

## 2014 MN Health Educators' Conference Friday Schedule of Events

For reference only; final printed schedule provided at conference

## Madden's on Gull Lake Town Hall Friday, April 25

7:00-8:30	Breakfast	Madden Inn Dining Room
7:00-6:00	Vendors	Lower Lobby, Town Hall
7:30-8:20	Vendor Session	
	<b>Look to Us for Consulting and More</b> ATI offers consulting for topics such as curriculum development, item wridevelopment and more. <i>Sponsored by ATI</i>	<b>Pillsbury</b> ting, accreditation, faculty
8:00-8:30	Check-in	Upper Lobby, Town Hall
8:00-4:00	Posters	Governors Ballroom
8:30-10:00	<b>Together, the Future of Nursing Will Involve, Revolve &amp; Evolv</b> Donna Meyer, President of the National Organization for Associate Degree	
10:00-10:30	Break	Lower Lobby, Town Hall
10:30-12:00	Transformation Realized! Prepare Your Students for Practice Clinical Reasoning to Your Class Keith Rischer, Owner/President of KeithRN	by Bringing Governors Ballroom
12:00	Boxed Lunch Pick-up	Governors Ballroom



#### Presentation Objectives

- Discuss the need for academic progression in nursing.
- > Describe challenges and solutions for a better educated nursing workforce nationally.
- Identify OADN's strategies and partnerships to help advance the profession of nursing.





- > Practice to the full extent of our education and training;
- Achieve higher levels of education and training;
- Be full partners...in redesigning health care in the United States;
- >...Better data collection.

#### FUTURE OF NURSING

Recommendations 3-6 relate to education progression in nursing

#### > (IOM, 2010)

- Implement nurse residency programs(3);
- Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020(4);
- Double the number of nurses with a doctorate by 2020(5);
- Ensure that nurses engage in lifelong learning(6)





#### BACKGROUND AND SIGNIFICANCE: Who is Practicing Nursing

- Percentage of nurses and highest degree achieved:
  - Diploma 15.5%
  - Associate Degree in Nursing 37.2%
  - Baccalaureate of Science in Nursing or higher 55%



The U.S. Nursing Workforce: Trends in Supply and Education Health Resources and Services Administration National Center for Health Workforce Analysis April 2013

#### Who is Practicing Nursing?

- The number of bachelor's prepared RN candidates doubled from 2001 2011
- Non-bachelor's prepared RN candidates constitute the majority of all RN candidates -60 percent in 2011
- > 28,000 RN's were awarded a post-licensure bachelor's in nursing (RN-BSN) in 2011
- Currently, 55% of the registered nurses have a BSN degree

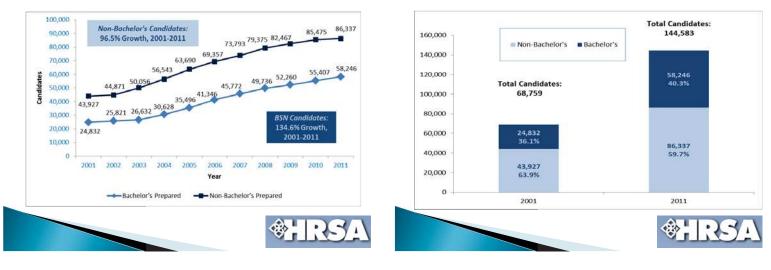
## AARP'S CAMPAIGN FOR ACTION

- National initiative to guide implementation of the recommendations in <u>The Future of</u> <u>Nursing: Leading Change, Advancing Health</u>
- Coordinated through the Center to Champion Nursing in America (CCNA), an initiative of AARP, the AARP Foundation and the Robert Wood Johnson Foundation (RWJF).



Growth in NCLEX-RN First-time Test Takers, by Bachelor's and Non-Bachelor's Degree Status, 2001 to 2011

Total Number and Percentage of NCLEX-RN First-Time Test Takers, by Bachelor's and Non-Bachelor's Degree Status, 2001 vs. 2011



#### ADVANCING ACADEMIC PROGRESSION

- Promising Solutions
  - Shared statewide or regional curriculum
  - Seamless progression
  - Community colleges granting BSN degrees
  - RN-to-MSN programs



## **RN-TO-MSN PROGRAM**

- Offers shorter timeline to completion than traditional BSN or MSN programs
- Driven by more AD graduates returning to school to obtain MSN without BSN
- > Values practice experience of AD nurses
- Seamless, university-based program that emphasizes practice components
- 173 programs
- > Easier to implement than other models







#### DISINCENTIVES TO RETURN TO DISINCENTIVES TO RETURN TO **SCHOOL SCHOOL** > Academic Institutional Barriers Personal Barriers Cost of education Advancing age Redundant curriculum o Multiple role strain o Not counting previous learning or experience Lack of flexibility with scheduling Limited resources Faculty not responsive to needs of adult Lack of confidence learner Low expectations Lack of effective advising Geographic constraints Lack of socialization into academic program • Changing requirements • Negative experience with undergraduate education Accreditation related issues

#### DISINCENTIVES TO RETURN TO SCHOOL

#### > Health Service Institution Barriers

- Lack of financial assistance
- Lack of flexibility
- o Lack of incentives to earn BSN
- Lack of effective partnering with academic institution
- Unsupportive institutional culture



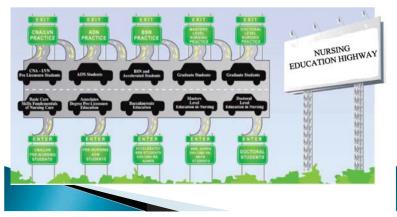
## ISSUES RELATED TO THE 80/20

- Retirement Cliff
- > 30 million more Americans with health care insurance
- > Faculty shortage decreasing educational capacity
- 75,587 qualified applications turned away to all professional nursing programs in 2011
   14,354 qualified applications were turned away from creduct
- 14,354 qualified applications were turned away from graduate programs in 2011
- ¾ million RNs need to return to school to reach the recommendation of 80/20



#### STRATEGIES FOR A BETTER EDUCATED NURSING WORKFORCE

#### For Academia



#### STRATEGIES FOR ACADEMIC **SEAMLESSNESS**

- Beyond articulation = seamlessness
  - o Can students be dual-enrolled?
  - Do all the pre-requisites align?
  - Are ADN/diploma students required to take more units?
  - o Are students appropriately counseled?
  - o Is the BSN program's GPA out of reach for RNs?
  - What is the mechanism to eliminate curriculum redundancy?
  - Will there be a mechanism to give RNs credit for their previous knowledge and experience?

#### STRATEGIES FOR A BETTER EDUCATED NURSING WORKFORCE

#### For Health Service Organizations

- Increase monetary incentives for earning a more advanced dearee in nursina
  - Pay differential
  - Clinical ladder

  - · Up front tuition reimbursement & stipends to reduce work hours
- > Make it Possible
  - o Consistent and flexible scheduling
  - Cohort on-site model
- > Make it Desirable
  - Create culture of appreciating evidence based practice and academia
  - Position role models

## MISSION

> The Organization for Associate Degree Nursing promotes Associate Degree Nursing through collaboration, advocacy, and education to ensure excellence in the future of health care and professional nursing practice.



## OADN ACTIVITIES

 Advocating for Community College Nursing Programs throughout the Country

#### JOINT STATEMENT ON ACADEMIC PROGRESSION

- > Released September 18, 2012
  - American Association of Community Colleges
  - Association of Community Colleges Trustees
  - American Association of Colleges of Nursing
  - National League for Nursing
  - $\,{}_{\circ}\,$  Organization for Associate Degree Nursing
  - January 6, 2014, Endorsed by the American Nurses Association





#### OADN BOARD VISITS HILL

OADN Board meets in Washington, DC with Congressional Leaders and staff.





OADN visits the Hill to advocate for Associate Degree Nursing Program and HRSA Title VIII funding.



- > OADN signs on as a member,
- The focus is on aligning health professional education with the needs of clinical practice, students, consumers, and the health care delivery system through the use of interprofessional education.



#### JOINING FORCES INITIATIVE

> OADN signed on to support the Joining Forces Initiative launched by Michelle Obama and Dr. Jill Biden calling all health professionals to be aware of the specific health issues facing service members, veterans, and their families.





#### WHITE HOUSE CONFERENCE

> OADN was invited to participate in the discussion of health care issues from the nursing practice and education perspective.



#### RWJF ACADEMIC PROGRESSION IN NURSING ADVISORY (APIN) COMMITTEE MEMBER

- > OADN represents associate degree nursing on the Academic Progression in Nursing Advisory Committee (APIN)
- Funded by the Robert Wood Johnson Foundation (RWJF), to advance state and regional strategies to create a more highly educated nursing workforce



#### Roundtable Discussion with National Nursing Leadership 2013 - 2014

- > American Association of Colleges of Nursing (AACN)
- > American Nurses Association (ANA)
- > American Organization of Nurse Executives (AONE)
- > Center to Champion Nursing in America
- > National League for Nursing (NLN)
- National Student Nursing Association (NSNA)

#### NURSING ASSOCIATION PARTNERSHIPS > American Association of Colleges of Nursing - Joint Brochure nerican Association of Colleges of Nursi DVANCING HIGHER - Webinars - Guest Conference Attendee National League for Nursing National League - Monthly Calls with CEO - Joint Conference Attendee - Exhibitor National Conference Future of Nursing: Campaign for Action - Presentation to the National Advisory Board - Champion Nursing Council Member FUTURE OF NURSING

#### NURSING ASSOCIATION PARTNERSHIPS

- Nursing Community Members
  - Collectively the Nursing Community represents over 850,000 registered nurses, advanced practice registered nurses, nurse executives, nursing students, and nursing faculty.
  - These 58 organizations are committed to improving the health and health care of our nation by collaborating to support Registered Nurses (RNs).



## NURSING ASSOCIATION PARTNERSHIPS

American Nurses Association
 Organizational Affiliate



Campaign for Action

 Nursing Organization Alliance Member



#### NURSING ASSOCIATION PARTNERSHIPS

> American Association of Community Colleges

- Affiliated Council
- Workforce Commission
- Presentation National AACC Conference

> Association of Community College Trustees

- Presentation at National Conference

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## Alpha Delta Ru Nursing Honor Society

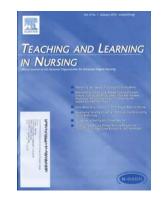


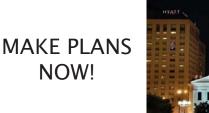
Recognizing the Excellence of Associate Degree Nursing Students



## **OADN Offers Many Benefits**

- > Teaching Learning Journal
- > Webinars
- > List Serve for Networking







## CONTACT INFORMATION

Donna Meyer, MSN, RN President, OADN <u>dmeyer@lc.edu</u>



What Do You See.

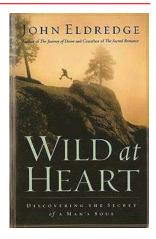
## Transformation Realized! Prepare Your Students for Practice by Bringing Clinical Reasoning to Your Classroom

Keith Rischer, RN, MA, CEN, CCRN email: <u>Keith@KeithRN.com</u> Website: KeithRN.com



## My Journey...

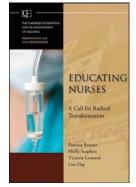
"Don't ask yourself what the world needs. Ask yourself what makes you come alive, and do that. Because what the world needs are people who have come fully alive."



## How do you Define.

#### RADICAL

- Very different from the usual or traditional: extreme
- Favoring <u>extreme changes</u> in existing views, practices, or institutions



## How do you Define...

- > TRANSFORMATION
  - Complete or <u>major change in</u> someone's or something's appearance, form
  - Synonyms:
    - ✓ changeover, metamorphosis





## Educating Nurses (2010)

- > Effective in forming professional identity
- > Clinical laboratory promotes learning
- > Not as effective in the classroom
  - Additive vs. removing ✓ TOO much CONTENT!
  - PPT driven-get through the content
  - False assumption...abstract knowledge leads to application

## Nursing Ed: Transformation Needed!

#### 1. Teach for salience-situated cognition

- Contextualize Content
- ✓ This includes CONCEPTS
- Must translate content to the bedside
- What clinical data is RELEVANT
- Emphasize APPLICATION of knowledge

## Nursing Ed: Transformation Needed!

## 2. Integrate classroom & clinical teaching

CONNECT classroom & clinical
 Make classroom rich, <u>ACTIVE</u> learning
 Decrease current fragmentation
 <u>BRIDGE</u> current clinical/theory divide

#### Nursing Ed: Transformation Needed!

#### 3. Emphasize clinical reasoning

- > THINK IN ACTION and REASON as a situation CHANGES over time
- Capture and UNDERSTAND significance of clinical TRENDS
- Grasp the essence of current clinical situation
- Filter clinical data to recognize what is MOST and least important
- IDENTIFY if actual problem is present

## Essential Equation to Practice



## Crisis in Critical Thinking Del Bueno (2005)

New grads unable to translate theory & knowledge to practice
Why???

## >NANDA

## NANDA vs. Clinical Reasoning

- Does not reflect how nurses think in practice
- Unable to capture ESSENCE of changing status
  - No NANDA statement to identify status change
  - May contribute to failure to rescue
- Reflects "nurse thinking"
- Concisely captures problem/priority
- Interventions readily follow
- Rescue of pt. facilitated

#### Five Rights of Clinical Reasoning (2009)

- RIGHT cues
- RIGHT patient
- RIGHT time
- RIGHT action
- RIGHT reason

## Clinical Reasoning Template: Pre-Care

- 1. What is the **primary problem** and what is the underlying cause/pathophysiology of this problem?
- 2. What clinical **<u>data</u>** from the chart is **<u>RELEVANT</u>** and needs to be **<u>trended</u>** because it is clinically significant?
- 3. What **nursing priority** will guide your plan of care?
- 4. What <u>nursing interventions</u> will you initiate based on this priority and what are the desired outcomes?
- 5. What **<u>body system(s)</u>** will you focus on based on your patient's primary problem or nursing care priority?
- 6. What is the **worst possible/most likely complication(s**) to anticipate based on the primary problem?
- 7. What nursing assessments will you need to initiate to **identify this complication** if it develops?

## Clinical Reasoning Template: Providing Care

- 8. What clinical assessment **<u>data</u>** did you just collect that is **<u>RELEVANT</u>** and needs to be <u>**TRENDED**</u> because it is clinically significant to detect a change in status?
- 9. Does your **<u>nursing priority</u>** or plan of care need to be **<u>modified</u>** in any way after assessing your patient?
- 10. After reviewing the primary care provider's note, what is the **rationale for any new orders** or changes made?
- 11. What **<u>educational priorities</u>** have you identified and how will you address them?

#### Caring and the "Art" of Nursing

12. What is the **patient likely experiencing/feeling** right now in this situation?

13. What can I do to **<u>engage myself with this patient's</u> <u>experience</u>**, and show that he/she <u>matters to me</u> as a person?

## "Jason" is still out there...



## Time to Reflect...

- What is your program doing well that is consistent with the best practice recommendations of the Carnegie Foundation research?
- > What needs to be changed?
- How does your program incorporate clinical reasoning in your content/curriculum and allow it to be PRACTICED?
- Identify the 3 most common complications (Jason's) that patients are most likely to experience on your clinical unit.
- How are you preparing your students to be proactive and not reactive to these status changes?

## Transforming the Classroom:

To Practically Prepare our Students for Professional Practice

## Time to Reflect ...

- How much of your theory lecture emphasizes CONTENT?
- What percentage of your theory lecture uses an active/applied learning strategy
- What content would benefit from an active/applied learning strategy?

## What We Can Learn from our History

"Only by constant repetition can you become really familiar with the work. Only by doing a thing well <u>again and again</u> can you obtain confidence, accuracy and precision. It is this constant, intelligent <u>practice</u> that constitutes the difference between the skilled trained professional woman and the amateur."

> Isabel Hampton Robb Nursing Ethics, 1900



## Ruts & Reasoning



## Passive vs. Active Learning

#### Passive (Lecture)

- > 80% forgotten in 24 hours
- After 20" begin to disengage
- Role of student:
  - Absorb knowledge
  - Take notes
  - Passive "tape recorder"
  - Regurgitate content

#### Active (case studies)

- Increased engagement
   Learning promoted
- Promotes higher level thinking/learning
- > Adult learning strategy
- Role of student:
  - Participate
  - Experience
  - Think & discover
  - Construct/apply knowledge

## **Clinical Reasoning Case Studies**

- I. Fundamental Reasoning
- II. Rapid Reasoning Study
- III. Unfolding Clinical Reasoning

## **Clinical Reasoning Case Studies**

- Developing Nurse Thinking by Identifying
  - Clinical RELEVANCE
  - Clinical **RELATIONSHIPS**
  - **APPLICATION** of the Applied Sciences
    - ✓ Pharmacology
    - ✓ F&E…lab values
  - Clinical **PRIORITIES**

## Principles of the NCLEX

- Context is the bedside
   Application /Analysis
- > Assesses ability to make safe judgments based on clinical reasoning
  - No NANDA
  - PRIORITY setting
  - RATIONALE
  - EXPECTED OUTCOME
  - RELEVANT data
    - ✓ Labs, VS, assessment

## NCLEX Client Need Categories

#### Fundamental/RR (62% NCLEX)

- Management of care:
   17-23%
- Medications/IV therapies:
   12-18%
- Reduction of risk:9-15%
- Physiologic adaptation:11-17%

#### Unfolding Studies (75% NCLEX)

- Management of care:
   17-23%
- Medications/IV therapies:
   12-18%
- Reduction of risk:9-15%
- Physiologic adaptation:11-17%
- > Health
- promotion/maintenance: **6**-12%

## Scenario Introduction

- Mandy White is an 18 year old woman who has struggled with bulimia since the age of 14.
- She presents to the ED this evening with c/o increasing weakness, lightheadedness and a brief syncopal episode this evening. She has been inducing vomiting after meals for the past 3 weeks. Is 5' 5" and weighs 83lbs (BMI 13.8)

## Scenario Introduction

- Mandy White is an 18 year old woman who has struggled with bulimia since the age of 14. She was sexually abused by her step father who was convicted and sent to prison. She lives with her mother and has recently been engaging in self injurious behavior (SIB) of cutting both forearms with broken glass and razors causing numerous scars.
- She presents to the ED this evening with c/o increasing weakness, lightheadedness and a brief syncopal episode this evening. She has been inducing vomiting after meals for the past 3 weeks. Is 5' 5" and weighs 83lbs (BMI 13.8) Mandy is brought in by her mother. She does not want to be treated. You hear her say to her mother, "I am so tired of living, I wish I were dead!"

## Build Your Own Scenario...

I. Data Collection	
History of Present Problem:	
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D	
Personal/Social History:	
	RELEVANT; therefore it has clinical significance to the nurse?
<b>RELEVANT Data from Present Problem:</b>	Clinical Significance:
RELEVANT Data from Social History:	Clinical Significance:

## I. Fundamental Reasoning

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## I. Fundamental Reasoning

	Classification:	Mechanica	of Action	Nursing Considerations:
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## II. Rapid Reasoning

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#### II. Rapid Reasoning III. Clinical Reasoning Begins...

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#### III. Unfolding Clinical Reasoning Study: I. Data Collection

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## III. Unfolding Clinical Reasoning Study:

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#### III. Unfolding Clinical Reasoning Study:

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## III. Unfolding Clinical Reasoning Study

#### VI. Education Priorities/Discharge Planning

- 1. What will be the most important discharge/education priorities you will reinforce with their medical condition to prevent future readmission with the same problem?
- 2. What are some practical ways you as the nurse can assess the effectiveness of your teaching with this patient?
- VII. Caring and the "Art" of Nursing
- 1. What is the patient likely experiencing/feeling right now in this situation?
- What can you do to engage yourself with this patient's experience, and show that he/she matter to you as a person?

## III. Unfolding Clinical Reasoning Study:

Optional QSEN Questions to Incorporate into Case Study Because this is a Word doc. you can add some or none of these QSEN or National Patient Safety Goal generations to situate this construction cargo case studies you build on your own?
Partiest-Centered Care: What can you do to demonstrate intentional caring and promote patient-centered care with sensitivity and respect for your patient in the context of thes clinical presentation? VCDSR-Partient-centered care
Design Amount Challenes (1944)
How can you ensure and assess the effectiveness of communication with the patient and family? (QSEN-Patient-Centered care)
How can you integrate your patient's preferences/values as you coordinate your plan of care or provide any needed education? (JOSCN-Mater Centred care)
How can you ensure that your patient is an active partner while under your care and promote self-care once they are discharged? //SSIV-Hater-Contend care)
Teamwork and Collaboration:
What can you do to facilitate a safe and effective update/report to the physician or oncoming nurse? (GSDV-Remeant and Collaboratory)
What would you do if you were not confortable performing any new skill that was required to take care of this patient? (CECIN-Teamont and Costooration)
Evidence-Based Practice:
As a new nerse, what resources could you utilize to provide current, evidence-based, and individualized care planning based on the needs of this patient? (2015): 2-semice-deused fraction)
Safety/Duality topcovenent: What eauly are after morase do it you almost gave the wrong dose of one of the ordered medications because of a similarity in the label provided by pharmacy to another drug? (G25X-3447/Duality inprovenent)
Informatics: What medical electronic data lasers are available in your clinical setting that would be a resource if needed to obtain needed information on a medication you have not given before or an illeesihargeny you
have never seen before? (GDEN-intormatica)

Optional 2012 National Patient Safety Goals Questions to Incorporate Into Case Study What are the special health patient and any decide the sub-time Laborate medication (2014) Into the special health patient control (1) decimal health special health patient control (1) decimal health patients and the special health (1) decimal healt

nove Shaff Communication: If any of my patient's lab results were "critical" or "panic values" what is the policy at my clinical site guides me as to how guidely the physicion must be notified? \_\_\_\_\_021 Valuono theoro classes -prover and scremencatore(

a Medicines Safely: What can I do with my patient to promote and ansare that they take their anti-coagularits such an Warfam safely and with no tramful consequences? (2012 Nacous Patient Safeg Goats—Low medicines safely)

What are my responsibilities as a primary trace when my patient is activated to ensure that all of their home modedates, discapes, and when tal taken are accurate for the physician? (2012 home Patient Early Geam—Line moderner antipia) What are my responsibilities as a primary trace when my patient is discharged to ensure that they ar knowledgeable and compliant with the other home modelations?

- west Infection: What can I do before I go into my patient's room and before I leave that will dramatically decrease the makinas of infection? 2021 Antimer Phanet Sales Goas—Prevent intections!
- What are some porticial, evidence-board practices it can implement to prevent infection due to multidue resultance organizations such as MREA or VREP. 2011 Material Patter Dailys Ocas— Prevent Infectional
- Wat are some profiled, indicators have practices 1 can implement to prevent bloodsmann infection 8 to control lines, including PRCF? CP2 Jointral Patient Safety Oban—Prevent Infectional Wat are some practical, indicators-based practices I can implement to prevent surgical site infections? 2022 Jointral View Table Oban, Owen Infectional
- What are some practical, evidence-based practices I can implement to prevent individing urinary cathe infections? (2012 National Puttert Safety Goat—Prevent infections)
- Iniversal Protocol for Any Investive Procedure: What a a "timeout" and what does it comint of that must be done before starting any investive procedure? (2012 National Patient Sality Goale— Universal protocol)

# No Student will **RISE** to *Low* Expectations





## Practical Application in Classroom

- Come to class PREPARED
  - Read textbook
  - APPLY reading
    - Work through clinical reasoning study BEFORE theory

#### > CONCEPTS not content

- Cut PPT content in half!
- Limit to 20-25" for each 50" lecture block

#### > Group DIALOGUE of case study

Faculty facilitates/directs/emphasizes salient points

## Creative Ways to Engage Class

- > Break classroom into small groups
- Assign question from case study
   Use textbooks/each other
- Each group presents to class
- > Educator role
  - Present mini lecture concepts
  - Guides/facilitates discussion
  - Reinforces key concepts

## Sepsis/Septic Shock Rapid Reasoning Activity

Keith Rischer, RN, MA, CEN, CCRN

## Sepsis Overview

- > 1,000,000 cases annually of sepsis
- 500 deaths a day
   Similar to out of hospital MI deaths
- Expected to increase as population ages
- Mortality rate 23-50% based on severity

## Who's at Risk?

- Extremes of age <1 yr & >65 yrs
- Chronic illness
   DM
   CRF
- Malnourishment
   ETOH
- > Invasive/surgical procedures
- Immunosuppression

## Sepsis Patho

- Precipitating event
  - Activation of inflammatory response
  - Vasodilation
  - Maldistribution of volume
  - Decreased venous return
  - Decreased CO
  - Decreased tissue perfusion

## Shock Defined

Perfusion to the cells is inadequate to deliver O2 & nutrients to support vital organs & cellular function

- Hypovolemic
- Cardiogenic
- Distributive
  - ✓ Neurogenic
  - Anaphylactic
  - ✓ Septic-SIRS
  - Multiple Organ Dysfunction Syndrome (MODS)

## Shock Patho: Common Themes

- > Hypoperfusion of tissues
- > Activation of inflammatory response
- SNS stimulation

## Stages of Shock

#### Compensatory

- BP WNL
- Tachycardia
- SNS stimulation

#### > Progressive

- Hypotensive
  - ✓ SBP <90 or decrease >40mm baseline

#### > Irreversible

- Hypotensive despite fluids/vasopressors
- Acidosis/MODS

## **Essential Labs to Trend**

- > CBC
  - WBC
  - Neutrophils
  - Bands
- > BMP
  - □ K+
  - Creatinine
  - CO2 (Bicarb.)
- > LFT
  - ALT/AST
- Lactate

## Importance of Lactate

- > Lactate production associated with insufficient O2 delivery
- Clear association with lactic acidosis and mortality
- Mortality rates
  - Norm.<2.0 = 4.3%
  - -2-4 mmol/L = 9%
  - > 4 mmol/L = 28.4%

## **UA Interpretation**

- > UA
  - Color
  - Clarity
  - Sp. Gravity
  - Protein
  - Glucose
  - Ketones Blood

  - Nitrate
  - Leukocyte esterase

> Micro RBC 



- Bacteria Epithelial

## **RED FLAGS for Sepsis**

- SIRS Criteria
  - □ Temp >100.4 or <96.8
  - □ HR >90
  - RR >20
  - □ WBC >12.000 or <4000
  - □ Bands >10%

- Clinical Sx
  - Hypotension SBP<90</p> ✓ Narrow pulse pressure
  - □ u/o <30 mL/hr
  - Decr. cap refill
  - Gluc. >120
  - Change in LOC
  - Creatinine incr. ✓ >2.0 men ✓ >1.4 women

## Medical Management Priorities

## > EARLY IDENTIFICATION!!

- Trend temp/HR/BP
- New confusion/LOC
- Trend labs...WBC/neuts/Lactate/creatinine

#### > Fluid replacement...early/aggressive

- Crystalloid: 20 mL/kg bolus over 30" □ MAP >65 or SBP >90
- > IV Abx
- > Vasopressors/tx to ICU

## Sepsis Rapid Reasoning

#### I. Data Collection

1. DAR CONCUTOR History of Present Problem: Jean Kelly is an 82 year old woman who has been feeling more fatigued for the last three days and has had a fever the last twenty-four hours. She reports pathful, burning sensation when she urinates as well as frequency of urination the last week. It has been >90 degrees this past tweek. She usually drinks 2-3 glasses of fliquid a day and a cup of tea. Her daughter became concerned and brought her to the emergency department (ED) when she did not know what day it was. She is mentally alert with no history of confusion.

#### Personal/Social History:

x expraner SOUML INSU(1): Jean lives independently in a senior apartment retirement community. She is widowed and has two daughters who are active and involved in her life. While taking her bath today, she was unable to get out of the hub and used the help button. When help arrived, she was able to get to the side of the tub and sit. Upon standing to ambulate she became dizzy and last her balance. She didn't get injured while coming down hard on the toilet seat.

What data from the histories is important & RELEVANT; therefore it has clinical significance to the nurse? RELEVANT Data from Present Problem: Clinical Significance

DELEVITE A C C LETTA	
RELEVANT Data from Social History:	Clinical Significance:
RELEVANT Data from Social History:	Clinical Significance:
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RELEVANT Data from Social History:	Clinical Significance:

## Identify Clinical Relationships

What is the RELATIONSHIP of your patient's past medical history (PMH) and current meds?

(Which medications treat which conditions? Draw lines to connect)		
PMH:	Home Meds:	
Diabetes type II	1.Allopurinol 100 mg bid	
Hyperlipidemia	2.Colchicine 0.6 mg pm	
Hypertension (HTN)	3.ASA 81 mg daily	
Gout	4.Pioglitazone (Actos) 15 mg daily	
	5.Simvastatin 20 mg daily	
	6.Metoprolol 25 mg bid	
	7.Lisinopril 10 mg daily	
	8. Furosemide (Lasix) 20 mg daily	

## Labs: BMP

#### Lab/diagnostic Results:

Basic Metabolic Panel (BMP)	Current	High/Low/WNL?	Most Recent:
Sodium (135-145 mEq/L)	140		138
Potassium (3.5-5.0 mEq/L)	3.8		3.9
Glucose (70-110 mg/dL)	184		128
Creatinine (0.6-1.2 mg/dL)	1.5		1.1
Misc. Chemistries:			
Lactate (0.5-2.2 mmol/L)	3.2		n/a

## What lab results are RELEVANT that must be recognized as clinically significant to the nurse? RELEVANT Lab(s): Clinical Significance: TREND: Improve/Worsening/Stable:

## Labs: CBC

Complete Blood Count (CBC)	Current	High/Low/WNL?	Most Recent:
WBC (4.5-11.0 mm 3)	13.2		8.8
Hgb (12-16 g/dL)	14.4		14.6
Platelets(150-450x 103/µl)	246		140
Neutrophil % (42-72)	93		68

What lab results are RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Lab(s):	Clinical Significance:	IKEND: Improve/Worsening/Stable:	

## Labs: UA

Color (yellow)         Yellow         Yellow           Clarity (clear)         Cloudy         Clear           Specific Gravity (1.015-1.030)         1.032         1.010           Protein (neg)         2+         1+           Glucose (neg)         Neg         Neg           Bilrubin (neg)         Neg         Neg           Bilrubin (neg)         Neg         Neg           Mitting (neg)         Pos         Pos           Mitter (neg)         Large         Few           Epithelial (neg)         Few         Few           RELEVANT Lab(s):         Clinical Significance:         TREND: Improve/Worsening/Sta	ine Analysis (UA):	Current:	High/Low/WNL?	Most Recent:	1
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	or (yellow)	Yellow		Yellow	1
Protein (neg)         2+         1+           Glucose (neg)         Neg         Neg           Ketones (neg)         Neg         Neg           Bilurubin (neg)         Neg         Neg           Bilurubin (neg)         Neg         Neg           Bilurubin (neg)         Neg         Neg           Nittite (neg)         Neg         Neg           Nittite (neg)         Pos         Pos           MICKO:             WBC's (<5)	rity (clear)	Cloudy		Clear	1
	cific Gravity (1.015-1.030	1.032		1.010	1
Ketones (neg)         Neg         Neg           Bilrubin (neg)         Neg         Neg           Bilrubin (neg)         Neg         Neg           Bilrubin (neg)         Neg         Neg           Bilrubin (neg)         Neg         Neg           Nitrite (neg)         Pos         Pos           LET (Leukocyte Esterase) (neg)         Pos         Pos           MICRO:	tein (neg)	2+		1+	1
Bilirubin (neg)         Neg         Neg           Blood (neg)         Neg         Neg           Blood (neg)         Pos         Pos           LET (Leukocyte Esterase) (neg)         Pos         Pos           MICRO:	cose (neg)	Neg		Neg	1
Blood (neg)     Neg     Neg       Nitrik (neg)     Pos     Pos       LET (Leukocyte Esterase) (neg)     Pos     Pos       MIC RO:     0     MIC NO:       RBC's ( $\leq$ 5)     1     0       WBC's ( $\leq$ 5)     >100     3       Bacteria (neg)     Large     Few       Epithelial (neg)     Few     Few	ones (neg)	Neg		Neg	1
Nittic (neg)         Pos         Pos           LET (Leukocyte Esterase) (neg)         Pos         Pos           MIC RO:	irubin (neg)	Neg		Neg	1
LET (Leukocyte Esterase) (neg)         Pos         Pos           MICRO:	od (neg)	Neg		Neg	1
MICR0:         0           RBC's (<5)	rite (neg)	Pos		Pos	1
RBC's (<5)         1         0           WBC's (<5)	Г (Leukocyte Esterase) (r	eg) Pos		Pos	1
WBC's (<5)	CRO:				1
Bacteria (neg)         Large         Few           Epithelial (neg)         Few         Few	C's (<5)	1		0	1
Epithelial (neg) Few Few	3C's (<5)	>100		3	1
	teria (neg)	Large		Few	1
RELEVANT Lab(s): Clinical Significance: TREND: Improve/Worsening/Sta	thelial (neg)	Few		Few	1
RELEVANT Lab(s): Clinical Significance: TREND: Improve/Worsening/Sta					-
	LEVANT Lab(s):	Clinical Significance:		TREND: Improve/Wor	sening/Stable:

## Vital Signs

#### II. Patient Care Begins:

Current VS:	WILDA Pain Assessment (5th VS):	
T: 101.8 (oral)	Words:	Ache
P: 110 (regular)	Intensity:	5/10
R: 24 (regular)	Location:	Right flank
BP: 102/50	Duration:	Continuous/ongoing
O2 sat: 98% room	Aggravate:	Nothing
air	Alleviate:	Nothing

The nurse recognizes the need to validate his/her concern of fluid volume deficit and performs a set of orthostatic VS and obtains the following:

Position:	HR:	BP:
Lying	110	102/50
Standing	132	92/42

What VS data is RELEVANT that must be recognized as clinically significant?
RELEVANT VS Data:
Clinical Significance:

## Nursing Assessment

Current Assessment:	
GENERAL	Resting comfortably, appears in no acute distress
APPEARANCE:	
RESP:	Breath sounds clear with equal aeration bilaterally, nonlabored respiratory effort
CARDIAC:	Pink, warm & dry, no edema, heart sounds regular-S1S2, pulses strong, equal with
	palpation at radial/pedal/post-tibial landmarks
NEURO:	Alert and oriented x2-is not consistently oriented to date and place, c/o dizziness when she
	sits up
GI:	Abdomen soft/nontender, bowel sounds audible per auscultation in all four quadrants
GU:	Admits to dysuria and frequency of urination the past week, right flank tendemess to gentle
	palpation
SKIN:	Skin integrity intact

What assessment data is RELEVANT that must be recognized as clinically significant? RELEVANT Assessment Data: Clinical Significance:

	Charlest Significantee
	1
	1
	1
	1
	1
	1
	1
	1
	1
L	1

## **Clinical Reasoning**

- III. Clinical Reasoning Begins... 1. What is the primary problem that your patient is most likely presenting with?
- 2. What is the underlying cause/pathophysiology of this concern?
- 3. What nursing priority(s) will guide your plan of care? (if more than one-list in order of PRIORITY)

4. What interventions will you initiate based on this priority?		
Nursing Interventions:	Rationale:	Expected Outcome:

5. What body system(s) will you most thoroughly assess based on the primary/priority concern?

6. What is the worst possible/worst possible complication to anticipate?

7. What nursing assessment(s) will you need to initiate to identify this complication if it develops?

## Medical Management & Priority Setting

Medical Management: Rationale for Treatment & Expected Outcomes			
Care Provider Orders:	Rationale:		Expected Outcome:
Place Foley catheter			
0.9% NS 1000 mL IV bolus			
Acetaminophen 650 mg			
Ceftriaxone 1g IVPBafter blood/urine cultures obtained			
Morphine 2 mg IV push every 2 hours prn-pain			
PRIORITY Setting: W	hich Orders Do You In	nplement First an	d Why?
Care Provider Orders:	Order of Priority:	Rationale:	
1. Place Foley catheter			
2 .0.9% NS 1000 mL IV bolus			
3. Acetaminophen 650 mg			
4. Ceftriaxone 1g IVPBafter blood/urine cultures obtained			
5.Morphine 2 mg IV push every 2 hours prn-pain			

## Pharm. & Dosage Calc

#### Medication Dosage Calculation:

Mechanism of Action:	Volume/time frame to	Nursing Assessment/Considerations:
	Safely Administer:	
	IV Push Rate Every	
	15-30 Seconds?	
		Safely Administer:

## DC Planning & Caring

8. What educational/discharge priorities have you identified and how will you address them?

#### Caring & the "Art" of Nursing

9. What is the patient likely experiencing/feeling right now in this situation?

10. What can I do to engage myself with this patient's experience, and show that she matters to me as a person?

## **SBAR**

It is now the end of your shift. Effective and concise handoffs are essential to excellent care and if not done well can adversely impact the care of this patient. You have done an excellent job to this point, now finish strong and give the following SBAR report to the nurse who will be carning for this patient.

Situation:

Background:

 $\mathbf{A}_{ssessment:}$ 

Recommendation:

## Time to Build Your Own...

	asoning
I. Data Colle	
History of Press	
ristory of Prese	In Problem.
What data from It	he history is RELEVANT that must be recognized as clinically significant to the nurs
RELEVANT data	from history: Rationale:
Past Medical Hi	story:
II. Patient C	are Begins:
Current VS:	are Begins: WLDA Pain Scale (5 <sup>4</sup> v2) Were
Current VS:	WILDA Pain Scale (5 <sup>4</sup> v5) Works
Current VS: T: P:	WiLDA Pain Scale (5 <sup>4</sup> V1)
Current VS: T: P: R: DP:	WILDA Pain Scale (t <sup>®</sup> Vd) Werner Locate Durate
Current VS: T: P: R: DP:	WitDA Pain Scale (2 <sup>5</sup> 1/5) Work Bonesty Dozinis Aggreene
II. Patient Co Current VS: T: P: R: DP: OZ set:	WILDA Pain Scale (t <sup>®</sup> Vd) Werner Locate Durate
Current VS: T: P: R: DP:	WitDA Pain Scale (2 <sup>5</sup> 1/5) Work Bonesty Dozinis Aggreene
Current VS: T: P: R: BP: OZ sat:	WitDA Pain Scale (2 <sup>5</sup> 1/5) Work Bonesty Dozinis Aggreene
Current VS: T: P: R: BP: O2 set: Current	WitDA Pain Scale (2 <sup>5</sup> 1/5) Work Bonesty Dozinis Aggreene
Current VS: T: P: R: DP: O2 set: Current Assessment:	WEDA Pais Scale (2 <sup>4</sup> v1) Wess Density Douter Douter Atreas
Current VS: T: P: R: BP: OZ sat: Current Assessment: OENERAL	WitDA Pain Scale (2 <sup>5</sup> 1/5) Work Bonesty Dozinis Aggreene
Current VS: T: P: R: DP: O2 sat: Current Assessment: GENERAL APPEARANCE	WEDA Para Seale (2 <sup>4</sup> v1)           Brance           Brance           Brance           Brance           Average           Average           Presting confiderably, oppears in no south distings
Current V5: T: P: BP: DP: OZ set: Current Assessment: GENERAL APPERANCE RESP	WEDA Pais Scale (2 <sup>4</sup> v1) Wess Density Douter Douter Atreas
Current V5: T: P: BP: DP: OZ set: Current Assessment: GENERAL APPERANCE RESP	WLDA Peak Seale (2 <sup>4</sup> vt);           With the seale (2 <sup>4</sup> vt);           With the seale (2 <sup>4</sup> vt);           Busines;
Current VS: T: P: R: DP: O2 sat: Current Assessment: GENERAL APPEARANCE	WLDA Pean Scale (2 <sup>6</sup> vic);           Works           Works           Scale           Dates:           Dates:           Algeroid:           Rendma:           Rendma:           Rendma:           Rendma:           Rendma:           Rendma:           Rendma:           Rendma:           Rendmain:
Current V5: T: P: BP: O2 sat: Current Assessment: GeneRAL APPERANCE RESP CANDAC	WLDA Plan Scale (2 <sup>6</sup> vr);           Wome           Wome           Loware           Dates:           Dates:           Ageronic           Rendro           Rendro           Rendro           Rendro           Rendro           Rendro           Rendro           Rendro
Current VS: T: P: BP: OZ set: Current Assessment: GENERAL APPERANCE RESP CARDIAC NEURO	WLCA Pers Seale (2 <sup>4</sup> vt);           With Seale (2 <sup>4</sup> vt);           We seale (2 <sup>4</sup> vt);           Busines;           Busines;           Busines;           Busines;           Busines;           Busines;           Busines;           Busines;           Personal           Pression;           Pression;           Busines;           Pression;           Busines;           Press;           Press;           Busine;           Press;           Busine;           Busine;      <
Current VS: T: P: BP: OZ set: Current Assessment: GENERAL APPERANCE RESP CARDIAC HELIRO	WLDA Plan Scale (2 <sup>6</sup> vr);           Wome           Wome           Loware           Dates:           Dates:           Ageronic           Rendro           Rendro           Rendro           Rendro           Rendro           Rendro           Rendro           Rendro
Current VS: T: P: R: DP: O2 sat: Current Assessment: GeneRad. APPERANCE RESP CARDAC	Het CAP for Safet (1 <sup>4</sup> VI)     With A Safet (1 <sup>4</sup> VI)     With A Safet (1 <sup>4</sup> VI)     Manual (1 <sup>4</sup> VI)     Ma

## One Student's Perspective.

*"I didn't feel like I was memorizing for the test. I felt like I was able to <u>apply the information</u>. It helped put knowledge into practice and made it clear <u>why it was relevant."</u>* 

## Educator's Perspective.

- "This format helps students to <u>apply information</u> and look at the big picture. I had so much fun teaching in this way and didn't see anyone nodding off in the back of the class!"
  - Janet Miller, Hibbing, MN
- "I've been using Keith's case studies for the past couple of years. I've decreased my PPT time to allow case studies during class. The student's love it, and our class time is much more productive. They score higher on their exams because of the application."
  - Rob Morris, RN, MSN, Vasalia, CA

## **Strengths**

- > Bridges current theory & clinical divide
- Promotes "thinking like a nurse" in practice
   Emphasizes clinical reasoning NOT content
  - Open ended vs. multiple choice
- Practice thinking (ruts) & common change of status
- Active learning strategy
  - Promotes student engagement...20" lecture MAX
- » NCLEX principles reinforced
- Integrate QSEN and National Safety Goals

#### **Barriers**

- Change
- Faculty buy in
- Time commitment
- Clinical currency

## Time to Reflect.

- > What barriers exist in your program/team to implement active/applied learning in classroom
- What are 1-2 practical steps I can initiate to bring needed change to my classroom?

## Next Steps...

- Required Reading:
  - Educating Nurses: A Call for Radical Transformation
  - Clinical Wisdom & Interventions in Acute/Critical Care
     Lisa Day: Using Unfolding Case Studies in a Subject-
- Centered Classroom
- > Collaborate as a team/department
- > Take first steps with one clinical reasoning case study
  - Choose one lecture/key content area
  - Start next semester!

## Transforming Nursing Education

- > Responsibility of nurse educators
- > Educational best practice
- > Patient outcomes impacted

## Framework for Change

- Time is now!
- Can't do it alone
- Have a vision for transformational change
   Emphasis of clinical reasoning
- Practical implementation
  - Clinical reasoning case studies
  - Active learning strategies

## It's Time for a Revolution!



## Current Grievances in Nsg. Ed.

- Over emphasis on NANDA nursing diagnostic statements to establish care priorities...Del Bueno
- 2. Under emphasis of clinical reasoning...Benner
- 3. Over emphasis of content...Benner
- 4. Under emphasis of application of content to the bedside...Benner
- Patient outcomes impacted including needless deaths due to resistance to make needed change



#### It's Time for a Revolution!

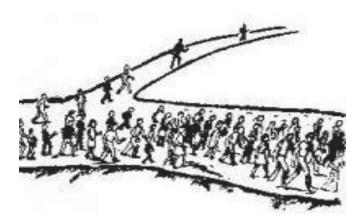
1. I will decrease classroom content and will contextualize nursing concepts that are most relevant to my topic.

2. I will use active learning strategies consistently in my classroom including the use of clinical reasoning case studies so students can practice critical/clinical thinking in my classroom.

3. I will embrace clinical reasoning as a pedagogy that promotes nurse thinking and will emphasize this in my classroom and clinical settings.

4. I will allow nursing priorities to be situated in new ways in addition to NANDA nursing diagnostic statements.

#### The Choice is Yours...



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## Think Like a Nurse!

#### Transforming Nursing Education so Our Graduates Are Prepared for Professional Practice

Keith Rischer, RN, MA, CEN, CCRN

According to Del Bueno, two-thirds of our current nursing graduates are unable to clinically reason at the most basic level to recognize a worsening change in patient status (1). This is commonly called "failure to rescue" and happens when the nurse does not recognize trends that reflect a deteriorating status change until it is too late and an adverse outcome or patient death results. For example, a patient, who is sliding into sepsis but early signs are not recognized by the nurse until they are in septic shock with severe hypotension and a lactate >4, may die as a result of the nurse's inability to clinically reason and think like a nurse.

Is the traditional model of educating nurses contributing to the inability of new nurses to transfer their knowledge to clinical practice? In the book *Educating Nurses: A Call to Radical Transformation,* Dr. Patricia Benner and her coauthors lay a clear vision of what must be done to change the paradigm of nursing education. This outline is intended to be a brief summary of the highlights from *Educating Nurses* and what the Carnegie Foundation identified is needed to change the paradigm of nursing education so that our graduates are properly prepared for professional practice.

## The Problem Is in the Classroom

#### 1. Too much CONTENT!

- a. Dorothy Del Bueno writes in A Crisis in Critical Thinking: "Why can't new registered nurse graduates think like nurses? Although well versed in content, the majority are unable or have considerable difficulty translating knowledge and theory into practice. Why? The author believes that a highly probable cause is the emphasis on teaching more and more CONTENT rather than a focus on APPLICATION OF KNOWLEDGE. A look at the size and plethora of nursing textbooks supports this conclusion"(1).
- b. Educators feel pressure to "cover" the content, but cover can also mean to conceal or hide from view (2). When content is "covered," how many of us realize that we may be inadvertently keeping our students from seeing what is truly important by hurrying through needed content?
- c. With the encyclopedic nature of current textbooks, students are typically expected to know and be tested on the entire chapter's content, but as a result acquire only superficial learning.
- d. Instead, nurse educators should emphasize what is most RELEVANT and then contextualize this content so students can acquire DEEP learning of what is essential (3).

#### 2. Content is not contextualized to practice

- a. Content is repeated from the chapter it was derived from with no clinical scenario or "hook" to intentionally apply it to practice in most classrooms. Have we forgotten that students can READ content but our primary responsibility as educators is to spend our lecture time to CONTEXTUALIZE essential knowledge to practice?
- b. Nursing is a practice discipline that takes place at the bedside. Therefore, all content must be intentionally situated to show how it is RELEVANT to the bedside.

#### 3. PowerPoint-driven learning does not engage students with clinical realities

- a. Benner states this best in *Educating Nurses: "Classroom teachers must step out from* behind the screen full of slides and ENGAGE students in clinic like learning experiences that ask them to learn to use knowledge and practice thinking in changing situations"(3).
- b. Lecture/PowerPoint–driven presentations are a PASSIVE pedagogy. Only 5-20 percent of content is ultimately retained. After only twenty minutes students begin to disengage. The role of the student is to absorb knowledge, take notes, and passively participate.
- c. Compare this to ACTIVE learning pedagogies that Benner advocates must take place in the classroom. Students actively participate, experience, and construct/apply knowledge. What classroom would you rather be in?

d. Del Bueno again weighs in: "Recall and understanding of content or selection of the correct answer do not equate to clinical judgment. Smart nurses are effective nurses when they THINK CRITICALLY, not when they can pass multiple choice tests" (1).

#### 4. Classroom theory is fragmented and poorly integrated with clinical practice

- a. Currently in most programs, classroom theory and clinical education are in their own separate orbits with little to no intersection. Abstract concepts related to various med/surg topics are typically presented in PowerPoint slides with minimal emphasis on how this content is relevant and how they are used in practice (3).
- b. Students who are novices with minimal clinical experience and little clinical imagination are unable to see the clinical connections required in practice.
- c. If theory content is not situated in the classroom, it is only by chance that the student will be able to practice and apply content with a patient in the clinical setting.

#### The Solution

#### 1. Contextualize theory concepts/content to the bedside

- a. Shift from a focus on covering decontextualized knowledge to an emphasis on teaching for a sense of salience, nurse thinking, and action in a particular situation (3).
- b. Concepts are most effectively caught when taught in the CONTEXT of a clinical scenario. As new concepts are introduced, the student is best served by learning the inter-relationships between these concepts and their situated use in practice. DEEP learning of concepts is essential to professional practice. This can take place most effectively when a situated scenario unfolds over time (2).
- c. Using knowledge can be practiced through clinically derived case studies that situate clinical realities and clinical reasoning in the safety of the classroom. Students are asked to identify what clinical data is important or relevant and WHY (rationale for everything!).
- d. Students must be able to recognize CLINICAL RELATIONSHIPS between sets of data. This must first be situated and PRACTICED in the CLASSROOM so students can transfer this skill to the bedside.

For example, a patient just admitted with heart failure exacerbation has an ejection fraction of 20 percent, elevated creatinine, elevated BNP, a chief complaint of SOB and assessment findings of crackles half up bilaterally in both lung fields. What are the clinical relationships and the physiologic rationale for these findings? This learning can be situated and practiced in the classroom to prepare students to identify these same relationships in the clinical setting.

## 2. Provide opportunities to PRACTICE clinical thinking/reasoning by using "clinical imagination" in the classroom

- a. Isabel Hampton Robb, the most influential American nurse educator of the early modern era also recognized the value of practicing any skill. She writes in *Nursing Ethics* (1900): "Only by constant REPITITION can you become really familiar with the work. Only by doing a thing well again and again can you obtain confidence, accuracy and precision. It is this constant, intelligent PRACTICE that constitutes the difference between the skilled trained professional woman and the amateur. Despite the common use of the term, the 'born nurse' does not exist...it will always be necessary to take hold of each task and do it over and over again, being guided by an intelligent, trained mind" (4).
- b. We must recognize that THINKING is a skill that must also be PRACTICED to become proficient. Foley catheterization and other clinical skills require repetition and we give opportunities to do this in our skills lab. The classroom must become this "lab" environment to practice nurse thinking with clinically derived case studies.
- c. Clinical imagination defined by Benner: "Nursing students need to acquire knowledge in a way that relates directly to the skilled know how they are developing in clinical situations and to acquire knowledge in a way that allows them to imagine situations and rehearse for them"
   (2). Clinical reasoning case studies are one way to make this possible.
- d. Conjure up possibilities of what could happen in this situation and be prepared for the worst possible problem. "What if" questions are an effective pedagogy in the classroom and clinical

to develop this needed nurse thinking skill of ANTICIPATE vs. REACT to a patient problem when it develops.

#### 3. Using knowledge to identify the essence of the clinical situation

- a. Using knowledge is much more than merely "applying" content.
- b. Teaching nurses to think and act like nurses requires the nurse to be able to grasp the nature of the clinical situation and recognize what clinical data and knowledge are most relevant or salient to what the situation requires and then initiate needed interventions. This is also a benchmark of expert practice (2).
- c. Practicing this skill in the classroom with clinically situated case studies as well as mentoring this emphasis in the clinical setting will prepare our students for the bedside.

## 4. Emphasize clinical reasoning as a systematic approach that reflects how nurses think in practice

- a. Critical thinking has long been the emphasis in nursing education, but it is inadequate to capture needed priority setting and action when a patient has a change in status. NANDA nursing diagnostic language is also unable to capture the essence of needed priority setting when a status change occurs.
- b. Essence of CLINICAL REASONING is the ability of the nurse to THINK IN ACTION, to reason as the situation changes by capturing trends in labs, VS, and assessment data collection, grasping the essence of situation and recognizing the NEED TO RESCUE (3).
- c. Series of clinical reasoning questions that I have compiled based on my own practice as well as input from Linda Caputi and Lisa Day's paradigm example in *Educating Nurses* that provide a template for thinking like a nurse in clinical practice:
  - i. What is the primary medical problem?
  - ii. What is the underlying cause/pathophysiology of this problem?
  - iii. What labs, VS, and assessment data are RELEVANT to this patient?
  - iv. What nursing priority(s) will guide your plan of care?
  - v. What nursing interventions will you initiate?
  - vi. What is the rationale for nursing interventions/physician orders?
  - vii. What body system(s) will you most thoroughly assess based on primary problem?
  - viii. What is the most likely/worst possible complication to anticipate?
  - ix. What nursing assessment(s) will you need to initiate and identify this complication if it develops?

#### My Response as a Nurse Educator

As a practicing nurse who continued to work part-time in the ED and ICU while teaching, the paradigm changes advocated in *Educating Nurses* resonated so strongly with me, I knew I could not go back to "classroom as usual" with content-heavy presentations. I reworked my content to emphasize essential concepts, then situated these concepts with recent examples I had seen in clinical practice. I then implemented clinically derived case studies that brought "clinical imagination" in the classroom. I have since created three levels of clinical reasoning case studies complete with student version and faculty key. Blank templates to develop your own clinical reasoning case studies can be downloaded from my website at no cost.

**1.** <u>Rapid Reasoning Activity</u>: Short/condensed "just right" clinical reasoning activity for any med/surg level to supplement your lecture content. Contains ten foundational clinical reasoning questions that provide a template for "nurse thinking" in practice as well as two questions that situate caring and the "art" of nursing practice.

**2.** Fundamental Reasoning Activity: Ideally suited for first year/fundamental level. Clinical scenario is presented to help students see the RELATIONSHIPS between data that lay the foundation for critical thinking as well as incorporating pharmacology, nursing process and priority setting.

**3<u>. Unfolding Reasoning Studies</u>:** Unfolds over time and is longer in length. The most common changes in patient status are also incorporated as "clinical curveballs" that must be recognized by the

student as well as same foundational clinical reasoning questions. Optional QSEN and National Patient Safety Goal questions are able to be included by the educator.

#### Practical implementation strategies for the classroom:

<u>No Student will **RISE** to low expectations.</u> This quote is my thesis statement that guides me in classroom and clinical education. Students will go no higher than what you expect of them. High but realistic is the bar I set as an educator and when students see the relevance of your expectations to practice, most will meet or exceed them. This statement gave me permission to be BOLD and implement needed changes to transform my classroom!

- a. With a typical fifty minute time block of lecture, I lectured no more than twenty to twenty-five minutes.
- b. I used the remaining time for a clinical reasoning case study that situated the content I just taught.
- c. These were my expectations as I implemented these needed paradigm changes in the classroom:
  - Come to class prepared by reading the textbook BEFORE class.
  - APPLY your understanding of the content by working through the clinical reasoning case study I posted one week before class either individually or preferably in small groups.
  - Group DIALOGUE of case study in class. I led the discussion, but student response and dialogue was expected with no spoon feeding allowed!
  - My role as educator was to facilitate/direct/emphasize salient points of the case study.
- d. Another nurse educator found the following approach effective in her classroom:
  - Break classroom into small groups.
  - Assign one to two questions from case study to each group.
  - Given fifteen to twenty minutes to collaborate using textbooks/each other.
  - Each group presented answers to class.
  - Role as educator was to facilitate/direct/emphasize salient points of the case study.

When I did a survey at the end of the semester implementing these changes in my classroom, <u>not one</u> student wanted to go back to the traditional content lecture. Below are sample comments from a student and another educator who used this pedagogy in her classroom.

**Student response**: "It was very helpful. I didn't feel like I was memorizing for the test. I felt like I was able to APPLY the information. It helped put KNOWLEDGE into PRACTICE and made it clear why it was RELEVANT."

**Faculty response**: "This format makes such a difference in helping to bring clinical into the classroom. It helps students to APPLY information and look at the big picture in our patients. I had so much fun teaching in this way and didn't see anyone nodding off in the back of the class!"

#### In Closing...

We have two choices as we face a fork in the road regarding our manner and approach to teaching our students. Follow the pack that do what is comfortable and resist needed change or choose the hard and narrow road of radical transformation that Benner is calling us as educators to embrace. Together, one classroom at a time, we can realize Benner's transforming vision of nursing education to not only promote the learning of our students, but more importantly produce better outcomes for the patients they care for.

#### References

- 1. Del Bueno, D. (2005). A crisis in critical thinking, Nursing Education Perspectives, 26(5), 278-282.
- 2. Benner, P. (2013). Educating Nurses Newsletter.
- 3. Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.
- 4. Hampton Robb, E. (1900). Nursing ethics. Cleveland, OH: E.C. Koeckert.

## **Notes/Reflections**

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#### I. Clinical reasoning reflections:

- a. What is your program doing well that is consistent with the best practice recommendations of the Carnegie Foundation research?
- b. What needs to be changed?
- c. How does your program incorporate clinical reasoning in your content/curriculum and allow it to be PRACTICED?
- d. Identify the 3 most common complications (Jason's) that patients are most likely to experience on your clinical unit.
  - 1.
  - 2.
  - 3.
- e. How are you preparing your students to be proactive and not reactive to these status changes?
- f. How much of your theory lecture emphasizes CONTENT?
- g. What percentage of your theory lecture uses an active/applied learning strategy
- h. What content would benefit from an active/applied learning strategy?
- i. What barriers are present in your program that will hinder needed transformation?
- j. ACTION PLAN...What will I do to bring about needed transformational change to our program?

#### Resources to Transform Nursing Education through an Emphasis on Clinical Reasoning

- 1. Book: Educating Nurses-A Call to Radical Transformation by Patricia Benner, Lisa Day, Molly Sutphen and Victoria Leonard
- 2. Book: Clinical Wisdom and Interventions in Acute and Critical Care, Second Edition: A Thinking-in-Action Approach by Patricia Benner, Patricia Hooper Kyriakidis, Daphne Stannard

## **Clinical Reasoning Questions to Develop Nurse Thinking**

(Formulate and reflect before and after report, but BEFORE seeing patient the first time)

- 1. What is the primary problem and what is the underlying cause/pathophysiology of this problem?
- 2. What clinical data from the chart is RELEVANT and needs to be trended because it is clinically significant?
- 3. What nursing priority will guide your plan of care?
- 4. What nursing interventions will you initiate based on this priority and what are the desired outcomes?
- 5. What body system(s) will you focus on based on your patient's primary problem or nursing care priority?
- 6. What is the worst possible/most likely complication(s) to anticipate based on the primary problem?
- 7. What nursing assessments will you need to initiate to identify this complication if it develops?

#### While Providing Care...(Review and note during shift after initial patient assessment)

- 8. What clinical assessment data did you just collect that is RELEVANT and needs to be TRENDED because it is clinically significant to detect a change in status?
- 9. Does your nursing priority or plan of care need to be modified in any way after assessing your patient?
- 10. After reviewing the primary care provider's note, what is the rationale for any new orders or changes made?
- 11. What educational priorities have you identified and how will you address them?

#### Caring and the "Art" of Nursing

- 12. What is the patient likely experiencing/feeling right now in this situation?
- 13. What can I do to engage myself with this patient's experience, and show that he/she matters to me as a person?

# A Declaration to

# Transform Nursing Education

When in the course of human events, it becomes apparent that nursing education is in need of a radical transformation to promote the learning of our students and to be adequately prepared for professional practice, I commit to use all of the resources available to me and to influence those around me to be a part of this needed change.

We hold these truths to be self-evident, that all nursing students are created equal, and deserve to be prepared for real world practice by the time they leave our nursing program. In order to accomplish this essential objective, I commit to implementing the following best practice standards founded in educational research and professional practice:

- 1. I will decrease classroom content and will contextualize nursing concepts that are most relevant to my topic.
- 2. I will use active learning strategies consistently in my classroom including the use of clinical reasoning case studies so students can practice critical/clinical thinking in my classroom.
- 3. I will embrace clinical reasoning as a pedagogy that promotes nurse thinking and will emphasize this in my classroom and clinical settings.
- 4. I will allow nursing priorities to be situated in new ways in addition to NANDA nursing diagnostic statements.

I embrace the responsibility of preparing the next generation of nurses for professional practice and will hold myself to the highest standards to promote their learning, which will then lead to better outcomes for the patient's they care for.

Signed\_\_\_\_\_ Date\_\_\_\_

#### **References from the Literature**

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## I. Data Collection

History of Present Problem:

**Personal/Social History:** 

What data from the histories is important & RELEVANT; therefore it has clinical significance to the nurse?		
RELEVANT Data from Present Problem: Clinical Significance:		
<b>RELEVANT Data from Social History:</b>	Clinical Significance:	

#### What is the RELATIONSHIP of your patient's past medical history (PMH) and current meds?

(Which medications treat which conditions? Draw lines to connect)

PMH:	Home Meds:

#### Lab/diagnostic Results:

<b>Basic Metabolic Panel (BMP)</b>	Current	High/Low/WNL?	Most Recent:
Sodium (135-145 mEq/L)			
Potassium (3.5-5.0 mEq/L)			
Glucose (70-110 mg/dL)			
Creatinine (0.6-1.2 mg/dL)			
Misc. Chemistries:			

<b>RELEVANT Lab(s):</b>	Clinical Significance:	TREND: Improve/Worsening/Stable:

Complete Blood Count (CBC)	Current	High/Low/WNL?	Most Recent:
WBC (4.5-11.0 mm 3)			
Hgb (12-16 g/dL)			
Platelets(150-450x 103/µl)			
Neutrophil % (42-72)			

#### What lab results are RELEVANT that must be recognized as clinically significant to the nurse?

<b>RELEVANT</b> Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

## **II. Patient Care Begins:**

Current VS:	WILDA Pain Scale (5 <sup>th</sup> VS)	
T:	Words:	
<b>P:</b>	Intensity:	
R:	Location:	
BP:	Duration:	
O2 sat:	Aggreviate:	
	Alleviate:	

#### What VS data is RELEVANT that must be recognized as clinically significant?

<b>RELEVANT VS Data:</b>	Clinical Significance:

Current Assessment:	
GENERAL	Resting comfortably, appears in no acute distress
APPEARANCE:	
RESP:	Breath sounds clear with equal aeration bilaterally, nonlabored respiratory effort
CARDIAC:	Pink, warm & dry, no edema, heart sounds regular with no abnormal beats, pulses strong,
	equal with palpation at radial/pedal/post-tibial landmarks
NEURO:	Alert & oriented to person, place, time, and situation (x4)
GI:	Abdomen soft/nontender, bowel sounds audible per auscultation in all four quadrants
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Skin integrity intact

What assessment data is RELEVANT that must be recognized as clinically significant?

<b>RELEVANT Assessment Data:</b>	Clinical Significance:

#### **III. Clinical Reasoning Begins...**

1. What is the primary problem that your patient is most likely presenting with?

2. What is the underlying cause/pathophysiology of this concern?

3. What nursing priority(s) will guide your plan of care? (if more than one-list in order of PRIORITY)

4. What interventions will you initiate based on this priority?					
Nursing Interventions:	Rationale:	Expected Outcome:			

5. What body system(s) will you most thoroughly assess based on the primary/priority concern?

6. What is the worst possible/most likely complication to anticipate?

7. What nursing assessment(s) will you need to initiate to identify this complication if it develops?

#### **Medical Management: Rationale for Treatment & Expected Outcomes**

Micular Munugement. Rationale for Treatment & Expected Outcomes				
<b>Care Provider Orders:</b>	Rationale:	Expected Outcome:		

#### **PRIORITY Setting: Which Orders Do You Implement First and Why?**

Care Provider Orders:	Order of Priority:	Rationale:

#### **Medication Dosage Calculation:**

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
<b>Normal Range:</b> (high/low/avg?)		Hourly rate IVPB: IV Push Rate Every 15-30 Seconds?	

8. What educational/discharge priorities will you identify once this patient is admitted to the unit?

#### Caring & the "Art" of Nursing

9. What is the patient likely experiencing/feeling right now in this situation?

10. What can I do to engage myself with this patient's experience, and show that he/she matters to me as a person?

It is now the end of your shift. Effective and concise handoffs are essential to excellent care and if not done well can adversely impact the care of this patient. You have done an excellent job to this point, now finish strong and give the following SBAR report to the nurse who will be caring for this patient:

Situation:
Background:
Assessment:

## Recommendation: