** statement

–***Don't.*** Explain what you ***don't*** intend; this addresses others' conclusions that you don't respect them or that you have a malicious purpose.

–***Do.*** Explain what you ***do*** intend; this confirms your respect or clarifies you real purpose.

❑ 11. Don't Questions

- What might others mistakenly think my reason is for bringing this up?

- What might they think about my level of respect for them?

- What can I say to help them believe this ***is not*** the case?

Notes:

❑ 12. Do Questions

- What is my genuine motivation for bringing this up?
- How do I really feel about the other person?
- What can I say to help him or her believe this ***is*** the case?

❑ 13. Examples

- "I **don't** want you to think I'm saying you aren't pulling your weight. I think you do great work. I **do** have some concerns about your documentation skills".

❑ 14.

- "I **don't** want to offend you. I care about our relationship. I **do** want to share how recent interactions with you have felt to me and I'd like you to let me know if you see it differently."

❑ 15.

- "I don't want to leave the impression that I think we don't work well together. I do want to discuss how we make decisions. I think we may have different assumptions about how decisions are made in this clinical setting"

❑ 16.

Notes:

- "I don't want to you think your contributions in post conference are not appreciated. I do want to talk with you about something you're doing that's having a negative effect with the group".

❑ 17. Clinical Narratives

1. Break into groups and review the clinical narrative
2. Identify/discuss major points with group members
3. How do you need to respond to this event?
4. What are the "W's" to consider?
5. How will you document this event? To whom will you forward the documentation?
6. Design a Solution Focused Feedback and a Contrasting Statement message for your student
7. What and who are your resources?

❑ 18. Clinical Narrative #1

- Liz Clarkson-Brown seems to forget a lot of the information you have given her. She confides to you that she has MS and thinks that it is starting to effect her thinking. She begs you not to tell anyone.

Notes:

❑ 19. Clinical Narrative #2

- You are working with Emily Day. When meeting with her about her care plans, she suddenly bursts into tears and says that she doesn't understand the purpose of care plans and doesn't understand what your expectations are.

❑ 20. Clinical Narrative #3

- You have observed that over the past two shifts that Juana Hernandez has difficulty setting, maintaining and carrying out sterile procedures. The patient needs a new saline lock and Juana has just touched the prepped venipuncture site with an ungloved finger.

❑ 21. Clinical Narrative #4

- Robin Baker seems overly confident in his clinical skills. He never asks for assistance or feedback and is flippant with his peers. His assigned patient has just complained to the charge nurse that she has been waiting over an hour for her pain medication. The students states, "Oh, I forgot, no biggie".

❑ 22. Clinical Narrative #5

- Juana Hernandez is a single mom. You notice that she seems fatigued, her clinical performance has worsened and she has been late for clinicals several times. She tells you that she is working another job and has childcare issues.

❑ 23. Clinical Narrative #6

Notes:

- You walk into the patient room and observe the student slapping an Alzheimer patient in the face. She states, "Well, I couldn't help it…he grabbed me inappropriately when I was giving him his bath!"

❑ 24. Clinical Narrative #7

- Chen is a Chinese American nursing student. He has been in the US for 3 years. During his psych rotation he lets a patient off of the unit. The patient goes directly to his mother's house and assaults her. Chen says that he didn't understand that he shouldn't let the patients off of the unit.

❑ 25. "Good Practices"

- Encourage contact between student and instructor.
- Consult with SON faculty.
- Develop cooperation among students.
- Use active learning techniques.
- Give prompt feedback.
- Assist student with time management.
- Communicate high expectations.
- Respect diverse talents and ways of learning

-Adapted from: Grienve, D. (2001). A Handbook for Adjunct & Part-Time Faculty & Teachers of Adults, Fourth Edition.

❑ 26. Questions?

Notes:

- Kathy Foss, RN, MSN
  UC Denver: College of Nursing
  303-724-1565
  University of Colorado Hospital
  720-848-6645
  e-mail: katherine.foss@uchealth.org

- Bari K. Platter, MS, RN, CNS
  University of Colorado Hospital
  720-848-3006
  e-mail: bari.platter@uchealth.org

Notes:

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