Clinical Scholars
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COLORADO**CENTER**
for Nursing Excellence

Transforming Healthcare Through Workforce Innovation

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Transforming Healthcare Through Workforce Innovation

❑ **Clinical Scholar**
    Why—Who— What— How

Marianne D. Horner, MS, RN, CNM

❑ **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

❑ **Who is a Clinical Scholar?**

- Difference between Clinical Scholar and other clinical educators

- Qualifications - http://www.dora.state.co.us/nursing/rules/ChapterII.pdf

- What is ANIP? Associate Nursing Instructional Personnel

❑ **Where does your paycheck come from?**

- Will you be directly teaching rotations of nursing students?

❑ **Categories**

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

❑ **What are the qualifications for a Clinical Scholar?**

- Clinical expertise

- Educational requirements

- Previous teaching

❑ **Ability to combine two roles**

- Clinical nurse

  — Competent

  — Expert

- Clinical Scholar

  — New role

  — Novice

❑ **Ability to Blend Two Distinct Cultures**

- Clinical organization's culture and values

- Culture and values of nursing education

  ∗ Schools of nursing

  ∗ Students

❑ **What does a Clinical Scholar Do?**

❑ **How do you Become a Clinical Scholar?**   <u>**Notes:**</u>

- Preparation

  ◊ Didactic course

  ◊ Formal academic education

- Role development from Novice → Expert

- Ongoing mentoring

- Deliberate reflection

❑ **Meet our Clinical Group!**

❑ **Innovations in Nursing Education**   <u>**Notes:**</u>

      Marianne Druva Horner, MS, RN, CNM

      Colorado Center for Nursing Excellence

❑ **Mr. Holland's Opus**

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

❑ **Let's look at our history….**

- Why?

- Why?

- Why?

❑ **How is health care changing?**

Notes:

❑ **Nurse as Innovator**

- From passive recipients of orders to thinkers and innovators

- Nurses must be educated in the ***economics*** of healthcare as we transition away from fee-for-service model.

❑ **Carnegie Foundation for the Advancement of Teaching**

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

❑

From Lisa Mikluch, Gonzaga University
RMNE Conference 2012

Notes:

☐ **Patient Safety and Quality**

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

☐ **Paradigm shift: What can we do?**

1. Incorporate QSEN throughout

2. From pathology / medical model

3. From heavy emphasis on acute care to more community based

4. Add economic content to curriculum

5. Tie content together – demonstrate **connections** between concepts and facts

A Work in Progress…

☐ **Other Resources**

- 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

❑ **What is Team Based Learning? (video)**   <u>Notes:</u>

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

Teaching Modality Using Games & Simulation

Purpose or Goal of Game-based or Simulation-based Learning:

- Engaged both right and left brain in learning
- Introduce a topic or concept
- Demonstrates knowledge and skill
- Enhance critical thinking
- Provide a more relaxed and fun learning environment
- Enhance team-building and relationships
- Practice integrating learning in a realistic environment
- Reinforce content and stimulates recall
- Engage students in active learning – increases motivation
- A method to evaluate competency and development

"Game" implies competition and rewards when the goal is reached.
Establish **Ground Rules** BEFORE beginning the game on:

- Participation requirements
- Rules of the game
- Dealing with conflict
- How to win the game

Steps for Using Games & Simulations:

- **Identifying the Game or Writing Scenarios based on Objectives/Outcome Goals**

    o **Games:** Physical Activities, Board Games, Group Games etc. (Examples: Kahoots, Socrative, Jeopardy; Wheel of Fortune; Who wants to be a Millionaire?; Family Feud; Card Games; Puzzles; Are you smarter than a 5th Grader? (i.e. Expert Nurse); Using Social Media with Twitter)

    o **Simulation**: Low or High Fidelity; Case Scenarios; Role-play

- **Creating a Learning Environment:**

    o Ground Rules – Set the tone to be a safe place to "practice and learn"
    o Goal: Learning - It is not to trip or test.
    o Major Learning Opportunity - Ability to make mistakes without risk to patient – *Participants learn more from mistakes than successes!*
    o Allow for questions and time to ask for help
    o When using Simulation Equipment for Clinical – take time to orientation to simulation – *expectations to treat the mannequins and standardized patients as real patient*

Teaching Modality Using Games & Simulation

- **Briefing –** just prior to start of the activity

  - Establish Ground-rules
  - Assign Roles
  - Establish purpose
  - Provide preparation and answer questions
  - Creates - psychological safety

- **Game or Simulation** (*UNINTERRUPTED Time*)

  - Allow participants uninterrupted time to complete the game or scenario

- **Debriefing–*WHERE THE GREATEST LEARNING HAPPENS!***

  o Focus is on "learning" not mistakes – *Participants will automatically want to point out what was wrong. Shift conversations when possible to a positive, "what did you learn?*
  o Always tie the activity to learning objectives
  o Reflect on takeaways and how will apply learning in other situations

- **Repeat or Scaffold Another Scenario** (where appropriate and followed by second debriefing)

  o Reinforce Learning

  o Practice building skills

  O Builds confidence

Reflection:

My focus when using games and/or simulation as a teaching modality will be to:

Notes:

❑ When the Healthcare Provider Needs Help

How to recognize substance misuse in our peers
Bonnie A. Wilensky MSN
Clinical Nurse Specialist

❑ Competencies Needed for Safe Practice of Nurses

➢ Current nursing/medical knowledge
➢ Ability to apply knowledge
➢ Capacity to use good judgement
➢ Effectively work with other team members
➢ Ability to perform cognitive & technical tasks
➢ Ability to function in a range of circumstances

❑ Objectives

➢ Understand substance use disorders
➢ Identify concerns/behaviors
➢ Support education & treatment
➢ Know barriers to seek assistance

❑ Impairment

➢ Can occur suddenly e.g. accident or injury
➢ Can result from an acute illness
➢ Gradual onset as with chronic disease
➢ Can be temporary with return to normal function
➢ Can be protracted requiring intervention

Notes:

❑ Questionable Behaviors

- ➢ Concerns among colleagues regarding failing health
- ➢ Questions about clinical skills
- ➢ Substance use disorder vs psychiatric illness
- ➢ Physical, psychological, intellectual, behavioral, spiritual, & societal diseases
- ➢ Missed time at work
- ➢ Leaving job duties for extended periods
- ➢ Mistakes
- ➢ Change in mood and behavior

❑ Identifying the Problem

- ➢ Inaccessible to patient and team
- ➢ Unexplained absenteeism
- ➢ Increased conflicts with coworkers
- ➢ Frequent moves/change in jobs
- ➢ Smell ETOH on breath
- ➢ Impaired motor coordination/function

❑ Substance Use Disorders

- ➢ Long standing history in healthcare
- ➢ Cross boundaries of:
    - -Gender
    - -Age
    - -Racial
    - -Religious
    - -Cultural
    - -Educational
    - -Socioeconomic

❑ Chemical Dependency Prevalence

- ➢ ~9.2% in the US
- ➢ 10% of nurses in US experience drug & ETOH addiction
- ➢ 6-8% of those with SUD negatively impact safe delivery of healthcare
- ➢ Danger to the patient
- ➢ Harm to nurse & profession
- ➢ Liability to institution

❑ The Role of Stress

- ➢ Ineffective coping can lead to SUD
- ➢ Level of stress exceeds internal & external resources
- ➢ Lack of social support
- ➢ Physical consequences: HTN, depression, cardiac changes, headaches, GI problems, and addiction disorders

❑ Substance Use Disorder

- ➢ Defined by the DSMMD V defines this as a single disorder measured on a continuum.
- ➢ Mild-severe
- ➢ Each substance addressed separately e.g. alcohol use, opiates, controlled substances, and illicit drugs
- ➢ Issues of tolerance and withdrawal are addressed (mild 2-3 sx, moderate 4-5 sx, and 6+ severe)

❑ Peer Assistance for Nurses

Challenging due to:
- ➢ Level of intelligence
- ➢ Knowledge of how drugs function
- ➢ Easy access to medications/controlled substances
- ➢ Ability to hide symptoms

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❑ Peer Assistance for Nurses

- ➢ Rules and Regulations vary from state to state
- ➢ Some states very punitive
- ➢ Revocation of license
- ➢ Must fully engage in treatment/recovery
- ➢ No relapse or remission
- ➢ Include strict guidelines that must be adhered to
- ➢ Monthly UDS
- ➢ Attendance at 12 step meeting
- ➢ Must be in program 3-5 years
- ➢ Program must maintain excellent data outcomes
- ➢ Individual counseling

❑ Colorado's Peer Assistance Program for Nurses

- ➢ History: Public discipline, probation, license suspension or revocation, lack of opportunity for monitoring or treatment
- ➢ Efforts by CAN resulted in statutory change
- ➢ Alternative to traditional disciplinary process
- ➢ Established in 1995
- ➢ Part of Colorado Nurse Practice Act
- ➢ Funded through license fees
- ➢ Selection through a bidding process with the state for contractor
- ➢ Deals with physical, emotional, psychiatric, psychological, drug abuse and alcohol abuse problems that may be detrimental to nursing practice
- ➢ Board selection of program through bidding process
- ➢ Must monitor status of licensee referred for treatment and assess for public safety

❑ **Colorado's Peer Assistance (continued)**

➢ Assistance and education regarding the recognition, identification, and prevention of physical, emotional, psychiatric, drug or ETOH abuse and refer for proper treatment
➢ Must monitor status of licensee for proper treatment
➢ Must provide counseling and support for licensee and family
➢ Must receive referral from the board and make services available to all statewide
➢ Demonstrate performance measures of results
➢ Management and monitoring services
➢ Support services
➢ Short term problem resolution
➢ Intervention
➢ Facilitated statewide education groups
➢ 24-hour phone assistance
➢ Workplace consultant and education
➢ Continuum of prevention and early intervention services

❑ **Barriers to Seek Treatment**

➢ Fear
➢ Embarrassment
➢ Fear of losing license
➢ Concern about confidentiality
➢ Limited understanding of SUD even in the healthcare industry
➢ Cost of treatment

❑ **Thoughts to Ponder**

➢ How would you respond if you identify a potential problem leading to unsafe practice in a colleague?
➢ Name various situations that could lead to an impairment
➢ Have you worked with Peer Assistance Services in Colorado? As a client? A collaborator?
➢ What was your experience?

Notes:

❑ Nursing Education
Changing Faculty Roles
Sara L Jarrett, EdD, MS, CNS, MA, BSN, RN

❑ Objectives:

◊ Reflect about the relationship of emerging nursing practice roles to current nursing education in USA.

◊ Articulate types of educational experiences that will best prepare nurses for emerging and future RN practice roles.

❑ Current Perspectives

◊ Faculty Role

◊ Educational Requirements

◊ Knowledge Needed for Education

◊ Clinical Practice Expectations

❑ Re-Tool, Re-Think, Re-Act

◊ Practice Changes

◊ Terminology Changes

◊ Education Changes

❑ Some New Perspectives

◊ RN Primary Care Practice

◊ Role of Technology in Nursing Practice

◊ Engagement in Understanding ACO's and Health Care Reform

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Notes:

❑ **Changing Paradigm Resources**

◊ Delivery of Education: A Call for Radical Transformation (2009)

◊ Institute of Medicine Report 2010– Future of Nursing (see IOM recommendations on the next page)

◊ Macy Foundation Conference—RN Practice—June 2016

◊ Remington Reports—Post-Acute Industry Innovator

❑ **Critical Questions for the Nursing Profession**

◊ What is the current state of practice and education?

◊ How do we inform key stakeholders to bring constructive systemic change?

◊ What should nursing education look like for the 21st century emerging practice needs?

❑ IOM Future of Nursing Recommendations

1. Build common ground around scope of practice and other issues in policy and practice

2. Continue pathways toward increasing the percentage of nurses with a baccalaureate degree.

3. Create and fund transition-to-practice residency programs.

4. Promote nurses' pursuit of doctoral degrees.

5. Promote nurses' interprofessional and lifelong learning.

6. Make diversity in the nursing workforce a priority.

7. Expand efforts and opportunities for interprofessional collaboration and leadership development for nurses.

8. Promote the involvement of nurses in the redesign of care delivery and payment systems.

9. Communicate with a wider and more diverse audience to gain broad support for campaign objectives.

10. Improve workforce data collection.

Notes:

❑ **DIVERSITY**

For Clinical Scholars
Amanda Quintana DNP, RN, FNP
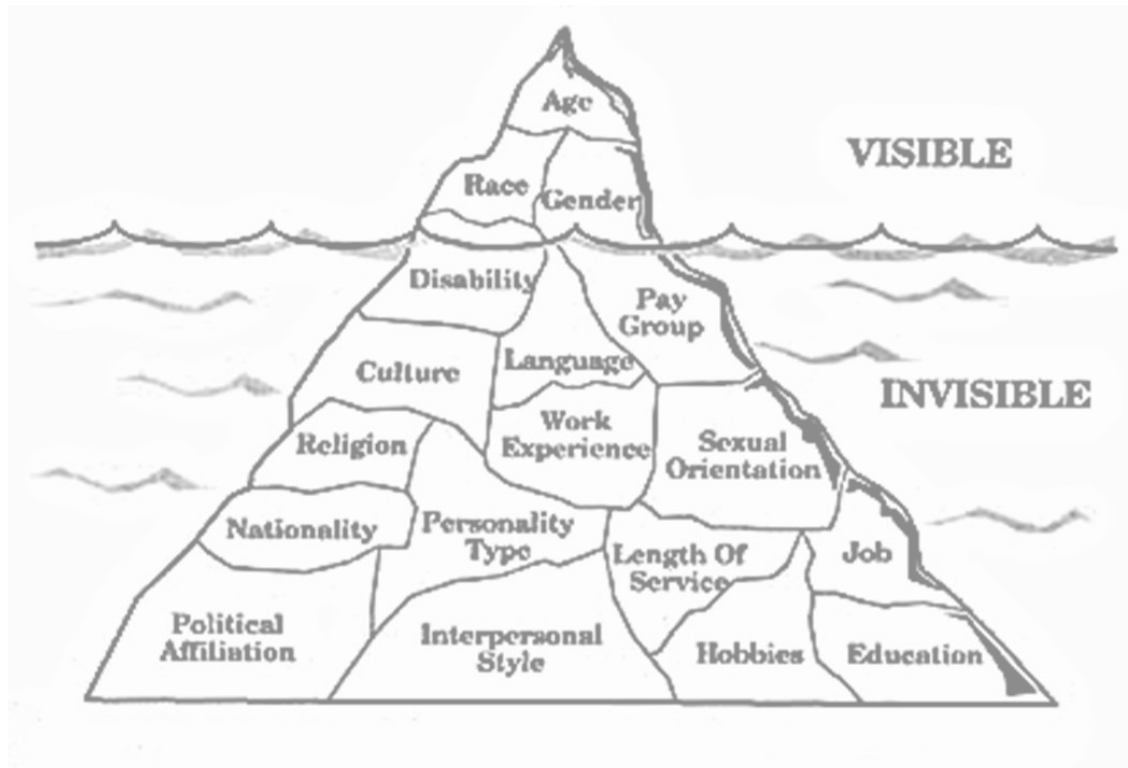and Natalee Mejia BSN, RN, MSN Student

❑ **What is Diversity?**

The human qualities that make each person unique and
differentiate us from others.

❑ **Diversity Isn't Always Obvious**

A lot of important information about others lies beneath the surface and won't be revealed unless we look for it.

❑ **Diversity's Value**

Why should I care about nursing diversity?

1.

2.

3.

❑ **Implicit Bias**

What is implicit bias?

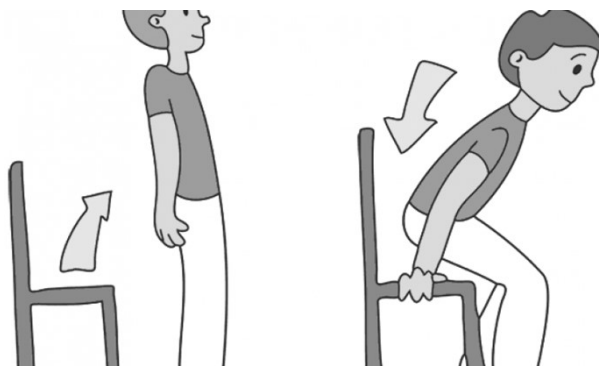- Project Implicit

  ◊ https://implicit.harvard.edu/
    implicit/selectatest.html

  ◊ Implicit Association Test (IAT)

❑ **Recognizing Privilege and Bias: An Interactive Exercise to Expand Health Care Providers' Personal Awareness**

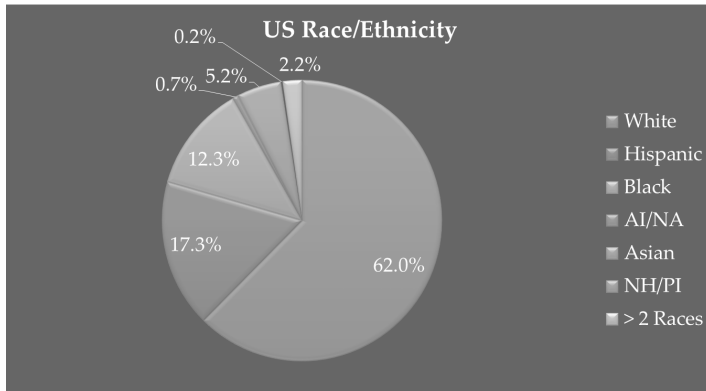Holm, Gorosh, Brady, and White-Perkins (Innovation Report, Academic Medicine)

Privilege and Responsibility Curricular Exercise (PRCE)

❑ **United States Diversity Demographics (2016)**
American Community Survey
(https://factfinder.census.gov/faces/tableservices/jsf/pages/
productview.xhtml?src=bkmk)

US Race/Ethnicity

0.2%
2.2%
0.7% 5.2%
12.3%
17.3%
62.0%

- White
- Hispanic
- Black
- AI/NA
- Asian
- NH/PI
- > 2 Races

❑ **Colorado Diversity Demographics**
(https://www.census.gov/quickfacts/table/PST045215/08)

3.3% 0.2%
1.6%
4.5%
3%
21.3%
68.6%

Race/Ethnicity
July 1, 2017 Data

- White
- Hispanic
- Black
- American Indian
- Asian
- Hawaiian/PI
- >2 Races
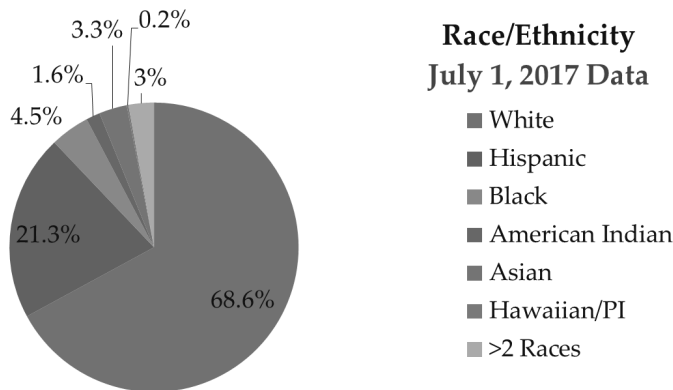
By 2035, Hispanics = 30.3% population; Total minority = 41%
(Colorado Demography Office, Nov. 2016)

☐ **2015 National Nursing Workforce Study**
https://www.ncsbn.org/workforce.htm

- **2017 data will be available in July 2018**

- Over 260,000 RNs and LPNs were randomly selected to participate in the survey (140,154 RNs and 120,793 LPNs).

- _____% response rate (n=78,700)

- _____% RNs racial/ethnic diverse. Newly- licensed nurses had a more diverse racial/ethnic composition.

- 6.7% of RNs were foreign educated

- % of men rose from _____% in 2009 to _____% in 2015

Data will vary from study to study

☐ **2015 National Nursing Workforce Study**
https://www.ncsbn.org/workforce.htm

% Male RN's in Workforce Nationally
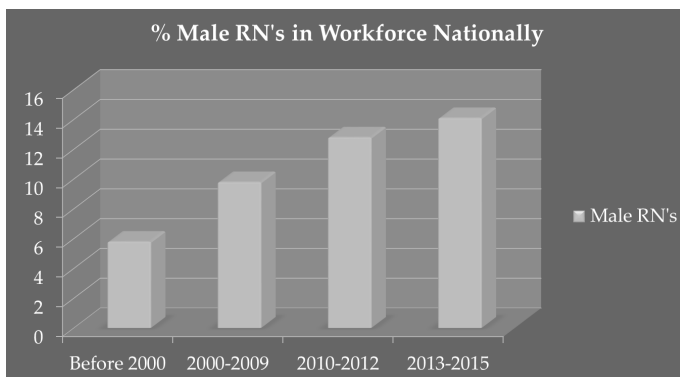
❑ **Faculty Diversity 2015 Data**
   http://www.aacn.nche.edu/government-affairs/Diversity-
                    spotlight.pdf

- **Nationwide**
   ⇒ Diverse Faculty = 14.9% (13.1% in 2013)

   ⇒ Diverse Nursing Students = 31.69% (30.1% in 2014)

- **Colorado**
   ⇒ Diverse Faculty = _____ %

   ⇒ Diverse Students = _____ %

❑ **Colorado Baccalaureate and Graduate Nursing Student Diversity Data by Program Level (Fall, 2015)**
http://www.aacn.nche.edu/government-affairs/resources/Colorado1.pdf

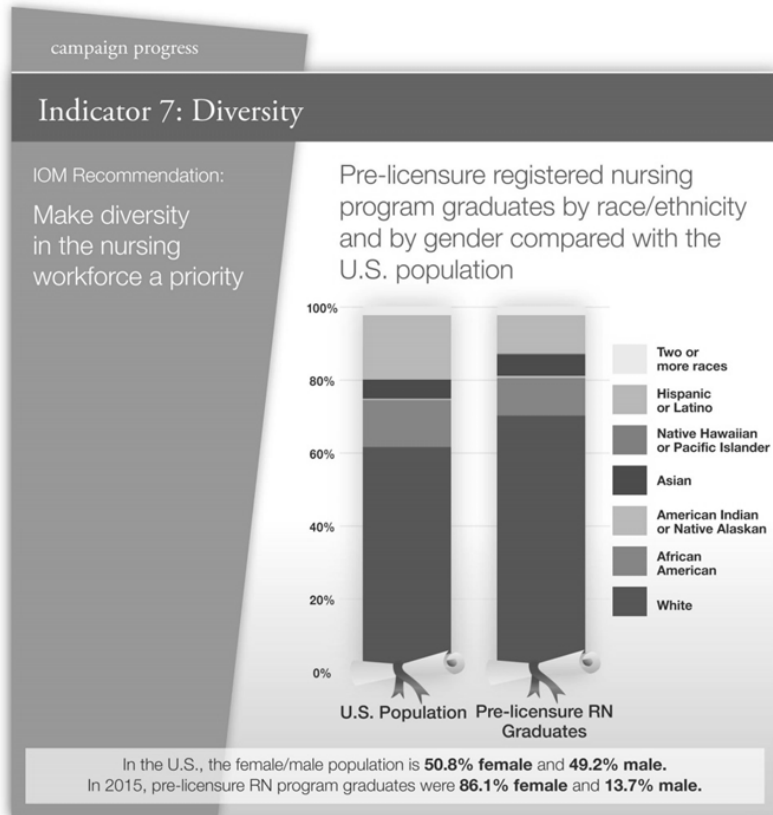|	BSN	MSN	PhD	DNP
Minority*				
Men				

*Minority = Hispanic, African American, Native American or Alaskan Native, Asian, Native Hawaiian, Pacific Islander, > 2 races.

❑ http://campaignforaction.org/resource/ racialethnic-composition-rn-workforce-us/

- Don't get hung up on what is different

- Don't be afraid of what you don't know

- Don't assume others should be like you

- Don't expect others to act and think like you

- Don't miss the similarities in those who are obviously different

- Remember that you share many things in common

- Embrace the challenge and learn from experiences

- Be sensitive—tune into what others respond to positively or negatively

- Appreciate differences– don't be afraid of them

- Be aware of your biases and filters

- Be an active listener

- Ask for feedback

- If you get it wrong - admit it and learn from it

** **Seinfeld Video:** https://www.youtube.com/watch?v=cpGfyp6MxkM **

ACTION

RESULTS

ENTHUSIASM

CHALLENGE

COLLABORATION

D

i

C

S

ACCURACY

SUPPORT

STABILITY
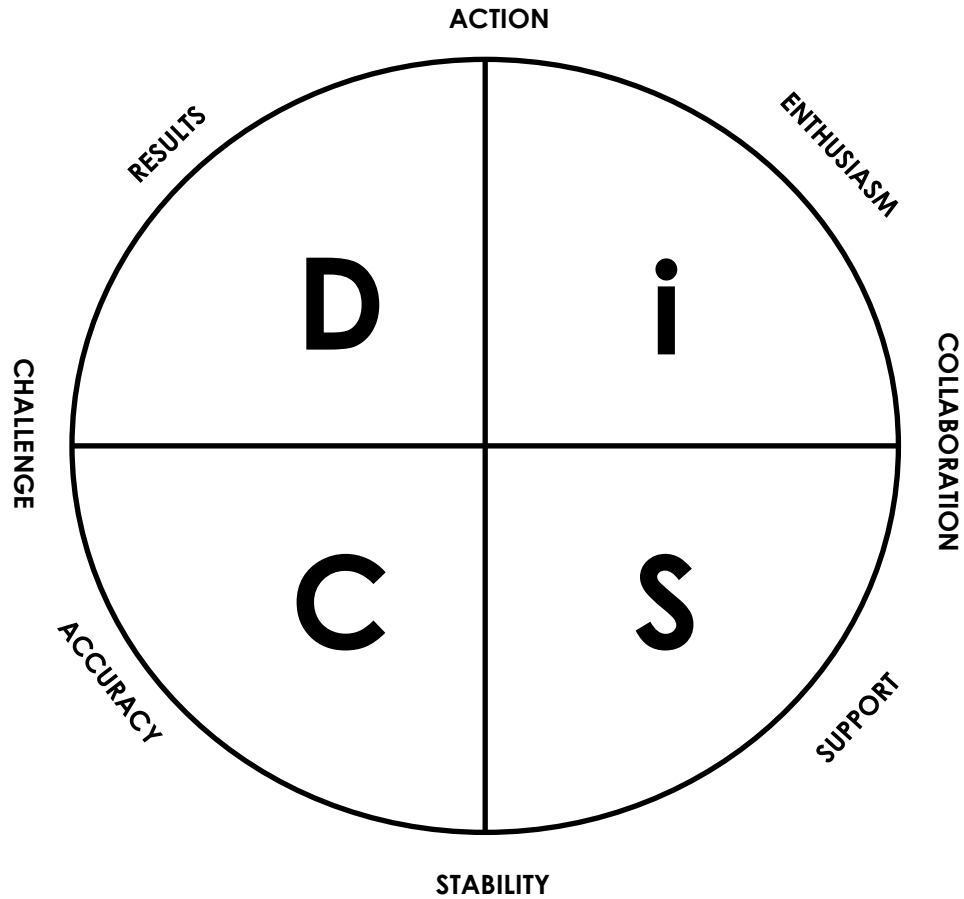
My Workplace Style Guide

How to work effectively with me:

⇒

⇒

⇒

⇒

Working Effectively with a D   **Dominance**

When trying to connect: Make efficient use of time, get right to the point, and expect candor

When Problems Need to Be Solved: Tackle problems boldly and avoid sugar-coating or over analysis

When Things get Tense: Stay calm, acknowledge their feelings, and avoid personal attacks.

Working Effectively with I   **Influence**

When Trying to Connect: Convey enthusiasm, make a personal connection, and be collaborative

When Problems Need to Be Solved: Remain optimistic, be open to change, and expect spontaneity

When Things Get Tense: Stay calm, acknowledge their feelings, and avoid personal attacks

Working Effectively with S   **Stable**

When Trying to Connect: Show warmth, take an easygoing approach, and be collaborative

When Problems Need to Be Solved: Respect their caution, acknowledge people's needs, and set a timeline

When Things Get Tense: Practice patience and diplomacy to avoid shutting them down

Working Effectively with C   **Conscientiousness**

When Trying to Connect: Focus on the facts, avoid pushing them, and expect skepticism

When Problems Need to Be Solved: Show appreciation for their logic, but down let them get bogged down

When Things Get Tense: Allow them time to process, and avoid becoming forceful or emotional

Notes:

❑ **Teaching Adults in the Clinical Setting**

> Monica Brock, MS, RN, CPAN
>
> Clinical Nurse Educator
>
> The Medical Affairs Company

❑ **Objectives**

- Discuss characteristics of adult learners

- Describe motivators and barriers to learning

- Apply effective adult and clinical teaching principles into practice.
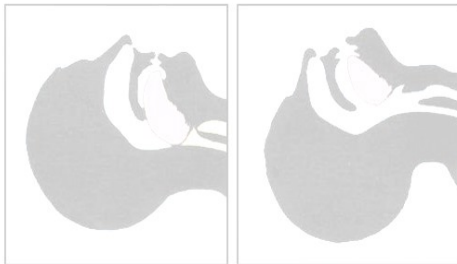
- Discuss difficult student behaviors and strategies to employ.

❑

❑ **Adult Learners**

❑ **Eliminating the "Is this going to be on the test?" mentality**

Connecting ideas learned in the classroom to real life examples in the clinical environment

❑ **Motivators to Learning**

Intrinsic:

Extrinsic:

❑ **Barriers to Learning**

- Demographic
- Geographic
- Cultural
- Socio-economic
- Transportation
- Child Care
- Fatigue
- Confidence
- Ill-Prepared
- Life events
- Instructor, Preceptor

❑ **How can you assess for barriers?**

❑

Name: Tabitha

Healthcare experience: got my CNA but havent used yet. Helping grandma w/ ADLs.

Goal: successfully/accurately take a set of V.S.

worry/concern: hurting a Patient

Anything else I need to know?

My grandma has a terminal illness and I have been helping with her cares for the last couple of months.

❑ **The Educator's Role**

- Facilitates learning while keeping patients & students safe

- Plan, implement and _____ learning experiences

- Give honest, specific and timely feedback

❑ **Skill Acquisition**

❑ **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, as we do

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❑ **Effective Clinical Teaching**

1. Identify what the students need to learn and involve them in determining learning needs.

How will you do this?

❑ **Effective Clinical Teaching**

2. Create a safe environment/establish mutual trust

Students must feel comfortable coming to you when they've *made* a mistake, or to ask a question that can *prevent* a mistake

❑ **Effective Clinical Teaching**

3. Look for and use teachable moments (they are powerful teaching tools)

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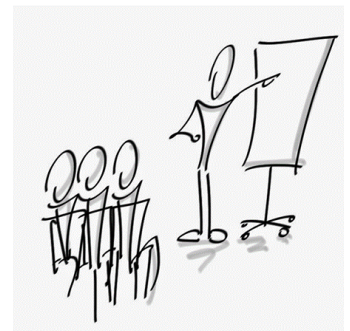
❑ **Effective Clinical Teaching**

4. Ask questions

Open ended questions help determine
_____ and builds

_____   _____

❑ **Effective Clinical Teaching**

5. Tell stories

❑ **Effective Clinical Teaching**

6. Have FUN!

Notes:

❑ **Difficult Student Behaviors**
   (and strategies to employ)

❑ **Difficult Student Behaviors**

- **Invisible Student**

  -lacks confidence

  -shy

  -quiet

- **Strategies**

  -seek this student out

  -ask direct questions

  --reinforce contributions

❑ **Difficult Student Behaviors**

- **Know-it-all student**

  -Need for attention

  -Ill prepared

  -Lack confidence

- **Strategies**

  -Redirect comments to the group

  -Talk to the student privately

  -Don't allow student to monopolize discussion

  -Admit you don't know all the answers

Notes:

❑ **Difficult Student Behaviors**

- **The Rambler**

  -Nervous

  -Ill-Prepared

- **Strategies**

  -Redirect

  -Ask them to summarize

  -Let's hear from some other in the group

  -Assign timer in post conference

❑ **Student Learning is....**

Significantly related to teacher behaviors!

❑ **THANK YOU!!!**
Brock_Monicab@yahoo.com

Learning preferences refer to a person's characteristic patterns of strengths, weaknesses and preferences in taking in, processing, and retrieving information.

What influences our preferences?

DISC

Generation

_____

_____

The VAK learning style uses the three main sensory receivers: Visual, Auditory, and Kinesthetic (movement) to determine the dominant learning style. It is sometimes known as VAKT (Visual, Auditory, Kinesthetic, & Tactile). It is based on modalities—channels by which human expression can take place and is composed of a combination of perception and memory.

VAK is derived from the accelerated learning world and seems to be about the most popular model due to its simplicity. While the research has shown a connection with modalities and learning styles, the research has so far been unable to prove the using one's learning style provides the best means for learning a task or subject. This is probably because it is more of a *preference*, rather than a *style*.

Auditory, Visual and Kinesthetic Learning

Auditory Learners

- Process new information best when it is spoken

- Lectures

- Discussions

- "I hear you"

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"

- Visual presentation through the use of pictures has been shown to be advantageous for all adults, irrespective of a high or low learning –style preference for visual images.

Kinesthetic Learners

- Process new information best when it can be touched or manipulated

- Written assignments

- Taking notes

- Examination of objects

- Interactive

- "I feel you"

Blended Learning

- According to VAK theorists, we need to present information using all three styles. This allows all learners the opportunity to become involved, no matter what their preferred style may be.

Generational Preferences for Learning

Generations are comprised of people who share a similar age and life stage, have been shaped during their formative years by similar conditions and technologies and have lived through the same events and experiences which have impacted them. For Generation Z, coming of age in the 21st Century has created a unique generation from the Global Financial Crisis to growing cultural diversity, from global brands to social media and a digital world. Generation Z are the most materially endowed, technological saturated, formally educated generation our world has ever seen. On average they will live longer, stay in education later, and work across more careers than any prior generation.

Generation Z
- Craves regular and technology-enhanced learning opportunities. Looks for educational opportunities that use visually enhanced methods of teaching. Visuals and videos are most often the norm

- Teachers must communicate in new ways with language that engages and communicates content to the student in understandable ways.

- Generation Z decides to pay attention within 8 seconds of exposure to a video or to other learning materials. Approximately 11% of Generation Z have experienced a diagnosis of ADHD.

- Digital integrators Use mobile technology and apps when possible.

- Learn by observation and practice.

- Thrives on opportunity. Guide them in how to achieve their goals. They want to participate in the journey! Want to shape their own journey with you as a guide.

- Simplicity and flexibility are vital

- Communicate is primarily brief

- Most pressing need is for immediate response - whether it is feedback in a class, answer to a question, or their most recent tweet.

- Less skilled at interpersonal face-to-face interactions and networking.

Notes:

Making the application of all the information on "Student Characteristics" to the Clinical Experience—SIMPLE!

How hard can it be?

Characteristics of the Students	Role of the Instructor/Scholar
– Adult Learners	– Patient Safety
– Auditory, Visual and Kinesthetic Learners	– Patient Rights
– Blended Learning	– Student Rights
– Generation Implications	– Student Safety
– Multiple Languages and ESL Students	– Faculty/Instructor/Scholar Rights
– Cultural /Ethnic Diversity	– Faculty/Instructor/Scholar Safety
– Racial Diversity	– Confidentiality
– Political Diversity	– Equity
– Religious Diversity	– School Requirements
– Personality (ie DiSC)	– Board of Nursing Requirements
– Intelligence –Cognitive and Emotional	– Clinical Site Requirements
– Gender/Sexual Identification/ Orientation Diversity	– FERPA Rules
– Social Class Diversity	– HIPAA Rules
– Social Determinants of Health	– Fairness & Justice
– Learning Disabilities	– Ethics and Moral Leadership
– Emotional or Psychiatric Disabilities	– Objectivity
– Stereotypes and biases	– Evaluation requirements
– Facts verses Fiction	– Advocating for Students
– Who is the Minority? Majority?	– Novice-to-Expert Teacher
– Family/Home Challenges (children, parents, financial)	– Individual Confidence and Self-regard
– Workload – (Job; Parenting; School etc.)	– Willingness to be Vulnerable (Brené Brown: *Power of Vulnerability*)
	– **Prepare the students for the realities of practice and the "real-world"**

"KISS Method"

K (Key/Knowledge)	I (Individualize/Information)
• Key -- helps "unlock" the differences • Key to understanding • Knowledge is the first step! • If don't know, ask!	• Always individualize – student/patient • Seek additional information • *What is true of one person, may not be true of another!* • If don't know… ask!
S (Student/School)	S (Success /Safety)

• Student is the priority
• Schools is your resource
  – Contact them
  – Policies for addressing
  – Support services & resources
• If don't know… ask!
	• Define Success with student
	• Show Understanding
	• <u>ALWAYS</u> ensure safety
	• If you don't know…ASK!

CASE STUDY APPROACH:

Directions: Take a few moments to review the information related to your student. Also review the information provided about this student on day one of the Clinical Scholar class. As a group, respond to the following questions and record information on a flipchart. **Be prepared to discuss your concerns and strategies for working with this student when we convene as a large group.**

Questions for Discussion:
- Identify with each case the "concerns" you may have or need to address related to the student
- Do you have any conscious or unconscious biases?
- Do you have enough information to understand the difference or concern?
    - If not, what do you need to ask?
    - How do you ask it?
    - Are there other resources you need to address this?
- How will you support this student to ensure there is an appropriate learning environment and accountability?
- How will you help support this student's preparation for entry into nursing practice and the "real world?"

STUDENT 1 – JUANA HERNADEZ

- Juana is a 28 year/old "Hispanic Student." During clinical she appears "apathetic and indifferent" with you <u>and</u> her classmates. She does not look at you and appears to be day-dreaming during clinical conference. When you give her eye contact during conference to "signal for her to become more of an active participant," she turns away.
- You have read that in the Hispanic Culture "silence before one's superiors, indirection in expressing one's thoughts, and avoiding eye contact all signal respect for authority."
- Based on her behaviors, you believe she is a "S" on the DiSC.
- What feedback and questions do you have for Juana?

STUDENT 2 – MICHAEL JONES

- Michael is a charmer. He is able to "sweet talk" the staff to help him do his work for every procedure. As a result, yesterday as you began to write his mid-term evaluation, you realize he has not demonstrated any skills for you. He has managed to do them with the nurse each time <u>before</u> you arrive at the scheduled time.
- At preconference today – you learn that his patient requires a sterile procedure before 11am. You tell him you will do this procedure with him and ask him to have all the supplies together by 10:30a. When you arrive, you find a sterile field set up in the patient room for the procedure and Michael is not in the room. As he enters, he says, "*I am ready for you today*!"
- Based on his behaviors, you believe Michael is a very high "I" in DiSC.
- What is your primary concern? How do you clarify this with Michael?

STUDENT 3 – KIRIN PATIL

- Kirin is a female student of Indian heritage. She is an excellent student and provides high-quality patient care. Her patients adore her!
- Today, you are reviewing her documentation, you are unable to understand what she has written. (Her spelling is correct, but her choice of words are inappropriate.)
- She can speak English and seems to understand directions. She can verbally communicate effectively with the team and her patients. She just has difficulty

translating to written English and struggles with documenting appropriate terminology.

- Based on her behaviors, you believe Kirin is a high "C-I" on DiSC.
- What approach will you take to support Kirin developing safe and effective documentation skills?

STUDENT 4 – EMILY DAY

- Emily is a Jehovah's Witness. She is assigned to care for a patient S/P a surgical procedure. During rounds this morning, the physician ordered "2 units of PRBC's" to be given.
- Emily pages you immediately and tells you she can "*no longer participate in this patient's care due to her faith.*"
- Based on her behaviors, you believe Emily is a high "D" on DiSC.
- What do you do about Emily's assignment?

STUDENT 5 – – GENET ALI

- Following report, Genet comes to you looking pale and somewhat fragile, to request a "*change in her assignment.*" She tells you she "*is fasting for Ramadan*" and would like to have a "*lighter assignment.*"
- She is repeating this course for the 2nd time after failing "theory" last semester. The patient assignment you gave her involves several new skills and assessment requirements to help you evaluate her competency.
- Based on her behaviors, you believe Genet is a high "C-S" on her DiSC.
- What are your concerns? Do you change her assignment? Do you send her home?
- How would you have responded if she requested the day off on the day before the Ramadan started?
- Would your response be different if you learned she had made a request for a different clinical group prior to the start of clinical course that would have been on night shift, which was not approved by the Course Coordinator?

Teaching Methodology: Using Case Studies for Integration of Learning

"Case studies are stories. They present realistic, complex, and contextually rich situations and often involve a dilemma, conflict, or problem that one or more of the characters in the case must negotiate. A good case study is the vehicle by which a chunk of reality is brought into the classroom to be worked over by the class and instructor. A good case keeps the class discussion grounded upon some of the stubborn facts that must be faced in real life situations. They bridge the gap between theory and practice and between academy and the workplace, allowing students to practice arguing different points of view." (Elberly (2015), Teaching Excellence & Educational Innovation.)

Considerations for Using Case Studies with Students:

- Give students time to read and think about the case.
- Provide guidelines for what you want the students to do or think about related to the case.
- Create small enough groups to ensure everyone is involved. Circulate between groups to provide support and encourage deeper reflection.
- Have groups present their solutions/reasoning.
- Ask additional questions for the group, to support a greater level of learning and integration. Where possible, tie content from class, reading, clinical into the case to help them see relevance beyond the exercise. (i.e.: what lessons have we learned from this case that we can apply with other situations in the future?).
- Synthesize issues raised and solutions generated.

Quick Laundry List – Strategies:

- Don't Assume
- Appreciate differences
- Ask questions to clarify the unspoken
- Set ground-rules and create a safe environment
- Avoid alienation, isolation and tokenism
- Avoid competitive learning environments
- Create a cooperative learning environment
- Acknowledge values (nursing or the clinical organization)
- Present alternative perspectives and debate, constructively
- Examine your own conscious and unconscious biases
- Give all students equal amounts of attention (positive and constructive)
- Vary teaching methods to include all types of learners
- Model what you want the students to do
- ***Hold students accountable to the role of the nurse during school to better prepare them for the realities of practice!***
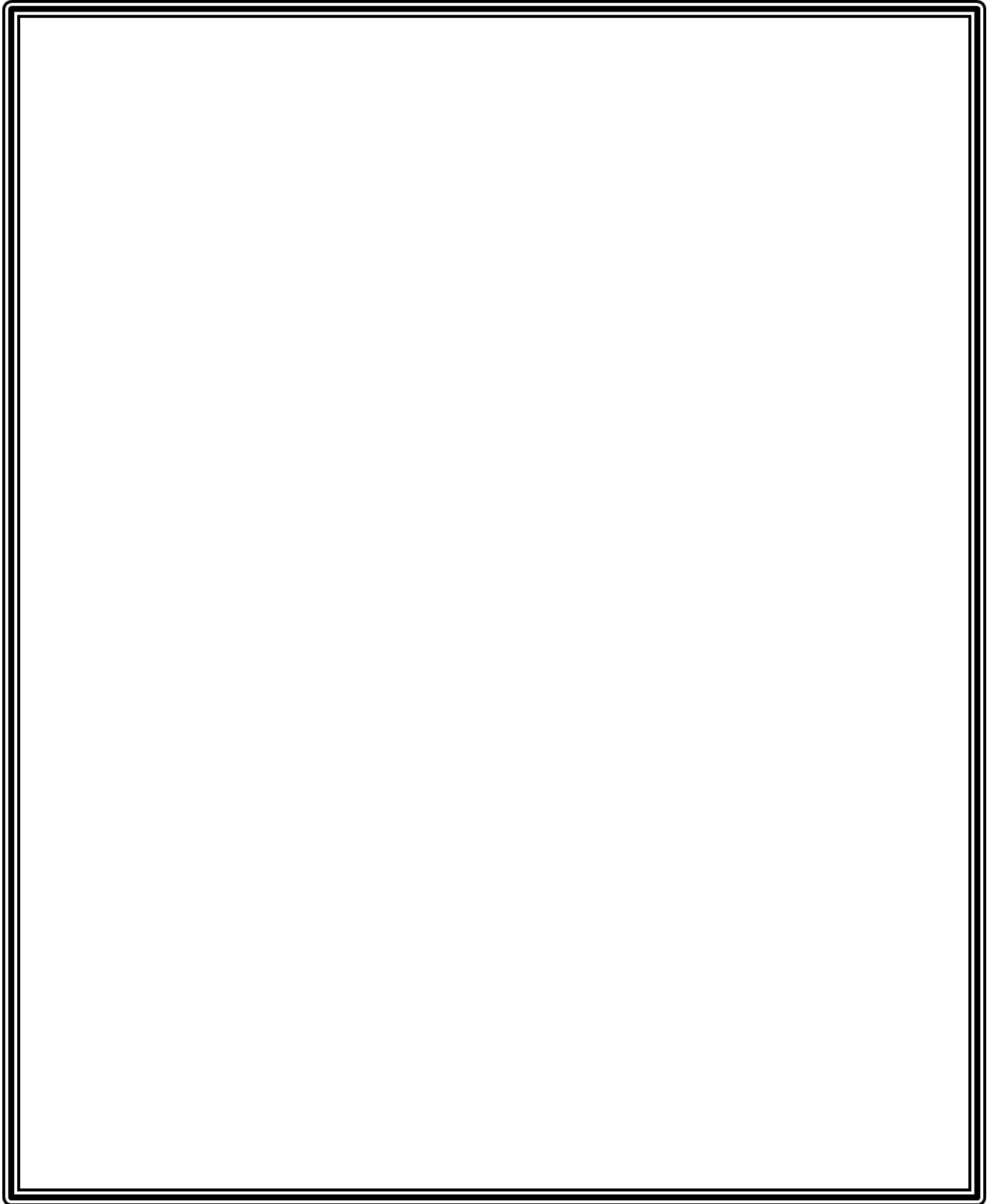
Will you accept the challenge?

"The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy"
Martin Luther King, Jr.

Reflective Practice

Perceptions:

Barriers:

Reflective Practice Action Plan

Methods that appeal to me:

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

Times I can make available for reflection:

___ First thing in the morning	___ During my commute
___ During my work day	___ At lunch
___ After exercising	___ Before bed
___ Setting a reminder on my phone/computer	___ 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:

Creating a Culture of Civility in the Clinical Setting

Setting the Tone:

Exercise: "Think of a time…"

Name it: _____

Feel It: _____

How did you respond? – circle one:

Fight (anger); Flight (avoid); Freeze (silence); Faint (pass-out); or Flow (calm and responsive)

Civility TOOL #1: _____

Emotional Intelligence Awareness:

- **Trigger** – My triggers include:

    o **My plan** for dealing with my triggers includes _____

- **Tilt** – the first physical sign your emotions and body are reacting

    o **My tilt feeling is**:

    o **When I recognize my tilt, I need to** _____

    o This is a reminder to: think and consider the other person's perspective

- **Triggered** – having a physiologic response

    o **My triggered feeling includes**:

    o **When I recognize I am triggered, I need to** _____

- **Amygdala Hijack** – out of control

    o **My Hijack includes**:

    o **When I recognize I am hijacked, I need to** _____

Three A's of Civility: Strategies:

1. _____

2. _____

3. _____

See Civility Toolkit

Points to Remember:

Incivility → leads to **RETALIATION** and increased **VIOLENCE** of self or others

The percentage of workers treated uncivilly:

_____**%** get even with their offender

_____**%** get even with their organization

Websites to check-out: *People can post reviews for:*
Company Reviews: www.glassdoor.com and Boss Reviews:
www.ebosswatch.com
Faculty: www.ratemyprofessor.com.
Social Media: Instagram, Twitter, Facebook, Snapchat

Exercise: What do you see?

Emotional Intelligence:

Character Incompetence (versus Technical Incompetence) → *Conscious or Unconscious*

- Fear of Rejection
- Lack of Trust
- Shame
- Unworthiness & Poor Self-Regard/Esteem
- Blame & Judgment
- Pretending & Assumptions
- Lack of Courage
- Lack of Compassion
- Lack of Vulnerability* (*Recommend: Brené Brown – Power of Vulnerability – TED Talks Video)
- Lack of Personal Accountability
- Sabotage

What about your self-talk - do you ever self-sabotage?

Humor & Incivility:

Strategies: Move to Action → Creating New Conversations

Awareness – Make it Conscious! – ***SET INTENTION for COMPASSION and Naming IT so everyone can SEE IT – no more silence!***

- Take New _____!

- Learn from the past and then_____!

AUTHENTIC CONVERSATIONS

Reflection: *What kind of conversations do your faculty have with each other? With students? What kind of conversations do your students have with each other? With faculty?*

- Listening
- Empathetic Dialogue and Cognitive Rehearsal
- Asking Questions

Accountability *"There is no accountability without clarity"* Tim Porter-O'Grady

a. **Create a "*Safe & Trusting*" Environment**

  i. Education → Coaching/Support

  ii. **Ground-rules & Clear Expectations** "*–Zero Tolerance Policy*"

  Situations that Demand a Conversation: (From *Silence Kills*)

  - Broken Rules and Agreements
  - Mistakes
  - Lack of Support
  - Incompetence
  - Poor teamwork
  - Disrespect
  - Micromanagement

  iii. **Personal Agreements** *"The Five Agreements"*

  iv. **Team/Classroom Agreements:** *"Commitment to My Co-worker"/"Classmate"*

    1. *Mutual Respect*

    2. *Mutual Learning*

    3. *Mutual Accountability*

b. **Make Feedback a "*Learning Opportunity*"**

c. **Continuous Improvement** → *Prioritize time for "Check-in" &"Huddles"*

d. **DWYSYWD** – Do What You Say You Would Do

e. **Take a TIMEOUT – to BREATHE if hijacked. Create a code that is acceptable. To be accountable, establish a timeframe within <u>48 hours</u> to get together.**

f. **Be Patient**

What do you want to make contagious with your students?

❑ **Feedback... What's Feedback?**

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

❑ **Objectives**

- Examine components of communication to foster providing effective feedback

- Discuss two methods of feedback

- Apply feedback concepts as they relate to the narratives

❑ **The Five "W's" of Effective Feedback**

- Why

- Who

- What

- Where

- When

  Additional 3 "W's"

- Wait

- Will

- Worry

❑ **Solution Focused Therapy**

- Strengths-based model

- Assumes that students are doing their best

- Is an adult: :adult model

❑ **Solution Focused Feedback Formula**

- Acknowledge or compliment

- Bridge or rationale

- Feedback

❑ **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)

❑ **Examples**

- 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)

❑ **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)

❑ Crucial Conversations

- 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

❑ 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.

❑ 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?

❑ 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?

❑ 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".

- "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."

- "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"

- "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".

❑ **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?

❑ **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.

❑ **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.

❑ 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.

❑ 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".

❑ 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.

❑ Clinical Narrative #6

- 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!"

❑ **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.

❑ **"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.

❑ **Interprofessional Communication:**

Clarity and Teamwork
The Key to Patient Safety

Dianne McCallister, MD, MBA
Chief Medical Officer
The Medical Center of Aurora

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

❑ **Causes of death in US**

1. Heart Disease

2. Cancer

3. _____

❑ **If we are more careful and try harder, can't we fix this?**

❑ **Let's talk a little bit about brain science...**

<u>Notes:</u>

❑ **Why is SBAR so critical when communicating with physicians?**

❑ **SBAR supports the medical model of decision making**

❑ **When….**

- Rules are broken
- Mistakes witnessed
- Failure to support others seen
- Demonstrated incompetence witnessed
- Poor teamwork seen
- Disrespectful behavior witnessed

❑ **Despite the risk to patients…**

- Fewer than 10% are willing to hold their team member accountable

❑ **How to have those difficult conversations…**

❑ **"CUS"**

- **C** - Express **Concern** - I am Concerned about…
- **U** - I am **Uncomfortable** with…. I need to have you hear my concerns
- **S** - Patient **Safety** Issue... we need to discuss before we proceed

❑ **This is the code and it means STOP!**

❑ **Caring Feedback Model**

- Helps others to "hear" your concerns with less defensiveness since your caring attitude is evident

❑ **Start with your statement of _____ _____ and ask for _____ to provide feedback**

   -For example, *"I know you always want the best for your patients. May I give you some feedback?"*

❑ **Add a touch of _____ that demonstrates how you understand the other person**

   -For example, *"I know you are incredibly short staffed and acuities are high"*

❑ **How to combine:**

Explain your **positive intent** and ask
permission to provide feedback

♦ **C** - Concern

♦ **U** - why you are uncomfortable

♦ Express **empathy**

♦ **S** - state that this is a safety issue

❑ **Let's practice…**

How to model this behavior for students

❑ **Interdisciplinary Care Rounds**

- **Why?**

- **Who?**

    ◊ The patient and family
    ◊ Physician
    ◊ Care Nurse & Charge Nurse
    ◊ Pharmacy
    ◊ Dietary
    ◊ Case Management
- **How?**
    ◊ Firm schedule
    ◊ Scripts
    ◊ Preparation by Providers

<u>**Notes:**</u>

❏ **Why is education regarding teams important?**

❏ **Would it be useful to expose students to a real team in action?**

CUS	Caring Feedback Model	Example
	Explain your positive purpose & ask permission to give feedback	
C: State your concern	Describe the specific behavior	
U: State why you are uncomfortable	Identify the consequences for the patient	
	Add a touch of empathy	
S: State that this is a safety issue	Make your request	

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COLORADO**CENTER**
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Transforming Healthcare Through Workforce Innovation

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	Add a touch of empathy	
S: State that this is a safety issue	Make your request	

Adapted from Steinbinder, A. (2016). Safeguarding patients: The courageous communication solution.

Notes:

'...effective communication requires more than an exchange of information. When done right, communication fosters understanding, strengthens relationships, improves teamwork, and builds trust." *Liz Papadopoulos*

What percentage of communication is verbal?

What percentage of communication is body language?

What percentage of communication is tone?

Professionally how do we most often communicate?

How much of communication and understanding is lost? How often do we fill in our own tone?

Poor communication leads to:

Pearls for positive communication: How do effective leaders design communication strategies that create positive outcomes?

- Ask yourself, what do I want this person to feel, think and do?

- In person conversations are crucial.

- Timing is important. If hijacked, then not right then, check your emotional state. Must be within 48 hours.

- Place matters. Private.

- How we communicate determines what kind of relationship we create.

- Know you lead as much with your actions as with your words.

- Little focus is placed on communication in the team, yet it is essential.

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."

Listening

Listening is an important aspect of communication. Rules for active listening:

- Stop talking

- Prepare yourself to listen. Remove distractions, set your intention.

- Put speaker at ease. Nod, gesture or use words to encourage speaker to continue.

- Listen for ideas; listen to body language and tone.

- Remove judgement and assumptions. Listen from the speakers' perspective.

- Summarize back to speaker what you heard and confirm their meaning.

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

- **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**

  _____
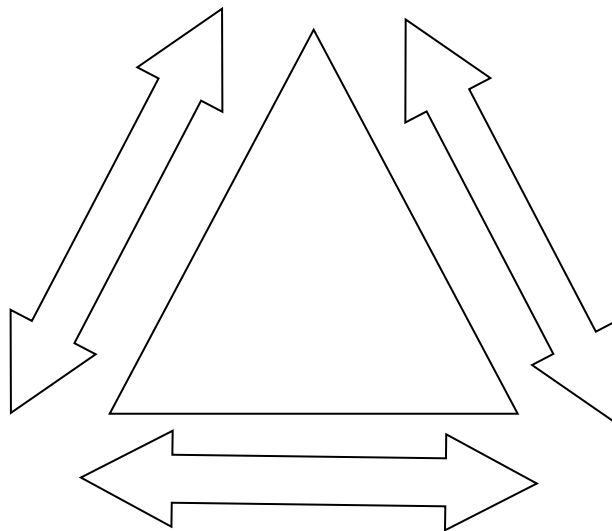
Gossip

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:

_____

_____

_____

Differentiation: Clarifying Internal Drivers
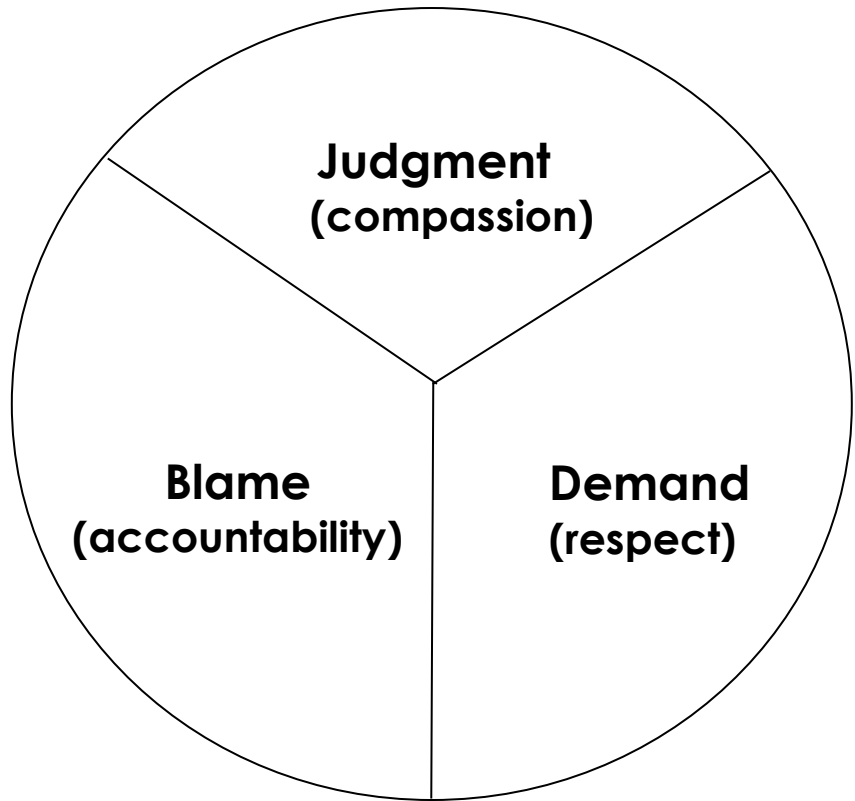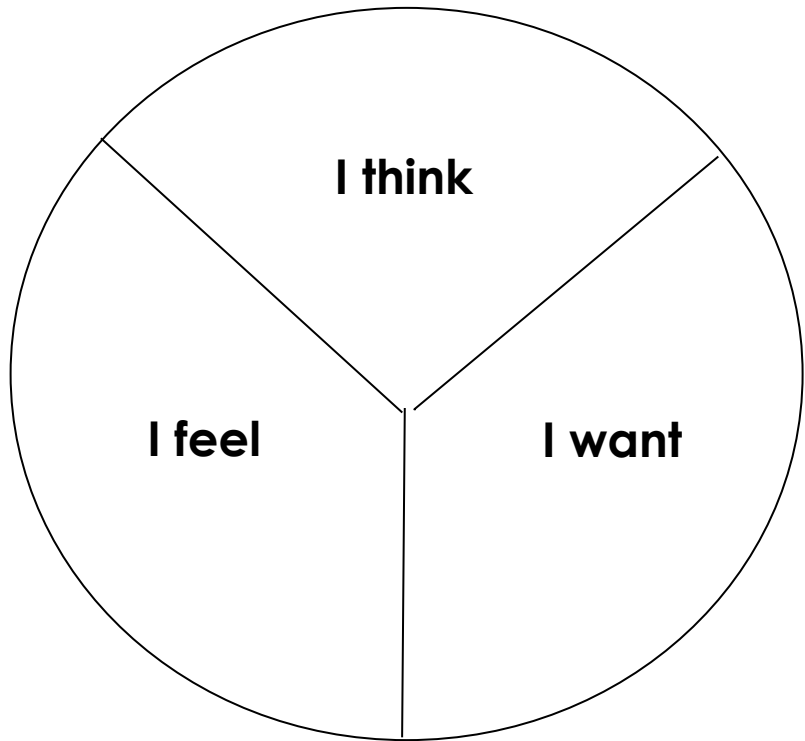
I think

I feel

I want

Judgment
(compassion)

Blame
(accountability)

Demand
(respect)

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.

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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 <u>multiple choice options</u>. 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.

❑ **The Power of Questions for Clinical Scholars**

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

❑ **Questions are the _____**
of the mind.

❑ **Questions from you to lead others**
through the process of discovery

❑ **Difficult or tough questions posed to you**

❑ **Reasons for You to Ask Questions**

- Stimulate the brain

- Create an exchange

- Discover knowledge and issues

- Allows you to listen

- Provides opportunities to acknowledge

- Lead another through a process of discovery
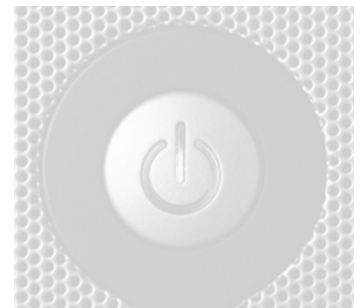
❑ **Questions are the Engine of the Intellect**

❑ **Is knowing Obsolete?**

❑ **Guidelines for Asking Questions**

Know Your Purpose

- What is to be gained?

- Put yourself in the other's shoes

- Phrase the question as a Win-Win

❑ **The Delivery**

- Speak clearly, calmly & directly

- Be positive with no underlying negativity or disapproval

- Don't bury the question

- Display interest in the answer

❑ **The Response**

- Active listening...

❑ **Active Listening has been called an Act of Generosity**

❑ **Additional Active Listening Tips**

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

❑ **Evaluation and Payoff**

- Recognize that clarifying questions may be needed
- Be prepared to question until the issue reaches completion
- Act on the information attained

❑ **When to use questions**

Based on *Teaching Tips* homework:

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

<u>**Notes:**</u>

❑ **Let's look at this a little more deeply…**

- To persuade

- To plant ideas

- To clear up fuzzy thinking

- To solve problems

- To decrease the sting of criticism

- Reduce mistakes

- Gain cooperation

- Reduce anxiety

- Diffuse difficult situations

- To motivate

❑ **How about using a question to deflect if you don't know the answer?**

❑ **Smart Questions**

- What has to be done?

- Please, will you tell me more about the process?

- From what perspective are you asking?

- What are some of the reasons this didn't work as well as you had hoped?

- How do you plan to proceed?

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❑ More Smart Questions

- How do you feel about that?

- Can you explain that further?

- What can I do to help you?

- What do you think is going on?

- What do you want to do?

- What will improve the situation?

- What is the discovery?

- What are your new choices?

- Were there other options you considered and discarded?

- What factors did you consider in making that decision?

❑ "Why" Questions

__A dangerous approach when used *with behavior!*__

- Creates defensiveness

- Cuts off communication

__Rephrase to…__

- What

- How

- Could

❑ **Questions...**

Leading another through the Process of Discovery

❑ **How to Scaffold Questions to "Lead"**

❑ **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...

❑ **How did that work?**

- What are the advantages?

- What are the barriers?

Always the beautiful answer
Who asks a more beautiful question
- E. E. Cummings

❏ **Getting Started...**
Clinical Scholar Role
Clinical Sites/Placements
Clinical Evaluation

Katherine Foss, MSN, RN
Supervisor, Clinical Entry Programs
University of Colorado Health: University Hospital

❏ **Objectives:**

- Identify structure and processes supporting Clinical Scholar role
- Examine and discuss clinical placement site exemplars
- Identify examples to incorporate creativity and diversity in your teaching strategies or clinical placement opportunities.

❏ **Philosophy of Teaching**

Clinical teaching is:
- *Just as important as classroom teaching*
- *A climate of mutual trust and respect*
- *A focus on essential knowledge, skills and attitudes*
- *Knowing a nursing students is a learner, not a nurse*
- *Knowing that nursing students do not perform at the same level*
- *Allowing sufficient time before performance evaluation*

Adapted from Gaberson &Oermann, 1999

❑ **Structure and Processes**

- Academic Mission and Hierarchy
- Clinical Scholar: Type of Position
- Faculty responsibilities
- Academic/Institution policies
- Course syllabus
- Course evaluation tool
- Evaluation: Clinical Scholar
- Evaluation: Clinical Setting or Experience

❑ **Shared Goal:** Identify student's ability to consistently provide safe care *with confidence*

Factors to consider:
- Course focus and objectives
- Practice setting or clinical placement site
- Number of students
- Individual learning needs

*Consider meaning and context of safe care
**Consider engagement, maturity, etc.

❑ **Small Group Exercise**

Develop an assignment for the Virtual Clinical Group

⇒ Tools to use:
- Unit census
- Clinical Readiness Self Assessment (obtained from each student)
- Course objectives include demonstration of appropriate client assessment and safe medication administration process

⇒ Describe the process associated with assignment making

⇒ Create a list of questions, if any, with the assignment making process

⇒ Create a list of valuable information obtained from students used to determine assignment and who might need early or closer supervision

❑ Changing Landscape of Clinical Placements

Creating Clinical Experience Templates:

* *Traditional clinical placement*
  ◊ Acute Care
  ◊ Sub-acute Care
  ◊ Long Term Care
* *Non-acute care clinical placement*
  ◊ Tri-County Public Health Department—Exemplar
  ◊ Ambulatory Care Exemplar
* *Non-traditional use of acute care clinical placement*
  ◊ Perioperative
  ◊ Mental Health on Med/Surg Units - Exemplar
  ◊ Interventional or Diagnostic care settings

❑ Managing Students in Multiple Locations:

- Students are in multiple locations without the Clinical Scholar
- Program staff member is assigned student and responsible for the student experience
- Experiences range from 4 to 8 hours
- Not all experiences will be hands-on or technical
  -Some will be observational only
- Pre/Post Conference Planning determined by Clinical Scholar
  -Encourage MI techniques or Reflective Practice
- Expectations of Students:
  -Professional conduct and planning ahead
  -Conversation about biases

❑ **Tri-County Health Department Opportunities:**

♦ Immunization Clinics / Shots for Tots and Teens Clinics
♦ Family Planning Clinics
♦ WIC and Healthy Communities and Access to Care
♦ Environmental Health Inspections
♦ HIV/STI clinics and Harm Reduction introduction
♦ Disease and Outbreak Investigations
♦ Emergency Preparedness and Bioterrorism Exercises; Masters of Disasters Simulation
♦ TB clinic
♦ Influenza clinics / Health Fairs / Back to School Events
♦ Project Cure / Domestic Violence Projects
♦ Correctional Facilities

❑ **Examplar: Non-Acute Care Clinical Placement**

University of Colorado Hospital: Ambulatory Care

- Ratio: One Clinical Scholar for 6 to 10 students
- 168 hours of clinical time
- Scheduling and Units
- Orientation to practice environment
- Utilizes Preceptor-Model of supervision
  -One Clinic RN is responsible for student experience

University of Colorado Hospital: Ambulatory Care Student Experiences:

- Patient care coordination across the continuum
- Telephone triage
- EBP protocols and practice at level of licensure
- Roles of multiple health professionals: assessment, treatment, evaluation
- Quality improvement projects
- Nurse managed clinics
- Clinic specific procedures

❑ **Exemplar: Non-traditional use of Acute Care Clinical Placement**

University of Colorado Hospital: Mental Health on Med/Surg Units

- Ratio: One Clinical Scholar for 6 students (10 students)
- 48 hours of clinical time
- Scheduling and Units
- Orientation to practice environment
  -Med/Surg Units
  -Emergency Department
  -Safety training

Managing students with different schedules:

- Program staff member assigned to student and responsible for the student experience
- Experiences are 8 hours
- Post Conference determined by Clinical Scholar
  - *Reflective practice*
  - *Role play*
  - *Communication and MI skills*

❑ **Exemplar: Non-traditional use of Acute Care Clinical Placement**

University of Colorado Hospital: Mental Health on Med/ Surg Units

Examples of Student Experiences:

- Behavioral assessment
- Creating behavioral health plan of care
- Discharge planning, referrals and community resources
- Addictions treatment
- Medical management of AWS
- Role spectrum of mental health providers
- Purposeful Visiting
- Screening mechanisms: Suicide, Depression, Abuse
- Medication Use
- Simulation

Small Group Scenarios:

In a small Clinical Scholar group, you will be asked to design a brief clinical rotation experience for one of the clinical sites below:

Group #1: Capstone Course: Long Term Care with two students

Group #2: OB: Inpatient & Primary Care Placement with six students, 24 hrs in hospital & 24 hrs in clinic.

Group #3: MSI: Assisted Living with six students

Group #4: Pediatrics: Neonatal ICU with six to eight students.

Group #5: Immunization Clinic at local Health Department with six students

Please answer the following:

1) **Identify orientation needs of the assigned clinical site:**

   a. Clinical Scholar and Students
   b. Identify unique opportunities at this clinic site

2) **What challenges do you anticipate with this clinical site?**

   a. Scheduling, location(s), and resources
   b. Communication between you, preceptor, and students, evaluation of students

3) **How could each of these challenges be overcome by you as the Clinical Scholar?**

4)   Three weeks into the rotation, the nurse preceptor notifies you, that one of the students made comments that were inappropriate regarding the patient population they interacted with. The comment was "Those people need to learn to stop getting free stuff and get a job, or find a better job so they can pay their own way". How do you handle this situation and what actions do you take?

Small Group Scenario Exercise Notes:

Questions?

www.qsen.org
Kathy Foss | Ph: 720-848-6645 | Email: Katherine.Foss@uchealth.org

❑ **Student Role in the Clinical Agency**

Amy Mills, MS, BS, CCRN, RN
St. Anthony Hospital, Centura

❑ **Objectives**

◊ Discuss the student role in the clinical agency

◊ Identify skills that pre-licensure students may and may not perform in the clinical agency

◊ Discuss the impact clinical agency staff have on student clinical learning experiences

❑ **Preparing students to practice safely, effectively, and compassionately in today's rapidly changing healthcare setting is a challenge.**

❑ **Requirements for Students in the Clinical Agency**

- Affiliation agreement is in place
- Verify clinical scholar or instructor
- Verify course level and number of students
- Attest student screenings are documented
      Background check, immunizations, BLS, OSHA training
- Agency orientation information completed
- Computer & medication access requirements
- Student badges process

❑ **Policies and guidelines for clinical placements are designed to facilitate student identity, patient/client safety and comfort, and infection control.**

❑ **Assumptions about Students**

- Students arrive with theory, knowledge, and simulated laboratory experience, ready to practice nursing skills on real patients

- Students tend to focus narrowly on basic tasks and skills

- Learners may be awkward and slow, which can frustrate a hurried clinician.

Student Role in the Clinical Agency - Amy Mills

❑ **Responsibilities of Students**

- Follow agency policies and procedures

- Ensure the safety of assigned patients

- Be accountable for their own actions

- Identify own learning needs

- Notify scholar of any omission/error in patient care

- Clinical attendance is mandatory

- Follow school and agency dress code

- Understand clinical course learning objectives

- Prepare for patient care

- Maintain patient confidentiality standards according to HIPAA regulations

- Report off to RN assigned to the patient when leaving the floor for any reason and at the end of the shift

❑ **Student Role**

- Be respectful and courteous

- Do not conduct person business on clinical time

- Do not use internet for personal needs

- Be a learner, not a critic

- Appreciate that they are guests of the facility

- Bring own experiences to clinical setting

Student Role in the Clinical Agency - Amy Mills

❑ **Skill Performance**

Students may not perform any skill or procedure that they have not been instructed and evaluated in doing by the school or agency

Students DO:
- Wash hands entering/exiting
- Answer call lights
- Hang routine IV fluids
- Flush IVs
- Change IV tubing
- Change wound & IV dressings
- Draw blood
- Monitor & assess patient responses
- Administer medications
- Monitor blood transfusions
- Insert NG tubes

Students DO NOT:
- Take MD orders/transcribe orders
- Change settings on PCAs
- Transport patients in their cars
- Witness or sign consent forms
- Discontinue central lines
- Recommend OTC drugs/therapy
- Perform ABG puncture
- Administer Chemotherapy
- Perform endotracheal intubation
- Remove narcotics from Pyxis
- Be the 2nd person check for blood or TPN

❑ **Medication Administration**

- **Must be with the direct, visual supervision of the scholar, instructor or RN preceptor**

- Must be co-signed on the eMAR by the RN

   Can administer oral, IM, SQ, IV

   Can monitor certain continuous infusions

   Can administer narcotics

Student Role in the Clinical Agency - Amy Mills

❑ **Documentation in Medical Record**

- Student must have own access code

- Scholar or RN must co-sign student's documentation

- Agency specific guidelines for charting and access to medical record
    - ◊ Care Plans
    - ◊ Discharge teaching
    - ◊ Patient Education

❑ **Student Injury**

- Any student injury must be reported immediately to the course faculty or clinical scholar

- Follow school worker's compensation policy

- May be seen at clinical agency or designated site

- Discuss risks associated with patient care

    - ◊ Needle sticks
    - ◊ Back injury
    - ◊ Compassion or emotional fatigue
    - ◊ Workplace violence

❑ **Staff Nurse Role**

- Staff nurses are meant to be resources for students when faculty members are unavailable

- Serve as nursing role models and educational facilitators of practical nursing skills

- Socialization into the profession is a crucial component of the student's education

❑ **Student Practice in Fast-Paced Regulatory-
   Driven Environments**

⇒ Review Expectations for:
- Core Measures
- Safety Culture and Behaviors for Error Prevention
- Creating Best Patient Experience (HCAHPS)
- Inter-disciplinary Communication
- Critical thinking and recognizing changes in patient condition
- Hourly Rounding
- Unpredictability of patients and routines
- Culture of the unit/organization

❑ **Clinical Learning Environment**

- A positive and enriched learning environment can influence a student's perception of the healthcare facility as a possible future employment site

- A negative experience with overburdened, unpleasant, uninterested staff can impede learning

- Some challenges, such as lack of clinical sites and poor attitudes from patients, are outside your control – Discuss issues in post-conference

❑ **Professional Practice Environment**

- What is the effect of Incivility, Bullying and Horizontal Violence on Students?

- What are some strategies to empower, educate and support students when this occurs?

❑ **Graduate Nurses report they want more practice with:**

- Performing technical skills
- Communicating with MDs
- Managing multiple patient assignments
- Caring for dying patients
- Responding to changes in patient condition
- Discussing the professional RN role

❑ **The education of students provides the foundation on which quality and safety are built**

Notes:

❑ **Early & Often**   <u>**Notes:**</u>

Documenting Student Progress

Marianne Horner, MS, RN, CNM

Colorado Center for Nursing Excellence

❑ **This is a discipline/ skill to develop - observation**

❑ **Student achievement is judged against**
_____ _____ **or**
_____

Apply the same standards to all students

❑ **Key Points in documenting student progress**

- Be attentive

- Observe and record completion of

_____

- Remember, there is so much more to attend to!

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❑ **What is Clinical Evaluation?**

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

❑ **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?

❑ **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

❑ **JUST DO IT!**

❑ **Anecdotal Notes are Formative Evaluation**

- Always record date / time

- Contextual information

- Possessing clarity

❑ **Objectivity is Critical**

- Write only what you are willing to have the student read

- Other parties may have occasion to examine your note

❑ **As Sergeant Friday would say...**

❑ **When shall we begin?**.

❑ **Let's practice...**

- Remember our clinical group?.

❑ **Practice...**

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

❑ **Clinical Practice**
   What is 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

❑ **Clinical Practice**
   What is Unsafe?

- Behavior that places the patient, family or staff in either physical or emotional *jeopardy*
- 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.

❑ **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?

❑ **Guard Confidentiality**

    How?

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

    Recommendation is to turn them in with your completed evaluation forms

❑

Anecdotal Note
+
Anecdotal Note
+
Anecdotal Note
=

Compilation into _____ Evaluation Tool

❑ **No Surprises!**

Notes:

Notes:

❑ **Grading Written Assignments:**
    The Challenge for New Clinical Faculty

Marianne Horner MS, RN, CNM

Colorado Center for Nursing Excellence
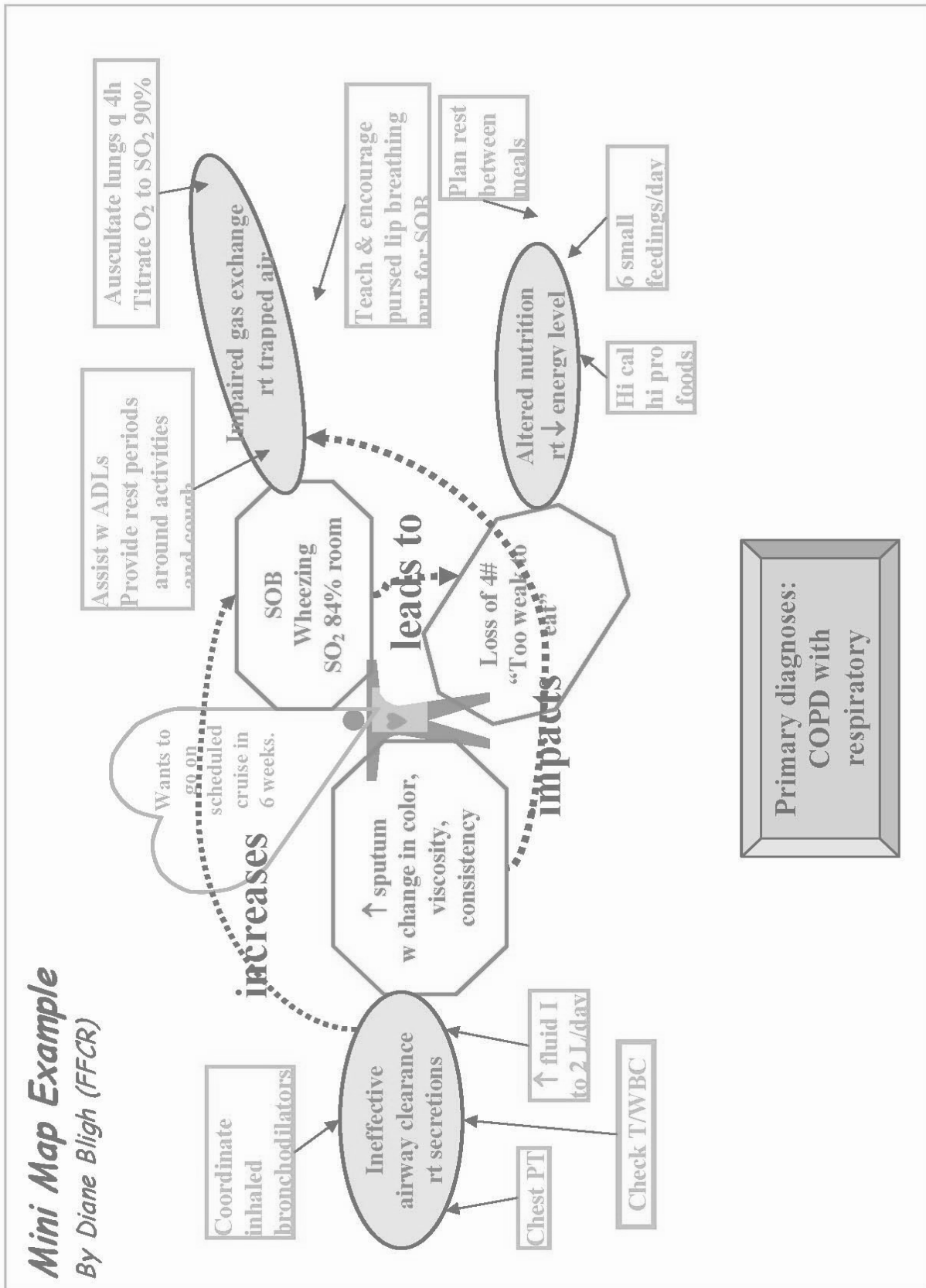
❑ **Grading a Care Plan**

- Why do we do care plans?

Notes:

❑ **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

.

Mini Map Example
By Diane Bligh (FFCR)

Notes:

Welcome to Post-Conference! YOU are the student ~ YOU are the Scholar

"Nursing is Unique" as a Profession

- Most "*trusted*" profession
- Nursing is the *ONLY* profession to require
    - Preparation prior to clinical
    - Post-conferencing as debriefing method
       "*Never tell them what to do but rather, evoke their inner wisdom*"

Reflection Exercise: THINK – PAIR – SHARE

Topic: Setting the Stage for Conferences:

Directions: Step 1 – THINK - Begin individually and answer *one or two* of these questions:

- What will be <u>your</u> purpose for clinical conferences?

- What will <u>your</u> conferences look like? feel like? How will <u>you</u> set up the room?

- What time of day will <u>you</u> hold the conferences and how long will they last?

- What order will <u>you</u> call on the students? How will you draw out the introverted students and settle the extroverted ones?

   Step 2 – PAIR – with a partner, share your ideas. Listen to your partner's ideas to be able to share with the group.

   Step 3 – SHARE – one at a time, share the ideas you heard from your partner with the large group.

Example – Reflection Exercise	Example – Debriefing - The "Teachable Moment!"

• Goal:
   -Provides an opportunity for reflection
   -Demonstrates immediate impact on their own learning
   -Evaluates the student's impact on others
 	
• Index Card or Paper - Write down:
   -2 things you learned in clinical today
   -2 things you taught someone during clinical today
	• *What happened today?*
	• Motivation & readiness to learn
	• Reinforce content
	• Apply "*Big Picture*"
	• Apply to a "*real*" event
	• Enhances retention, critical thinking, decision-making and application in future situations
	Topics:

Video: Example of a Clinical Day for Debriefing

Debriefing Process: How <u>you</u> facilitate the conference makes a difference!
Positive Experiences
- What went well? What did <u>you</u> do well? What do you want to remember to do again?

Learning Opportunities
- There are great learning opportunities for students related to negative experiences. Our goal as scholars is to debrief in a positive/constructive manner to help students see:
  - ⇒ *What can I control?*
  - ⇒ *What can I influence?*
  - ⇒ *What do I have no control over?*
- *Questions to ask when debriefing a learning opportunity:*
- o What did you learn from the experience?
- o What will you do differently next time?
- o How will you use or apply this in the future?

PURPOSE OF CLINICAL CONFERENCES
- Reflection (debriefing) or Preparation for day's events
- Information gathering & sharing
- Evaluate preparation & critical thinking & decision-making
- Facilitate open communication
- Practice real-time group problem solving
- Correlate theory to direct patient care
- Application of Nursing Process
- Teach new content

Example of Instructor Led Exercise: *The Pipe Game* –
Classroom Simulated Clinical Experience

- **Players:**

  o Clinical Course Faculty
  o Quality Control/Safety Officer and Timekeeper
  o Family Member
  o Clinical Scholars/Instructors
  o Students

- **Object of the Game:** *"Safely admit, treat and discharge a patient to home using the pipes to simulate care path."*

Debrief: First Exercise
- What went well?
- What did you learn to do better next time?
- What additional information do you need to be successful next time?

Debrief:
- What went well?
- What did you learn?
- How can you apply these learnings to your role as a scholar and your post-conferences?

Takeaways to Remember:

CLINICAL CONFERENCE GUIDELINES	PRE-CLINICAL CONFERENCES	POST-CLINICAL CONFERENCES
• Set clear guidelines during student orientation — Ground rules for respect, safety, and confidentiality — Leadership: Instructor versus Student lead — Topics are goal-oriented – *not social* — Participation expectation(s) — Course Requirements, *as applicable* — Guest Speaker expectations • Establish times and location for conferences **Scheduling Conferences -** Identify goal for the conference — Time conference to meet goal: Unit/Shift timing AND enhance learning ☐ Keep consistent (for staff and students)	• Meet 15 minutes to one hour prior to start of shift • Review prep-work, give assignment • Assess readiness for patient care — *Brief patient history* — *Plan of Care* — *Priorities* — *Mental/physical capacity/level* • Debrief previous shift if necessary • Notify of events on the unit • Stimulates critical thinking before start What time will you use for pre-clinical conferences? What will be the purpose of your pre-conference? How long will It last? Where will it be located?	• Conference should start when two or more students are present • Meet 30 minutes to one hour at the end of their shift or during shift • Reflection on events of the day away from the unit • Evaluation of "Plan of Care" in peer setting • Instructor evaluates participation What time will you use for post-clinical conferences? What will be the purpose of your post-conference? How long will It last? Where will it be located?

TYPES OF CLINICAL CONFERENCES

- Student-led
- Formal student presentation
- Instructor-led
- Invited speaker
- Hospital conference/forum
- On-line Post-conferences

STUDENT-LED CONFERENCES	STUDENT PRESENTATIONS	INSTRUCTOR-LED
- Assign a student leader prior - Group interaction using critical thinking skills, decision-making and problem solving techniques **Examples of Student Led Conferences** - Case Scenario - Correlate findings - Explain procedures, dx, test - Ethical dilemmas - Conflict resolution - Article – EBP Review	- Topic assigned prior to conference date - Formal presentation - May be graded - Have group discussion after presentation – entire group learns - Group feedback given in positive constructive manner - *Peer Feedback - Have students do in writing*	- Presentation of Topic - Facilitator for discussion - Reflection - student to share clinical experience - <u>Use</u> critical thinking and decision-making - Develop Care Plans/ Concept Map
INVITED SPEAKER	**HOSPITAL CONFERENCE OR FORUM**	**ON-LINE CLINICAL CONFERENCES**

- Clinical Expert
- Specialty Topic
- Discuss Nursing Roles and other disciplines
- Relevant to course
- **Examples**:
  — Wound Care Specialist
  — Case Manager
  — Diabetic Educator
  — Respiratory Therapist
  — Nurse Leader
  — Infection Control Nurse
	- Topic presented relates to disease process currently studying
	- Medical Grand Rounds
	- National speaker
	- Punctuality important
	- Debrief after conference
	- Creates a culture of life-long learning as "professional responsibility"
		- Question or situation presented to all students electronically
		Email
		Blackboard/On-line Location
		- Type of "Group Reflective Practice"
		- Provide ground rules and due dates
		- *Be realistic* with the assignment in relation to other course work
		On-Line Conference Topics
		- Ethical issues
		- Laboratory Data review
		- Priority Setting
		- Patient Education
		- Communication
		- Professional Behaviors
		- Apply theory to clinical

Post-Conference Topic Suggestions and Ideas

Instructor-led Activities for any course:	**Reflective Practice Exercise**:
• Medication Matching List • NCLEX questions with discussion • Laboratory Application – *"What's a nurse to do?"* • *"What if, what else, what then?"* – Revolving Case-Study • *"Sticky Situations"* – Post-it Note issues from during the day • *"Think-Pair-Share"* – group work and present back • "Free Write" – reflective writing exercise • Games – Kahoots, Socrative, Jeopardy/ Family Feud etc. • Write a Song! – *"The Laryngospasms"* or *"Too Live Nurse!"*	Introspective Exercise where students are given the time to answer one of the following questions: • I demonstrated professionalism today by… • Today, my communication was… • I acted as a leader by… • Today I was not happy with the way I did _____ and want to do _____ next time • I showed compassion and caring to my patient with… • I made a difference today by… • I learned to ____ today and I want to remember _____ • My patient taught me _____

Suggested Topics for Discussion in the Post-Conferences – Ideas are listed by Clinical Course **---** *Clinical Scholars should refer to the course syllabus for specific content, clinical competencies and/or objectives assigned to the course by the Nursing Education Program to ensure the activities are relevant to the development level of the student and the program curriculum.*

Fundamentals	
Activities of Daily Living	Interview a Patient
Nurse-Patient Relationship	Establishing Trust
Therapeutic Communication	Range of Motion Exercises
Oral Feeding – Including Assessment of Swallowing	Intake and Output
Hand-washing and Universal Precautions	Fall Prevention
Insertion of Foley Catheter	Turning and Positioning the immobile patient
Touching Boundaries	Humor with Patients
Physical Assessment - Normal verses Abnormal	Bed weights and/or Hoyer Lifting – *students get to be the patient*

Vital Signs	Overview of Central Supply and Scavenger Hunt on how to find and order supplies.
Diet and Nutrition – sample diets and menus	Cognitive Rehearsal for "*Difficult Conversations*" – Authentic Conversations – "Adult-to-Adult"
Communication with other members of the health-team	QSEN -- Quality and Safety -- Overview of the Nurse's Role
First Response Teams – *When to call? And When to call the MD? (What to say – SBAR)*	Incivility – patients, family, staff, classmates – how do I respond?
Multi-drug resistant infections	Delegation
Always Events; Never Events; Sentinel Events	Skin Care/Assessment
Pain and Symptom Management/Control	Mobility
Culture/Diversity	Infection control and Isolation Precautions
Care of the Medical/Surgical Client/Acute - I	
The Nursing Process	Intravenous Therapy - Techniques/ Management
Patient Assessment – Head to Toe	Medication Administration
Patient/Client Care Planning by the Registered Nurse	Wound Care/Simple
Prioritization of Patient Care	Oxygen Therapy Modalities
Development of Care Plans	Central Venous Line Care
Patient Skin Care	Chest Tube Awareness
Client Advocacy	Nasogastric Tubes – Care of and Feeding Process
Registered Nurse Scope of Practice	Post-Operative Care/Simple
Nurses' Notes Documentation	Suctioning and Tracheotomy Care
Ventilator Awareness	Conflict Resolution in the Clinical Arena
Patient Safety and Joint Commission Initiatives	Ethical Situations
Safe Hand-offs—Transition of Care Nurse/ Nurse; Unit/Unit; Setting/Setting/Provider	Interdisciplinary Communication—SBAR

Guest Speakers – RT/PT/OT/DTY/ Spiritual Care/Infection Control	Case Presentations related to theory topic
Teaching and Support for Significant others and or family members	QSEN -- Quality and Safety -- Overview of the Nurses Role
Caring for the Caregiver	
Care of the Medical/Surgical Client/Complex - II	
Care of patients/clients with Diabetes, Chronic Lung Disease, Congestive Heart Failure, CVA	Post-Operative Care/Complex
Delegation of Tasks	Chest Tube Management
Emergency Procedures/Medications	Wound Care/Complex
Blood Administration - demonstration	Total /Partial Parenteral Nutrition Central Venous Line Management
Ventilator Management	Wound Care/Complex
Prioritization/Time Management with Multiple Patients	Giving a Nursing End-of-Shift Report
Nurse as a Patient Advocate	Discharge Planning and Teaching
Role-Play taking Phone Orders from Physician	Care of patient in Specialty Areas – (OR, ED, ICU, PACU, etc.)
Hemodialysis / Peritoneal Dialysis	Ethics – issues r/t Patient Rights, Death/ Dying, Visitation etc.
New Graduate Experience and Reality Shock – Tools to survive	Epidural Pain Management
EKG – Rhythms and Arrhythmias	QSEN -- Quality and Safety -- Overview of the Nurses Role
Care of the Pediatric Client	
Medication Administration to Pediatric Patients/ Clients	Assessment Techniques for Children
Use of Age-Appropriate Toys/Games, Child Life	Growth and Development Issues
Care of the Child Post Operative- Appendectomy	RSV
Care of the Child with Failure to Thrive	Gastrointestinal Issues
Adolescent Drug Abuse/Child Abuse Issues	Obtaining Consents
Communicating with Parents and Child/Family	Ethical issues
Developing Nurse-patient relationship with a child and parents/family	Pain management/control for children

Non-accidental Trauma	Care of Burn Victim
Dealing with child with no parents or family	Cardiovascular issues in children
QSEN -- Quality and Safety -- Overview of the Nurses Role	

Care of the Childbearing Client	
Ante/Postpartum Assessments	Family Teaching
Breastfeeding and patient teaching	Fetal Monitor Observation
Pre-term Labor and PIH	Gestational Diabetes
PIH and Intravenous Medications	Fetal Distress
Fetal Monitoring	Newborn Intensive Care Issues
Grief Associated With Loss of a Baby	Cultural Aspects of Childbirth
Pre- and Post-Epidural Management	Teen Pregnancy
Complications	Care of the Newborn
Newborn Assessment	Dealing with a Mom that needs to stay hospitalized and baby gets transported to Children's Hospital
Care of Multiple-Birth Delivery	QSEN -- Quality and Safety -- Overview of the Nurses Role
Labor – Stages of Labor	Assessing a Cervix
Estimating Blood Loss	

Psychiatric Mental Health Nursing	
Therapeutic Communication in a Psychiatric Setting	Medications Used in the Psychiatric Milieu
Group Activities	Mental Illness and its Impact on Family
Psychiatric milieu	Safety
Suicide Risks and precautions	Low level interventions
Conflict Management	DT's
Restraints – Chemical and Physical	Mental Health Holds
Outpatient Resources and Community Agencies	Boundaries – what to disclose and not disclose to a patient about personal life
QSEN -- Quality and Safety -- Overview of the Nurses Role	Seclusion
ECT	"Room Time"/"Time Outs"/ De-escalation
All Nursing Clinical Courses/Geriatrics	
Biology of Aging	Impediments to Mobility
Alzheimer's/Dementia in the Elderly	End of Life Issues
Depression and Psycho-social Issues in the Elderly	Family Support Issues
Medication Administration to the Elderly	Grief Associated with Loss/Disease/Death
Nutrition and Feeding Issues/Patient and Family	Loneliness
Patient and Family Education	Case Management
Caring	Professionalism
Therapeutic communication	Safety
Priority Setting	Assignment Making – (related to NCLEX for patient room assignments/nurse assignments)
Multi-disciplinary Team Meetings	Legal – Ethical Considerations – reportable events
QSEN - Quality Care Initiatives	Discharging to Another Care Setting – proper handoffs
Culture and Diversity	

Community Health / Public Health	
Community Assessment	Community Education
Bioterrorism	Public Health Emergency
Emergency Response Teams	Public Health Awareness
Home Health –verses - Public Health – verses Community Health -- What is the difference?	Environmental Health
Diseases and Epidemics and Pandemics	Community Resources
Community Resource Identification – Case Study	Refugee and Immigrant Community and Cultural Considerations
Traumatic Brain Injury (TBI) Care Coordination	Family Planning (Birth Control and STD education in Schools)
HCP – Helping Children with Special Needs	Geographical Information – Systems and Mapping Health and Disparity Issues
Case Management, Medical Homes and Patient Advocates for getting though the healthcare system	Community Education and Immunizations with new diseases: H1N1 – *How do we protect? How do we prevent? How do we control?*
QSEN -- Quality and Safety -- Overview of the Nurses Role	Nurse Safety in Home Health
Patient Safety in Home Health	Patient-Centered Care
Homeless Coalition	Evidence-based Practice Delivery

Ambulatory Care Settings – Primary Care Clinics	
Roles and Responsibilities	Crisis in Clinic
Phone Triage	Patient Education
Working with MA's versus CNA's	Group Teaching
Delegation	Documentation and Productivity

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Additional Topics	
Nursing Leadership	Scope of Practice
Staffing	Licensure Requirements
Charge Nurse Role	Nursing Organizations
Delegation	Time Management
Future of Nursing - IOM	Professionalism
Civility - Attitude	Communication in Intraprofessional Teams
Ethical and Legal Issues	Standards for Care – Best practice
Developing Trust	Emotional Intelligence
Connect Core Values and Personal Values	Calling a Physician for Patient Condition Change
Resiliency and Quadruple Aim	Healthy Boundaries

Final recommendations
Set boundaries upfront - Keep it safe! / Avoid Private & Confidential Information
Have planned objective/goal but be flexible! Keep interactive! Make it FUN!

❑ **Legal and Ethical Issues in Nursing Education**

Linda Stroup, PhD, RN
Chair and Professor, Department of Nursing
Metropolitan State University of Denver

❑ **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.

❑

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❑ HIPAA Humor

- Knock, knock

- Who's there?

- HIPAA

- HIPAA who?

- Sorry, I'm not allowed to disclose that information.

Nurstoons by Carl Elbing

Panel 1: I'M SORRY, ACCORDING TO HIPAA GUIDELINES I CAN'T GIVE YOU ANY INFORMATION WITHOUT IDENTIFICATION

Panel 2: LATER THAT DAY... WELL, THESE PIECES OF I.D. CONVINCE ME OF WHO **YOU** ARE, BUT **NOT** THAT YOU'RE MARRIED TO THE PATIENT

Panel 3: LATER THAT DAY... OKAY, YOUR MARRIAGE LICENSE PROVES IT... YOUR HUSBAND WAS DISCHARGED THIS MORNING, BUT GOT TIRED OF WAITING FOR A RIDE, SO HE TOOK A CAB HOME.

www.nurstoon.com

❑ 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?

❑ OSHA

- Schools responsible for education and testing

- Alliance for Clinical Education protocols

- Agencies may have additional requirements

❑ 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

❑ 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

❑ FERPA

- 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."

- 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

- 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

- 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.

❑ **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

❑ **Written Consent**

- 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

❑ **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

❑ **ADA**

- 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

- 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

❑ **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

❑ Student Handbooks

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

    Workman's compensation

    Needle stick injuries

    Impaired students

    Grievances

❑ 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

❑ Impaired Students

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

❑ Grievances

- School policy defines policy and procedure

❑ 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

❑ 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 --

  - 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 THIS clinical setting by policy/procedure?

❑ 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.

❑ Patient Rights

- Right to privacy
- Right of refusal
    –Care
    –Procedures

❑ 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

❑ ANA Code of Ethics

- Protection of patient rights and confidentiality

- Protection of patient health and safety by acting on questionable practice

- Patient protection and impaired practice

❑ Selected Resources

- Colorado Nurse Practice Act

- ANA Standards of Practice

- ANA Code of Ethics

- Agency policy and procedures

- Student Scope of Practice

- Student Handbook

❑ **Clinical Scholars Risk Management**

Kerri Tillquist RN, BSN
ICU Clinical Education Specialist
Clinical Scholar, LNC

❑ **Objectives**

- Provide an overview of legal implications and liability issues in practice and in documentation for the Clinical Scholar
- List four elements professional negligence
- Summarize documentation errors and how to correct them to minimize vulnerability for the Clinical Scholar
- List common reasons nurses are involved in lawsuits

❑ **What is nursing?**

"Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy of care of individuals, families, communities, and populations."

American Nursing Association
Definition of Nursing in Social policy statement
American Nursing Association 2003.

❑ **Documentation as a Bridge**

Do you want this?

Or this?

❑ **Why have a chart?**

- What is a chart?

- Why have a medical record?

    -Presumed to be true

    -Attorney's chief source of information

    -Formal documentary evidence

❑ Clinical Scholars are responsible for...

Safety First!

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

❑ Nurse Practice Act

- The first place for Clinical Scholars to start in consideration of legal risks.
- Nursing faculty must have a clear understanding of the legal definition of an RN in our state, the scope of practice for which the student is being prepared, and any legal requirements of nursing students and faculty in Colorado.
- Our Nurse Practice Act is used in court as a general guide for standard of practice.

❑ Nurse Practice Act (cont.)

- In court, legal actions against nurse educators fall under tort law which is civil law.
- Most common claim against nurses is negligence, or failure to do that which a reasonable nurse would do, which results in damage or harm.

TATTOO MOMENT TO FOLLOW...

❑ **Four Elements of Professional Negligence**

These elements must exist for a charge to be made against a Clinical Scholar, regarding the performance of a student's interaction with a patient:

1. Duty
2. Breach in duty
3. Injury or harm
4. Proximate cause/actual causation/damages

❑ **"Failure is the inability to measure up to certain normal standards."**

Webster's Dictionary

❑ **Common reasons RN's are involved in lawsuits…**

- Failure to properly delegate and supervise
- Failure to intervene, counsel and support the student
- Failure to monitor and assess the student
- Failure to communicate concerns to the faculty of record, college and possibly the hospital
- Failure to follow orders
- Contributing to medical errors
- Failure to ensure patient safety
- Failure to follow P&P/SoC
- Failure to document

❑ 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

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

1. Not questioning the 1.25mg order

2. Telling the SN to take med from unit stock and to give it alone, because it was a potentially dangerous drug

3. Staff 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 meds

4. Calling Clinical Scholar to supervise SN

❑ **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 med IV without supervision

❑ **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 even the SN decided to ask questions."

2. Been available to supervise student nurse in her tasks

❑ **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."

❑ **Teaching Strategies for Working With Students**

"To limit legal liability for both the student and nurse educator, it is important to assess the students' abilities and limitations and set benchmarks for students; students should not progress until the benchmarks are reached. The nurse educator should discuss with nursing staff the skills most often used on the particular clinical unit and use skills checklists to document progress and evaluation forms to document achievements/failures. This will provide legal documentation of education and student progress while also providing constant feedback to the staff and students. All skills and behaviors on which the students will be evaluated should be tied to the learning objectives of the course. Any concerns about the student's performance should be discussed immediately with the student, and skills performed by the students should be supervised in the clinical setting, even if the student has previously demonstrated proficiency in that particular skill in the laboratory setting."

Nurse Educator
Vol. 40, No. 3, May/June 2015, p. 127

❑ **Teaching Strategies for Working With Students (cont.)**

"Instruction in legal liability should be included in the first required courses in any nursing program because this would aid students in understanding actual responsibilities to patients and their own risk of legal liability… It would also increase awareness of our litigious society and encourage adherence to the standards of nursing expected by the nursing program and the state Board of Nursing."

Nurse Educator
Vol. 40, No. 3, May/June 2015, p. 128

❑ **Nurses must practice to the level of technology provided by the institution!**

XEPT???

❑ **Avoiding Lawsuits**

• Develop a strong, trusting relationship to help avoid law suits. If a lawsuit is inevitable, juries favor a caring nurse. Juries love nurses!

• **A.C.T**.; accurate, complete, timely medical records

• Educate patient to be an informed advocate of their healthcare

• Omit blame/jousting from behavior repertoire

❑ **Common Sense Touchstones**

• Your care and treatment should be what you expect for your family, or for yourself

• With support from hospital resources-apologize early

• Every encounter is an opportunity to 'right' a possible wrong

• Seek consultation and support from your resources (Risk Management or Legal)

Notes:

❑ **"Character is who you are in the dark"**

D.L. Moody

❑ **Distinguishing Roles and Clinical Scholar's Legal Responsibility For Student Incident**

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

Hospital

Precepting Nurse

Student

Clinical Scholar

School or College of Nursing

❑ **When is a Clinical Scholar potentially liable?**

- Scholars are responsible for their own actions

- Occurrences under their direct supervision

- Nursing actions for which a student is not deemed competent or prepared to do—improper delegation

- Failure to report to the hospital, college, faculty

❑ **When is a Precepting Nurse Potentially Liable?**

- When there is failure to follow hospital policy and procedure

- When there is failure to reasonably supervise nursing care

- Does the student practice under your license?

❑ **Malpractice Insurance - Yes or No?**

-Personal Decision

-Dependent on role/job duties, course and scope

-Not expensive

-May provide peace of mind

-Know what your policy provides: other insurance clause

❑ **What is <u>never </u>covered by insurance?**

- Intentional acts

- Practicing outside scope of practice

- Criminal acts

- Wanton negligence

❑ **New Challenges in Healthcare and Nursing**

❑ 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

❑ Criticisms of Copy/Paste

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

❑ Electronic Medical Record

REMEMBER!

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

What is a forensic copy?

❑ WORDS

❑ **Educaré**

The Latin word educaré means to "lead out" from ignorance; hence an educated person has come to think critically and logically.

❑ **FREEDOM**

❑ **INQUIRY**

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

-Sir Winston Churchill

❑ **Nursing Education**

PROFESSIONAL ENGAGEMENT

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

❑ **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.

❑ **Engagement**

- PROFESSIONAL ENGAGEMENT

  – ACCOUNTABILITY FOR PRACTICE AND COMPETENCE

  – CITIZENSHIP

  – STEWARDSHIP

  – ADVOCACY

❑ **Competence**

- DETERMINANTS OF COMPETENCE

- ACCOUNTABILITY

  – PERSONAL

  – PROFESSIONAL

  – INSTITUTIONAL

  – PUBLIC POLICY

❑ **Citizenship**

- SOCIAL CONTRACT THEORY – PROFESSIONAL RIGHTS AND RESPONSIBILITIES

- BETTERMENT OF THE PROFESSION

- DEFINING IDENTITY OF THE PROFESSION

❑ **Stewardship**

- TIME , TALENT, TREASURE

- SELF, PROFESSION, HEALTH CARE SYSTEM

- ENGAGING OTHERS IN ACTION AND SOLUTIONS

❑ **Advocacy**   <u>Notes:</u>

- INDIVIDUAL

- PRACTICE

- POLICY

    – INSTITUTIONAL

    – PUBLIC

❑ **Paradigm Shift**

- ENVISIONING THE FUTURE

- FORECASTS AND TRENDS

❑ **Looking to the Future Health Care System**

- COMPLEXITY OF PATIENT CARE

- HEALTH CARE FINANCING

- STAFFING ISSUES

- CONTINUUM OF CARE

❑ **Looking to the Future of Nursing Education**

- CHANGES IN EDUCATIONAL PREPARATION (DEGREES)

- CHANGES IN CRITERIA FOR PROGRAMS

- TECHNOLOGY

- PUBLIC POLICY ISSUES

❑ **Summary and Discussion**

- WHAT SHOULD BE NURSING'S NEXT STEPS?

- HOW DO WE ASSURE A PREFERRED FUTURE FOR NURSING ROLES AND NURSING EDUCATION?

❑ **Website Resources**

- http://www.aacn.nche.edu/

- http://www.aacn.nche.edu/publications/baccalaureate-toolkit

- http://www.aacn.nche.edu/publications/brochures/GradStudentsBrochure

❑ Website Resources

- http://www.aacn.nche.edu/Media/ FactSheets/nursfact.htm

- http://bhpr.hrsa.gov/healthworkforce

- http://www.bls.gov/news.release/ ecopro.toc.htm

- http://www.nurses-co.org/default.asp

- http://www.bls.gov/news.release/ ecopro.toc.htm

- http://www.nln.org/

Notes:

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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 educated BS-prepared nurses pass NCLEX on their first attempt?
    a. 58%
    b. 78%
    c. 85%
    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

❑ **Helping Students Prepare for NCLEX-RN Exam**

<u>Notes:</u>

Teresa Connolly PhD, RN
University of Colorado School of Nursing

❑

HELP!

❑ **Why is NCLEX content included in the Clinical Scholar content?**

❑ **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

❑ Objective

- Discuss clinical and it's relationship to NCLEX

  –Adult Learners like clear applicability

  –Opportunities for NCLEX utilization

  –About the test…

❑ 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*

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

- 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

❑ The cost of the NCLEX exam is:

- $200 each attempt

- Only 3 attempts allowed

- And there is a 45 day waiting period between attempts

❑ **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

❑ **Types of questions**

- Multiple choice
- Multiple response
- Fill in the blank
- Hot spot
- Chart/Exhibit
- Order response items
- Auditory item (breath sounds, heart sounds)
- Graphic item (graphic choices as answers)

***Any item format, including standard multiple-choice items, may include multimedia, charts, tables or graphic images

❑ **Types of Questions**

- 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

❑ **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%

- **Integrated Processes:** integrated throughout Client Needs categories and subcategories
  - Nursing Process
  - Caring
  - Communication and documentation
  - Teaching/Learning
  - Culture and spirituality

❑ **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.

  –On April 1, 2013 the NCSBN board of directors voted on the passing standard revision to 0.00 logits on the NCLEX-RN logistic scale, 0.16.

  -On Dec. 9th 2015, NCSBN voted to keep the current passing standing until March 31, 2019

❑ **Pass Rates 2016:**

- First time: 85% (US Educated)
- Repeat takers: 46% (US Educated)
- 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.

❑ **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

❑ **Results are received:**

- By mail within 4-6 weeks of taking the exam
- Or non-official e-mail notification with nominal fee of $7.95

❑ **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.)

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❑ How Do I Teach Critical Thinking?

- 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?

- 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?

- 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?

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

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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

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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

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

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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

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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

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Reality Shock! "I am a Clinical Scholar, it won't happen to me!"

Words from one of my students…

Nursing Education is an opportunity to "*Pay it Forward*"
➢ That is Magic!
➢ As a Clinical Scholar – <u>you</u> will "*evoke inner wisdom*!"

What is Reality Shock?
➢ "Refers to the specific shock-like reactions of new workers when they find themselves in a work situation for which they have spent time preparing and suddenly find they are not prepared." Marlene Kramer, 1974
➢ Shock can occur when one changes roles and moves from a familiar, comfortable environment to a new role.
➢ When expectations & perceived expectations are unclear
➢ Results in powerlessness, insecurity and depression

Kramer's Four Phases of Reality Shock
➢ Honeymoon Phase
➢ Shock
➢ Recovery
➢ Resolution

Research on Reality Shock
➢ Can last six months to a year
➢ When training and support added ➔ there is a 25-50% improvement in retention
➢ <u>Two - Key Concepts</u>
    o Job Satisfaction
    o Sense of Belonging

Benner's Theory
  - ➢ Novice to Expert – *Where are you?*
  - ➢ Clinical Scholars/ Clinical Instructors - Clinical **Experts** ➔ **Novice** Teachers
    - ➢ "Be __patient__ with yourself as you become expert teachers!"

Research on Reality Shock - Novice Faculty Research
  - ➢ Most classic and significant research by *Siler & Kleiner*
  - ➢ Four Themes from the interviews emerged:
    - o Expectations
    - o Learning the "Game"
    - o Being Mentored
    - o Fitting In

Expectations:
   "… it's an entirely different culture than __anything__ I've ever been exposed to. There… is a different language and set of expectations that you don't encounter in the other settings."

Performance Concerns:
   "I tried to be over-prepared and anticipate every possible question. Then, somebody would ask me some off-the-wall question, and I wouldn't know what to say. I felt mortified I couldn't answer their question! Actually, that group of students was pretty tolerant, but I felt like I should know everything when I didn't."

Memorable Experiences:
   "I will never forget the feeling of having to tell someone they've failed and the agony that went with it. [The Student] will never know how many nights' sleep I lost over it. Is this the right thing to do?... Hoping I made the right decisions… I really agonized over it… I still think it was in the student's and I hope in the profession's best interest. But, it was like, oh man, if this is what being a faculty person is, I don't know."

Coping:

"… *everything was really overwhelming at first, I came in just all excited. It felt like… the story about a donkey that fell into a well and they couldn't get him out, so they decided to bury him. They threw in dirt and more dirt. Instead of letting them bury him, the donkey shook the dirt of his back and stomped it down. He stomped it down until he was able to walk his way out. And, that is the way I felt at first, they were dumping on me and now I've figured out how to step on top of the dirt they're dumping on me and go on.*"

You are not alone…

Examples of <u>my</u> experiences to ponder… how will you handle these situations?

- ➢ Your first day as the Clinical Instructor/Scholar? First lecture…
- ➢ A student complains your assignments "are not fair?"
- ➢ Your student is not prepared or safe to care for the patient?
- ➢ Your student's first death experience?
- ➢ Joint Commission or State Surveyor talking to your student?
- ➢ Your student makes a medication error?
- ➢ An irate family member or patient refusing care by your student?
- ➢ Student with an undiagnosed learning disability? Unable to repeat a task safely?
- ➢ Student experiencing "violence at home" - comes to clinical with a black eye?
- ➢ Your first student not meeting the objectives resulting in your need to give a failing grade?
- ➢ A "bad" evaluation from a student?
- ➢ Complaint by student – not following grievance procedures!
  - o Going to another Faculty Member
  - o Formal Petition
  - o To a Political Leader

There are tremendous responsibilities to balance…

- ➢ What does it feel like?
- ➢ Remember… We <u>all</u> need time for learning
- ➢ Students **and** *New Scholars* **need time to learn** <u>*before*</u> performance is evaluated
  - o How do you survive?

Strategies to Remember:

Stop, listen and think!
- ➢ Take a deep breath!
- ➢ Oxygen is good for brain tissue!
- ➢ Pause to THINK before responding.
- ➢ AVOID saying the first thought that comes into your mind!
- ➢ Take a break <u>or</u> think overnight!

Communicate, communicate, COMMUNICATE!
- ➢ Be transparent!
- ➢ Explain the values & philosophies for your decisions
- ➢ Give rationale for expectations
- ➢ Be explicit with "ground-rules" Day 1 - *put them in writing*!
- ➢ Explain the clinical learning process – "*it is your job to evaluate them!*"
- ➢ Communicate with
    - o Students
    - o the school of nursing
    - o the clinical agency
    - o and each other!

Establish TRUST upfront!   Here is your script!
- ➢ During the first clinical day – Ask for a show of hands…
    - o *How many of you are hoping to become mediocre nurses?*
    - o *How many of you are hoping to become highly competent nurses?*
- ➢ Tell them: "*I trust that you want my feedback to help you achieve your goal, thus I will honor you by sharing my observations. I ask that you trust that my sole purpose in sharing both positive and constructive feedback is to help you achieve your goal.*"
- ➢ Then – when feedback: "*It may be hard for you to hear this, but I promised at the beginning of the course to give you feedback to help you to your goal…*"

Reference: *Susan Luparell PhD, APRN, BC - 2007*

Then…Build on the Trust
➢ Explain to the students your role for "*questioning*" during clinical

Keep students & patients <u>SAFE</u>.
➢ Prepare the ***patient***
  o You are their safety net!
➢ **Protect** the students in front of others ➔ Talk in **private** whenever possible

"*Inspire*" the Next Generation
➢ You are "Real Nurses"
➢ Demonstrate the Art and the Science of Nursing!
➢ Show them YOUR passion for nursing!

Role Model what you do best…
➢ Clinical Experts ➔Role Model Nursing

➢ Role Model Respect
  o Say "Please" and "Thank you"
  o Say "I am sorry" when you are
  o Articulate & give rationale for why you are <u>or</u> are not doing things
  o Use I feel – I think – I want and avoid You, But and Why!

➢ Emulate Caring… Ethics… Integrity… Professionalism… etc.
  o To student
  o To patient
  o To staff
  o To school
  o With yourself

More Listening and Less Talking - *Remember the 80/20 Rule*

- *It is not about us!*
- *It is about the <u>students</u>!*
- Leaders and Educators should:
    - o **<u>Tell</u>** 20% of the time!
    - o **<u>Ask</u>** 80% of the time!
    - o If asked, "*What should I do?* "
        - ▪ STOP → Be Curious → Ask them a question
        - ▪ *Resist the temptation to give them the answer*! Asking ?s – Evokes Inner Wisdom!

Really "Supervise" the Students

- Be Present & Visible – to the Students; Patients; and Staff
- Validate progress towards competency!
- Focus on "*Critical Thinking & Decision-making*" → not just skills
- Use "Teachable Moments"
- No Multitasking!

Practice Delivering Constructive Feedback – With Compassion

- Control the setting - Choose the place, time & your words
- Direct feedback at "observable objectives"
- Write out your script!
- Visualize & Practice OUT LOUD (*use a mirror or friend to rehearse*)
- Begin with "*I trust…*" *statement and* "I feel → I think → I want"
- *Mean what you say & say what you mean!*
- Anticipate reactions and plan for them

Develop Immediacy Skills

- Be available → Arrive early & stay late *(only takes 5-10 min.)*
- Feedback –
    - o Verbal ASAP and in private
    - o Written assignments in timely manner → <u>*always*</u> before next paper
    - o 48 hour rule for crucial conversations
        - ➢ ****Instructors with better immediacy skills have less incivility problems****

Documentation & Notification
- Follow guidelines for anecdotal notes & evaluation
- Early & Often: Be timely, objective, specific and clear
- Follow your "chain of command" keep the right people in the loop!
    - Legally
    - Support for you

When the Red Flags are Waving…
- Believe your Gut!
- Take Action
- "*Failure to take action immediately after an act of incivility increases the scope of action that eventually will have to be taken*." Feldman

Use Your Resources - You are Not ALONE!
- Faculty/School
- Staff/Other Clinical Scholars
- Policy & Procedure Manuals/School Handbooks/Disciplinary Process
- Your Mentor
- Faculty from this course: *we gave you our emails! Please reach out to us!!*

Find a Mentor or Coach!
- If you don't have one → find one!
- If you <u>do</u> have one:
    - Thank them for supporting you
    - Meet with them regularly
    - Allow them to <u>be</u> your mentor/coach!

Make time for ROUTINE Reflection!
- Reflect on the clinical experience for the Student, Patient, Staff
- Reflect on the Course
- Reflect on your role as the Scholar
    - What did I do well?
    - What did I learn?
    - What will I repeat? What do I need to do differently next time?

Play nice in the sandbox!
- ➢ Take personal accountability for your communication
- ➢ No more silence! → Acknowledge & name incivility
- ➢ Be courageous → have authentic conversations
- ➢ Be vulnerable by inviting feedback → *this is a learning opportunity (especially when it is hard to hear!)*

Keep a sense of humor!   Perceptions…

- ➢ If you **don't use** Humor:
  - o Distant
  - o Arrogant
  - o Threatening
  - o Intimidating

- ➢ If you **use** Humor:
  - o Approachable
  - o Confident
  - o Creative
  - o In Control

Don't get too comfortable! - Keep STRETCHING yourself!
- ➢ Be a safety detective! Stay alert! Be PRESENT!
- ➢ Expect the unexpected!
- ➢ Life is not always fair – AND it is *always* a learning opportunity!
- ➢ Then, when something does happen → your amygdala will not be hijacked!

Continue to build confidence… "The Basics" - **SELF CARE –**
- ➢ Breathe!!! Put YOUR mask on first!
- ➢ Accentuate a Positive Attitude!!
- ➢ Be Your OWN cheerleader!!
- ➢ Eat Right!
- ➢ Get enough sleep!
- ➢ Don't take work home with you!
- ➢ Take Breaks!
- ➢ Take it one step at a time!
- ➢ Keep current!

Personal Supply Kit to Survive Reality Shock! *(please feel free to email me and let me know if you want the list of supplies!)*

Final words of wisdom to help keep it all in perspective!
➢ Thumbs UP Everybody! Welcome to Nursing Education!
➢ We are so glad you are here!
➢ Remember to *Evoke their Inner Wisdom* and you will *Make some Magic*!

Keep in touch!

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