1. Teaching Adults in the Clinical Setting

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

2. 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.

3. Notes:
4. Adult Learners

- How can I apply this today?
- Why do I need to know this?

5. 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

6. Motivators to Learning

Intrinsic:

Extrinsic:
7. Barriers to Learning

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

8. How can you assess for barriers?

9.

Name: Tabitha
Healthcare experience: got my CNA but haven't 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 care for the last couple of months.
10. The Educator’s Role

- Facilitates learning while keeping patients & students safe
- Plan, implement and __________ learning experiences
- Give honest, specific and timely feedback

11. Skill Acquisition

12. 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
13. Effective Clinical Teaching

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

How will you do this?

14. Effective Clinical Teaching

- 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

15. Effective Clinical Teaching

- Look for and use teachable moments (they are powerful teaching tools)
16. Effective Clinical Teaching

- Ask questions

Open ended questions help determine __________________________ and builds __________________________

17. Effective Clinical Teaching

- Tell stories

18. Effective Clinical Teaching

- Have FUN!
19. Difficult Student Behaviors  
(and strategies to employ)

20. Difficult Student Behaviors

- Invisible Student
  - lacks confidence
  - shy
  - quiet

- Strategies
  - seek this student out
  - ask direct questions
  -- reinforce contributions

21. 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
22. 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

23. Student Learning is….

Significantly related to teacher behaviors!

24. THANK YOU!!!

Monica.Brock@TheMedCo.com
1. Nursing Education

PROFESSIONAL ENGAGEMENT

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

2. Objectives

- EXPLORE PROFESSIONAL ENGAGEMENT AS A FRAMEWORK FOR A PARADIGM CHANGE IN ROLE DEVELOPMENT FOR THE 21ST CENTURY NURSE.

- RELATE PROFESSIONAL ENGAGEMENT TO THE FUTURE OF NURSING EDUCATION AND HEALTH CARE DELIVERY.

3. Engagement

- PROFESSIONAL ENGAGEMENT
  - ACCOUNTABILITY FOR PRACTICE AND COMPETENCE
  - CITIZENSHIP
  - STEWARDSHIP
  - ADVOCACY
4. Competence

- Determinants of Competence
- Accountability
  - Personal
  - Professional
  - Institutional
  - Public Policy

5. Citizenship

- Social Contract Theory – Professional Rights and Responsibilities
- Betterment of the Profession
- Defining Identity of the Profession

6. Stewardship

- Time, Talent, Treasure
- Self, Profession, Health Care System
- Engaging Others in Action and Solutions
7. Advocacy

- INDIVIDUAL
- PRACTICE
- POLICY
  - INSTITUTIONAL
  - PUBLIC

8. Paradigm Shift

- ENVISIONING THE FUTURE
- FORECASTS AND TRENDS

9. Looking to the Future Health Care System

- COMPLEXITY OF PATIENT CARE
- HEALTH CARE FINANCING
- STAFFING ISSUES
- CONTINUUM OF CARE
10. Looking to the Future of Nursing Education

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

11. Summary and Discussion

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

12. Website Resources

- http://www.aacn.nche.edu/
- http://www.aacn.nche.edu/publications/baccalaureate-toolkit
- http://www.aacn.nche.edu/publications/position-statements
13. Website Resources

- http://www.aacn.nche.edu/Media/FactSheets/nursfact.htm
- http://bhpr.hrsa.gov/healthworkforce
- http://www.nurses-co.org/default.asp

14. Website Resources

- http://www.nln.org/
1. Nursing Education

- Trends and Issues
- Changing Faculty Roles

2. Objectives

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

3. Yesterday and Today

- HISTORICAL PERSPECTIVES
- TODAY’S REALITIES

4. Current Issues—Shifts in Nursing Education

- THE LEARNER
- THE FACULTY
- THE LOCATION
- THE INFORMATION
- THE EDUCATIONAL PROCESS
5. Health Care System Issues and Nursing Education

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

6. The Changing Paradigm

- EDUCATIONAL PREPARATION – EDUCATING NURSES: A CALL FOR RADICAL TRANSFORMATION (2009)
- INSTITUTE OF MEDICINE REPORT – FUTURE OF NURSING (2010)
- EDUCATION INSTITUTIONS
- SHORTAGES
Making the application of all the information on “Student Characteristics” to the Clinical Experience—SIMPLE!

How hard can it be?

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

**K (Key/Knowledge)**
- Key -- helps “unlock” the differences
- Key to understanding
- Knowledge is the first step!
- If don’t know, ask!

**I (Individualize/Information)**
- 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)**
- Student is the priority
- Schools is your resource
  - Contact them
  - Policies for addressing
  - Support services & resources
- If don’t know… ask!

**S (Success /Safety etc)**
- Define Success with student
- Show Understanding
- *ALWAYS* 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?
- 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 and 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.”

STUDENT 2 – MICHAEL JONES

- Michael is a charmer. He is able to sweet talk the staff on the unit to help him with every procedure. 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 before 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!”
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, seems to understand your directions and is able to communicate effectively with the team and her patients, she just has difficulty with writing English and documenting inappropriate medical terminology.

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.”

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.”
- She is repeating this course for the 2nd time after failing “theory” last semester.
- How would you have responded if she requested the day off on the day before the Ramadan started? Would your response be difference based on when she made the request (i.e.: at the beginning of the semester versus the day before?)
STUDENT 6 – JOAN SMITH
• During orientation, Joan was enthusiastic and driven. She has an incredible smile and her personality is engaging - she quickly made friends with other students.
• Tonight, after clinical she is out for dinner with her family and gets in a minor motor vehicle trauma. She calls you right away to tell you she will not be in clinical tomorrow and asks you to give her “something to do for the clinical hours while she recovers at home.”

STUDENT 7 – LIZ CLARKSON-BROWN
• While walking to post-conference, you overhear Liz talking with Emily.
• She rolls her eyes several times and even points her finger at Emily when she says, “Well, you’ll understand better when you are more grown up.”
• During post-conference she shakes her head every time Emily speaks to discuss her experience.

STUDENT 8 – ROBIN BAKER
• Robin is a student with previous experience as an EMT prior to nursing school. He has a significant amount of field experience and is excellent with assessments.
• He is impatient with his classmates and didactic faculty and says his abilities are “far beyond” theirs and he just wants to get “on-with-it.”
• He has a charismatic and confident personality. During skills he is rushed and does not focus on details. During clinical & conferences he monopolizes the discussions and your time. He likes to be the first to answer and then when he is done, he is ready to move on to the next topic.
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.

Deb Center MSN, RN, CNS, CTACC
~ Colorado Center for Nursing Excellence ~
deb@ColoradoNursingCenter.org
Who is responsible for setting the tone for civility within your work or classroom environment?

Setting the Tone:
“All I really know is people do the best they can with what they know.” Oprah

The #1 Fear in Life: __________________________
The #1 Need in Life: __________________________

“There are only two things in life you can control:
your ________ and your _________. The rest is an _________________.

Coach O

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)

TOOL #1: ____________________________________________

- 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 __________________________
Civility — Deb Center

Three A’s of Civility: Strategies:

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________


Points to Remember:

• “Incivility has the power to intimidate people into silence. It isolates the targets and makes them feel ashamed and responsible. Angry words lead to physical avoidance and withdrawal.” AACN “Silence Kills”

• “Memory of incivility can linger for years.” → Diagnosed PTSD r/t incivility in the workplace & classroom.

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:

   Faculty: www.ratemyprofessor.com.

   Social Media: Instagram, Twitter, Facebook, Snapchat


Exercise: What do you see?

EI: 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* (Recommended: Brené Brown – Power of Vulnerability – TED Talks Video)
• Lack of Personal Accountability
• Sabotage

Humor & Incivility: How does this impact your classroom or your team?

Strategies: Move to Action → Creating New Conversations

Center’s Three A’s of Civility Strategies
1. Awareness
2. Authentic Conversations
3. Accountability


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?
The 8 Rights of Adult-to Adult Conversations:

1. Right _____________________________________________________________________________
2. Right _____________________________________________________________________________
3. Right _____________________________________________________________________________
4. Right _____________________________________________________________________________
5. Right ______________________, ____________________________, and ______________________
6. Right _____________________________________________________________________________
7. Right _____________________________________________________________________________
8. Right _____________________________________________________________________________

**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 **48 hours** to get together.
Be:

What do you want to make contagious? Civility Strategies on a Budget:
1. **Clinical Scholar**
   Why—Who—What—How

Marianne D. Horner, MS, RN, CNM

2. **Why would a person want to be a Clinical Scholar?**
   - Originally developed as a strategy to soften the impact of the faculty shortage and.....
   - Personal motivation

3. **Who is a Clinical Scholar?**
   - Difference between Clinical Scholar and other clinical educators
   - Qualifications - http://www.dora.state.co.us/nursing/rules/ChapterII.pdf

4. **Where does your paycheck come from?**
   - Will you be directly teaching rotations of nursing students?
5. Categories

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

6. What are the qualifications for a Clinical Scholar?

- Clinical expertise
- Educational requirements
- Previous teaching
7. Ability to combine two roles

- Clinical nurse
  - Competent
  - Expert

- Clinical Scholar
  - New role
  - Novice

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

- Novice
  1.
  2.
  3.
  4.
  5.
  6.
9. Patricia Benner: Skill Acquisition: Novice to Expert

- Expert

1. 

2. 

3. 

10. Ability to Blend Two Distinct Cultures

- Clinical organization’s culture and values

- Culture and values of nursing education
  — Schools of nursing
  — Students
11. What does a Clinical Scholar Do?

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 

12. How do you Become a Clinical Scholar?

- Preparation
  - Didactic course
  - Formal academic education

- Role development from Novice → Expert

- Ongoing mentoring

- Deliberate reflection
13. Meet our Clinical Group!
### Benner's Stages of Clinical Competence

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

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

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

<table>
<thead>
<tr>
<th>Proficient</th>
<th>The proficient performer <em>perceives situations as wholes</em> rather than in terms of chopped up parts or aspects, and performance is <em>guided by maxims</em> (definition: general truth).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Can now recognize when the expected normal picture does not materialize. This <em>holistic</em> understanding improves decision making.</td>
</tr>
<tr>
<td></td>
<td>- Decision making becomes less labored because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones.</td>
</tr>
<tr>
<td></td>
<td>- Uses maxims as guides, which reflect what would appear to the competent or novice performer as unintelligible nuances of the situation, they can mean one thing at one time and quite another thing later. Once one has a deep understanding of the situation overall, however, the maxim provides direction as to what must be taken into account. Maxims reflect nuances of the situation.</td>
</tr>
<tr>
<td></td>
<td>- Able to see what is most important in a given situation</td>
</tr>
<tr>
<td></td>
<td>- Perceives deviation from the normal pattern</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expert</th>
<th>The expert nurse no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- With an enormous background of experience, now has an <em>intuitive grasp</em> of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions.</td>
</tr>
<tr>
<td></td>
<td>- Operates from a deep understanding of the total situation.</td>
</tr>
<tr>
<td></td>
<td>- The performer is no longer aware of features and rules; his/her performance becomes fluid and flexible and highly proficient.</td>
</tr>
<tr>
<td></td>
<td>- This is not to say that the expert never uses analytic tools. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience. Analytic tools are also necessary for those times when the expert gets a wrong grasp of the situation and then finds that events and behaviors are not occurring as expected.</td>
</tr>
<tr>
<td></td>
<td>- Has a vision of what is possible.</td>
</tr>
</tbody>
</table>
The one thing humans do more than communicate:

We can not NOT

Communication consists of

Humans Communicate
Once the message is sent, it

It can be amended AND the first impression is

This is often unconscious.

How we communicate determines what kind of relationships we make.

Self-regard is a major influence in all communication.

Stress results when self-regard is threatened.

Communication is learned from
Poor Communication leads to:

________________________

________________________

________________________

________________________

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

________________________

to smoothly functioning teams.
Guidelines for Communication

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


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

- Your preferred position is

- If I’m a victim

- After I’ve been “persecuted”

- Rescuer goes to Persecutor

- In this game we can take any role
## Gossip

**Definition** — Talking about someone that is not present.

**Good Gossip** — Talk that enhances another’s view of the person being talked about.

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

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

Is it true?
Is it fair?
Will it bring goodwill and better relationships for all concerned?

Self-Awareness

Why am I gossiping?
What need am I filling?
Would I say this directly?

There is a relationship between gossip and wanting to belong. Social bonding.
Before you text, type or speak, THINK first.

T is it ________________________________
H is it ________________________________
I is it ________________________________
N is it ________________________________
K is it ________________________________
Dealing with Difficult People

Definitions:

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

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

**Confront** – to face especially in challenge; meet or bring face to face
Levels of Accountability

8. 
   
7. 
   
6. 
   
5. 
   
4. 
   
3. 
   
2. 
   
1. 
1. Introduction
   - Difficult person
   - Difficult situation
     Empowerment in a conflict situation is defined as:

2. Stimuli for upset or reaction:
   - Trigger is Outside
   - The responding Feeling is Inside
     ”You Make me Feel so …..”

3. What are Responses?
   - Stress or Fear

4. Automatic Reactions?
   - Unconscious – fight or flight
Physiological Responses?

- Create list of responses / reactions

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

- Patterns:
  Raised adrenalin leads to:
  Assumptions
  
  Examples:

________________________________________________________________
________________________________________________________________
________________________________________________________________
• We go through life reacting to
  
  External World

  Vs.

  Responding Creatively

Internal

1. Feelings _______________________________

2. Thoughts _____________________________

3. Wants _______________________________
Which is most difficult for you to identify?

Exercise:

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

How does that look for you?

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

examples

<table>
<thead>
<tr>
<th>Feel</th>
<th>→</th>
<th>→</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think</td>
<td>→</td>
<td>→</td>
</tr>
<tr>
<td>Want</td>
<td>→</td>
<td>→</td>
</tr>
</tbody>
</table>
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 and Conflict Resolution - Ingrid Johnson and Susan Moyer

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

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

Set the Climate and State Your Case
What will you say in this step?

•

•

•

•

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

•

•

•

•

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

•

•

•

•
How to Confront Effectively

Definition of Confrontation

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

Guidelines for When Confrontation is Appropriate

Don’t Confront:

Who: External Customers
When: You are angry or out of control.
      The personal risk is too high.

Do Confront:

Who: Colleagues and personal relationships
When: Quality of work is the issue.
      Relationship will be damaged if not confronted.
      Personal quirks – less important but still legitimate.
Confrontation Steps

Set the Climate and State Your Case

- Ask for time.
- State your intentions.
- State your concerns or reservations.
- Own your responsibility.
- Describe the behavior being confronted.
- State the impact of the behavior (thoughts and feelings).

Listen for Understanding

- Give 100% attention.
- Demonstrate understanding.

Negotiate and Make Agreements

- Make specific personal requests.
- Offer help in the change.
- Describe the positive/negative consequences.
- State the agreements reached.
- Establish a follow-up.
- Share the appreciation.
More Tips on Handling Angry People

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

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

2. **Responding to hostile comments:**
   - Apologize to the person. Not a personal apology such as “It’s all my fault.” A more neutral, professional apology, “I’m sorry we’re having difficulty agreeing on this issue” or “I’m sorry you’re upset.”

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

4. **Keep the discussion tentative.**
   - Raise questions
   - Mention other possibilities
   - Suggest ways to give both of you time to think

5. **Avoid your own dogmatic statements.** Stay flexible. Try temporary arrangements, especially if the problem is temporary.
   - Yelling, screaming, and physical gestures. The words often contain threats and are not always coherent or logical.
   - This tactic is usually unpredictable even to the person who uses it.

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

7. **Get the other person’s attention.** Speak loudly, but do not use an angry tone. Use phrases such as:
   - “Stop, stop”
   - “Hold on”
   - “Wait a minute”
   - “Slow down”
   - “Ok, I understand”

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

9. **Be prepared to repeat yourself, but do not use an angry tone in the repetition.**
10. Take a break. Give the other person a chance to calm down. Move to a different location.

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

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

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

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

• What will your conferences look like? feel like? How will you set up the room?

• What time of day will you hold the conferences and how long will they last?

• What order will you 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.
Conferencing - Deb Center

<table>
<thead>
<tr>
<th>Example – Reflection Exercise</th>
<th>Example – Debriefing - The “Teachable Moment!”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Goal:</td>
<td>• What happened today?</td>
</tr>
<tr>
<td>- Provides an opportunity for reflection</td>
<td>• Motivation &amp; readiness to learn</td>
</tr>
<tr>
<td>- Demonstrates immediate impact on their own learning</td>
<td>• Reinforce content</td>
</tr>
<tr>
<td>- Evaluates the student’s impact on others</td>
<td>• Apply “Big Picture”</td>
</tr>
<tr>
<td>• Index Card or Paper - Write down:</td>
<td>• Apply to a “real” event</td>
</tr>
<tr>
<td>- 2 things you learned in clinical today</td>
<td>• Enhances retention, critical thinking, decision-making and application in future situations</td>
</tr>
<tr>
<td>- 2 things you taught someone during clinical today</td>
<td>Topics:</td>
</tr>
</tbody>
</table>

Video: Example of a Clinical Day for Debriefing

Debriefing Process: How you facilitate the conference makes a difference!

Positive Experiences
• What went well? What did you 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:
  - Clinical Course Faculty
  - Quality Control/Safety Officer and Timekeeper
  - Family Member
  - Clinical Scholars/Instructors
  - 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?

Take Aways to Remember:
## Conferencing - Deb Center

<table>
<thead>
<tr>
<th>CLINICAL CONFERENCE GUIDELINES</th>
<th>PRE-CLINICAL CONFERENCES</th>
<th>POST-CLINICAL CONFERENCES</th>
</tr>
</thead>
</table>
| • 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 | • 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 | • 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 pre-clinical conferences?  
  What will be the purpose of your pre-conference?  
  How long will it last?  
  Where will it be located?  
  
  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? |

### Scheduling Conferences
- Identify goal for the conference  
- Time conference to meet goal: Unit/Shift timing AND enhance learning  
- Keep consistent (for staff and students)
TYPES OF CLINICAL CONFERENCES

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

## STUDENT-LED CONFERENCES

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

## INVITED SPEAKER

<table>
<thead>
<tr>
<th>INVITED SPEAKER</th>
<th>HOSPITAL CONFERENCE OR FORUM</th>
<th>ON-LINE CLINICAL CONFERENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Clinical Expert</td>
<td>- Topic presented relates to disease process currently studying</td>
<td>- Question or situation presented to all students electronically</td>
</tr>
<tr>
<td>- Specialty Topic</td>
<td>- Medical Grand Rounds</td>
<td>Email</td>
</tr>
<tr>
<td>- Discuss Nursing Roles and other disciplines</td>
<td>- National speaker</td>
<td>Blackboard/On-line Location</td>
</tr>
<tr>
<td>- Relevant to course</td>
<td>- Punctuality important</td>
<td>Type of “Group Reflective Practice”</td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td>- Debrief after conference</td>
<td>- Provide ground rules and due dates</td>
</tr>
<tr>
<td>- Wound Care Specialist</td>
<td>- Creates a culture of lifelong learning as “professional responsibility”</td>
<td>- Be realistic with the assignment in relation to other course work</td>
</tr>
<tr>
<td>- Case Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diabetic Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Respiratory Therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Nurse Leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Infection Control Nurse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 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:**
- 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 – Jeopardy/Family Feud etc.
- Write a Song! – “The Laryngospasms” or “Too Live Nurse!”

**Reflective Practice Exercise:**
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.

<table>
<thead>
<tr>
<th>Fundamentals</th>
<th>Activities of Daily Living</th>
<th>Nurse-Patient Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview a Patient</td>
<td></td>
<td>Establishing Trust</td>
</tr>
<tr>
<td>Range of Motion Exercises</td>
<td>Oral Feeding – Including Assessment of Swallowing</td>
<td>Intake and Output</td>
</tr>
<tr>
<td>Fall Prevention</td>
<td>Hand-washing and Universal Precautions</td>
<td>Turning and Positioning the immobile patient</td>
</tr>
<tr>
<td>Humor with Patients</td>
<td>Insertion of Foley Catheter</td>
<td>Humor with Patients</td>
</tr>
<tr>
<td>Bed weights and/or Hoyer Lifting – students get to be the patient</td>
<td>Physical Assessment - Normal verses Abnormal</td>
<td></td>
</tr>
<tr>
<td>Vital Signs</td>
<td>Overview of Central Supply and Scavenger Hunt on how to find and order supplies.</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Diet and Nutrition – sample diets and menus</td>
<td>Cognitive Rehearsal for “Difficult Conversations” – Authentic Conversations – “Adult-to-Adult”</td>
<td></td>
</tr>
<tr>
<td>Communication with other members of the health-team</td>
<td>QSEN -- Quality and Safety -- Overview of the Nurse’s Role</td>
<td></td>
</tr>
<tr>
<td>First Response Teams – When to call? And When to call the MD? (What to say – SBAR)</td>
<td>Incivility – patients, family, staff, classmates – how do I respond?</td>
<td></td>
</tr>
<tr>
<td>Multi-drug resistant infections</td>
<td>Delegation</td>
<td></td>
</tr>
<tr>
<td>Always Events; Never Events; Sentinel Events</td>
<td>Skin Care/Assessment</td>
<td></td>
</tr>
<tr>
<td>Pain and Symptom Management/Control</td>
<td>Mobility</td>
<td></td>
</tr>
<tr>
<td>Culture/Diversity</td>
<td>Infection control and Isolation Precautions</td>
<td></td>
</tr>
</tbody>
</table>

### Care of the Medical/Surgical Client/Acute - I

<table>
<thead>
<tr>
<th>The Nursing Process</th>
<th>Intravenous Therapy - Techniques/Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Assessment – Head to Toe</td>
<td>Medication Administration</td>
</tr>
<tr>
<td>Patient/Client Care Planning by the Registered Nurse</td>
<td>Wound Care/Simple</td>
</tr>
<tr>
<td>Prioritization of Patient Care</td>
<td>Oxygen Therapy Modalities</td>
</tr>
<tr>
<td>Development of Care Plans</td>
<td>Central Venous Line Care</td>
</tr>
<tr>
<td>Patient Skin Care</td>
<td>Chest Tube Awareness</td>
</tr>
<tr>
<td>Client Advocacy</td>
<td>Nasogastric Tubes – Care of and Feeding Process</td>
</tr>
<tr>
<td>Registered Nurse Scope of Practice</td>
<td>Post-Operative Care/Simple</td>
</tr>
<tr>
<td>Nurses’ Notes Documentation</td>
<td>Suctioning and Tracheostomy Care</td>
</tr>
<tr>
<td>Ventilator Awareness</td>
<td>Conflict Resolution in the Clinical Arena</td>
</tr>
<tr>
<td>Patient Safety and Joint Commission Initiatives</td>
<td>Ethical Situations</td>
</tr>
</tbody>
</table>
### Care of the Medical/Surgical Client/Complex - II

<table>
<thead>
<tr>
<th>Safe Hand-offs – Transitions of Care Nurse/Nurse; Unit/Unit; Setting/Setting/Provider</th>
<th>Interdisciplinary Communication - SBAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guest Speakers – RT/PT/OT/DTY/ Spiritual Care/Infection Control</td>
<td>Case Presentations related to theory topic</td>
</tr>
<tr>
<td>Teaching and Support for Significant others and or family members</td>
<td>QSEN -- Quality and Safety -- Overview of the Nurses Role</td>
</tr>
<tr>
<td>Caring for the Caregiver</td>
<td></td>
</tr>
</tbody>
</table>

#### 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 |
| Ventilator Management | Central Venous Line Management |
| Prioritization/Time Management with Multiple Patients | Wound Care/Complex |
| Nurse as a Patient Advocate | Giving a Nursing End-of-Shift Report |
| Role-Play taking Phone Orders from Physician | Discharge Planning and Teaching |
| Hemodialysis / Peritoneal Dialysis | Care of patient in Specialty Areas – (OR, ED, ICU, PACU, etc.) |
| New Graduate Experience and Reality Shock – Tools to survive | Ethics – issues r/t Patient Rights, Death/ Dying, Visitation etc. |
| EKG – Rhythms and Arrhythmias | Epidural Pain Management |
| | QSEN -- Quality and Safety -- Overview of the Nurses Role |

### Care of the Pediatric Client

<table>
<thead>
<tr>
<th>Medication Administration to Pediatric Patients/ Clients</th>
<th>Assessment Techniques for Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Age-Appropriate Toys/Games, Child Life</td>
<td>Growth and Development Issues</td>
</tr>
<tr>
<td>Care of the Child Post Operative-Appendectomy</td>
<td>RSV</td>
</tr>
</tbody>
</table>

---

**Nurses Empowering Nurses to Cultivate Healthy Communities**

68
<table>
<thead>
<tr>
<th>Topic</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of the Child with Failure to Thrive</td>
<td>Gastrointestinal Issues</td>
</tr>
<tr>
<td>Adolescent Drug Abuse/Child Abuse Issues</td>
<td>Obtaining Consents</td>
</tr>
<tr>
<td>Communicating with Parents and Child/Family</td>
<td>Ethical issues</td>
</tr>
<tr>
<td>Developing Nurse-patient relationship with a child and parents/family</td>
<td>Pain management/control for children</td>
</tr>
<tr>
<td>Non-accidental Trauma</td>
<td>Care of Burn Victim</td>
</tr>
<tr>
<td>Dealing with child with no parents or family</td>
<td>Cardiovascular issues in children</td>
</tr>
<tr>
<td>QSEN -- Quality and Safety -- Overview of the Nurses Role</td>
<td></td>
</tr>
</tbody>
</table>

**Care of the Childbearing Client**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante/Postpartum Assessments</td>
<td>Family Teaching</td>
</tr>
<tr>
<td>Breastfeeding and patient teaching</td>
<td>Fetal Monitor Observation</td>
</tr>
<tr>
<td>Pre-term Labor and PIH</td>
<td>Gestational Diabetes</td>
</tr>
<tr>
<td>PIH and Intravenous Medications</td>
<td>Fetal Distress</td>
</tr>
<tr>
<td>Fetal Monitoring</td>
<td>Newborn Intensive Care Issues</td>
</tr>
<tr>
<td>Grief Associated With Loss of a Baby</td>
<td>Cultural Aspects of Childbirth</td>
</tr>
<tr>
<td>Pre- and Post-Epidural Management</td>
<td>Teen Pregnancy</td>
</tr>
<tr>
<td>Complications</td>
<td>Care of the Newborn</td>
</tr>
<tr>
<td>Newborn Assessment</td>
<td>Dealing with a Mom that needs to stay hospitalized and baby gets transported to Children’s Hospital</td>
</tr>
<tr>
<td>Care of Multiple-Birth Delivery</td>
<td>QSEN -- Quality and Safety -- Overview of the Nurses Role</td>
</tr>
<tr>
<td>Labor -- Stages of Labor</td>
<td>Assessing a Cervix</td>
</tr>
<tr>
<td>Estimating Blood Loss</td>
<td></td>
</tr>
</tbody>
</table>
### Psychiatric Mental Health Nursing

<table>
<thead>
<tr>
<th>Topic</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Communication in a Psychiatric Setting</td>
<td>Medications Used in the Psychiatric Milieu</td>
</tr>
<tr>
<td>Group Activities</td>
<td>Mental Illness and its Impact on Family</td>
</tr>
<tr>
<td>Psychiatric milieu</td>
<td>Safety</td>
</tr>
<tr>
<td>Suicide Risks and precautions</td>
<td>Low level interventions</td>
</tr>
<tr>
<td>Conflict Management</td>
<td>DT’s</td>
</tr>
<tr>
<td>Restraints – Chemical and Physical</td>
<td>Mental Health Holds</td>
</tr>
<tr>
<td>Outpatient Resources and Community Agencies</td>
<td>Boundaries – what to disclose and not disclose to a patient about personal life</td>
</tr>
<tr>
<td>QSEN -- Quality and Safety -- Overview of the Nurses Role</td>
<td>Seclusion</td>
</tr>
<tr>
<td>ECT</td>
<td>“Room Time”/”Time Outs”/ De-escalation</td>
</tr>
</tbody>
</table>

### All Nursing Clinical Courses/Geriatrics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biology of Aging</td>
<td>Impediments to Mobility</td>
</tr>
<tr>
<td>Alzheimer’s/Dementia in the Elderly</td>
<td>End of Life Issues</td>
</tr>
<tr>
<td>Depression and Psycho-social Issues in the Elderly</td>
<td>Family Support Issues</td>
</tr>
<tr>
<td>Medication Administration to the Elderly</td>
<td>Grief Associated with Loss/Disease/Death</td>
</tr>
<tr>
<td>Nutrition and Feeding Issues/Patient and Family</td>
<td>Loneliness</td>
</tr>
<tr>
<td>Patient and Family Education</td>
<td>Case Management</td>
</tr>
<tr>
<td>Caring</td>
<td>Professionalism</td>
</tr>
<tr>
<td>Therapeutic communication</td>
<td>Safety</td>
</tr>
<tr>
<td>Priority Setting</td>
<td>Assignment Making – (related to NCLEX for patient room assignments/nurse assignments)</td>
</tr>
<tr>
<td>Multi-disciplinary Team Meetings</td>
<td>Legal – Ethical Considerations – reportable events</td>
</tr>
<tr>
<td>QSEN - Quality Care Initiatives</td>
<td>Discharging to Another Care Setting – proper handoffs</td>
</tr>
<tr>
<td>Culture and Diversity</td>
<td></td>
</tr>
</tbody>
</table>
### Community Health / Public Health

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

### Additional Topics

<table>
<thead>
<tr>
<th>Nursing Leadership</th>
<th>Scope of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>Licensure Requirements</td>
</tr>
<tr>
<td>Charge Nurse Role</td>
<td>Nursing Organizations</td>
</tr>
<tr>
<td>Delegation</td>
<td>Time Management</td>
</tr>
<tr>
<td>Future of Nursing - IOM</td>
<td>Professionalism</td>
</tr>
<tr>
<td>Civility - Attitude</td>
<td>Communication in Intraprofessional Teams</td>
</tr>
<tr>
<td>Ethical and Legal Issues</td>
<td>Standards for Care – Best practice</td>
</tr>
</tbody>
</table>

### Final recommendations

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

Documenting Student Progress

Marianne Horner, MS, RN, CNM

Colorado Center of Nursing Excellence

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

3. Student achievement is judged against specific standards or criteria

- Apply the same standards to all students

4. Key Point in documenting student progress

- Be attentive

- Observe and record completion of tasks

- Remember, there is so much more to attend to!
5. When briefing & de-briefing tasks...

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

6. Document interactions that demonstrate emerging clinical judgment

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

7. JUST DO IT!
8. Anecdotal Notes are Formative Evaluation

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

9. Objectivity is Critical

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

10. As Sergeant Friday would say...

11. When shall we begin?
12. Let’s practice...

- Remember our clinical group?

13. Practice...

- Here is Emily Day…

- You are her Clinical Scholar observing this interaction

- Write an anecdotal note

14. Guard Confidentiality

- How?

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

- Recommendation is to turn them in with your completed evaluation forms
16. Anecdotal Note + Anecdotal Note + Anecdotal Note = Compilation into Summative Evaluation Tool

17. No Surprises!

18. A+
1. Grading Written Assignments: The Challenge for New Clinical Faculty

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

2. Grading a Care Plan

- Why do we do care plans?

3. Care Maps/Mind-Mapping

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

4. Mini Map Example

- (see handout at the end of this section)
5. Grading a Paper

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

6. Process for Grading Written Assignments

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

7. Process, continued

- First reading:
  - Scan for common strengths / concerns
  - Adjust expectations if needed
  - Keep preliminary marking to a minimum
8. Process, continued

- Second reading
  - Apply rubric
  - Provide comments / feedback
  - Identify strengths, offer encouragement
  - Be specific re. point deductions

9. Additional Considerations

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

10. Additional Considerations

- What about plagiarism?
  - Turnitin.com
  - Plagiarism.org
- Color of writing instrument
- Okay to submit for early reading?
11. Technology Support

- iAnnotate app to “hand grade”
  - iAnnotate for grading papers - http://www.youtube.com/watch?v=sxOP9s7ZcZY
  - Branchfire.com/iannotate/

12. Technology Support

- Quickoffice Pro for papers and clinical evaluations

- Also university electronic platform such as Blackboard; Ecollege, etc.
Mini Map Example
By Diane Bligh (FFCR)

Ineffective airway clearance rt secretions
- Coordinate inhaled bronchodilators
- → fluid intake 1 to 2 L/day
- ↑ chest PT
- Check T/WBC

Impaired gas exchange rt trapped air
- SOB
  - Wheezing
  - SO2 84% room
- Assists w ADLs
  - Provide rest periods around activities and cough
  - Titrate O2 to SO2 90%
- Auscultate lungs q 4h

Loss of 4# “Too weak to eat”
- Altered nutrition rt ↓ energy level
  - Plan rest between meals
  - Hi cal hi pro foods
  - 6 small feedings/day

Wants to go on scheduled cruise in 6 weeks.

Primary diagnoses:
- COPD with respiratory
 Evaluating or Creating Learning? MIND MAPPING/CARE MAPPING
By Diane Bligh (FRCC)

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

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

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

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

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

Marianne Druva Horner, MS, RN, CNM
Colorado Center for Nursing Excellence

2. Mr. Holland’s Opus

3. “Did You Know” + nursing education as we know it = ???

4. Let’s look at our history….

- Why?
- Why?
- Why?

5.
6. How is health care changing?

7. Carnegie Foundation for the Advancement of Teaching
   - Educating Nurses: A Call for Radical Transformation
   - Patricia Benner, et al.

8. [Image of a bucket and a wooden structure]
9. Patient Safety and Quality

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

10. 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. Use unfolding case studies
5. Tie content together – demonstrate connections between concepts and facts

- A Work in Progress...
12. How To Vote via Texting

1. Standard texting rates only (worst case US $0.20)

2. We have no access to your phone number

3. Capitalization doesn’t matter, but spaces and spelling do

13. Poll Results

14. Other Resources

- 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:
1. Interprofessional Communication:

**Clarity and Teamwork—**
The Key to Patient Safety

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

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

2. Team Strategies & Tools to Enhance Performance and Patient Safety
3. Causes of death in US

1. Heart Disease
2. Cancer
3. Preventable medical errors

4. If we are more careful and try harder, can’t we fix this?

5. Let’s talk a little bit about brain science...

6. How much can one mind hold?
   - The law of 7s.

7. Gorilla Video
8. Only smart people can read this. I cdnuolt blveiee taht I cluod aula-clty uesdnatnrd waht I was rdanieg. The phaonnmeal pweor of the hmuan mnid, aoccdrinig to a rscheearch at Cmabrigde Uinervtisy, it deosn't mtaer in waht ordr the ltteers in a wrod are, the olny iprmoatnt tihng is taht the frist and lsat ltteer be in the rghit pclae. The rset can be a taotl mses and you can sittl raed it wouthit a porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe. Amzanig huh? yae and I awlyas tghuhot slpeling was ipmorant!

9. Why is SBAR so critical when communicating with physicians?

10. Differential Diagnosis

- Can create knowledge-based error
- This type of logic has
  -30% chance of error
  30% chance of not detecting an error was made
11. **Medical Training Addresses These Errors**

Tactics used to minimize errors in diagnosis:

- Structured problem solving—same information in same order *every* time—(might look rigid to others)

- Identify all possibilities and *then* identify the right answer based on facts

- Interruption = Restart From the Top

12. **SBAR supports the medical model of decision making and provides information in the order that allows accurate decision making**

13. **When...**

- Rules are broken
- Mistakes witnessed
- Failure to support others seen
- Demonstrated incompetence witnessed
- Poor teamwork seen
- Disrespectful behavior witnessed
14. Despite the risk to patients…

- Fewer than 10% directly confronted their colleague

15. How to have those difficult conversations...

16. “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 proceeds”
17. This is the code and when these particular words are used, there can be no mistake regarding the importance of what is being said and it means STOP!

18. Caring Feedback Model

Helps others to “hear” your concerns with less defensiveness since your caring attitude is evident.

19. Start with your statement of positive intent and ask for permission 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 empathy that demonstrates how you understand the other person

- for example, “I know you are incredibly short staffed and acuities are high”
20. 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

21. Let's practice...

How to model this behavior for students

22. Could this be helpful?

Questions & Comments
<table>
<thead>
<tr>
<th>CUS</th>
<th>Caring Feedback Model</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Explain your positive purpose &amp; ask permission to give feedback</td>
<td></td>
</tr>
<tr>
<td>C:</td>
<td>State your concern</td>
<td>Describe the specific behavior</td>
</tr>
<tr>
<td>U:</td>
<td>State why you are uncomfortable</td>
<td>Identify the consequences for the patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add a touch of empathy</td>
</tr>
<tr>
<td>S:</td>
<td>State that this is a safety issue</td>
<td>Make your request</td>
</tr>
</tbody>
</table>

InterProfessional Teams - Marianne Horner & Dianne McCallister
**CUS Caring Feedback Model Example**

<table>
<thead>
<tr>
<th></th>
<th>Explain your positive purpose &amp; ask permission to give feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>C: State your concern</td>
<td>Describe the specific behavior</td>
</tr>
<tr>
<td>U: State why you are uncomfortable</td>
<td>Identify the consequences for the patient</td>
</tr>
<tr>
<td>S: State that this is a safety issue</td>
<td>Make your request</td>
</tr>
</tbody>
</table>

Nurses Empowering Nurses to Cultivate Healthy Communities

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**
  - **Games:** Physical Activities, Board Games, Group Games etc. (Examples: 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)
  - **Simulation:** Low or High Fidelity; Case Scenarios; Role-play

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

- **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!**
  - 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?”
  - Always tie the activity to learning objectives
  - Reflect on takeaways and how will apply learning in other situations

- **Repeat or Scaffold Another Scenario** (where appropriate and followed by second debriefing)
  - Reinforce Learning
  - Practice building skills
  - Builds confidence

**Reflection:**

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


1. Auditory, Visual and Kinesthetic Learning

2. Learning preferences

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

3. Auditory Learners

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

4. Visual Learners

- Process new information best when it is visually illustrated or demonstrated
  See things in pictures
- Graphics
- Images
- Illustrations
- Demonstrations
- “I see what you are saying”
5. Kinesthetic Learners

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

6. Blended Learning
1. Clinical Scholar Workshop: Legal and Ethical Issues in Nursing Education

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

2. Objectives

- Discuss selected legal information that guides the clinical scholar role.

- Discuss selected ethical issues that can occur in the clinical setting with nursing students.

- Identify at least three resources that are available to clinical scholars related to legal and ethical issues in the clinical setting.

3. 

- Agency Policies & Procedures
- OSHA
- HIPAA
- FERPA
- ADA Regulations
- Background Checks
- Workman’s Compensation
- Impaired Students
- Accountability
- Rights
4. HIPAA Humor

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

5. 

6. HIPAA

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

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

8. Background Checks

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

9. Family Educational Rights and Privacy Act (FERPA)

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

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

11. FERPA

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

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

12. FERPA

- Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):
  - School officials with legitimate educational interest;
  - Other schools to which a student is transferring;
  - Specified officials for audit or evaluation purposes
13. FERPA

- Appropriate parties in connection with financial aid to a student;

- Organizations conducting certain studies for or on behalf of the school;

- Accrediting organizations;

- To comply with a judicial order or lawfully issued subpoena;

- Appropriate officials in cases of health and safety emergencies; and

- State and local authorities, within a juvenile justice system, pursuant to specific State law.

14. FERPA

- The following items are not considered educational records under FERPA:

  ◊ Private notes of individual staff or faculty, (NOT kept in students’ advising folders)

  ◊ Campus police records

  ◊ Medical Records

  ◊ Statistical data compilations that contain no mention of personally identifiable information about any specific student
15. Written Consent

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

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

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

- Offices for Students with Disabilities processes requests for accommodations

- School may ask for reasonable medical documentation

- Learner is very stable on medication, or is using a prosthetic, and is not currently substantially limited in a major life activity, that person is not “disabled” under the ADA or Section 504

18. ADA

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

19. ADA

- Some key points:

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

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

  Minimum functional abilities
20. **Student Handbooks**

- Each college has a student handbook containing specific information related to:
  
  - Workman’s compensation
  
  - Needle stick injuries
  
  - Impaired students
  
  - Grievances

21. **Workman’s Compensation**

- Students are usually covered by the college in the clinical area

- College has specific agencies, clinics, providers that must be used

- Established time lines very important

- Needle stick or other injury usually covered here

22. **Impaired Students**

- Identify source for college and agency policy

- Notify course facilitator/school immediately
23. Grievances

- School policy defines policy and procedure

24. Colorado Nurse Practice Act

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

25. Student Scope of Practice

- What must be considered ??

- If the RN scope is based on what was included in the completed nursing education program and additional knowledge/training
26. **Student Scope of Practice**

- 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?

27. **Clinical Agency Policies and Procedures**

- Clinical scholars and students must follow agency policy

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

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

29. ANA Code of Ethics with Interpretive Statements

- Establishes the ethical standard for nursing profession
- Revised in Spring 2015
- Nine provisions:
  - First three describe fundamental values and commitments of the nurse
  - Next three address boundaries of duty and loyalty
  - Last three address aspects of duties beyond individual patient encounters
30. ANA Code of Ethics

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

31. Selected Resources

- Colorado Nurse Practice Act
- ANA Standards of Practice
- ANA Code of Ethics
- Agency policy and procedures
- Student Scope of Practice
- Student Handbook
NCLEX Exam: Test Your Knowledge

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

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

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

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

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

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

7. NCLEX questions are in a multiple choice format.
   a. True
   b. False
8. Results are received
   a. Immediately upon completion of the exam at the testing center
   b. By mail within two weeks of the exam
   c. By mail within 4-6 weeks of taking the exam
   d. By phone within a few days of testing

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

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

Teresa Connolly PhD, RN
University of Colorado School of Nursing

2. 

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

4. Why?

- License to practice dependent on passing NCLEX

- Great way to assess student’s thought processes/critical thinking.

- Good review of content relevant to patient prior to student caring for given client.

- Help student develop NCLEX practice patterns
5. Objective

- Discuss clinical and its relationship to NCLEX
  - Adult Learners like clear applicability
  - Opportunities for NCLEX utilization
  - About the test…

6. The NCLEX is created by:

- National Council of State Boards of Nursing in order to:
  - Determine if a student is ready to be a safe and effective nurse.
  - Safeguard the public.
  - Test for minimum competency.

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

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

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

- Security at the test site by Palm Vein Technology and digital fingerprinting
8. The cost of the NCLEX exam is:

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

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

- It is a variable length, adaptive test, given by computer
- Computer adaptive test
  - Variable number of questions
  - 75 - 265
  - Can’t go back and change an answer
  - Can’t skip questions
  - Up to 6 hours to complete

10. Types of questions

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

- Chart/exhibit questions
  
  - Display a client's chart showing 3 tabs that the candidate would need to click on and read the information in order to answer the question.
  
  - Tabs could include any of the following:
    - prescriptions,
    - history and physical,
    - lab results,
    - miscellaneous reports,
    - imaging results (e.g. chest x-ray, etc.),
    - flow sheets,
    - medication administration record,
    - progress notes,
    - vital signs

12. Passing the Exam

- The NCSBN Board of Directors determined that
  
  - safe and effective entry-level RN practice requires a greater level of knowledge, skills, and abilities than was required in 2007, when NCSBN implemented the current standard.
  
  - The new passing standard is 0.00 logits on the NCLEX-RN logistic scale, 0.16 logits higher than the previous standard of -0.16.
  
  - The new passing standard took effect on April 1, 2013, and is the standard until 2016
13. Pass Rates 2015:

- First time: 85% (US Born)
- Repeat takers: 45% (US Born)
- And….it doesn’t necessarily mean that if a student fails the NCLEX on the first try, he/she is likely to get extra help and pass on the second attempt.

14. Pass Rates

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

15. Results are received:

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

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

- Students who perform well on critical thinking assessments, do well on NCLEX and visa versa.
17. 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?

18. How Do I Teach Critical Thinking?

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

  – Am I holding them responsible for prerequisite information?

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

19. How Do I Teach Critical Thinking?

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

- Am I helping students to apply knowledge gained in one clinical experience to other situations?
20.

21. Topics

- Client Needs
  - Safe and Effective Care Environment
    - Management of Care 17-23%
    - Safety and Infection Control 9-15%
  - Health Promotion and Maintenance 6-12%
  - Psychosocial Integrity 6-12%
  - Physiological Integrity
    - Basic Care and Comfort 6-12%
    - Pharmacological and Parenteral Therapies 12-18%
    - Reduction of Risk Potential 9-15%
    - Physiologic Adaptation 11-17%
22. Topics — But wait, there's more!

- Integrated Processes: integrated throughout the Client Needs categories and subcategories
  - Nursing Process
  - Caring
  - Communication and
  - Teaching/Learning

23. Whew!

- And we wonder why students are anxious about this process?
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, b, d, d, b
NCLEX Review: Women’s Health

1. A nurse in a health care clinic is instructing a pregnant woman in how to perform “kick counts”. Which statement by the woman indicates a need for further instructions?
   a. “I should place my hands on the largest part of my abdomen and concentrate on the fetal movements to count the kicks.”
   b. “I will record the number of movements or kicks.”
   c. “I need to lie flat on my back to perform the procedure.”
   d. “A count of fewer than 10 kicks in a 12-hour period indicates the need to contact the physician.”

2. A physician has prescribed transvaginal ultrasonography for a woman in the first trimester of pregnancy and the woman asks the nurse about the procedure. The nurse accurately provides which of the following information to the client?
   a. The procedure takes about 2 hours
   b. Transmission gel is spread over the abdomen, and a transducer will be moved over the abdomen to obtain the picture.
   c. It will be necessary to drink 1 to 2 quarts of water before the examination
   d. The transvaginal probe encased in a disposable cover and coated with gel is inserted into the vagina.

3. A nurse in a maternity unit is reviewing the records of the clients on the unit. Which of the clients would the nurse identify as being at most risk for developing disseminated intravascular coagulation (DIC)?
   a. A gravida IV who delivered 8 hours ago and has lost 500 mL of blood
   b. A gravida II who has just been diagnosed with dead fetus syndrome
   c. A primigravida with mild preeclampsia
   d. A primigravida who delivered a 10-lb baby 3 hours ago

4. A pregnant woman reports to a health care clinic, complaining of loss of appetite, weight loss, and fatigue. Following assessment of the woman, tuberculosis is suspected. A sputum culture is obtained and identifies Mycobacterium tuberculosis. The nurse provides instructions to the mother regarding therapeutic management of the tuberculosis. The nurse tells the client that
   a. Medication will not be started until after delivery of the fetus.
   b. Isoniazid (INH) plus rifampin (Rifadin) will be required for a total of 9 months.
   c. The newborn infant will need to receive medication therapy immediately after birth.
   d. Therapeutic abortion is required.

5. A home care nurse is monitoring a pregnant client with pregnancy induced hypertension (PIH) who is at risk for preeclampsia. At each home care visit, the nurse assesses the client for which three classic signs of preeclampsia? ____________
6. A nurse implements a teaching plan for a pregnant client who is newly diagnosed with gestational diabetes mellitus. Which statement, if made by the client, indicates a need for further education?

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

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

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

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

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

9. A nurse is monitoring a new mother in the postpartum period for signs of hemorrhage. Which of the following signs, if noted in the mother, would be an early sign of excessive blood loss?

a. A temperature of 100.4 degrees F.
b. An increase in the pulse rate from 88 to 102 beats per minute
c. An increase in the respiratory rate from 18 to 22 breaths/minute
d. A blood pressure change from 130/88 to 124/80

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

a. __________________________

C, d, b, b, hypertension, proteinuria and generalized edema; c; d; 1,4,2,5,3; b, calcium gluconate
NCLEX Review—Medical Surgical Nursing

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

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

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

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

5. A client with a spinal cord injury suddenly experiences an episode of autonomic dysreflexia. After checking the client’s vital signs, list in order of priority, the nurse’s actions. (Number 1 is first priority and #5 is last priority).
   a. Check for bladder distention
   b. Raise the head of the bed
   c. Contact the physician
   d. Loosen tight clothing on the client
   e. Administer an antihypertensive medication
6. A nurse is completing a time tape for a 1000-mL IV bag that is scheduled to infuse over 8 hours. The nurse has just placed the 11:00 am 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 osmolality less than 100 mOsm/kg

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

C, a, a, b; 3, 1, 4, 2, 5; 375 mL, d, c, c, b
NCLEX Review -- Psychiatric Nursing

1. The nurse is working with a client who has sought counseling after trying to rescue a neighbor involved in a house fire. In spite of the client’s efforts, the neighbor died. Which action does the nurse engage in with the client during the working phase of the nurse-client relationship?
   a. Exploring the client’s potential for self-harm
   b. Exploring the client’s ability to function
   c. Inquiring about the client’s perception or appraisal of the neighbor’s death
   d. Inquiring about and examining the client’s feelings that may block adaptive coping

2. A client is admitted to a mental health unit for treatment of psychotic behavior. The client is at the locked exit door and is shouting, “Let me out. There’s nothing wrong with me. I don’t belong here.” The nurse analyzes this behavior as
   a. Projection
   b. Denial
   c. Regression
   d. Rationalization

3. An 18-year-old woman is admitted to an inpatient unit with the diagnosis of anorexia nervosa. A cognitive behavioral approach is used as part of her treatment plan. The nurse understands that the purpose of this approach is to
   a. Help the client identify and examine dysfunctional thoughts and beliefs
   b. Emphasize social interaction with clients who withdraw
   c. Provide a supportive environment
   d. Examine intrapsychic conflicts and past issues

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

5. A client who is delusional says to the nurse, “The federal guards were sent to kill me.” The nurse’s best response is
   a. “The guards are not out to kill you.”
   b. “I don’t believe this is true.”
   c. “I don’t know anything about the guards. Do you feel afraid that people are trying to hurt you?”
   d. “What makes you think the guards were sent to hurt you?”
6. The nurse is planning activities for a client who has bipolar disorder with aggressive social behavior. Which of the following activities would be most appropriate for this client?
   a. Ping pong
   b. Writing
   c. Chess
   d. Basketball

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

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

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

10. The nurse is planning care for a client being admitted to the nursing unit who attempted suicide. Which of the following priority nursing interventions will the nurse include in the plan of care?
    a. Check whereabouts of the client every 15 minutes
    b. Suicide precautions with 30 minute checks
    c. One-to-one suicide precautions
    d. Ask the client to report suicidal thoughts immediately

D, b, a, aversion therapy, c, b, #7-a, d,e; c, Alcoholics Anonymous, c
CORE COMPETENCIES OF NURSE EDUCATORS ©
WITH TASK STATEMENTS

Competency 1 – Facilitate Learning

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

- Implements a variety of teaching strategies appropriate to learner needs, desired learner outcomes, content, and context
- Grounds teaching strategies in educational theory and evidence-based teaching practices
- Recognizes multicultural, gender, and experiential influences on teaching and learning
- Engages in self-reflection and continued learning to improve teaching practices that facilitate learning
- Uses information technologies skillfully to support the teaching-learning process
- Practices skilled oral, written, and electronic communication that reflects an awareness of self and others, along with an ability to convey ideas in a variety of contexts
- Models critical and reflective thinking
- Creates opportunities for learners to develop their critical thinking and critical reasoning skills
- Shows enthusiasm for teaching, learning, and nursing that inspires and motivates students
- Demonstrates interest in and respect for learners
- Uses personal attributes (e.g., caring, confidence, patience, integrity and flexibility) that facilitate learning
- Develops collegial working relationships with students, faculty colleagues, and clinical agency personnel to promote positive learning environments
- Maintains the professional practice knowledge base needed to help learners prepare for contemporary nursing practice
- Serves as a role model of professional nursing
Competency 2 – Learner Development and Socialization

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

- Identifies individual learning styles and unique learning needs of international, adult, multicultural, educationally disadvantaged, physically challenged, at-risk, and second degree learners
- Provides resources to diverse learners that help meet their individual learning needs
- Engages in effective advisement and counseling strategies that help learners meet their professional goals
- Creates learning environments that are focused on socialization to the role of the nurse and facilitate learners’ self-reflection and personal goal setting
- Fosters the cognitive, psychomotor, and affective development of learners
- Recognizes the influence of teaching styles and interpersonal interactions on learner outcomes
- Assists learners to develop the ability to engage in thoughtful and constructive self and peer evaluation
- Models professional behaviors for learners including, but not limited to, involvement in professional organizations, engagement in lifelong learning activities, dissemination of information through publications and presentations, and advocacy
Competency 3 – Use Assessment and Evaluation Strategies

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

- Uses extant literature to develop evidence-based assessment and evaluation practices
- Uses a variety of strategies to assess and evaluate learning in the cognitive, psychomotor, and affective domains
- Implements evidence-based assessment and evaluation strategies that are appropriate to the learner and to learning goals
- Uses assessment and evaluation data to enhance the teaching-learning process
- Provides timely, constructive, and thoughtful feedback to learners
- Demonstrates skill in the design and use of tools for assessing clinical practice
Competency 4 – Participate in Curriculum Design and Evaluation of Program Outcomes

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

- Ensures that the curriculum reflects institutional philosophy and mission, current nursing and health care trends, and community and societal needs so as to prepare graduates for practice in a complex, dynamic, multicultural health care environment
- Demonstrates knowledge of curriculum development including identifying program outcomes, developing competency statements, writing learning objectives, and selecting appropriate learning activities and evaluation strategies
- Bases curriculum design and implementation decisions on sound educational principles, theory, and research
- Revises the curriculum based on assessment of program outcomes, learner needs, and societal and health care trends
- Implements curricular revisions using appropriate change theories and strategies
- Creates and maintains community and clinical partnerships that support educational goals
- Collaborates with external constituencies throughout the process of curriculum revision
- Designs and implements program assessment models that promote continuous quality improvement of all aspects of the program
Competency 5 – Function as a Change Agent and Leader

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

- Models cultural sensitivity when advocating for change
- Integrates a long-term, innovative, and creative perspective into the nurse educator role
- Participates in interdisciplinary efforts to address health care and educational needs locally, regionally, nationally, or internationally
- Evaluates organizational effectiveness in nursing education
- Implements strategies for organizational change
- Provides leadership in the parent institution as well as in the nursing program to enhance the visibility of nursing and its contributions to the academic community
- Promotes innovative practices in educational environments
- Develops leadership skills to shape and implement change
Competency 6 – Pursue Continuous Quality Improvement in the Nurse Educator Role

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

- Demonstrates a commitment to life-long learning
- Recognizes that career enhancement needs and activities change as experience is gained in the role
- Participates in professional development opportunities that increase one’s effectiveness in the role
- Balances the teaching, scholarship, and service demands inherent in the role of educator and member of an academic institution
- Uses feedback gained from self, peer, student, and administrative evaluation to improve role effectiveness
- Engages in activities that promote one’s socialization to the role
- Uses knowledge of legal and ethical issues relevant to higher education and nursing education as a basis for influencing, designing, and implementing policies and procedures related to students, faculty, and the educational environment
- Mentors and supports faculty colleagues
Competency 7 – Engage in Scholarship

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

- Draws on extant literature to design evidence-based teaching and evaluation practices
- Exhibits a spirit of inquiry about teaching and learning, student development, evaluation methods, and other aspects of the role
- Designs and implements scholarly activities in an established area of expertise
- Disseminates nursing and teaching knowledge to a variety of audiences through various means
- Demonstrates skill in proposal writing for initiatives that include, but are not limited to, research, resource acquisition, program development, and policy development
- Demonstrates qualities of a scholar: integrity, courage, perseverance, vitality, and creativity
Competency 8 – Function within the Educational Environment

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

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

These competencies were developed by the NLN’s Task Group on Nurse Educator Competencies
Judith A. Halstead, DNS, RN (Chair), Wanda Bonnel, PhD, RN,
Barbara Chamberlain, MSN, RN, CNS, C, CCRN, Pauline M. Green, PhD, RN, Karolyn R. Hanna, PhD, RN,
Carol Heinrich, PhD, RN, Barbara Patterson, PhD, RN, Helen Speziale, EdD, RN, Elizabeth Stokes, EdD, RN,
Jane Sumner, PhD, RN, Cesarina Thompson, PhD, RN, Diane M. Tomasic, EdD, RN,
Patricia Young, PhD, RN, Mary Anne Rizzolo, EdD, RN, FAAN, (NLN Staff Liaison)
1. Principles for Planning the Clinical Day

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

2. Getting Started....

Objectives:

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

3. Foundations.... What's my Style?

- Models and best practices
- Learning and teaching styles
- Essential Skills
- Challenges and rewards
4. Philosophy of Teaching

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

- Adapted from Gaberson & Oermann, 1999

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

- Academic Mission and Hierarchy
- Type of Position
- Faculty Responsibilities
- Educational Policies
- Course Syllabus and Evaluation Tool
- Resources
6. In the Beginning...

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

7. Strategies for Assignments

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

Notes:
8. Assignment Responsibility

Who is Responsible?

- Instructor
- Student
- Agency Leadership
- Collaborative Effort

9. Approach to Assignments

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

10. Instructor Priorities

- Is there a student not meeting performance criteria?
- Is there a student performing below ability?
- Which student needs more opportunities to perform skills?
- What feedback have you received about a student?
11. How Do You Know Students are Prepared?

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

12. How do I Evaluate Student Performance?

13. Definitions:

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

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

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

14. **What is Clinical Evaluation?**

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


15. **Why is Clinical Evaluation Important?**

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


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


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

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

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

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

- Changing characteristics of students
  - 2nd career, older, nontraditional students
  - Competing time demands
  - Disabilities
  - English as a second language
  - Gender and culture
18. Challenges...How can I help students to be successful?

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

19. Clinical Practice: Safe versus Unsafe

Safe:

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

Unsafe:

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

20. 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?

21. Notifications

- Did you finish charting the assessment on your patient?
- Okay, let’s see... skin is cool.
- Pupils fixed... lung sounds absent?
- He didn’t eat any of his breakfast.

22. Behaviors of Impaired Performance

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

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

24. Struggling “Sounds Likes”

- Echolalia

- Common phrases used:
  - I’m not sure what you mean
  - I didn’t have time to…
  - I couldn’t find…
  - I had no idea I was to know...
  - I wasn’t taught…
  - I’m sorry….
  - I need more time…
25. Elephant in the Room

- Who knows it?

26. Strategies to Improve Clinical Performance

- Identify, discuss and document EARLY and OFTEN

- Explore other influences on performance

- Actively listen to the student’s self assessment of performance

- Assess and discuss learning needs

27. Strategies to Improve Clinical Performance

- Place responsibility on the student

- Redirect efforts back to necessary knowledge or skill

- Be descriptive about improvement strategies

- Ensure that the student has heard and understood feedback

- Reinforce success
28. Anticipate a Response

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

29. Moving forward...

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

30. Online Resources

- www.qsen.org
- http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol132008/No3Sept08/NursingPracticetoNursingEducation.aspx

Notes:
1. Creating a Culture of Inquiry

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

2. Definitions

- Culture:
  - Set of shared attitudes, values, goals & practices

- Inquiry:
  - Examination into facts or principles
  - A request for information
  - Systematic investigation

3. Questions are the __________ of the mind.

4. Categories

- Questions asked ________________

- Questions asked ________________
5. Reasons to Ask Questions

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

6. Guidelines for Asking Questions

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

7. The Delivery

- Speak clearly, calmly & directly
- Be positive
- No underlying negativity or disapproval
- Don’t bury the question
- Display interest in the answer
8. The Response

- Active listening...

9. Additional Active Listening Tips

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

10. The Evaluation

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

11. The Payoff

- Act on the information attained
- If performance improves or something changes, acknowledge
12. **When to use questions**

Based on Teaching Tips homework:

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

13. **Misconceptions**

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

14. **One Minute Preceptor Questions**

- What do you think is going on?
- What do you want to do?
- What factors did you consider in making that decision?
- Were there other options you considered and discarded?
15. 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?

16. “Why” Questions

- A dangerous approach when used with behavior:
  - Creates defensiveness
  - Closes communication
- Rephrase to
  - What….
  - How….
  - Could….
17. Questions…

Leading another through the Process of Discovery

18. How to scaffold questions to “Lead”

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

- Trade questions with your partner who will ask the question. Take turns until time is up. Get feedback from your partner about your skill

- DO NOT ANSWER or go to explanation, lead through questions...

20. How did that work?

- What are the advantages?

- What are the barriers?
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 – you will “evolve 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.
  ➢ Expectations & perceived expectations
    o not clearly defined or are unrealistic
  ➢ Results in powerlessness, insecurity and depression

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

Research on Reality Shock
  ➢ Can last 6 months to a year
  ➢ When training and support added ➔ there is a 25-50% improvement in retention
  ➢ Two - Key Concepts
    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:
   ○ Expectations
   ○ Learning the “Game”
   ○ Being Mentored
   ○ 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 dirt and more dirt. Instead of letting them bury him, the donkey shook the dirt off 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 my 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!
  - Going to another Faculty Member
  - Formal Petition
  - To a Political Leader

There are tremendous responsibilities to balance…

- What does it feel like?
- Remember… We all need time for learning
- Students and New Scholars need time to learn before performance is evaluated
  - 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 or 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
  - Students
  - the school of nursing
  - the clinical agency
  - and each other!

Establish TRUST upfront! Here is your script!
- During the first clinical day – Ask for a show of hands…
  - How many of you are hoping to become mediocre nurses?
  - 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 SAFE.
➢ Prepare the patient
   ○ 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
   ○ Say “Please” and “Thank you”
   ○ Say “I am sorry” when you are
   ○ Articulate & give rationale for why you are or are not doing things
   ○ Use I feel – I think – I want and avoid You, But and Why!

➢ Emulate Caring… Ethics… Integrity… Professionalism… etc.
   ○ To student
   ○ To patient
   ○ To staff
   ○ To school
   ○ With yourself
More Listening and Less Talking - *Remember the 80/20 Rule*

- *It is not about us!*
- *It is about the students!*

Leaders and Educators should:
  - **Tell** 20% of the time!
  - **Ask** 80% of the time!
  - 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 –
  - Verbal ASAP and in private
  - Written assignments in timely manner → *always* before next paper
  - 48 hour rule for crucial conversations
    - ***Instructors with better immediacy skills have less incivility problems***

---

*Reality Shock - Deb Center*

---

*Nurses Empowering Nurses to Cultivate Healthy Communities*
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 do have one:
  - Thank them for supporting you
  - Meet with them regularly
  - Allow them to be 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:
  - Distant
  - Arrogant
  - Threatening
  - Intimidating
- If you **use** Humor:
  - Approachable
  - Confident
  - Creative
  - 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!

Deb Center MSN, RN, CNS
Colorado Center for Nursing Excellence
Deb@ColoradoNursingCenter.org
303-715-0343 ext. 14
Perceptions:

Barriers:
A Model for Structured Reflection
(Johns, 2005)
A Continuum of Reflective Practice
(Johns, 2005)
Reflective Practice Action Plan

Methods that appeal to me:

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

Times I can make available for reflection:

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

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

Reflective questions that would be especially helpful for me:
1. Clinical Scholars Risk Management

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

Adapted from an original presentation by Leslie Stephens-Wallman

2. Objectives

- Provide an overview of legal implications and liability issues in practice and in documentation for the Clinical Scholar
- List four elements of 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

3. 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
4. Documentation as a Bridge

Do you want this?

5. Or this?

6. 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
7. 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

8. 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.

9. 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...
10. 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

11. “Failure is the inability to measure up to certain normal standards.”

12. 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
13. **St Elsewhere, NY 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

14. **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
15. **Student Nurse admitted:**

- She knew Digoxin could stop a heart
- Had never given the drug herself
- She made no effort to consult/educate herself prior to administering
- Knew she was not authorized to give med IV without supervision

16. **Clinical Scholar should have:**

- 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.”
- Been available to supervise student nurse in her tasks

17. **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.”
18. 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_

19. 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_
_A. B. C.,_ 40th ed., May/June 2015, p. 128
20. Nurses must practice to the level of technology provided by the institution!

XEPT???

21. Patient/Family Teaching

Any instructions on care to pt or family member:
- Medication prescribed
- Treatments
- Dietary requirements
- Referral information

Discharge instructions:
- In writing & signed by patient or responsible family member

22. History of incident:

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

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

24. What else went wrong?

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

25. Avoiding Lawsuits

- Develop a strong, trusting relationship to help avoid lawsuits. 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

26. 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)
27. Distinguishing Roles and Clinical Scholar’s Legal Responsibility For Student Incident

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

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

29. 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

30. 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
31. Mitigation of Risk

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

32. When is a School Liable?

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

33. Documentation of Competency/Concerns

- Anecdotal notes of Clinical Instructor
  Objective
  Kept on all students
  Regular intervals
  Provided to school at the end of rotation
- College/Scholar documentation of mastered skills

34. Prompt notification of Student Concerns

- In writing
- Objective
- Specific examples with dates
- Recommendations/Plan of action
- Shared with student when appropriate
- Shared with faculty/college
35. Special liability for schools and Clinical Scholars

“Nor shall any State deprive any person of life, liberty, or property without due process of the law.”

36. Procedural Due Process

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

37. Substantive Due Process

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

38. 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
39. Employer vs. Individual Insurance Policy

- Importance of an “Umbrella” - what happens in court and why employer insurance could be your best decision

- Downsides of relying on employer insurance:
  - Respondeat Superior “let the master respond”
  - Theory of Contribution
  - Your consent for settlements is not required

- Why you may need to have supplemental private insurance: how do you practice?

- National Practitioner Database Bank: report

40. What is never covered by insurance?

- Intentional acts
- Practicing outside scope of practice
- Criminal acts
- Wanton negligence

41. New Challenges in Healthcare and Nursing
42. 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

43. 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
44. 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?

45. WORDS

46. Educaré

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

47. FREEDOM
48. INQUIRY

49. “It’s not enough that we do our best; sometimes we have to do what is required.”

-Sir Winston Churchill
1. Student Role in the Clinical Agency

Presented by:
Amy H. Mills, MS, BS, RN, CCRN
Nurse Educator, St. Anthony Hospital,
Affiliate Faculty, Regis University,

Original Presentation created by:
Kathy Casey, RN, MSN
Lutheran Medical Center

2. 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

3. Preparing students to practice safely, effectively, and compassionately in today’s rapidly changing healthcare setting is a challenge.
4. 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

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

6. 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.
7. 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

8. 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

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

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

11. 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
12. 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

13. 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

14. 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
15. 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

16. 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

17. 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?
18. Graduate Nurses report they want more practice with:

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

19. The education of students provides the foundation on which quality and safety are built
1. Feedback... What’s Feedback?

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

2. Objectives

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

3. The Five “W’s” of Effective Feedback

- Why
- Who
- What
- Where
- When

Additional 3 “W’s”

- Wait
- Will
- Worry
4. Solution Focused Therapy

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

5. Solution Focused Feedback Formula

- Acknowledge or compliment
- Bridge or rationale
- Feedback

6. Examples

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

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

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

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

8. Examples

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

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

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

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

- Three elements of a crucial conversation:
  - Strong emotions
  - Opposing opinions
  - High stakes

10. Contrasting Statements

- A don’t/do statement

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

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

11. Don’t Questions

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

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

- What can I say to help them believe this is not the case?
Verbal Feedback — Bari Platter

12. Do Questions

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

13. Examples

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

14.

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

15.

- “I don’t want to leave the impression that I think we don’t work well together. I do want to discuss how we make decisions. I think we may have different assumptions about how decisions are made in this clinical setting”
16. “I don’t want you to think your contributions in post conference are not appreciated. I do want to talk with you about something you’re doing that’s having a negative effect with the group”.

17. Clinical Narratives

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

18. Clinical Narrative #1

Liz Clarkson-Brown seems to forget a lot of the information you have given her. She confides to you that she has MS and thinks that it is starting to effect her thinking. She begs you not to tell anyone.
19. Clinical Narrative #2

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

20. Clinical Narrative #3

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

21. Clinical Narrative #4

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

22. Clinical Narrative #5

- Juana Hernandez is a single mom. You notice that she seems fatigued, her clinical performance has worsened and she has been late for clinicals several times. She tells you that she is working another job and has childcare issues.
23. Clinical Narrative #6

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

24. Clinical Narrative #7

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

25. “Good Practices”

- Encourage contact between student and instructor.

- Consult with SON faculty.

- Develop cooperation among students.

- Use active learning techniques.

- Give prompt feedback.

- Assist student with time management.

- Communicate high expectations.

- Respect diverse talents and ways of learning

Verbal Feedback — Bari Platter

26. Questions?

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

Notes:
1. Working with Non-Acute Care Clinical Placements

Bryce Andersen MS, RN
Immunizations and Core Nursing Manager
Tri-County Health Department
303-363-3022

Outline:
- Managing students in multiple locations
- Planning Pre-and Post Conferences
- Verifying evaluations of skills you didn’t witness
- Beyond observational student experiences

2. Clinical Scholar Role at TCHD

- One Public Health Nurse for 6 students (We have 4 CS’s)
- We accept 3 rotations each year from 3 schools
- We have the students for 45 hours maximum
- We go to school for orientation and meet with students
- 1st day at TCHD: orientation, tour, assign calendar events
- Ready, Set, GO!

3. Managing Students in Multiple Locations

- Everyday, except the first day, some students are in multiple locations without their CS.
- Assign students to a staff member in the program for the 4 or 8 hour shift, and that person is responsible for the student experience.
- Students are expected to act as professional adults and plan ahead.
4. Planning Pre/Post Conferences

- This is up to the CS how they touch base with their students, and how much time the CS has during that rotation - and this adds to the ‘Art’ of nursing!

- We encourage MI techniques or Reflective Practice – get them to think on their feet.

5. Eval’s You Haven’t Witnessed

- CS works closely with assigned staff member to make sure student: Teamwork is key!

- Not all skills listed are completed, and that is ok.

- CS always does a private mid-term and final review with each student and we address lacking skills and behavior early and aggressively.
6. Student Experiences

⇒ All students want hands-on activities

⇒ Examples for TCHD hands-on activities:

- Immunization clinics
- Family Planning clinics
- WIC and Healthy Communities and Access to Care
- Environmental Health Inspections
- HIV/STI clinics
- Disease and Outbreak Investigations
- Current Projects at TCHD (PEP, HPV, Ebola, Zika)
- Emergency Preparedness and Bioterrorism Exercises and Planning
- TB clinic
- Influenza clinics
- Shots For Tots and Teens Clinic
- Homeless Shelters / Project Cure / Domestic Violence Projects

7. Experiential Learning Opportunities

⇒ Hands-Off experiences:

- Vaccine Debate – prep work and research
- Vaccine myths and addressing patient questions and concerns
- Virtual Vaccine Clinic
- Home visitation simulation
- WIC Scavenger Hunt
- Operation Masters Of Disasters Simulation