Newsletter

Summer 2008

July 11, 2008

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Expanding Nursing Education Capacity

The National Center for Health Workforce Analysis in the Health Resources and Services Administration projects that, if current trends continue unabated, by 2020 the national shortfall of registered nurses (RNs) will exceed one million. The same study predicts Ohio will have a shortage of 34,000 RNs.

To address this critical issue, the Robert Wood Johnson Foundation; the U.S. Department of Labor, Employment and Training Administration; the Center to Champion Nursing in America; and the U.S. Department of Health and Human Services, Health Resources and Services Administration hosted a national Nursing Education Summit on June 26-27, 2008. According to the U.S. Department of Labor, the Nursing Education Summit provided a forum for state teams to share best practices, consult with experts, learn about innovative strategies, and develop and refine plans to effectively expand nursing education capacity. The summit included discussion of four key aspects of increasing nursing education capacity: 1) Strategic Partnerships and Resource Alignment; 2) The Role of Policy and Regulation; 3) Increasing Faculty Capacity and Diversity; and 4) Education Redesign.

Nursing programs consistently site a shortage of faculty as one of the key factors limiting their ability to increase capacity. Evidence of this was reflected in data reported by the Northeast Ohio Nursing Initiative in 2004 which showed nearly 1500 qualified candidates were turned away from Northeast Ohio nursing programs. As a response to that data, in 2005, nursing leadership at Cleveland Clinic and deans and directors of area nursing programs formed the Deans' Roundtable Faculty Initiative. For almost three years the initiative has worked to increase the number of potential nursing faculty. Now the Deans' Roundtable is working to strengthen and expand its membership, bringing together regional stakeholders to address the nursing and nursing faculty shortages.

From late summer of 2007 through early winter 2008, Joan Kavanagh, Director and Maureen Talty, Programmer Analyst, both in the Department of Nursing Education and Professional Practice Development at Cleveland Clinic, presented the Deans' Roundtable Faculty Initiative to several area hospitals. Nursing leaders at Akron Children's Hospital, Summa Healthcare System, Robinson Memorial Hospital, University Hospitals of Cleveland (UH), Louis Stokes Cleveland Department of Veterans Affairs (VA) and MetroHealth graciously invited us into their hospitals so we could share information and invite their nurses to join the initiative.

As a result of those presentations, nurses from the VA, UH and Metro Health attended our faculty orientation program this past January. The day provided a unique opportunity for those nurses to meet faculty from participating schools and learn about potential teaching opportunities.

The Deans' Roundtable Faculty Initiative is committed to strategic partnerships and a regional effort to address the nursing and nursing faculty shortages.

Together, we can make a difference!

"MetroHealth is excited to be a part of this program. It provides opportunities for staff nurses to grow professionally and contribute to the needs of the larger nursing community. The Deans' Roundtable also empowers nurses to become an active part of the solution to address both the current and future nursing shortages."

Jane Fusilero, RN, MSN, MBA, CNAA
Vice President and Chief Nursing Officer

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Participating Organizations:

- Aultman College of Nursing
- Bryant & Stratton College
- Frances Payne Bolton School of Nursing at Case
- Center for Health Affairs
- Cleveland State University
- Cuyahoga Community College
- Hiram College
- Huron School of Nursing
- Lakeland Community College
- Lorain County Community College
- Kent State University
- Marymount School of Nursing
- Notre Dame College
- Ohio League for Nursing
- University of Akron
- Ursuline College

Ask the Dean; Teaching Challenges

Guest Educator:
Diane Jedlicka, PhD, RN, CNS
Chair, Nursing Division
Notre Dame College

Dear Nurse Educator:
My students often struggle with establishing priorities. It seems so clear to me, but the students have trouble deciding what they should do first when they walk into the patient's room. If they can't get their priorities straight, they end up becoming disorganized and stressed. How can I help them learn to better prioritize their patient's care?

Puzzled Practitioner

Dear Puzzled,
Often we try to help students by creating checklists of tasks they can use rather than focusing on the desired patient outcomes. There are several strategies you can use to help your students prioritize their patient's care. A good time to help the student with this process is during pre-conference. A simple approach is to just ask the student what they think should be done first. You can guide the student to reflect on their reasoning by asking them what would happen if this would not get done right away. What would the potential effects be for the patient? This helps them consider the consequences of their decision and determine what is most important for patient outcomes. Sometimes the student may miss key cues from the patient because they are more focused on completion of their tasks, rather than noting changes in the status of their patient. Sound clinical judgement requires complex decision-making skills and students need support to help build their confidence and acumen.

Another strategy that can be helpful is to use a mnemonic device, such as ***CURE*** (Nelson, et. al., 2006), to reinforce the process and help the student to prioritize:

Critical – the first tier priorities represent the patient's critical needs. These are life threatening issues related to airway, breathing and/or circulation. Respiratory obstruction with stridor or patient unresponsiveness are classic examples of life threatening situations. These require immediate action and response.

Urgent – this second tier of priorities focuses on safety issues and pain control. An example of this would be attending to a low blood sugar.
Routine Responsibilities – the third tier priorities include more "task" oriented duties such as taking routine vital signs or hanging a tube feeding. These are normal or usual activities that nurses complete during a shift.

Extras – these represent aspects of care that are wonderful to accomplish if time permits. They often add to the patient's comfort and can include activities such as providing a fresh pitcher of ice water or arranging for the patient's hair to be shampooed.

Using the ***CURE*** mnemonic is one strategy that is practical and easy to apply. It can help your students achieve more confidence in delivering safe, effective nursing care. There are other strategies you may have developed from your own practice. Reflect on how you establish your priorities and how you learned to make these decisions.

References: Nelson, J., Kummeth, P.,Crane, L., Mueller, C., Olson, C., Schatz, T., & Wilson, D. (2006). Teaching prioritization skills. *Journal for Nurses in Staff Development, 22* (4), 172-178.

Sometimes the student may miss key cues from the patient because they are more focused on completion of their tasks, rather than noting changes in the status of their patient.

Sound clinical judgement requires complex decision-making skills and students need support to help build their confidence and acumen

Faculty Corner; Educator Tip

Anecdotal Notes Regarding Student Performance

Jackie Morgan, MBA, MSN, CCRN, CNS-BC
Assistant Professor of Nursing
Cuyahoga Community College

Some of life's best lessons are learned the hard way and in my case, I learned a lesson about writing anecdotal notes way back during my first experience as a clinical instructor in the 1990's. In nursing we educate about the components of critical thinking and although intuition is one of the elements displayed by a critical thinker, it should not be relied upon all by itself as a clinical instructor in nursing. We all have had students we knew "just were not going to make it" or did not "have what it takes," however, it is imperative that you turn those intuitive thoughts into solid rationale and examples. The other lesson I have since learned is that the term "anecdotal" does not always have to have a negative connotation. In fact, it can be very positive or even serve as a "friendly reminder" for the clinical instructors themselves!

Always begin with course objectives. After all, it is upon these objectives that student performance is matched. Thus, when you sense "something is not right" or a student has clearly not mastered a skill or has performed under par, link your observations to specific course objectives. And, conversely, if a student has done something exceptional, again, link that performance to course objectives. In this positive sense, your anecdotal note will be more useful for the student as a foundation for continued success in the course, and for the instructor the compliment will be less misconstrued as "she likes him/her the best." If everyone is judged on the same course objectives in both the positive and negative sense, the judgments are fair. It is then the basis for final evaluation, be it positive or negative.

Write notes often and as soon as possible. I may go a bit far, but I actually write a weekly note on each student. Luckily at Tri-C, we have a form with pre-printed categories on which to write such notes. However, if you do not have a form already created, again start with class objectives. Have each objective serve as a category and use each one to jot notes about each student's performance that day or week. It will be easier to summarize the performance of each student at the end of the term. It will also serve to remind you, as the clinical instructor, as to the types of experiences the student has had and what skills they have performed. This will assist you not only during evaluation time but each week when deciding upon patient assignments. These daily/weekly anecdotal notes do not necessarily need to be shared with students unless there was a particular performance issue, be it positive or negative. It will help you gather objective data about each student, making the final evaluation smooth.

When writing "official" anecdotal notes that will be shared with the student, be as objective as possible. Try to park your emotions at the door. Stick to the facts with exact times, quotes and witnessed observations. You can write them in any format but again, I cannot stress enough, link them with course objectives. I tend to summarize the issues in a chronologic paragraph first, and then link each issue to the specific course objective. When sharing the notes with the student, ask them to link the issues to the course objectives, perhaps covering that area on the page or computer screen, before sharing your observations. This may be a way for students to see for themselves where they went wrong and also helps the students understand why the course objectives have been developed in the first place. This is particularly helpful if you have already done a thorough job of reviewing the course objectives at the beginning of the clinical rotation, giving examples of ways the objectives can be successfully met as well as actions that can jeopardize mastery.

Make sure the anecdotal notes are not a mystery to the students. If you feel you are writing negative anecdotal notes more frequently on one student, share your concern immediately. You may have students that are meeting course objectives but not going the "extra mile" or growing within the course. Share your observations with these students as well because their interpretation of their performance may be very different from yours. It is not acceptable to wait until final evaluations to share these observations.

Get feedback. If you fear you have written a non-objective note or a biased note, keep the student's name off of the draft and have an experienced faculty read what you have written. Have them critique you on your objectivity, ensuring that the course objectives can be readily linked to the documented concern. Additionally, feel free to e-mail me with any questions you may have, or any stories you have experienced both positive and negative. Writing concise, effective anecdotal notes is a skill that takes time to develop. Good luck!

Jacqueline.Morgan@tri-c.edu

Members of the Deans' Roundtable Faculty Initiative

Back Row (l to r): Kelly Bryant, Ursuline College, Patricia Livingston, Huron School of Nursing, Marilyn Lotas, Frances Payne Bolton School of Nursing, Edith Allgood, Tri-C, Robert Schloss, Consultant, Davina Gosnell, Hiram College, Kathleen Mahoney, Lakeland Community College, Cheryl McCahon, Cleveland State University, Kathy Ross-Alaomolki, University of Akron, Joan Kavanagh, Cleveland Clinic, Maureen Talty, Cleveland Clinic, Cindy Willis, Cleveland Clinic Western Market, Cheryl O'Malley, Fairview Hospital, Vicki Bowden, Bryant & Stratton College, Barbara Zinner, Marymount Hospital, Ann Kavanagh, Kent State University

Front Row (l to r): Sr. Kathleen Flanagan, Ursuline College, Marjorie Placek, Cleveland State University, Aileen Maslinski, Center for Health Affairs, Mary Jo Boehnlein, Tri-C, Michelle Dumpe, Cleveland Clinic, Diane Jedlicka, Notre Dame College, Marcy Caplin, Kent State University, Jane Mahowald, Ohio League for Nursing

Not Pictured: Lisa Anderson, Center for Health Affairs/Northeast Ohio Nursing Initiative, Kathleen Knittel, Huron School of Nursing and Hope Moon, Lorain County Community College

Best Practices in Teaching

Points for Influencing and Evaluating Clinical Professionalism

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Have you ever had a student walk into clinical late? You glance at your watch to note the time of arrival and wonder, "How late is too late?" You are not alone. The literature contains a number of articles indicating an increasing problem with attendance, punctuality and adherence to dress code (APAD) among nursing students. Unfortunately, the literature does not offer solutions to objectively evaluate these issues.

Employers expect their employees to be reliable, competent and compassionate. As nurse educators, we have a responsibility to help instill these qualities in our students. The concern many faculty have with enforcing consequences for breaching these professional policies is fear of legal ramifications by students. However, it has been noted that when policies are objective, measurable, recordable, clear, accessible and uniformly implemented by all faculty, the courts will uphold the decision of the faculty if a student does contest.

At the Breen School of Nursing we designed a policy for APAD issues (see page 5)based on area hospitals' point systems. It has been implemented in all clinical rotations since 2003. We felt the tool would be applicable and fair while also preparing students for how future employers will evaluate them. There was minimal resistance from both faculty and students. In five years, there have been three clinical failures for students who accumulated more points than allowed with the policy. Interestingly, none of these students have appealed the failure. In our experience, the policy has created an atmosphere where students are required to take responsibility for their own actions.

Within the literature and through our experience, the more objective a tool can be, the easier it is to implement and justly apply to all students. It takes the guess work out of the equation. Regardless of the reason (flat tire, childcare issues, or faulty alarm clock), the outcome is the same: the student is assigned points based on the circumstances of the infraction. How late is too late? After glancing at my watch, I refer to the tool for the appropriate penalty. (continued on page 5)

Best Practices in Teaching

Points for Influencing and Evaluating Clinical Professionalism

Dress Code and Attendance Deficiency Point System

Point Value:	Occurrence:
	Tardiness:
1	5-14 minutes late
2	15-29 minutes late
3	30 or > minutes late
	Absence:
3	Absence from clinical with notifying instructor at least 1/2 hour prior to scheduled starting time
5	No call/No show (Not taking appropriate action to notify instructor of an absence from clinical. Individual instructors will make clearly defined arrangements prior to the start of the first clinical day)
	Dress Code Violations:
1	Breaking of dress code
5	Refusing to adjust to dress code after instructor addresses violation with the student
	Consequences:
≥ 5	Written contract in the form of a Performance Improvement Plan
9 or greater	• Failure of clinical • A student who accumulates 9 or more points will receive an F in the Theory Course associated with the clinical. • There will be no option to withdraw from the course to prevent receiving a failing grade.
Uncontrollable Circumstances:	
The school and/or instructor may make a decision to not penalize the student or the entire group if occurrence resulted from an uncontrollable circumstance. No points will be rewarded in these circumstances. **(Copyright of The Breen School of Nursing at Ursuline College.)**	

Note: The tool is based on a seven week rotation, 12 hours of clinical a week.

References:

Bofinger, R., & Rizk, K. (2006). Point system versus legal system: An innovative approach to clinical evaluation. *Nurse Educator, 31*(2), 69-73.

Rizk, K., & Bofinger, R. (2008). Florence Nightingale Versus Dennis Rodman: Evaluating Professional Image in the Modern World. In Oermann, M.H. (Ed.). *Annual Review of Nursing Education* (Vol. 6). New York: Springer.