

Continuing Nursing Education Disclosure Form

Title of Event: Clinical Scholars February 2016

Date and Location of Event: February 22-26 (Snow Day Feb. 29th)

Colorado Center for Nursing Excellence - 5290 E. Yale Cir. Suite 100, Denver, CO 80222

The objectives for this event are:

- 1. Participants will be able to discuss the role of the Clinical Scholar identifying personal attributes of self that may be utilized to enhance the student experience.
- 2. Participants will be able to demonstrate creative and individualized approaches to employ in working with a variety of learners.
- 3. Participants will be able to employ a variety of communication techniques to enhance teamwork and effective interactions in practice situations in the classroom.
- 4. Participants will be able to identify and discuss at least three separate subject areas that are directly involved in implementation of the clinical scholar role.
- 5. Participants will be able to utilize the NLN Competencies for Nurse Educators to identify specific skills that I now possess to begin to function in the clinical educator role.
- 6. 37.3 contact hours will be awarded. To receive contact hours the participants must remain for the entire presentation. No partial contact hours will be awarded.
- 7. No conflicts of interest have been disclosed by any speaker.
- 8. No conflicts of interest have been disclosed by any planner.

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



Clinical Scholar Workshop Guidelines and Expectations

By signing below I agree to the following:

Administrative Rules

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

Exploration, Discovery and Growth Rules

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

Project Expectations

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

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

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

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

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

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



She has been an author/co-author on several publications related to nursing and nursing education. She has spent the majority of her career learning and attempting to fully understand the issue of incivility in nursing, healthcare and society. Along the way, she has learned a few lessons and now has a few strategies to share related to creating and sustaining a healthy work environment. As a coach, she strives to establish an individual relationship based on trust, safety, transparency and compassion. Her goal is to help those working with her gain a new level of self-awareness in order to break patterns of the past and create a new future. Her non-judgmental approach to reframing situations has been described as "insightful" and "intuitive," allowing clients a new perspective into their situation. She believes there is amazing human potential inside each of us often forgotten or lost in the chaos of our world. She looks forward to helping you find yours again!

Kathy Casey, RN, MSN Kathy is the manager of clinical education at Lutheran Medical Center. She coordinates clinical orientation of new hires, student placements, clinical faculty orientation, preceptor training, and coordinates the New Graduate Orientation Program. She is an adjunct clinical faculty at Regis University, School of Nursing in Denver, Colorado and at the University of Colorado Denver, College of Nursing in Aurora, Colorado. Her research interests include developing evidence that supports improved strategies for the education, preparation, transition and retention of new graduate nurses in the professional workforce. Kathy and her colleague Regina Fink, RN, PhD, AOCN, FAAN collaborated in developing the Casey-Fink Readiness for Practice Survey, an instrument which examines senior nursing students' perceptions of readiness for practice, the Casey-Fink Graduate Nurse Experience Survey, which is widely used to evaluate graduate nurse role transition into clinical practice and the Revised Casey-Fink Nurse Retention Survey, designed to measure nurse retention and job satisfaction. Kathy has published in the Journal of Nursing Administration, Journal of Nursing Education and the Journal for Nurses in Staff Development. She is a peer reviewer for the Journal of Nursing Education. She has a BS in Nursing from Pacific Lutheran University, Tacoma, Washington and a Master of Science from the University of Colorado, School of Nursing, Aurora, Colorado.

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



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

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

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



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

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

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

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



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

She completed her doctoral work in Sociology at the University of Colorado, Boulder, where her major areas of study were Leadership, Women's studies and the Family. She received her BS from Indiana University and her MSN from the University of Colorado. She has held multiple leadership positions from the head nurse to director and administrator. She has served as Project director on seven major state and federal grants totaling more than \$6.4 million. In all these positions, she has developed innovative and creative approaches to problem solving.

She has authored numerous articles and co-edited five advanced textbooks, including *Beyond Leading and Managing, Nursing Administration for the Future,* and *Fast Facts for the Classroom Nursing Instructor,* both of which she co-authored with Dr. Patricia Yoder-Wise. Dr. Kowalski is the recipient of numerous awards and honors including state and national awards for leadership. Among these is the 2010 Florence Nightingale recipient, Distinguished Alumnae of the University of Colorado, School of Nursing, selected as one of the Ten Outstanding Young Women of America, and is a charter member of the Colorado Nurses Association Hall of Fame. She is a past president of CNA. She was elected to the American Academy of Nursing in 1981. She speaks nationally and is known for her strong presentation style and teaching skills.



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

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

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

Amanda D. Quintana DNP, RN, FNP (amanda@coloradonursingcenter.org) Project Director—Colorado Center for Nursing Excellence. Dr. Amanda Quintana was born and raised in the San Luis Valley in the oldest town in Colorado. Dr. Quintana has been a registered nurse for 25 years. She received both her Bachelor of Science in Nursing and Master of Science in Nursing, as a Family Nurse Practitioner, from Regis University in Denver, CO. In 2010, Amanda successfully completed her Doctor of Nursing Practice degree from the University of Colorado College in Denver. Amanda's clinical nursing career has been in medical/surgical nursing, neurological nursing, ENT, family practice and internal medicine. In addition to her clinical experience, Dr. Quintana has also worked as a nurse educator and a nurse administrator in nursing academia. She is currently a Project Director for the Colorado Center for Nursing Excellence and is currently working on a HRSA Nursing Workforce Diversity Project to increase nursing diversity in the state. Dr. Quintana is very active in the nursing community. She is a member of the American Nurses Association, Colorado Nurses Association, Colorado Organization of Nurse Leaders, Sigma Theta Ta – Alpha Kappa at Large, and National Association of Hispanic Nurses.



In 2007, she was awarded the San Luis Valley Nightingale Award for excellence in nursing and DNA 6 Nurse of the year in 2010. She is also a 2008 Bighorn Leadership in Rural Health graduate. In 2009-2010 she planned, developed, implemented and evaluated an Anticoagulation Management System (AMS) for the San Luis Valley in collaboration with SLVRMC as her DNP quality improvement project.

Linda Stroup, RN, MSN, PhD (c) (Istroup@mscd.edu), has held many roles in nursing from staff, clinical instructor, nursing faculty, and nursing education administrator, including her current position as Associate Chair of the Department of Nursing at Metropolitan State College of Denver. Linda is currently a doctoral student in a PhD program at Colorado State University in the School of Education with an emphasis in College and University Leadership. Linda's clinical expertise is in the areas of cardiology and medical/surgical nursing. She has held a variety of leadership positions in nursing, including treasurer of the Colorado Council on Nursing Education and treasurer of District 20 of the Colorado Nurses Association. Linda is committed to quality professional nursing education and strengthening partnerships between education and service.







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TEACHING ADULTS IN THE CLINICAL SETTING

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

Notes:

Objectives

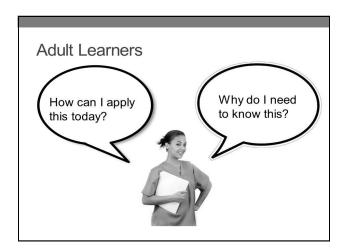
- Apply effective adult and clinical teaching principles into practice.
- Describe motivators and barriers to learning for adults.
- Discuss difficult student behaviors and strategies to employ.







Notes:



The Educator's Role

- · Facilitate learning while keeping patients & students safe
- · Plan, implement and evaluate learning experiences
- · Give honest and timely feedback





Remember when?



Notes:

Effective Clinical Teaching

- Identify what the students need to learn
- Involve learners in determining learning needs
- · Create a safe environment
- · Establish mutual trust
- · Use teachable moments
- · Have fun!



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 and hear
- 70% of what we say
- 90% of what we say as we do

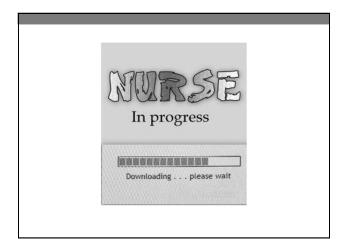
(Active Learning)

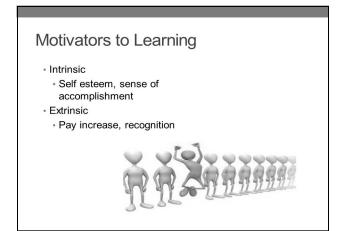




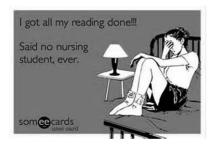
Skill Acquisition Cognitive (Knowledge) Affective (Feelings) Psychomotor (Action)

Notes:





Barriers to Learning



Notes:

Barriers to Learning

- Geographic
- Transportation
- Demographic
- · Child Care
- Socioeconomic
- Fatigue



- Conditions
- Confidence
- **STUDENT**

- Cultural
- III-Prepared Theory-Practice
- Gap
- · Instructor, Preceptor

Preventing problems

- · Communication is key!
- Clear expectations
- · Early and regular feedback
- Mutual respect





Notes:

Difficult Student Behaviors

Invisible student

Strategies

- Lacks confidence
- · Shy
- Quiet

- · Seek this student out
- · Ask direct questions
- · Reinforce contributions
- Utilize written progress reports



Difficult Student Behaviors

Know-it-all student

Strategies

- Need for attention
- III prepared
- · Lack Confidence
 - HELLO MY NAME IS MR KNOW-IT-ALL
- Redirect comments to the group
- Talk to student privately
- Don't allow student to monopolize discussion
- Admit you don't know all the answers

Difficult Student Behaviors

The Rambler

Strategies

- Nervous
- III-Prepared

- Redirect
- Ask them to summarize
- Lets hear from some other in the group
- Assign timer in post conference



Student Learning is...

Significantly related to teacher behaviors

SUPPORTIVE

Patient

Knows how to teach

Approachable

Clinically competent

Notes:

Notes:	



☐ 1. Nursing Education	<u>Notes:</u>
Professional Engagement	
Sara L Jarrett, EdD, MS, CNS, RN, CNE	
☐ 2. Objectives	
 Explore professional engagement as a framework for a paradigm change in role development for the 21st century nurse. Relate professional engagement to the future of nursing education and health are delivery. 	
☐ 3. Engagement	
PROFESSIONAL ENGAGEMENT	
– ACCOUNTABILITY FOR PRACTICE AND COMPETENCE	
– CITIZENSHIP	
– STEWARDSHIP	
– ADVOCACY	

☐ 4. Competence

Notes:

- DETERMINANTS OF COMPETENCE
- ACCOUNTABILITY
 - PERSONAL
 - PROFESSIONAL
 - INSTITUTIONAL
 - PUBLIC POLICY

☐ 5. Citizenship

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

☐ 6. Stewardship

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



☐ 7. Advocacy	<u>Notes:</u>
• INDIVIDUAL	
• PRACTICE	
• POLICY	
– INSTITUTIONAL	
– PUBLIC	
■ 8. Paradigm Shift	
• ENVISIONING THE FUTURE	
• FORECASTS AND TRENDS	
9. Looking to the Future Health Care System	
• COMPLEXITY OF PATIENT CARE	
• HEALTH CARE FINANCING	



STAFFING ISSUES

CONTINUUM OF CARE

☐ 10. Looking to the Future of Nursing Education

Notes:

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

☐ 11. Summary and Discussion

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

☐ 12. Website Resources

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



☐ 13. Website Resources

Notes:

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

☐ 14. Website Resources

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

Notes:	



Changing Faculty Roles — Sara Jarrett

☐ 1. Nursing Education

Notes:

- Trends and Issues
- Changing Faculty Roles

■ 2. Objectives

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

☐ 3. Yesterday and Today

- HISTORICAL PERSPECTIVES
- TODAY'S REALITIES

☐ 4. Current Issues—Shifts in Nursing Education

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



Changing Faculty Roles — Sara Jarrett

☐ 5. Health Care System Issues and Nursing Education

Notes:

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

☐ 6. The Changing Paradigm

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

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

How hard can it be?

Role of the Instructor/Scholar →
- Patient Safety
- Patient Rights
- Student Rights
– Student Safety
- Faculty/Instructor/Scholar Rights
- Faculty/Instructor/Scholar Safety
- Confidentiality
– Equity
- School Requirements
- Board of Nursing Requirements
- Clinical Site Requirements
– FERPA Rules
– HIPAA Rules
- Fairness & Justice
– Ethics and Moral Leadership
- Objectivity
- Evaluation requirements
 Advocating for Students
- Novice-to-Expert Teacher
 Individual Confidence and Self-regard
– Willingness to be Vulnerable (Brené
Brown: Power of Vulnerability)
- Prepare the students for the realities
of practice and the "real-world"

"KISS Method"

 K (Key/Knowledge) 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 knowASK!

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 <u>and</u> her classmates. She does not look at you and appears to be day-dreaming during clinical conference. When you give her eye contact during conference to "signal for her to become more of an active participant," she turns away.
- You have read that in the Hispanic Culture "silence before one's superiors, indirection in expressing one's thoughts, and avoiding eye contact all signal respect for authority."

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 <u>before</u> you arrive at the scheduled time.
- At preconference today you learn that his patient requires a sterile procedure before 11am. You tell him you will do this procedure with him and ask him to have all the supplies together by 10:30a. When you arrive, you find a sterile field set up in the patient room for the procedure and Michael is not in the room. As he enters, he says, "I am ready for you today!"



STUDENT 3 – KIRIN PATIL

- Kirin is a female student of Indian heritage. She is an excellent student and provides high quality patient care. Her patient's 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 in appropriate 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 2^{nd} 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 RN, MSN, CNS, Coach

~ Colorado Center for Nursing Excellence ~
deb@ColoradoNursingCenter.org



Notes:	_



Civility — Deb Center

Who is responsible for setting the tone for civility within your work or classroom environment?

<u>Setting t</u>	he Tone:		
		ople do the best they can with what the	
	The #1 Need	in Life: d in Life:	
	only two things in life yo	can control:	
your	and <u>your</u>	The rest is an	'' Coach O
Exercise:	"Think of a time"		
Name it: _			
Feel It:			
-	rou response? – circle ; or Flow (calm and	one: Fight (anger); Flight (avoid); Fr d responsive)	eeze (silence); Faint
TOC	DL #1:		
 Trigger 	r – My triggers include	:	
	o My plan for dealing	ng with my triggers includes	
• Tilt – th	e first physical sign yo	our emotions and body are reacting	
	o My tilt feeling is:		
	o When I recognize	my tilt, I need to	
	o This is a reminder t	to: think and consider the other pers	on's perspective
 Trigger 	r ed – having a physiol	ogic response	
	 My triggered feeli 	ng includes:	
	o When I recognize	I am triggered, I need to	
• Amygo	dala Hijack – out of co	ontrol	
	o My Hijack include	es:	
	 When I recognize 	I am hijacked. I need to	



Your ability to get the results you seek is directly influenced by the moods and emotion you work from. Take charge and take responsibility for your emotional state.

"No one can make you angry without your consent." Eleanor Roosevelt
Three A's of Civility: Strategies:
1
2
3Reference: Center, D. (2010). Journal of Continuing Education in Nursing, 41(11), 488-489
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:
Company Reviews: <u>www.glassdoor.com</u> and Boss Reviews: <u>www.ebosswatch.com</u>
Faculty: www.ratemyprofessor.com.
Social Media:
Reference: Weckerle, A. (2013) Civility in the Digital Age: How Companies and People Can Triumph over Haters, Trolls, Bullies, and Other Jerks. Que Publishing;: Pearson Education, Inc.
Exercise: What do you see?

How aware are you of your self-talk?



El: Character Incompetence (versus Technical Incompetence) \rightarrow Conscious or Unconscious

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

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

Stress: A Major Contributor to Incivility

Student/Staff Stressors	Faculty /Leader Stressors
Workload (assignments, exams, group activities, clinical, deadlines, etc.) Balancing family, school, work, etc. Financial obligations Competition for grades/performance Unclear expectations Entitlement attitude à "know it all"; consumer mentality; "owed an education"; not taking personal responsibility (i.e.: blame others, lack accountability or make excuses) Others:	Workload or workload inequity Balancing family, work, and other competing demands Requirements for higher education/ career growth Publication, grants, or other scholarly requirements Power imbalances (FT-PT or Adjunct- Clinical, or Tenure/non-tenured or levels of leaders) Maintaining Clinical or Practice Competency Problematic Students or Faculty or staff Salary and Financial Obligations Keeping current with technology and online obligations Regulation and accreditation Retention Recruitment Changing healthcare environment Others:



<u>Strategies: Move to Action → Creating New Conversations</u>

Center's Three A's of Civility Strategies

- 1. Awareness
- 2. Authentic Conversations
- 3. Accountability

Reference: Center, D. (2010). 3-A's of Civility - Awareness; Authentic Conversations and Accountability Journal of Continuing Education in Nursing, 41(11), 488-489.

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

- Self
- Team
- Classroom

Self-Reflection: Do your students see it? Do your faculty see it? How can you make them conscious? How can you name it to help them see it?

•	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?

Reference: Showkeir and Showkeir (2008) Authentic Conversations: Moving from Manipulation to Truth and Commitment

The 8 Rights of Adult-to Adult Conversations:

1.	Right	
	Right	
3.	Right	
4.	Right	
5.	Right,	, and
	Right	
	Right	
	Right	



Accountability

"There is <u>no</u> 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 Coworker"/"Classmate"

Mutual Respect
 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:

My two greatest take-aways from this session is:

I WILL - CALL TO ACTION

Promise to **myself**: I will

Promise to **students/staff**: I will Promise to **faculty/peers**: I will Promise to **boss/leader**: I will

Promise to significant relationships: I will



Notes:



☐ 1. Clinical Scholar Why—Who— What— How	<u>Notes:</u>
Marianne D. Horner, MS, RN, CNM	
2. Why would a person want to be a Clinical Scholar?	I
 Originally developed as a strategy to seeinpact of the faculty shortage and 	
Personal motivation	
☐ 3. Who is a Clinical Scholar?	
Difference between Clinical Scholar as clinical educators	nd other
• Qualifications - http://www.dora.state nursing/rules/ChapterII.pdf	e.co.us/
☐ 4. Where does your paycheck com	e from?
• Will you be directly teaching rotations nursing students?	of



□ 5. Categories

Notes:

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

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

- Clinical expertise
- Educational requirements
- Previous teaching



☐ 7. Ability to combine two roles	Notes:
Clinical nurse	
— Competent	
— Expert	
Clinical Scholar	
— New role	
— Novice	
8. Do you remember what it is like to be a novice?	
novice:	
• Novice	
1.	
2.	
3.	
4.	
5.	
6.	



	atricia Benner: Skill Acquisition: Novice Expert	<u>Notes:</u>
•	Expert	
	1.	
	2.	
	3.	
□ 10. <i>i</i>	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?	<u>Notes:</u>
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
12. How do you Become a Clinical Scholar?	
• Preparation	
— Didactic course	
— Formal academic education	
• Role development from Novice → Expert	
Ongoing mentoring	
Deliberate reflection	



☐ 13. Meet our Clinical Group!



Benner's Stages of Clinical Competence

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

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



Benner's Stages of Clinical Competence

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

1		
Proficient	proficient performer perceives situations as wholes rather than in terms of pped up parts or aspects, and performance is guided by maxims (definition: eral truth). Can now recognize when the expected normal picture does not materialize. This holistic understanding improves decision making. Decision making becomes less labored because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones. Uses maxims as guides, which reflect what would appear to the competent or novice performer as unintelligible nuances of the situation, they can mean one thing at one time and quite another thing later. Once one has a deep understanding of the situation overall, however, the maxim provides direction as to what must be taken into account. Maxims reflect nuances of the situation. Able to see what is most important in a given situation Perceives deviation from the normal pattern	
Expert	 The expert nurse no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. With an enormous background of experience, now has an <i>intuitive grasp</i> of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. Operates from a deep understanding of the total situation. The performer is no longer aware of features and rules; his/her performance becomes fluid and flexible and highly proficient. This is not to say that the expert never uses analytic tools. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience. Analytic tools are also necessary for those times when the expert gets a wrong grasp of the situation and then finds that events and behaviors are not occurring as expected. Has a vision of what is possible. 	



Communication

The one thing humans do more than communicate:			
We can no	t NOT		
Communic	ation consists of		
Humans Co	ommunicate		

Once the message is sent, it		
It can be amended <u>AND</u> the first impression is		
This is often unconscious.		
How we communicate determines what kind of relationships we make.		
Self-regard is a major influence in all communication.		
Stress results when self-regard is threatened.		
Communication is learned from		

or Comm	iunicatio	n leads to:
		_
		_
		_
tle focus i place. Y		l on communication in the work
place. I	EI II IS	
to smoo	thly funct	tioning teams.

Guidelines for Communication

- 1. Approach each interaction as though the other person has no knowledge of effective communication. Assume responsibility for creating the sender-receiver rhythm.
- 2. Share your thoughts and feelings. Be self-revealing.
- 3. Casual conversation or "small talk" can be important to relationships, particularly when it is light and humorous. It balances the deep meaningful talk.
- 4. Acknowledging, praising, and encouraging the other person is supportive and brings life and energy to the relationship.
- 5. Present messages in a way that the other person can receive them.
- 6. When you have a problem or issue with another, take responsibility for the problem and speak about it as your problem also.
- 7. Use language of equality even when position titles are not of the same level.

Communication Patterns

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

Remember ERIC:

Emotional

Reaction

Impedes

Communication

Communication Pitfalls

1. Advice Giving

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

2. Making others wrong

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

3. Defensiveness

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

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

4. Judging the other person

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

5. Patronizing

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

6. Giving False Reassurance

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

7. Asking Why Questions

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

8. Blaming Others

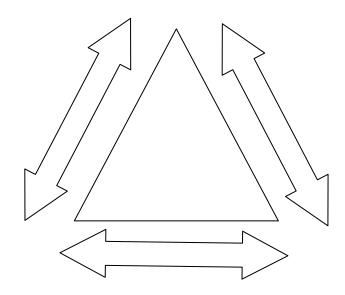
Saying things such as "You make me so angry" is blaming the other person for your feelings, which you choose at any given time. In nearly every situation, the responsibility for communication breakdown is a joint responsibility. You can always choose your response, even if that response is to say, "I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



Triangulation

Fun Game

- You can enter the game at any door
- Your preferred position is
- If I'm a victim
- After I've been "persecuted"
- Rescuer goes to Persecutor
- In this game we can take any role



Gossip

Definition — Talking about someone that is not present.

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

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

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

Gossip Test

Is it true?

Is it fair?

Will it bring goodwill and better relationships for all concerned?

Self-Awareness

Why am I gossiping?

What need am I filling?

Would I say this directly?

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

Before you text, type or speak, THINK first.

T is it $_$	 	 	
H is it			

is it _____

N is it _____

K is it

Dealing with Difficult People

Definitions:

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

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

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

Levels of Accountability

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

Differentiation/Awareness Model

1. Introduction

- Difficult person
- Difficult situation Empowerment in a conflict situation is defined as:

2. Stimuli for upset or reaction:

- Trigger is Outside
- The responding Feeling is Inside "You Make me Feel so"

3. What are Responses?

• Stress or Fear

4. Automatic Reactions?

• Unconscious – fight or flight

Physiological Responses?

Cre	eate list of responses / reactions
	tterns: aised adrenalin leads to: Assumptions
	Examples:

 We go through life reacting to External World

Vs.

Responding Creatively

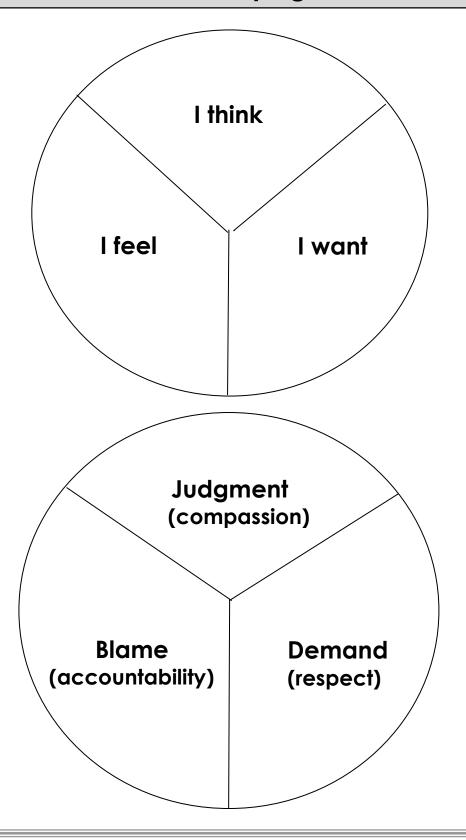
Internal

1. Feelings

- 2. Thoughts _____
- 3. Wants _____

Which is most difficult	for you to identify?
Exercise:	
In the unclear areas – this is opportunity to arise / grow.	s where automatic responses have an
How does that look for you?	?
If we get fused / one in read	ction at our internal level
	examples
Feel ===>	
Think ===>	
Want ===>	

Differentiation: Clarifying Internal Drivers



Communication Practice Session

identify feelings or sensations I'm feeling
refer to your perspective of the situation, check assumptions I think
identify what you want from the relationship or situation I want
How I'd like to work together is

Communication Practice Session

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Feeling Descriptions

afraid agitated aggravated alarmed alienated alone angry anxious apathetic appreciated ashamed attacked awkward bewildered blamed blamey blank burned-out calm caring closed cold comfortable

committed compassionate competent complete concerned confident conflicted confused connected considered contented controlled creative curious cut-off cynical touchy trusting

unappreciated

uncomfortable

unconsidered

understood unresponsive unsure defeated defensive dejected dependent depressed deprived desperate disappointed disrespected doubtful eager easy embarrassed engaged

envious evasive excited excluded exhilarated fearful foggy friendly frustrated full furious generous genuine gentle glad grateful guilty helpless hopeful hopeless hostile humiliated hurried hurt ignored

uptight

useless

victimized vindictive violent washed-up wishy washy worn out immobilized impatient inadequate incompetent indecisive ineffective inhibited insecure involved isolated jealous judgmental left out lonely lost mean

misunderstood
nervous
numb
open
optimistic
overwhelmed
out of control
pain
paralyzed
paranoid
passionate
peaceful
persecuted

playful pleased possessive preoccupied pressed pressured protective proud

pessimistic

pushed

pushed-out quiet regretful rejected relieved remorseful repelled repulsed resentful resentment resigned respected restrained rigid

scared scattered

sad

secure
set-up
self-reliant
shy
silly
sincere
sleepy
sluggish
sorry
stiff
stubborn
stupid
supported
supportive

suspicious sympathetic tender terrified threatened tired torn worried



Confrontation Skills Worksheet

	say in this step?		
•			
•			
•			
	erstanding		
at are you	likely to hear from t	he other persor	n? Topics, tone, emotion
•			
•			
•			
•			
otiate an	d Make Agreements	;	
	_		ner person? What are so
	reements between t		=
•			
•			
•			



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.



Communications and Conflict Resolution — Ingrid Johnson and Susan Moyer

- **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 <u>your</u> purpose for clinical conferences?
- What will your conferences look like? feel like? How will you set up the room?
- What time of day will <u>you</u> hold the conferences and how long will they last?
- What order will <u>you</u> call on the students? How will you draw out the introverted students and settle the extroverted ones?

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

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



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

Video: Example of a Clinical Day for Debriefing

Debriefing Process: How <u>you</u> facilitate the conference makes a difference! <u>Positive Experiences</u>

 What went well? What did <u>you</u> do well? What do you want to remember to do again?

Learning Opportunities

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



PURPOSE OF CLINICAL CONFERENCES

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

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

- Players:
 - Clinical Course Faculty
 - o Quality Control/Safety Officer and Timekeeper
 - o 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 postconferences?

Take Aways to Remember:



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



TYPES OF CLINICAL CONFERENCES

• Student-led

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

STUDENT-LED CONFERENCES	STUDENT PRESENTATIONS	INSTRUCTOR-LED
 Assign a student leader prior Group interaction using critical thinking skills, decision-making and problem solving techniques Examples of Student Led Conferences Case Scenario Correlate findings Explain procedures, dx, test Ethical dilemmas Conflict resolution Article – EBP Review 	 Topic assigned prior to conference date Formal presentation May be graded Have group discussion after presentation – entire group learns Group feedback given in positive constructive manner Peer Feedback - Have students do in writing 	 Presentation of Topic Facilitator for discussion Reflection - student to share clinical experience <u>Use</u> critical thinking and decision-making Develop Care Plans/ Concept Map
INVITED SPEAKER	HOSPITAL CONFERENCE OR FORUM	ON-LINE CLINICAL CONFERENCES
 Clinical Expert Specialty Topic Discuss Nursing Roles and other disciplines Relevant to course Examples: Wound Care Specialist Case Manager Diabetic Educator Respiratory Therapist Nurse Leader Infection Control Nurse 	 Topic presented relates to disease process currently studying Medical Grand Rounds National speaker Punctuality important Debrief after conference Creates a culture of lifelong learning as "professional responsibility" 	 Question or situation presented to all students electronically Email Blackboard/On-line Location Type of "Group Reflective Practice" Provide ground rules and due dates Be realistic with the assignment in relation to other course work On-Line Conference Topics Ethical issues Laboratory Data review Priority Setting Patient Education Communication Professional Behaviors Apply theory to clinical



Post-Conference Topic Suggestions and Ideas

Instructor-led Activities for any course:

- 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 _____

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

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



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



0.6.111.66		
Safe Hand-offs – Transitions of Care	Interdisciplinary Communication - SBAR	
Nurse/Nurse; Unit/Unit; Setting/Setting/		
Provider		
Guest Speakers – RT/PT/OT/DTY/ Spiritual	Case Presentations related to theory	
Care/Infection Control	topic	
Teaching and Support for Significant	QSEN Quality and Safety Overview of	
others and or family members	the Nurses Role	
Caring for the Caregiver		
Care of the Medical/Sur	gical Client/Complex - II	
Care of patients/clients with Diabetes,	Post-Operative Care/Complex	
Chronic Lung Disease, Congestive Heart		
Failure, CVA		
Delegation of Tasks	Chest Tube Management	
Emergency Procedures/Medications	Wound Care/Complex	
Di la la companya di	Total /Partial Parenteral Nutrition	
Blood Administration - demonstration	Central Venous Line Management	
Ventilator Management	Wound Care/Complex	
Prioritization/Time Management with	Giving a Nursing End-of-Shift Report	
Multiple Patients		
Nurse as a Patient Advocate	Discharge Planning and Teaching	
Role-Play taking Phone Orders from	Care of patient in Specialty Areas – (OR,	
Physician	ED, ICU, PACU, etc.)	
Homodialysis / Paritangal Dialysis	Ethics – issues r/t Patient Rights, Death/	
Hemodialysis / Peritoneal Dialysis	Dying, Visitation etc.	
New Graduate Experience and Reality	Epidural Pain Management	
Shock – Tools to survive		
EKG – Rhythms and Arrhythmias	QSEN Quality and Safety Overview of	
EKO – KITYITIITIS GITG ATTTYTTITIGS	the Nurses Role	
Care of the Pediatric Client		
Medication Administration to Pediatric	Assessment Techniques for Children	
Patients/ Clients	The second secon	
Use of Age-Appropriate Toys/Games,	Growth and Development Issues	
Child Life	2.2.7 22.2.7.3.0000	
Care of the Child Post Operative-	RSV	
Appendectomy .		



	7
Care of the Child with Failure to Thrive	Gastrointestinal Issues
Adolescent Drug Abuse/Child Abuse Issues	Obtaining Consents
Communicating with Parents and Child/ Family	Ethical issues
Developing Nurse-patient relationship with a child and parents/family	Pain management/control for children
Non-accidental Trauma	Care of Burn Victim
Dealing with child with no parents or family	Cardiovascular issues in children
QSEN Quality and Safety Overview of the Nurses Role	
Care of the Chi	ildbearing Client
Ante/Postpartum Assessments	Family Teaching
Breastfeeding and patient teaching	Fetal Monitor Observation
Pre-term Labor and PIH	Gestational Diabetes
PIH and Intravenous Medications	Fetal Distress
Fetal Monitoring	Newborn Intensive Care Issues
Grief Associated With Loss of a Baby	Cultural Aspects of Childbirth
Pre- and Post-Epidural Management	Teen Pregnancy
Complications	Care of the Newborn
Newborn Assessment	Dealing with a Mom that needs to stay hospitalized and baby gets transported to Children's Hospital
Care of Multiple-Birth Delivery	QSEN Quality and Safety Overview of the Nurses Role
Labor – Stages of Labor	Assessing a Cervix
Estimating Blood Loss	



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



Community Health / Public Health		
Community Assessment	Community Education	
Bioterrorism	Public Health Emergency	
Emergency Response Teams	Public Health Awareness	
Home Health –verses - Public Health – verses Community Health What is the difference?	Environmental Health	
Diseases and Epidemics and Pandemics	Community Resources	
Community Resource Identification – Case Study	Refugee and Immigrant Community and Cultural Considerations	
Traumatic Brain Injury (TBI) Care Coordination	Family Planning (Birth Control and STD education in Schools)	
HCP – Helping Children with Special Needs	Geographical Information – Systems and Mapping Health and Disparity Issues	
Case Management, Medical Homes and Patient Advocates for getting though the healthcare system	Community Education and Immunizations with new diseases: H1N1 – How do we protect? How do we control?	
QSEN Quality and Safety Overview of the Nurses Role	Nurse Safety in Home Health	
Patient Safety in Home Health	Patient-Centered Care	
Homeless Coalition		
Addition	al Topics	
Nursing Leadership	Scope of Practice	
Staffing	Licensure Requirements	
Charge Nurse Role	Nursing Organizations	
Delegation	Time Management	
Future of Nursing - IOM	Professionalism	
Civility - Attitude	Communication in Intraprofessional Teams	
Ethical and Legal Issues	Standards for Care – Best practice	

Final recommendations

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



DiSC — Karren Kowalski

Notes:	



DiSC — Karren Kowalski

Notes:	



Diversity — Amanda Quintana and Hillary St. John

Notes:	<u>Notes:</u>



Diversity — Amanda Quintana and Hillary St. John

Notes:	



1 .	Early & Often	<u>Notes:</u>
	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	<u>Notes:</u>
• 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	



■ 8. Anecdotal Notes are Formative Evaluation	Notes:
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. I	Let's practice	Notes:
•	Remember our clinical group?.	
□ 13. F	Practice	
•	Here is Emily Day	
•	You are her Clinical Scholar observing this interaction	
•	Write an anecdotal note	
14. 0	Guard Confidentiality	
•	How?	
	What to do with notes at the end of the tation?	
•	Recommendation is to turn them in with your completed evaluation forms	



16. Anecdotal Note + Anecdotal Note +	
Anecdotal Note = Compilation into	
Summative Evaluation Tool	

Notes:

☐ 17. No Surprises!

□ 18. A+

Notes:	



1. Grading Written Assignments:The Challenge for New Clinical Faculty	<u>Notes:</u>
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)	
D. 4. Mini Mana Francisco	
■ 4. Mini Map Example	



(see handout at the end of this section)

□ 5	. G	rading a Paper	Notes:
	•	6th edition APA manual	
	•	http://www.apastyle.org	
- 6		ocess for Grading Written ssignments	
	•	Review guidelines and rubric with students at orientation	
	•	Focus on PURPOSE of assignment	
	•	De-identify papers, read in random order	
- 7	. Pr	ocess, continued	
	•	First reading:	
		– Scan for common strengths / concerns	
		 Adjust expectations if needed 	
		- Keep preliminary marking to a minimum	



■ 8. Process, continued

Notes:

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

9. Additional Considerations

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

☐ 10. Additional Considerations

- What about plagiarism?
 - Turnitin.com
 - Plagiarsm.org
- Color of writing instrument
- Okay to submit for early reading?



☐ 11. Technology Support

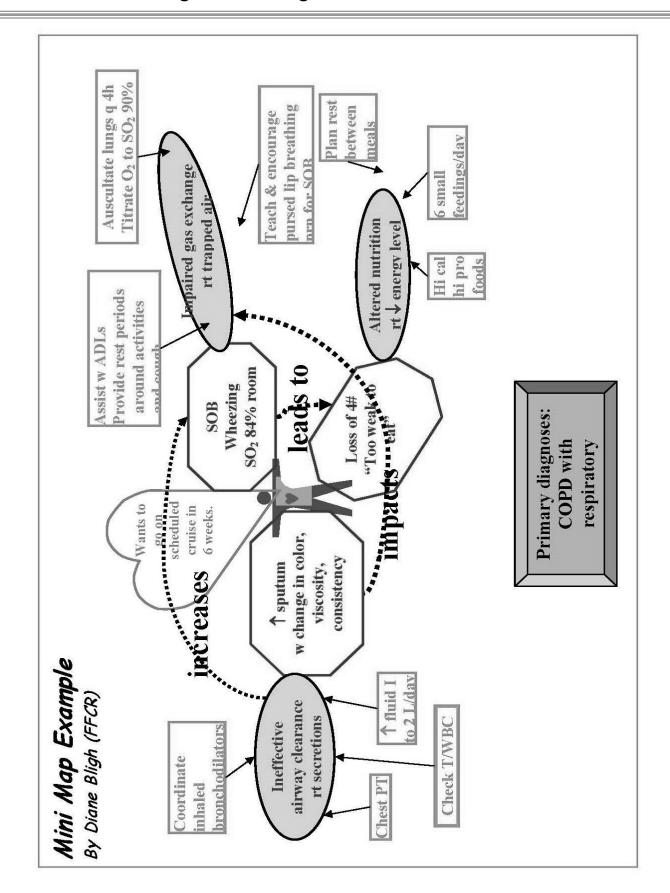
Notes:

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

☐ 12. Technology Support

- Quickoffice Pro for papers and clinical evaluations
- Also university electronic platform such as Blackboard; Ecollege, etc.







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



lacksquare 1. Innovations in Nursing Education

Notes:

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**.



Notes:

☐ 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.





Notes:

☐ 9. Patient Safety and Quality

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

10.



$lue{}$ 11. 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

Notes:

- 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:



InterProfessional Teams — Marianne Horner

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

Notes:

Diann McCallister, MD, MBA

Chief Medical Officer,

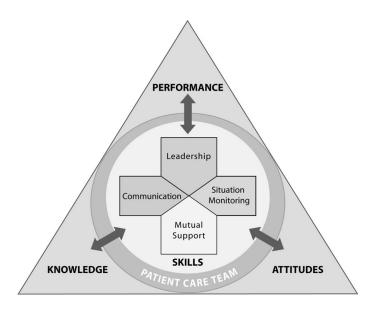
The Medical Center of Aurora

Marianne Horner, MS, RN, CNM

Project Director

Colorado Center for Nursing Excellence

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



InterProfessional Teams — Marianne Horner

	3.	Commu	nication	& 1	Teamwork
--	----	-------	----------	-----	-----------------

Notes:

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

4. Communication Overload and Assumptions

• Does this seem familiar?

☐ 5. Video Clip

InterProfessional Teams — Marianne Horner

☐ 6. How much can one mind hold?	<u>Notes:</u>
• The law of 7s.	
☐ 7. Video Clip	
■ 8. Olny srmat poelpe can raed tihs. I cdnuolt blveiee taht I cluod aulacity uesdnatnrd waht I was rdanieg. The phaonmneal pweor of the hmuan mnid, aoccdrnig to a rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the Itteers in a wrod are, the olny iprmoatnt tihng is taht the frist and Isat Itteer be in the rghit pclae. The rset can be a taotl mses and you can sitll raed it wouthit a porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey Iteter by istlef, but the wrod as a wlohe. Amzanig huh? yaeh and I awlyas tghuhot slpeling was ipmorantt!	
 9. Human Factors: How Our Brain's Wiring Can Contribute to Errors 	
Physician's Differential Diagnosis— can create a knowledge-based error	
This type of logic has	
—30% chance of error	
— 30% chance of not detecting an error was made	



InterProfessional Teams — Marianne Horner

☐ 10. Medical Training Addresses These Errors	<u>Notes:</u>
Tactics utilized to minimize errors in diagnosis	
• Structured problem solving – same information in same order every time – (might look rigid to others)	
 Identify all possibilities and then identify the right answer based on facts 	
□ 11. Let's Talk about SBAR	
☐ 12. Sue Sheridan	

Jeopardy — Deb Center and Susan Moyer

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)
- o **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"
- o 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 manikins 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
- 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
- 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

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Jeopardy — Deb Center and Susan Moyer

Notes:



Learning Styles — Susan Moyer

1	. Auditory, Visual and Kinesthetic Learning	<u>Notes:</u>
- 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"	



Learning Styles — Susan Moyer

□ 5. Kinesthetic Learners

Notes:

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

☐ 6. Blended Learning

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

Notes:

Linda Stroup, PhD, RN

Chair, Department of Nursing

Metropolitan State University of Denver

☐ 2. Objectives

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





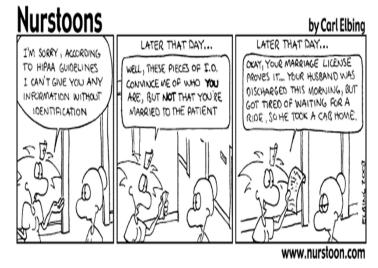


☐ 4. HIPAA Humor

Notes:

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

□ 5.



☐ 6. HIPAA

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



□ 7. OSHA Notes:

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

■ 8. Background Checks

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

9. Family Educational Rights and Privacy Act (FERPA)

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



□ 10. FERPA Notes:

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

□ 11. FERPA

- Provide parent/eligible student an opportunity to seek correction of records he/she believes to be inaccurate or misleading
- Parent or eligible students have the right to inspect and review the student's education records maintained by the school

□ 12. FERPA

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



□ 13. FERPA Notes:

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

□ 14. FERPA

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



☐ 15. Written Consent

Notes:

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

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

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

□ 17. ADA Notes:

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

□ 18. ADA

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

□ 19. ADA

• Some key points:

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

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

Minimum functional abilities



■ 20. Student Handbooks • Each college has a student handbook containing specific information related to: Workman's compensation Needle stick injuries Impaired students

☐ 21. Workman's Compensation

Grievances

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

☐ 22. Impaired Students

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



23.	Grievances	Notes:

• School policy defines policy and procedure

☐ 24. Colorado Nurse Practice Act

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

☐ 25. Student Scope of Practice

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

☐ 26. Student Scope of Practice

Notes:

- Begin by asking the following question: Is this task within my scope of practice?
- Basic Nursing Education Preparation
 - -Has the skill/task been taught in the nursing program?
 - -Is the skill/task in the course guidelines or previous course guidelines?
 - -Is it allowable in <u>THIS</u> clinical setting by policy/procedure?

☐ 27. Clinical Agency Policies and Procedures

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

_			
<u> </u>	28.	Patient Rights	<u>Notes:</u>
	•	Right to privacy	
	•	Right of refusal	
		-Care	
		–Procedures	
		ANA Code of Ethics with Interpretive Statements	
	•	Establishes the ethical standard for nursing profession	
	•	Revised in Spring 2015	
	•	Nine provisions:	
		- First three describe fundamental values and commitments of the nurse	
		-Next three address boundaries of duty and loyalty	
		-Last three address aspects of duties beyond individual patient encounters	

☐ 30. ANA Code of Ethics

Notes:

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

☐ 31. Selected Resources

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

NCLEX Exam: Test Your Knowledge

- 1. The NCLEX is created by:
 - a. The local State Board of Nursing
 - b. The American Association of Colleges of Nursing (AACN)
 - c. The National League for Nursing (NLN)
 - d. The National Council of State Boards of Nursing (NCSBN)
- 2. A candidate's eligibility to take the NCLEX exam is determined by:
 - a. The student's college or university
 - b. The local State Board of Nursing
 - c. AACN
 - d. NCSBN
- 3. The cost of the NCLEX exam is:
 - a. \$120.00
 - b. \$150.00
 - c. \$200.00
 - d. \$250.00
- 4. Which of the following best describes the format of the NCLEX:
 - a. It is a variable length adaptive test given by computer
 - b. It is a 265 item computer exam
 - c. It is a 75 item computer exam
 - d. It is given by computer, orally or in paper and pencil format, depending on the student's learning needs.
- 5. The NCLEX exam must be completed within:
 - a. 3 hours
 - b. 4 hours
 - c. 5 hours
 - d. 6 hours
- 6. If a student fails the NCLEX on the first try, he/she is likely to get extra help and pass on the second attempt.
 - a. True
 - b. False
- 7. NCLEX questions are in a multiple choice format.
 - a. True
 - b. False



- 8. Results are received
 - a. Immediately upon completion of the exam at the testing center
 - b. By mail within two weeks of the exam
 - c. By mail within 4-6 weeks of taking the exam
 - d. By phone within a few days of testing
- 9. What percentage of US born BS-prepared nurses pass NCLEX on their first attempt?
 - a. 58%
 - b. 78%
 - c. 86%
 - d. 98%
- 10. The most important component in determining likelihood of success on the NCLEX exam is:
 - a. Knowledge of pathophysiology
 - b. Quality clinical experience in medical/surgical nursing
 - c. Knowledge of nursing process
 - d. Critical thinking ability

□ 1. Helping Students Prepare for NCLEX-RN Exam

Notes:

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



Notes:

☐ 5. Objective

- Discuss clinical and it's relationship to NCLEX
 - -Adult Learners like clear applicability
 - -Opportunities for NCLEX utilization
 - -About the test...

☐ 6. The NCLEX is created by:

- National Council of State Boards of Nursing in order to:
 - -Determine if a student is ready to be a safe and effective nurse.
 - -Safeguard the public.
 - -Test for minimum competency.
- Questions are based on the knowledge and activities of an *entry level nurse*

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

- After the state board of nursing declares a candidate eligible, they will receive an Authorization to Test
- Security at the test site by Palm Vein Technology and digital fingerprinting



■ 8. The cost of the NCLEX exam is:

Notes:

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

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

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

☐ 10. Types of questions

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



■ 11. Types of Questions

Notes:

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

☐ 12. Passing the Exam

- The NCSBN Board of Directors determined that
 - -safe and effective entry-level RN practice requires a greater level of knowledge, skills, and abilities than was required in 2007, when NCSBN implemented the current standard.
 - -The new passing standard is 0.00 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



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ш	1.5.	Pass	Rates	ZUL5	•

Notes:

• 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.
- (Giddens, J. (2002). The relationship of critical thinking to performance on the NCLEX-RN. Doctoral dissertation, Colorado State University.)



■ 17. How Do I Teach Critical Thinking?

Notes:

- This all goes back to your skills in asking the right questions!
- Am I designing my instruction so that students have to think through the purpose of what they are doing?

☐ 18. How Do I Teach Critical Thinking?

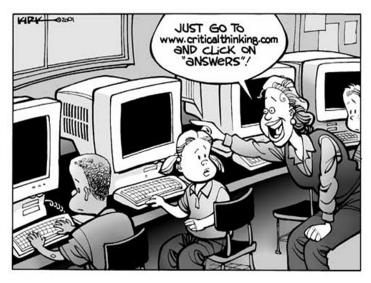
- Am I designing instruction so that students are knowledgeable about accessing the information they need to learn?
 - -Am I holding them responsible for prerequisite information?
 - -Am I encouraging them to use sources other than the textbook?

☐ 19. How Do I Teach Critical Thinking?

- Am I designing my instruction so that students learn the criteria they need to assess their own thinking?
- Am I helping students to apply knowledge gained in one clinical experience to other situations?



□ 20. <u>Notes:</u>



☐ 21. Topics

- Client Needs
 - -Safe and Effective Care Environment
 - •Management of Care 17-23%
 - •Safety and Infection Control 9-15%
 - -Health Promotion and Maintenance 6-12%
 - -Psychosocial Integrity 6-12%
 - -Physiological Integrity
 - •Basic Care and Comfort 6-12%
 - •Pharmacological and Parenteral Therapies 12-18%
 - •Reduction of Risk Potential 9-15%
 - •Physiologic Adaptation 11-17%



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

Notes:

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

☐ 23. Whew!

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

NCLEX Review—Pediatrics

- 1. A 4-day old newborn infant is receiving phototherapy at home for a bilirubin level of 14 mg/dL. The nurse should plan to include which of the following in the plan of care during the home visit to the mother of the newborn infant?
 - a. Having minimal contact with the newborn infant to prevent stimulation.
 - b. Advising the mother to limit newborn infant oral intake during phototherapy
 - c. Applying lotions to exposed newborn infant's skin
 - d. Assessing skin integrity and fluid and electrolyte status of the newborn infant.
- 2. A nurse is caring for a post-term, small for gestational age newborn infant immediately after admission to the nursery. The priority nursing action would be to monitor the results of what serum laboratory study?
- 3. The mother of a 4-year old child calls the clinic nurse and expresses concern because the child has been masturbating. The most appropriate response by the nurse is which of the following?
 - a. "The child is very young to begin this behavior and should be brought to the clinic."
 - b. "This is not normal behavior, and the child should be seen by the physician."
 - c. "This is a normal behavior at this age."
 - d. "Children usually begin this behavior at age 8 years."
- 4. A clinic nurse provides information to the mother of a toddler regarding toilet training. Which statement, if made by the mother, indicates a need for further information regarding the toilet training?
 - a. "The child will not be ready to toilet train until the age of about 18 to 24 months."
 - b. "Bladder control usually is achieved before bowel control."
 - c. "The child should not be forced to sit on the potty for long periods."
 - d. "The ability of the child to remove clothing is a sign of physical readiness."
- 5. A nurse is preparing to care for a child after a tonsillectomy. The nurse documents on the plan of care to place the child in which most appropriate position?
 - a. Supine
 - b. Trendelenburg's
 - c. Side lying
 - d. High Fowler's



- 6. An emergency room nurse is caring for a child diagnosed with epiglottitis. Assessing the child, the nurse monitors for which indication that the child may be experiencing airway obstruction?
 - a. The child is leaning backward, supporting himself with the hands and arms
 - b. The child has a low-grade fever and complains of a sore throat
 - c. The child is leaning forward with the chin thrust out
 - d. The child exhibits nasal flaring and bradycardia.
- 7. A nurse is reviewing the physician's orders for a child who was just admitted to the hospital with a diagnosis of Kawasaki disease. The nurse expects to note an order for which of the following as a part of the treatment plan?
 - a. Morphine sulfate
 - b. Immune globulin
 - c. Heparin infusion
 - d. Digoxin (Lanoxin)
- 8. A clinic nurse reviews the record of a 3-week-old infant and notes that the physician has documented a diagnosis of suspected Hirschsprung's disease. The nurse reviews the assessment findings documented in the record, knowing that which symptom most likely led the mother to seek health care for the infant?
 - a. Diarrhea
 - b. Projectile vomiting
 - c. Regurgitation of feedings
 - d. Foul-smelling ribbonlike stools
- 9. A physician orders intravenously administered potassium for a child with hypertonic dehydration. A nurse performs which priority assessment before administering the potassium?
 - a. Taking the temperature
 - b. Taking the blood pressure
 - c. Obtaining a weight
 - d. Checking the amount of urine output
- 10. A clinic nurse reviews the record of a child just seen by a physician. The physician has documented a diagnosis of suspected aortic stenosis. The nurse expects to note documentation of which of the following clinical manifestations specifically found in this disorder?
 - a. Hyperactivity
 - b. Exercise intolerance
 - c. Pallor
 - d. Gastrointestinal disturbances
- D, glucose, c, b, c, c, b, d, d, b



NCLEX Review: Women's Health

- 1. A nurse in a health care clinic is instructing a pregnant woman in how to perform "kick counts". Which statement by the woman indicates a need for further instructions?
 - a. "I should place my hands on the largest part of my abdomen and concentrate on the fetal movements to count the kicks."
 - b. "I will record the number of movements or kicks."
 - c. "I need to lie flat on my back to perform the procedure."
 - d. "A count of fewer than 10 kicks in a 12-hour period indicates the need to contact the physician."
- 2. A physician has prescribed transvaginal ultrasonography for a woman in the first trimester of pregnancy and the woman asks the nurse about the procedure. The nurse accurately provides which of the following information to the client?
 - a. The procedure takes about 2 hours
 - b. Transmission gel is spread over the abdomen, and a transducer will be moved over the abdomen to obtain the picture.
 - c. It will be necessary to drink 1 to 2 quarts of water before the examination
 - d. The transvaginal probe encased in a disposable cover and coated with gel is inserted into the vagina.
- 3. A nurse in a maternity unit is reviewing the records of the clients on the unit. Which of the clients would the nurse identify as being at most risk for developing disseminated intravascular coagulation (DIC)?
 - a. A gravida IV who delivered 8 hours ago and has lost 500 mL of blood
 - b. A gravida II who has just been diagnosed with dead fetus syndrome
 - c. A primigravida with mild preeclampsia
 - d. A primigravida who delivered a 10-lb baby 3 hours ago
- 4. A pregnant woman reports to a health care clinic, complaining of loss of appetite, weight loss, and fatigue. Following assessment of the woman, tuberculosis is suspected. A sputum culture is obtained and identifies Mycobacterium tuberculosis. The nurse provides instructions to the mother regarding therapeutic management of the tuberculosis. The nurse tells the client that
 - a. Medication will not be started until after delivery of the fetus.
 - b. Isoniazid (INH) plus rifampin (Rifadin) will be required for a total of 9 months.
 - c. The newborn infant will need to receive medication therapy immediately after birth.
 - d. Therapeutic abortion is required.
- 5. A home care nurse is monitoring a pregnant client with pregnancy induced hypertension (PIH) who is at risk for preeclampsia. At each home care visit, the nurse assesses the client for which three classic signs of preeclampsia? ______



6. A nurse implements a teaching plan for a pregnant client who is newly diagnosed with ge 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 a provider."	my health care
7. A nurse assists in the vaginal delivery of a newborn infant. After the delivery, the nurse of umbilical cord lengthen and a spurt of blood from the vagina. The nurse documents the signs of	
a. Hematomab. Placenta previac. Uterine atonyd. Placental separation	
8. A nurse is monitoring a client in labor who is receiving oxytocin (Pitocin) and notes that experiencing hypertonic uterine contractions. List in order of priority the actions that the (Number 1 is the first action)	
Stop the oxytocin infusionPerform a vaginal examinationReposition the clientCheck the client's blood pressure and heart rateAdminister 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. You 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 	Which of the
10. A nurse is caring for a pregnant client with severe preeclampsia who is receiving magnes intravenously. The nurse ensures that what medication, the antidote to magnesium sulfaroom? 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	blad	lder	disten	ition

- b. ____Raise the head of the bed
- c. ____Contact the physician
- d. ____Loosen tight clothing on the client
- e. ____Administer an antihypertensive medication



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

- 7. The nurse is caring for a client experiencing hematologic toxicity as a result of chemotherapy. The nurse develops a plan of care for the client. The nurse plans to
 - a. Restrict all visitors
 - b. Restrict fluid intake
 - c. Insert an indwelling urinary catheter to prevent skin breakdown
 - d. Restrict fresh fruits and vegetables in the diet.
- 8. Megestrol acetate (Megace), an antineoplastic medication, is prescribed for the client with metastatic endometrial carcinoma. The nurse reviews the client's history and contacts the physician if which of the following is documented in the client's history?
 - a. Asthma
 - b. Myocardial infarction
 - c. Thrombophlebitis
 - d. Gout
- 9. A nurse is monitoring a client with diabetes insipitus. Desmopressin (DDAVP, Stimate) has been prescribed for the client. Which of the following outcomes reflects a therapeutic effect of this medication?
 - a. Serum osmolality greater than 320 mOsm/kg
 - b. Increased blood pressure
 - c. Decreased urine output
 - d. Urine osmoloality less than 100 mOsm/kg
- 10. The family of a bedridden client with diabetes mellitus calls a nurse to report the following symptoms: blood glucose of 400 mg/dL (by fingerstick), polydipsia, and increased lethargy. To determine a possible diagnosis, the nurse asks the family which most important question?
 - a. "Has there been any change in the dietary intake?"
 - b. "Have there been any ketones in the urine?"
 - c. "Has there been any fever?"
 - d. "Have you increased the amount of fluids provided?"

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



NCLEX Review-- Psychiatric Nursing

- 1. The nurse is working with a client who has sought counseling after trying to rescue a neighbor involved in a house fire. In spite of the client's efforts, the neighbor died. Which action does the nurse engage in with the client during the working phase of the nurse-client relationship?
 - a. Exploring the client's potential for self-harm
 - b. Exploring the client's ability to function
 - c. Inquiring about the client's perception or appraisal of the neighbor's death
 - d. Inquiring about and examining the client's feelings that may block adaptive coping
- 2. A client is admitted to a mental health unit for treatment of psychotic behavior. The client is at the locked exit door and is shouting, "Let me out. There's nothing wrong with me. I don't belong here." The nurse analyzes this behavior as
 - a. Projection
 - b. Denial
 - c. Regression
 - d. Rationalization
- 3. An 18-year-old woman is admitted to an inpatient unit with the diagnosis of anorexia nervosa. A cognitive behavioral approach is used as part of her treatment plan. The nurse understands that the purpose of this approach is to
 - a. Help the client identify and examine dysfunctional thoughts and beliefs
 - b. Emphasize social interaction with clients who withdraw
 - c. Provide a supportive environment
 - d. Examine intrapsychic conflicts and past issues
- 4. The nurse is providing information to a client about the use of disulfiram (Antabuse) for the treatment of alcohol abuse. The nurse understands that this form of treatment works on the principle of which therapy?
- 5. A client who is delusional says to the nurse, "The federal guards were sent to kill me." The nurse's best response is
 - a. "The guards are not out to kill you."
 - b. "I don't believe this is true."
 - c. "I don't know anything about the guards. Do you feel afraid that people are trying to hurt you?"
 - d. "What makes you think the guards were sent to hurt you?"



NCLEX Preparation — Teresa Connolly

6.	The nurse is planning activities for a client who has bipolar disorder with aggressive social behavior. Which of the following activities would be most appropriate for this client? a. Ping pong b. Writing c. Chess d. Basketball
7.	Select all nursing interventions for a hospitalized client with mania who is exhibiting manipulative behavior. Communicate expected behaviors to the client Enforce rules and inform the client that he or she will not be allowed to attend therapy groups Ensure that the client knows that he or she is not in charge of the nursing unit Be clear with the client regarding the consequences of exceeding limits set regarding behavior Assist the client in testing out alternative behaviors for obtaining needs.
8.	A nurse is conducting a group therapy session. During the session, a client with mania consistently talks and dominates the group session and her behavior is disrupting group interactions. The nurse would initially a. Ask the client to leave the group session b. Tell the client that she will not be able to attend any future group sessions c. Tell the client that she needs to allow other clients in the group time to talk d. Ask another nurse to escort the client out of the group session
9.	A client who has been drinking alcohol regularly admits to having a "problem". The client is asking for assistance with the problem. The nurse would support the client to attend which self-help community groups?
10	The nurse is planning care for a client being admitted to the nursing unit who attempted suicide. Which of the following priority nursing interventions will the nurse include in the plan of care?
	 a. Check whereabouts of the client every 15 minutes b. Suicide precautions with 30 minute checks c. One-to-one suicide precautions d. Ask the client to report suicidal thoughts immediately
D,	b, a, aversion therapy, c, b, #7-a, d,e; c, Alcoholics Anonymous, c





CORE COMPETENCIES OF NURSE EDUCATORS © WITH TASK STATEMENTS

Competency 1 – Facilitate Learning

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

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

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Competency 2 – Learner Development and Socialization

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

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



Competency 3 – Use Assessment and Evaluation Strategies

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

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

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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,

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☐ 1. Principles for Planning the Clinical Day

Notes:

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

☐ 2. Getting Started....

Objectives:

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

☐ 3. Foundations.... What's my Style?

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



☐ 4. Philosophy of Teaching

Notes:

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

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

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



☐ 6. In the Beginning... Notes: • Pre-Clinical Contact ♦ myClinicalExchange ♦ phone or email? Student Orientation ♦ what, where, when, and who? • Clinical Preparation • "The Ground Rules" ☐ 7. Strategies for Assignments Goal: Identify the student's ability to consistently provide safe care with confidence. Factors to include: ♦ Level of and number of students ♦ Clinical course focus and objectives ♦ Practice or Care setting ♦ Census ♦ Available resources



level

♦ Individual student learning needs and skill

☐ 8. Assignment Responsibility <u>Notes:</u>

Who is Responsible?

- Instructor
- Student
- Agency Leadership
- Collaborative Effort

■ 9. Approach to Assignments

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

□ 10. Instructor Priorities

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



☐ 11. How Do You Know Students are Prepared?

Notes:

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

☐ 12. How do I Evaluate Student Performance?

☐ 13. Definitions:

• Struggle

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

• Failure

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

Success

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

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



☐ 14. What is Clinical Evaluation?

Notes:

- The nature of clinical evaluation involves assessing and evaluating students in areas of critical thinking, therapeutic interventions, communication, teaching, research, leadership and management, professionalism, and adherence to standards of practice.
- Smith, M., et al (2001). Legal issues related to dismissing students for clinical deficiencies. Nurse Educator, (26)1: 33-38

■ 15. Why is Clinical Evaluation Important?

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

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

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

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

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

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



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

Notes:

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

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

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

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

Notes:

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

☐ 19. Clinical Practice: Safe versus Unsafe

Safe:

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

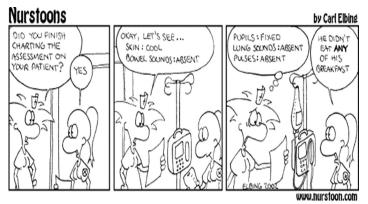
Unsafe:

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

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



□ 20. <u>Notes:</u>



☐ 21. Room for Debate

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

☐ 22. Behaviors of Impaired Performance

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



<u> </u>	23.	Struggling "Looks Like"	Notes:
	•	Poor eye contact	
	•	Shuffling paperwork	
	•	Easily distracted	
	•	Disengaged body language	
	•	Habits of nervousness	
	•	Makes excuses	
	24.	Struggling "Sounds Likes"	
	•	Echolalia	
	•	Common phrases used:	
		◊ I'm not sure what you mean	
		♦ I didn't have time to	
		◊ I couldn't find	
		♦ I had no idea I was to know	
		◊ I wasn't taught	
		♦ I'm sorry	
		◊ I need more time	



☐ 25. Elephant in the Room

Notes:

• Who knows it?

☐ 26. Strategies to Improve Clinical Performance

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

☐ 27. Strategies to Improve Clinical Performance

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



☐ 28. Anticipate a Response

Notes:

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

□ 29. Moving forward...

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

☐ 30. Online Resources

- www.qsen.org
- http://nursing.unm.edu/resources/teaching-and-learning-strategies.html



- 1	. Cre	eating a Culture of Inquiry	Notes:
•		ren Kowalski, PhD, RN, FAAN	
•	Mar	ianne Horner, MS, RN, CNM	
- 2	. De	finitions	
•	Cult	ture:	
	\(\)	Set of shared attitudes, values, goals & practices	
•	Inqı	airy:	
	\Diamond	Examination into facts or principles	
	\Diamond	A request for information	
	\Diamond	Systematic investigation	
□ 3		estions are the of mind.	
4	l. Ca	tegories	
•	Que	estions asked	
•	Que	estions asked	



□ 5. Reasons to Ask Questions

Notes:

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

☐ 6. Guidelines for Asking Questions

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

☐ 7. The Delivery

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



-	8.	The Response	Notes:
	•	Active listening	
	9.	Additional Active Listening Tips	
	•	Can you paraphrase the response?	
	•	Are follow up questions, clear, easy?	
	10). The Evaluation	
	•	As you listen, evaluate the response	
	•	Clarifying questions may be needed	
		Be prepared to question until issue reaches completion	
	11	. The Payoff	
	•	Act on the information attained	
		If performance improves or something changes, acknowledge	



1	2. When to use questions	Notes:				
	Based on Teaching Tips homework:					
	• What are some questions you came up with?					
	• In which category?					
1	3. 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?

Questions — Karren Kowalski and Marianne Horner		
<u>Notes:</u>		



Could....

•	17.	Questions Leading another through the Process of Discovery	<u>Notes:</u>
	18.	How to scaffold questions to "Lead"	
		Write down 2 clinically based questions a student might pose Trade questions with your partner who will ask the question. Take turns until time is up. Get feedback from your partner about your skill DO NOT ANSWER or go to explanation, lead through questions	
-	20.	How did that work? What are the advantages? What are the barriers?	



Words from one of my students...

Nursing Education is an opportunity to "Pay it Forward"

- ➤ That is Magic!
- As a Clinical Scholar <u>you</u> will "evoke inner wisdom!"

What is Reality Shock?

- ➤ "Refers to the specific shock-like reactions of new workers when they find themselves in a work situation for which they have spent time preparing and suddenly find they are not prepared." Marlene Kramer, 1974
- Shock can occur when one changes roles and moves from a familiar, comfortable environment to a new role.
- > 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
- \triangleright When training and support added \rightarrow 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 <u>patient</u> with yourself as you become expert teachers!"

Research on Reality Shock - Novice Faculty Research

- Most classic and significant research by Siler & Kleiner
- Four Themes from the interviews emerged:
 - o Expectations
 - o Learning the "Game"
 - o Being Mentored
 - o Fitting In

Expectations:

"... it's an entirely different culture than <u>anything</u> 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 offthe-wall question, and I wouldn't know what to say. I felt mortified I couldn't answer their question! Actually, that group of students was pretty tolerant, but I felt like I should know everything when I didn't."

Memorable Experiences:

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



Coping:

"... everything was really overwhelming at first, I came in just all excited. It felt like... the story about a donkey that fell into a well and they couldn't get him out, so they decided to bury him.

They threw in dirt and more dirt. Instead of letting them bury him, the donkey shook the dirt of his back and stomped it down. He stomped it down until he was able to walk his way out. And, that is the way I felt at first, they were dumping on me and now I've figured out how to step on top of the dirt they're dumping on me and go on."

You are not alone...

Examples of 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!
 - o Going to another Faculty Member
 - o Formal Petition
 - To a Political Leader

There are tremendous responsibilities to balance...

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



Strategies to Remember:

Stop, listen and think!

- Take a deep breath!
- Oxygen is good for brain tissue!
- ➤ Pause to THINK before responding.
- ➤ AVOID saying the first thought that comes into your mind!
- Take a break 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
 - o the school of nursing
 - o the clinical agency
 - o and each other!

Establish TRUST upfront! Here is your script!

- ➤ During the first clinical day Ask for a show of hands...
 - O How many of you are hoping to become mediocre nurses?
 - O How many of you are hoping to become highly competent nurses?
- Figure 12. 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*
 - O You are their safety net!
- ➤ **Protect** the students in front of others → Talk in **private** whenever possible

"Inspire" the Next Generation

- ➤ You are "Real Nurses"
- Demonstrate the Art and the Science of Nursing!
- ➤ Show them YOUR passion for nursing!

Role Model what you do best...

- ➤ Clinical Experts → Role Model Nursing
- ➤ Role Model Respect
 - o Say "Please" and "Thank you"
 - o Say "I am sorry" when you are
 - O Articulate & give rationale for why you are or are not doing things
 - Use I feel I think I want and avoid You, But and Why!
- Emulate Caring... Ethics... Integrity... Professionalism... etc.
 - o To student
 - To patient
 - o To staff
 - To school
 - o 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:
 - o **Tell** 20% of the time!
 - o **Ask** 80% of the time!
 - o If asked, "What should I do?"
 - STOP \rightarrow Be Curious \rightarrow 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 \rightarrow I think \rightarrow I want"
- ➤ Mean what you say & say what you mean!
- ➤ Anticipate reactions and plan for them

Develop Immediacy Skills

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



Documentation & Notification

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

When the Red Flags are Waving...

- ➤ Believe your Gut!
- ➤ Take Action
- Failure to take action immediately after an act of incivility increases the scope of action that eventually will have to be taken." Feldman

Use Your Resources - You are Not ALONE!

- Faculty/School
- > Staff/Other Clinical Scholars
- ➤ Policy & Procedure Manuals/School Handbooks/Disciplinary Process
- Your Mentor
- Faculty from this course: we gave you our emails! Please reach out to us!!

Find a Mentor or Coach!

- ➤ If you don't have one → find one!
- ➤ If you <u>do</u> have one:
 - Thank them for supporting you
 - o Meet with them regularly
 - o 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
 - O What did I do well?
 - O What did I learn?
 - O 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
- \triangleright Be courageous \rightarrow have authentic conversations
- ➤ Be vulnerable by inviting feedback → this is a learning opportunity (especially when it is hard to hear!)

Keep a sense of humor! Perceptions...

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

- ➤ If you <u>use</u> Humor:
 - o Approachable
 - Confident
 - o 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!

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Reality Shock — Deb Center

Notes:	_



Reflective Practice

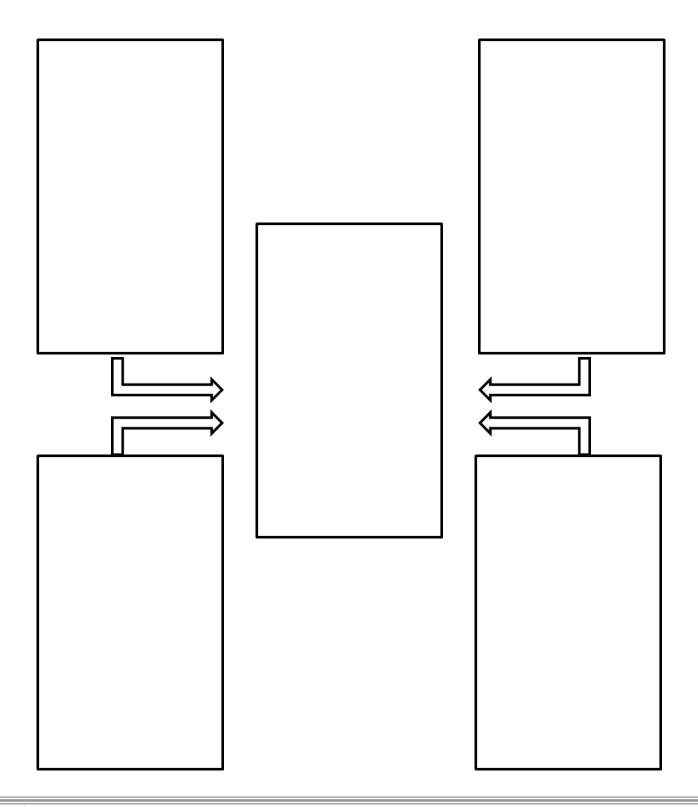


Perceptions:

Barriers:

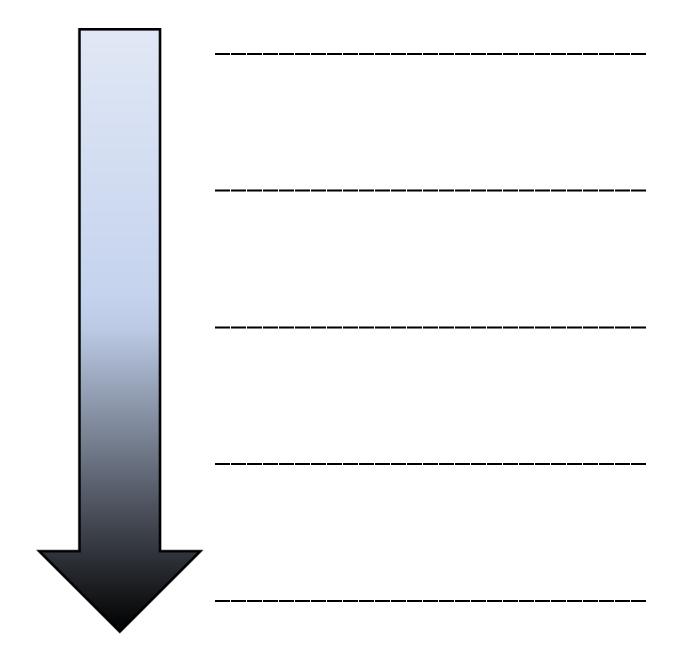
A Model for Structured Reflection

(Johns, 2005)



A Continuum of Reflective Practice

(Johns, 2005)



Reflective Practice Action Plan

Answering questions	Exercising
Asking questions	A hobby, like gardening, knitting, fishing
Talking	Music, playing or listening
Journaling	Reading more on a given subject
Doodling, drawing, painting	Meditating
Making lists or flowcharts	Other ideas:
Stream of consciousness writing	
imes I can make available for reflect	
imes I can make available for reflecti	During my commute
imes I can make available for reflecti — First thing in the morning — During my work day	During my commute At lunch
imes I can make available for reflecti	During my commute
imes I can make available for reflection — First thing in the morning — During my work day — After exercising	During my commute At lunch

Reflective questions that would be especially helpful for me:

Reflective Practice — Marianne Horner

Notes:	



□ 1. Clinical Instructors, Legal Liability & Risk Management

Notes:

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

☐ 2. Adapted from presentation by:

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

□ 3.



☐ 4. Responsible for Safety of the Public

Notes:

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

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

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

— Sir Winston Churchill

☐ 6. Common Issues for Scholars

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



□ 7. Jury Verdicts All States

Notes:

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

■ 8. St. Elsewhere, New York vs Smith

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



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

Notes:

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

☐ 10. Student Nurse admitted:

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

☐ 11. Clinical Scholar should have:

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



		What should the Clinical Scholar do now?	<u>Notes:</u>
-	13.	Supervision	
	•	Failure to monitor performance	
	•	Failure to appropriately assign	
	•	Failure to intervene, report and support	
-	14.	Negligence/Liability An act or failure to act that is below the standard of care. Causation: This act, or failure to act, results in a permanent body or monetary injury to the patient.	
	15.	The Four Legal Principles Reasonable and Prudent Under the Circumstances	
	•	Due Diligence	
	•	Best Interests of the Patient	



• Good Faith

☐ 16. Legal Responsibilities

Notes:

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

☐ 17. Plaintiff Attorney's Toolbox

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

☐ 18. Punitive damages 2.5 MIL

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



☐ 19. High Risk Activities

Notes:

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

■ 20. Communication

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

☐ 21. Medication

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



☐ 22. Medical Legal View of Records

Notes:

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

☐ 23. Monitoring & Observing

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

☐ 24. Treatment

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



☐ 25. Patient/Family Teaching

Notes:

- Any instruction on care to pt or family
 - Medication prescribed
 - Treatments
 - Dietary requirements
 - Referral information
- Discharge instructions!

In writing & signed by patient or responsible family

☐ 26. History of incident

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



□ 27. Issues Notes:

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

☐ 28. What else went wrong?

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

■ 29. Avoiding Lawsuits

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



☐ 30. Common Sense Touchstones Notes: • Your care and treatment should be what you expect for your family, or for you With support from hospital resources, apologize early • Every encounter is an opportunity to ":right" a possible error Seek consultation and support from your resources (Risk Management or Legal) ☐ 31. Distinguishing Roles and Scholar's **Legal Responsibility For Student Incident** ☐ 32. Who can be liable for student error in a lawsuit? • Hospital Precepting Nurse

- Student
- Clinical Instructor
- School or College of Nursing



☐ 33. When is a Clinical Scholar potentially liable?

Notes:

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

☐ 34. When is a Hospital Liable?

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

☐ 35. When is a Precepting Nurse Liable?

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



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

Notes:

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

☐ 37. When is a School Liable?

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

☐ 38. Documentation of Competency/ Concerns

• Anecdotal notes of Clinical Instructor

Objective

Kept on All Students

Regular intervals

Provided to School at the end of the rotation

College/Scholar documentation of mastered skills



☐ 39. Prompt Notification	<u>Notes:</u>
In writing	
• Objective	
• Specific examples with dates	
 Recommendations/Plan of action, shared with student when appropriate, shared with faculty/ College 	
40. Special liability for schools and clinical scholars	
 "Nor shall any State deprive any person of life, liberty, or property without due process of law." 	
Procedural Due Process	
Substantial Due Process	

☐ 41. Procedural Due Process

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

☐ 42. Substantive Due Process

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



■ 43. Malpractice Insurance Yes or No?

Notes:

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

□ 44. Employer vs. Individual Insurance Policy

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



45 .	What is never covered by insurance	Notes:
•	Intentional Acts	
•	Outside course and scope	
•	Criminal Acts	
	New Challenges of Medicine and Nursing	

☐ 47. A Word About Social Media

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



□ 48. <u>Notes:</u>



☐ 49. Criticisms of Copy/Paste

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

☐ 50. ELECTRONIC MEDICAL RECORD

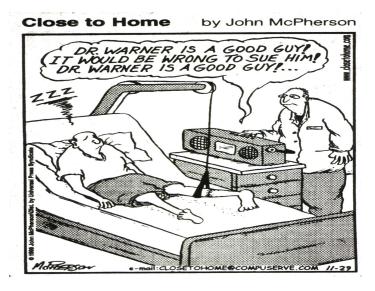
Remember!

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

Can all be tracked



□ 51. <u>Notes:</u>



☐ 52. Thank You

Questions?

NOTES:

Student Role in the Clinical Agency

Kathy Casey, RN, MSN Lutheran Medical Center

Objectives

- Discuss the student role in the clinical agency
- Identify skills that pre-licensure students may and may not perform in the clinical agency
- Discuss the impact clinical agency staff have on student clinical learning experiences

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



Requirements for Students in Clinical Agency

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

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

Assumptions about Students

- Students arrive with theory, knowledge, and simulated laboratory experience, ready to practice nursing skills on real patients
- Students tend to focus narrowly on basic tasks and skills
- Learners may be awkward and slow, which can frustrate a hurried clinician.



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

Responsibilities of Students

- Clinical attendance is mandatory
- Follow school and agency dress code
- Understand clinical course learning objectives
- Prepare for patient care
- Maintain patient confidentiality standards according to HIPAA regulations
- Report off to RN assigned to the patient when leaving the floor for any reason and at the end of the shift

Student Role

- Be respectful and courteous
- Do not conduct person business on clinical time
- Do not use internet for personal needs
- Be a learner, not a critic
- Appreciate that they are guests of the facility
- Bring own experiences to clinical setting



NOTES:

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

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
 - Administer medications
 - Monitor blood transfusions
 - Insert NG tubes

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

 - Be the 2nd person check for blood or TPN

Medication Administration

- Must be with the direct, visual supervision of the scholar, instructor or RN preceptor
- Must be co-signed on the eMAR by the RN
 - · Can administer oral, IM, SQ, IV
 - · Can monitor certain continuous infusions
 - Can administer narcotics



Documentation in Medical Record

- Student must have own access code
- Scholar or RN must co-sign student's documentation
- Agency specific guidelines for charting and access to medical record
 - Care Plans
 - Discharge teaching
 - Patient Education

Student Injury

- Any student injury must be reported immediately to the course faculty or clinical scholar
- Follow school worker's compensation policy
- May be seen at clinical agency or designated site
- Discuss risks associated with patient care
 - Needle sticks
 - Back injury
 - Compassion or emotional fatigue
 - Workplace violence

Staff Nurse Role

- Staff nurses are meant to be resources for students when faculty members are unavailable
- Serve as nursing role models and educational facilitators of practical nursing skills
- Socialization into the profession is a crucial component of the student's education



Students Practice in Fast-Paced, Regulatory-Driven Environments

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

Clinical Learning Environment

- A positive and enriched learning environment can influence a student's perception of the healthcare facility as a possible future employment site
- A negative experience with overburdened, unpleasant, uninterested staff can impede learning
- Some challenges, such as lack of clinical sites and poor attitudes from patients, are outside your control - Discuss issues in post-conference

Professional Practice Environment

- What is the effect of Incivility, Bullying and Horizontal Violence on Students?
- What are some strategies to empower, educate and support students when this occurs?



Graduate Nurses report they want more practice with:

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

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

Duestions?



□ 1.	Feedback What's Feedback?	Notes:
	Bari K. Platter, MS, RN, PMHCNS-BC Clinical Nurse Specialist CeDAR (Center for Dependency, Addiction and Rehabilitation)	
□ 2.	Objectives	
	• Examine components of communication to foster providing effective feedback	
	Discuss two methods of feedback	
	 Apply feedback concepts as they relate to the narratives 	
□ 3.	The Five "W's" of Effective Feedback	
	• Why	
	• Who	
	• What	
	• Where	
	• When	
	Additional 3 "W's"	
	• Wait	
	• Will	
	• Worry	



☐ 4. Solution Focused Therapy

Notes:

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

☐ 5. Solution Focused Feedback Formula

- Acknowledge or compliment
- Bridge or rationale
- Feedback

□ 6. Examples

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



☐ 7. Examples Notes:

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

- It's important to develop good working relationships with your peers; this is something that continues to be important after you graduate (Rationale)
- So I'd like to give you some feedback about a couple of times when you have been joking with the group; people have started to feel uncomfortable and begin to shut down. I'd like you to think about how your comments are being interpreted by your peers. (Feedback)

■ 8. Examples

- I think it is wonderful that you feel confident in this clinical area (Compliment)
- I know you want to work at this hospital when you graduate (Rationale)
- So I'd like to talk with you about your interactions with the staff; I have received some feedback that they think you are a "know it all". I'd like to give you some suggestions to work more effectively with the staff. (Feedback)

□ 9. Crucial Conversations

Notes:

- A communication program developed to help people communicate effectively when the stakes are high
- Three elements of a crucial conversation:
 - ♦ Strong emotions
 - ♦ Opposing opinions
 - ♦ High stakes

☐ 10. Contrasting Statements

- A *don't/do* statement
- -**Don't.** Explain what you **don't** intend; this addresses others' conclusions that you don't respect them or that you have a malicious purpose.
- −**Do.** Explain what you **do** intend; this confirms your respect or clarifies you real purpose.

☐ 11. Don't Questions

- What might others mistakenly think my reason is for bringing this up?
- What might they think about my level of respect for them?
- What can I say to help them believe this *is not* the case?



12.	Do Questions	Notes

- 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. <u>Notes:</u>

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

□ 17. Clinical Narratives

- 1. Break into groups and review the clinical narrative
- 2. Identify/discuss major points with group members
- 3. How do you need to respond to this event?
- 4. What are the "W's" to consider?
- **5.** How will you document this event? To whom will you forward the documentation?
- 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

Notes:

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

☐ 20. Clinical Narrative #3

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

□ 21. Clinical Narrative #4

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

☐ 22. Clinical Narrative #5

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



☐ 23. Clinical Narrative #6

Notes:

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

☐ 24. Clinical Narrative #7

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

☐ 25. "Good Practices"

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

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



□ 26. Questions? <u>Notes:</u>

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Notes:	
3157581	





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