2014 MN Health Educators' Conference
Thursday Schedule of Events

For reference only; final printed schedule provided at conference

Madden's on Gull Lake
Town Hall
Thursday, April 24

6:30-8:00	**Breakfast**	**Madden Inn Dining Room**
7:00-8:30	**Check-in**	**Upper Lobby, Town Hall**
7:00-6:00	**Vendors**	**Lower Lobby, Town Hall**

7:00-7:50 **Vendor Sessions** - ***see three options below***

ATI's New Pre-graduation Comprehensive Review Course **Olson Board Room**
A supplement to your current curriculum. (1 CEU)

Flipping the Classroom **Pillsbury**
Learn how to engage students and emphasize permanent memory retention while recognizing no two learners are the same. (1 CEU) *Sponsored by Elsevier*

Confused About the NCLEX Test Plan? **Sibley**
Gain a deeper understanding of the NCLEX test plan and recent changes.
(An abbreviated session from Wednesday) *Sponsored by Hurst*

8:00-4:00	**Posters**	**Governors Ballroom**
8:00-9:30	**The Agile Leader: The Health Educator in a Sea of Change**	
	Ted Schick, Owner of Schick Corporate Learning	**Governors Ballroom**
9:30-9:45	**Break**	**Lower Lobby, Town Hall**

9:45-11:00 **The Evolving Landscape of Curriculum: Involving Educators in Care of Older Adults: *Quest for Quality in Health Care for Older Adults***
NLN's Innovations in Teaching: An ACES Workshop
ACES (Advancing Care Excellence for Seniors) **Governors Ballroom**

Susan Forneris & Elaine Tagliareni, National League for Nursing
Jeanne Cleary, Ridgewater College

11:00-12:00 ***Innovations in Teaching Using Unfolding Cases and Simulation***

12:00-1:00 **Lunch & Vendor Time** **Governors Ballroom**

1:00–2:00 ***Innovations in Teaching Using Unfolding Cases and Simulation – cont'd***

2:00–2:45 ***Individualized Aging and Complexity of Care: Geriatric Syndromes***

2:45-3:00 **Break & Networking** **Governors Ballroom**

2:30-3:15 ***Coordinating and Managing Care During Transitions***

3:15-4:00 ***Leading, Advancing and Sustaining Care Excellence***

Wrap-up, Review, Q & A

4:15-5:15 **Keys to Successful Simulation** **Golf Villas B – Across the Street**

Monica Buchanan, National League of Nursing, Ambassador to Education
Tracy Moshier & Jacquie Semaan, Lake Superior College (1 CEU)

4:15-5:15 **MN-OADN Meeting** **Olson Board Room, Lower Level**

4:15-5:15 **Evolving High School Partnerships: Round Table Discussion for NA Coordinators** **Pillsbury, Lower Level**

Sheryle Cuffe, Hibbing Community College
Pat Reinhart, Minneapolis Community & Technical College

Panelists: Krista Hoekstra, Pine Technical College; Heidi Shinabargar, Itasca Community College; and Bonnie Wendt, Minnesota Department of Health Registry (1 CEU)

5:00-6:00 **Reception / Cash Bar** **Upper & Lower Lobby, Town Hall**

6:00-7:30 **Banquet & Retirement Recognition** **Governors Ballroom**

7:30-8:30 **Entertainment: Song Blast - Dueling Guitars** **Governors Ballroom**

ACES
Advancing Care Excellence for Seniors
Innovations in Teaching

NLN
National League for Nursing

The Evolving Landscape of Curriculum: *Involving Educators in Care of Older Adults*

Workshop Agenda – 2014 MN Health Educators Conference	
9:45 – 11:00am	**Session I** ***The Quest for Quality in Health Care for Older Adults: The NLN ACES Framework*** Elaine Tagliareni EdD, RN, CNE, FAAN & Susan Gross Forneris PhD RN CNE CHSE-A
11:00am – 12:00pm	**Session II** ***Innovations in Teaching Using Unfolding Cases and Simulation*** Susan Gross Forneris PhD RN CNE CHSE-A & Jeanne Cleary BSN MA RN
12:00 – 1:00pm	**Lunch**
1:00 – 2:00pm	**Session III** ***Individualized Aging and Complexity of Care: Geriatric Syndromes*** Elaine Tagliareni EdD, RN, CNE, FAAN & Susan Gross Forneris PhD RN CNE CHSE-A
2:00 – 2:45pm	**Session IV** ***Coordinating and Managing Care During Transitions*** Elaine Tagliareni EdD, RN, CNE, FAAN & Jeanne Cleary BSN MA RN
2:45 – 3:00pm	**Break and Networking**
3:00 – 4:00pm	**Session V** ***Leading, Advancing and Sustaining Care Excellence*** Elaine Tagliareni EdD, RN, CNE, FAAN & Susan Gross Forneris PhD RN CNE CHSE-A

Developed through a partnership with Community College of Philadelphia.

Funded by the Hearst Foundations, John A. Hartford Foundation, Laerdal Medical and the Independence Foundation.

Innovations in Teaching: An ACES Workshop

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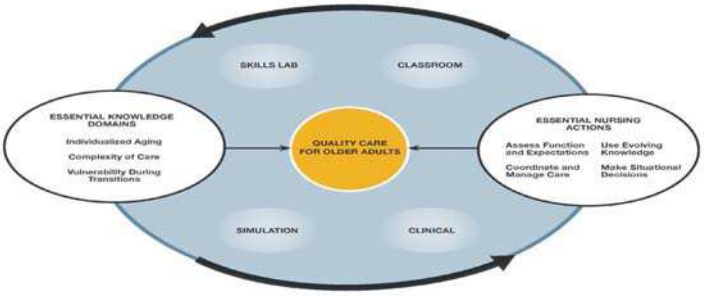
The Quest for Quality in Health Care for Older Adults: The ACES Framework

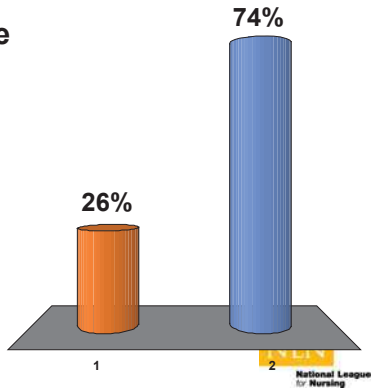
Opening Session

NLN ACES Framework



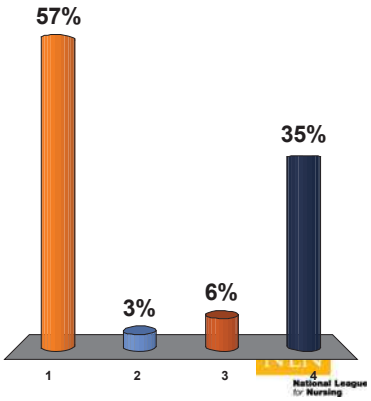
Do you have a mandatory stand alone gerontology course?

1. Yes
2. No



What is your primary source for gerontological nursing care?

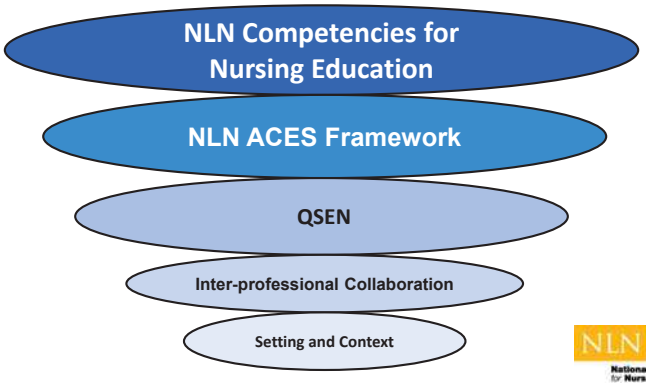
1. Med/Surg textbooks
2. AACN Gero Comps
3. Hartford Institute
4. Geriatrics textbook



NLN's Vision of Nursing Education

- Attending to changing demographic and health care needs
- Teaching evolving knowledge of caring for older adults
- Designing intentional encounters
- Cultivating clinical decision-making skills
- Managing and coordinating care during transitions

Competent, Individualized Care for Older Adults



- Institutional Values
- Leadership
- Patient & family centered approaches

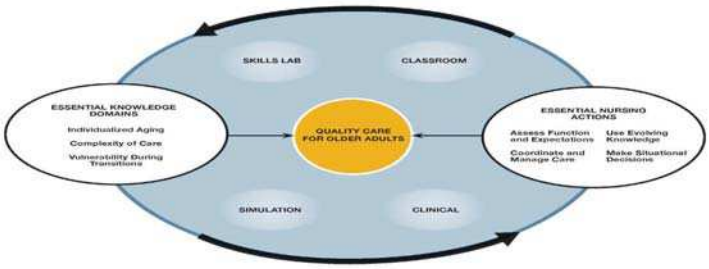
Inter-professional Collaboration

- The concept of inter-professional practice
- Safety and inter-professional team-based care
- Core competencies for inter-professional collaborative practice

QSEN
(*Quality and Safety in Nursing Education*)

- Patient-centered care
- Evidence-based practice
- Teamwork and collaboration
- Safety
- Quality improvement
- Informatics

NLN ACES Framework



ACES
Essential Knowledge Domains

- Individualized Aging
- Complexity of Care
- Vulnerability during Transitions

Let's meet Dorothy…

ACES
Essential Nursing Actions

- **A**ssess Function and Expectations
- **C**oordinate and Manage Care
- Use **E**volving Knowledge
- Make **S**ituational Decisions

Let's meet Doris…

NLN Education Competencies Model

- Reflect the NLN's core values of caring, integrity, diversity, and excellence
- Incorporate a vision for the future preparing nurses to deliver quality health care for individuals, families and communities.

Program Outcomes

- Spirit of Inquiry
- Human Flourishing
- Professional Identity
- Nursing Judgment

Reflections

What connections emerge among QSEN, the NLN Program Outcomes and ACES?

Making the connection to your curriculum

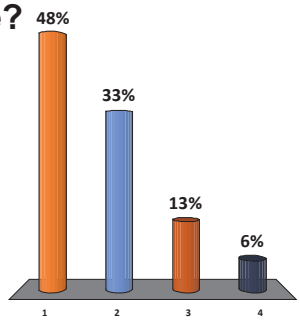
- What would it be like if we started with assessing function and expectations as well as physical assessment?
- How would the teaching of gerontology be turned upside down if we started with complexity?
- How will a focus on transitions lead to situational decisions making by the nurse?

Reflection

- Do Dorothy and Doris present a different perspective about aging?
- What might the outcomes be for students by using their stories early in the curriculum?

Challenges to Change?

1. Time
2. Faculty ownership
3. Lack of content experts
4. Standardized testing



The Future

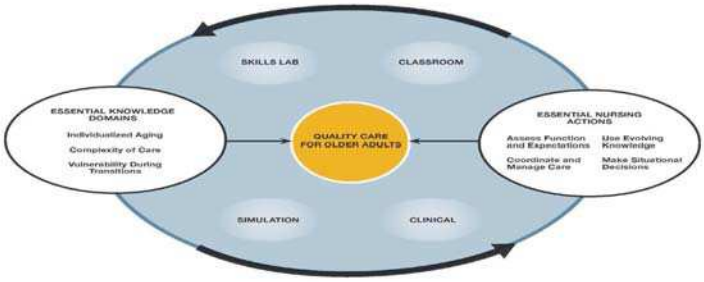
Transformation of nursing practice requires a fundamental re-conceptualization of nursing education in order to substantively change how nurses are prepared for and engage in practice.

While the nature of nursing practice has changed drastically, the pedagogical assumptions have not!

The Fundamental Questions:

- Do our current pedagogical approaches reflect these changes?
- Are we teaching as we were taught and for a healthcare system and a client base that no longer exists?

NLN ACES Framework



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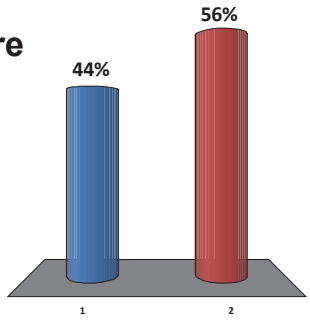
Unfolding Cases and Simulation

Session II

Do you currently use simulation to teach care of older adults?

1. Yes
2. No



How do You Use Simulation in Your Nursing Program?

- Classroom/Didactic/Lecture
- Clinical site/in situ
- Skills lab
- Clinical hours, replacing or augmenting care at clinical sites
- With practicing nurses - orientation

Definition of an Unfolding Case

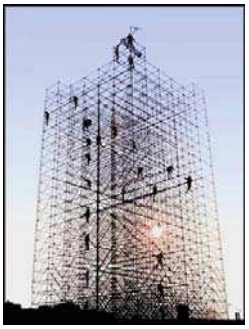
- Evolves over time in a manner that is unpredictable to the learner
- Elements and new situations develop and are revealed with each encounter
- The ACES cases incorporate the power of storytelling with the experiential nature of simulation scenarios

Elements of an ACES Unfolding Case

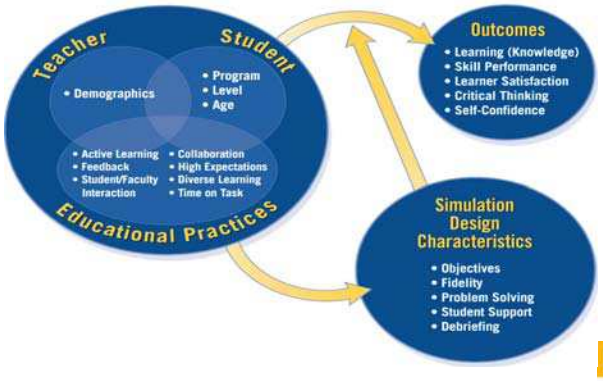
- First Person Monologues
- Simulation Scenarios
- Finish the Story
- Instructor Toolkits

Pedagogy of Unfolding Cases

- Constructivist Learning Theory
- Scaffolding
- Narrative Pedagogy



NLN/Jeffries Framework



Educational Practices

- Active learning
- High expectations
- Time on task
- Prompt feedback
- Student/faculty interaction
- Diverse ways of learning
- Collaboration

Chickering, A.W. & Gamson, Z.F. (1987). Seven principles for good practice in undergraduate education. American Association of Higher Education Bulletin (AAHE Bulletin), 3-7.

Every Unfolding Case Includes:

- Complexity
- Missing information
- Varied settings
- Family dynamics/role strain
- Common syndromes of aging
- Differences in responses of older adults to illness
- Assessing risk/benefit in context of respect for individual's preferences/values
- Evidence-based practice/use of validated tools/ inter-professional team approach

Let's meet Henry & Ertha…

Try these questions…

- What are your concerns for Henry and Ertha?
- What is the cause of the concern?
- What else do you need to know about Henry and Ertha?
- What are you going to do about it?

www.nln.org/ACES

Adapted from Benner (2010) . *Educating Nurses: A Call for Radical Transformation*

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Simulation – 1

- Takes place a few hours after Henry was admitted through the emergency room with an acute exacerbation of COPD
- He is short of breath and concerned about Ertha because he has been the one taking care of and supporting her

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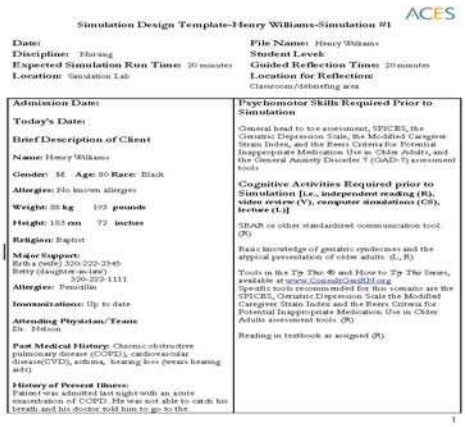
ACES

Simulation Design Template-Henry Williams-Simulation #1

Date:
Discipline: Nursing
Expected Simulation Run Time: 20 minutes
Location: Simulation Lab

File Name: Henry Williams
Student Level:
Guided Reflection Time: 20 minutes
Location for Reflection: Classroom/debriefing area

Admission Date: Today's Date: Brief Description of Client Name: Henry Williams Gender: M Age: 80 Race: Black Allergies: No known allergies Weight: 88 kg 193 pounds Height: 183 cm 72 inches Religion: Baptist Major Support: Ertha (wife) 320-222-2345 Betty (daughter-in-law) 320-222-1111 Allergies: Penicillin Immunizations: Up to date Attending Physician/Team: Dr. Nelson Past Medical History: Chronic obstructive pulmonary disease (COPD), cardiovascular disease(CVD), asthma, hearing loss (wears hearing aid) History of Present Illness: Patient was admitted last night with an acute exacerbation of COPD. He was not able to catch his breath and his doctor told him to go to the	Psychomotor Skills Required Prior to Simulation General head to toe assessment, SPICES, the Geriatric Depression Scale, the Modified Caregiver Strain Index, and the Beers Criteria for Potential Inappropriate Medication Use in Older Adults, and the General Anxiety Disorder 7 (GAD-7) assessment tools Cognitive Activities Required prior to Simulation [i.e., independent reading (R), video review (V), computer simulations (CS), lecture (L)] SBAR or other standardized communication tool (R) Basic knowledge of geriatric syndromes and the atypical presentation of older adults (L, R) Tools in the Try This ® and How to Try This Series, available at www.ConsultGeriRN.org Specific tools recommended for this scenario are the SPICES, Geriatric Depression Scale the Modified Caregiver Strain Index and the Beers Criteria for Potential Inappropriate Medication Use in Older Adults assessment tools (R) Reading in textbook as assigned (R).

1

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Simulation – 2

Occurs five days later – Henry is sitting in his wheelchair waiting to be transferred to the rehabilitation center where he will receive pulmonary rehabilitation

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Simulation – 2

He will need teaching, medication reconciliation, and a plan of care for his wife Ertha until an assisted living apartment is located and available for both of them

Simulation – 3

- Takes place 15 days later as Henry is awaiting transfer from the rehabilitation center. He received pulmonary rehabilitation including education on how to pace himself, how to take his medications, when to do his breathing treatments and when to contact the doctor.
- This scenario will include how Henry, Ertha, and the family have been dealing with the changes in their health and living situation.

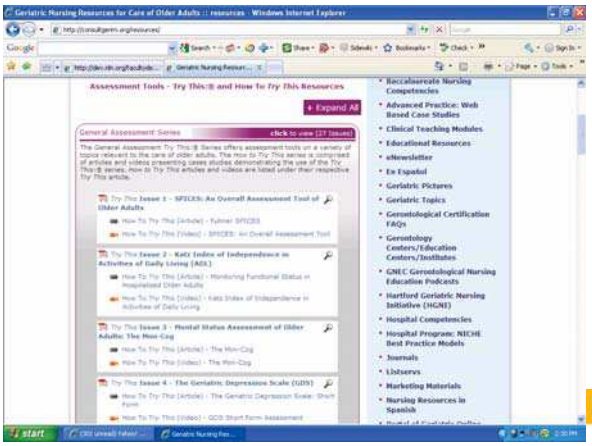
Discussion Questions

- What are your concerns about this patient?
- What is the cause of the concern?
- What information do you need?
- What are you going to do about it?
- What is this individual experiencing?

Adapted from Benner (2010) . *Educating Nurses: A Call for Radical Transformation*

Tool Kit

- Contains:
  - o Suggestions on how to use monologues
  - o Ways to adjust content to fit curriculum
  - o Ways to level unfolding case
  - o Use of the critical thinking questions
  - o Links to the best practice for geriatric care
  - o ACES Essential Nursing Actions



http://sirc.nln.org/

Let's watch a debrief of the Henry & Ertha simulation…

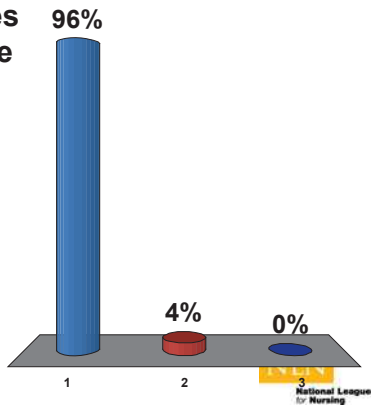
Finish the Story Assignment

- Opportunity for curriculum-specific activity
- Reinforces ACES beliefs about aging and about teaching
- Direct knowledge of older adults in planned, intentional encounters is necessary for nurses to promote human flourishing and to provide competent, individualized, and humanistic care

How do you think use of unfolding cases will impact the way you help students understand individualized care for older adults and care-givers?

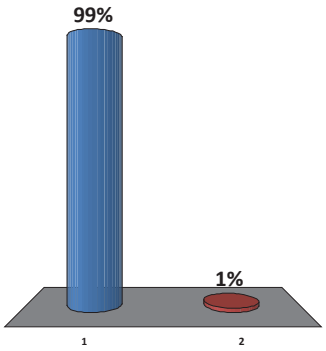
First person monologues as case studies improve student learning?

1. Agree
2. Neither agree nor disagree
3. Disagree



Has your opinion of unfolding cases changed?

1. Yes – I will use them in the future
2. No – I will stay with what I use now



Thank you – Questions?

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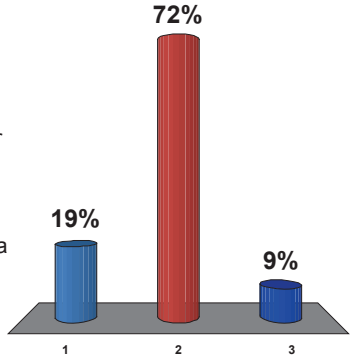
Complexity of Care: Geriatric Syndromes

Session III

What are Geriatric Syndromes?

1. Term developed by QSEN for older adult education competencies
2. Term used for clinical conditions that do not fit into a disease category
3. Medical diagnosis found only in older adults



What are Geriatric Syndromes?

- Term used to capture clinical conditions in older persons that do not fit into discrete disease categories
- Multifactorial health conditions that occur when the impairments of multiple systems overwhelm the person's homeostasis

What are Geriatric Syndromes?

- Specific signs and symptoms that occur more often in the elderly and contribute to mortality & morbidity.

Classic Geriatric Syndromes

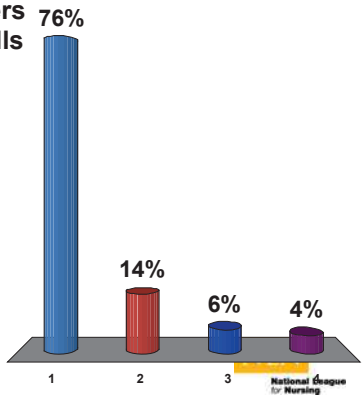
- Delirium
- Falls
- Incontinence
- Eating and/or feeding problems
- Sleep problems
- Skin issues

Evolving Geriatric Syndromes

- Sarcopenia
- Polyprovider
- Polypharmacy
- Pain
- Frailty

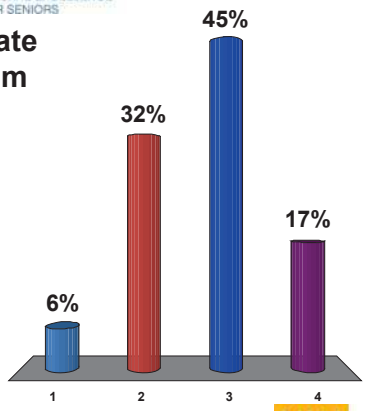
What % of primary care providers ask older adult clients about falls during a basic assessment?

1. 37%
2. 52%
3. 68%
4. 98%



What is the mortality rate one year after a delirium diagnosis?

1. 20%
2. 40%
3. 60%
4. 80%



Commonalities of Geriatric Syndromes

- Normal aging changes, multiple co-morbidities, adverse effects of therapeutic interventions
- 4 shared risk factors:
  - o Older age
  - o Baseline cognitive impairment
  - o Baseline functional impairment
  - o Impaired mobility

Why is the Concept of Geriatric Syndromes Important?

- Presents an avenue to address common and often debilitating conditions leading to hospitalizations
- Presence of these syndromes leads to:
  - o Frailty
  - o Increased mortality
  - o Longer hospitalizations
  - o Increased use of resources

Let's meet Maria…

Reflection

- **What evidence of geriatric syndromes did you hear as Maria told her story?**
- **What tools can we provide for students to assess geriatric syndromes?**

Remembering Geriatric Syndromes?

S P I C E S

Fulmer SPICES is a framework for assessing older adults that focuses on six common "marker conditions"

Sleep disturbances
Problems with Eating and /or feeding
Incontinence
Confusion
Evidence of Falls
Skin breakdown

SPICES

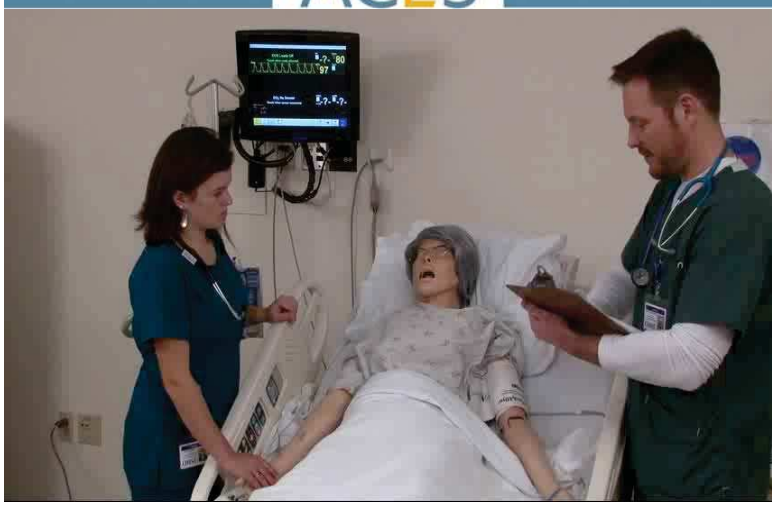
- Mnemonic is not intended to be all inclusive
- Tool to address the "vital signs" of an individualized assessment
- Provides an overall assessment of:
  - Care being given and patient response
  - Failure to progress in healing
- It points to the need for further assessment.

Assessment Tools

- SPICES
- Hendrich Ii Fall Risk Assessment For Older Adults
- Mental Status Assessment For Older Adults (Mini-cog)
- Geriatric Depression Scale
- Transitional Care Model
- Care Giver Strain

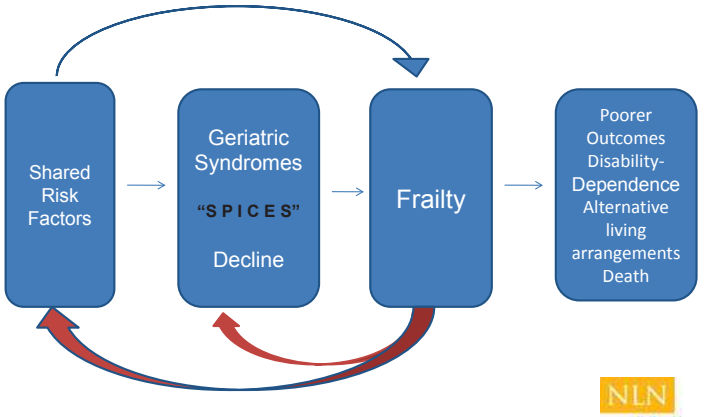
Teaching Geriatric Syndromes

Let's watch an ACES Simulation using Millie…



Reflection

How did the students use of SPICES assist them organize care to meet Millie's individualized needs?



Integrating Geriatric Syndromes Across the Curriculm

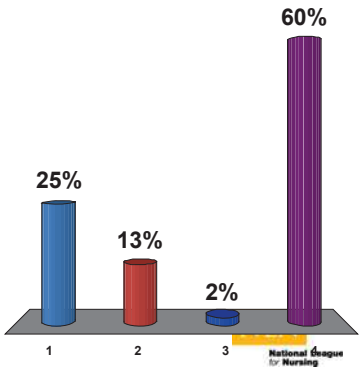
- Introduce **Geriatric Syndromes** in the first nursing course as a syndrome.
- Create intentional encounters that allow students to assess an older adult.
- Incorporate best evidence in practice about the syndromes into classroom and clinical education.
- Reinforce the assessment of geriatric syndromes in the context of multiple co-morbidiites and varied care settings.

Teaching Strategies

www.nln.org/ACES

Where do you plan to teach geriatric syndromes in your curriculum?

1. Fundamentals
2. Medical/surgical courses
3. Community experiences
4. All of the above



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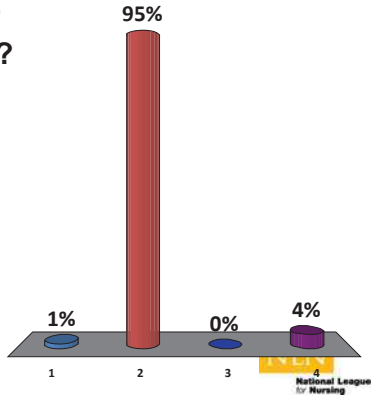
Coordinating and Managing Care During Transitions

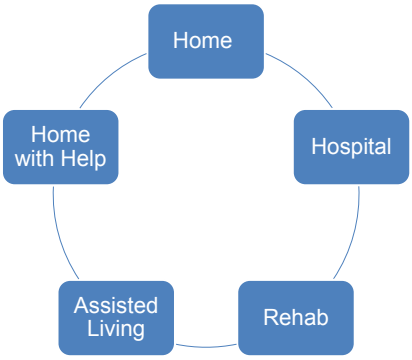
Session IV

Assess Function and Expectations	• Assess the older adult's individual aging pattern and functional status using standardized assessment tools. • Use effective communication techniques to recognize, respond to, and respect an older adult's strengths, wishes, and expectations. • Include findings of assessment of older adult's cognition, mood, physical function, and comfort to fully assess the individual aging pattern.
Coordinate and Manage Care	• Manage chronic conditions, including atypical presentations, in daily life and during life transitions to maximize function and maintain independence. • Assist older adults and families/caregivers to access knowledge and evaluate resources. • Advocate during acute exacerbations of chronic conditions to prevent complications.
Use Evolving Knowledge	• Understand geriatric syndromes and unique presentations of common diseases in older adults. • Access and use emerging information and research evidence about the special care needs of older adults and appropriate treatment options. • Interpret findings and evaluate clinical situations in order to provide high quality nursing care based on current knowledge and best practices.
Make Situational Decisions	• Analyze risks and benefits of care decisions in collaboration with the interdisciplinary team and the older adult and family/caregivers. • Evaluate situations where standard treatment recommendations need to be modified to manage care in the context of the older adult's needs and life transitions. • Consider the older adult's wishes, expectations, resources, cultural traditions, and strengths when modifying care approaches.

How easy is it for you to transition to a new job? Home? Change in plans?

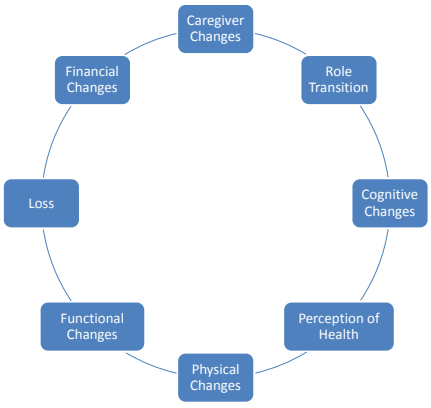
1. Piece of cake.
2. I need the details and some control.
3. I trust everything to others.
4. I would rather die than change.





Reflection

What other types of transitions have you seen in the older adults around you?

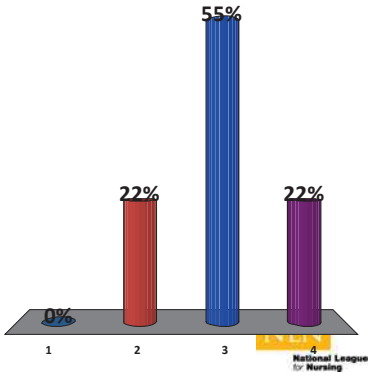


How is Transition Different than Discharge?

How Are Decisions Made When Transitioning?

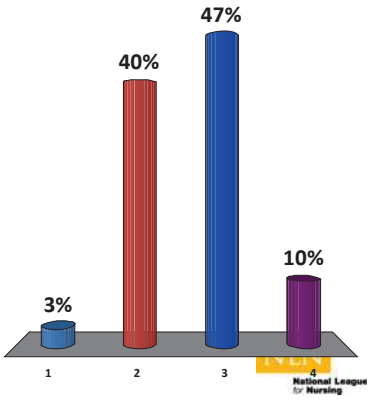
What percent of Medicare patients are re-hospitalized within 30-days?

1. 10%
2. 20%
3. 40%
4. 60%



How much do readmissions cost?

1. 25 million/year
2. 150 million/year
3. 800 million/year
4. 15 billion/year



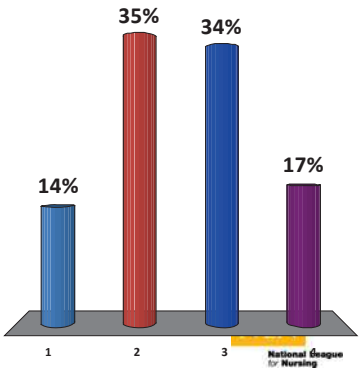
Causes of Poor Outcomes in Transitions

- Failure in Planning
- Failure in Communication
- Failure in Addressing Frailty
- Failure in Coordination of Care
- Failure in Patient and Caregiver Education
- Failure in client communication

Transitional Care Model

The re-hospitalization rate of older adults decreased by how much when the transitional care model was utilized?

1. 20%
2. 48%
3. 55%
4. 61%



try this: Best Practices in Nursing Care to Older Adults

The Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults

Transitional Care Model Screening Criteria

- Age 80 or older
- Moderate to severe functional deficits
- An active behavioral and/or psychiatric issue
- Four or more active co-existing health issues
- Six or more prescribed medications
- Two or more hospitalizations within the past 6 months

Transitional Care Model Screening Criteria

- A hospitalization within the past 30 days
- Inadequate support system
- Low health literacy
- Documented history of non-adherence to the therapeutic regimen
- Cognitive impairment

Let's watch a simulation of Julia and Lucy…

High stakes risks during transitions in a vulnerable population

Consider Risks in Relation to Benefits

Risks and Benefits in Transitions Across Care Settings

- Liability
- Weighing Risks & Benefits
- Documentation
- Discussions with client and family…..together

How do we prepare students to assist clients with situational decisions?

Start the discussion with…

- What is important to you?
- What risks do you see?
- Is there any way to modify these risks in light of what others have expressed as concern?
- Are you willing to take this risk to do the activity you want?

Best Practices for Safety

- Safe Medication Administration
- Safe Ambulation
- Safe Environment
- Safe Swallowing
- Safe from Harm

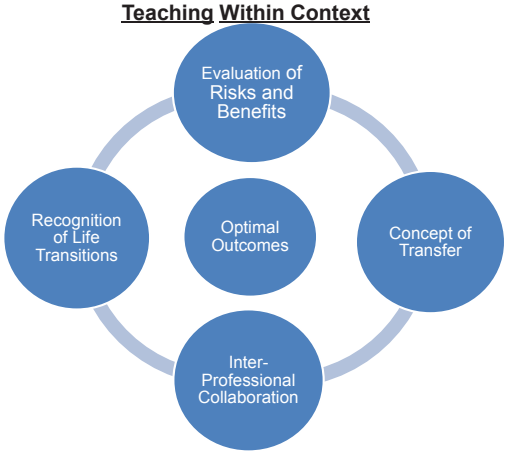
Are we creating a "Silo Effect" in the management of transitions?

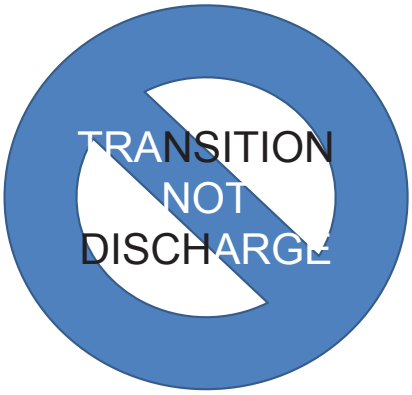
Let's watch a simulation of Julia and Lucy….

Reflection

What transitions are Julia and Lucy facing?

Teaching Within Context





ACES
ADVANCING CARE EXCELLENCE FOR SENIORS

Questions?

NLN
National League for Nursing

Innovations in Teaching: An ACES Workshop

A partnership of the NLN and Community College of Philadelphia

Funded by:
The Hearst Foundations
The John A. Hartford Foundation
The Independence Foundation
Laerdal Medical

Leading, Advancing, and Sustaining Care Excellence

Session V

What is Debriefing?

- A post-simulation experience
- Usually facilitated by faculty
- Crucial or pivotal to learning
- The “heart and soul” of simulation

Let's watch a debrief of the Julia & Lucy simulation…

Reflection

- What debriefing techniques were evident?
- What else would you like to discuss with your students?
- What is different in this approach about how students consider the care of older adults?

Sharing Your Ideas

- Posting a teaching strategy
- Creating a simulation using an unfolding case
- Writing an abstract

Applying for a Hearst Award

- Criteria
- Deadline
- Apply!

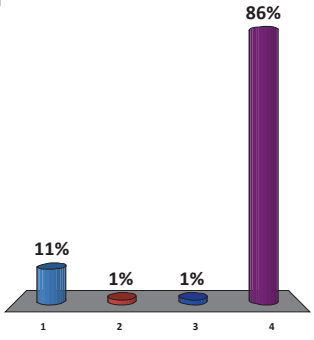
2012 Hearst Award winners from College of the Desert at 2012 NLN Summit.

What are the next steps?

- Evaluation of this Workshop/Survey for CE contact hours
- Webinars #1 and #2
- NLN Pre-Summit Workshop
  Invitational only for ACES attendees
- Publications/teaching strategies

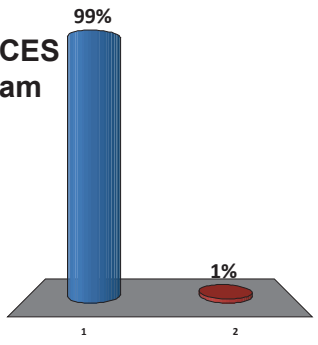
Which of these will you do?

1. Use the ACES unfolding cases
2. Create intentional encounters
3. Adapt current simulation activities
4. All of the above



I plan to use some component(s) of the NLN/ACES framework the next time I am teaching about the care of older adults

1. Yes
2. No



Sharing Our Practical Wisdom!

- What new thinking emerged for you from today's discussion?
- What is one thing you could try next week?

www.nln.org/ACES

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**	
	Look to Us for Consulting and More — **Pillsbury** ATI offers consulting for topics such as curriculum development, item writing, accreditation, faculty development and more. *Sponsored by ATI*	
8:00-8:30	**Check-in**	**Upper Lobby, Town Hall**
8:00-4:00	**Posters**	**Governors Ballroom**
8:30-10:00	**Together, the Future of Nursing Will Involve, Revolve & Evolve** — **Governors Ballroom** Donna Meyer, President of the National Organization for Associate Degree Nursing	
10:00-10:30	**Break**	**Lower Lobby, Town Hall**
10:30-12:00	**Transformation Realized! Prepare Your Students for Practice by Bringing Clinical Reasoning to Your Class** — **Governors Ballroom** Keith Rischer, Owner/President of KeithRN	
12:00	**Boxed Lunch Pick-up**	**Governors Ballroom**

Together, the Future of Nursing will Involve, Revolve, and Evolve

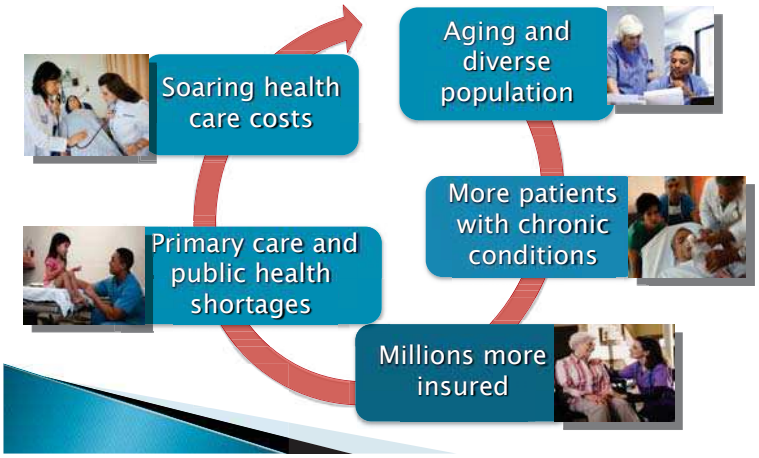
Minnesota Health Education Conference
April 25, 2014

Donna Meyer, MSN, RN
President
Organization for Associate Degree Nursing (OADN)

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.

HEALTH CARE SYSTEM CHALLENGES



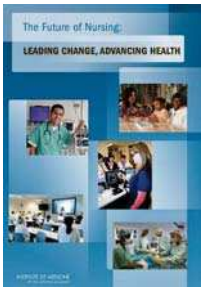
FUTURE OF NURSING: KEY MESSAGES

- 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

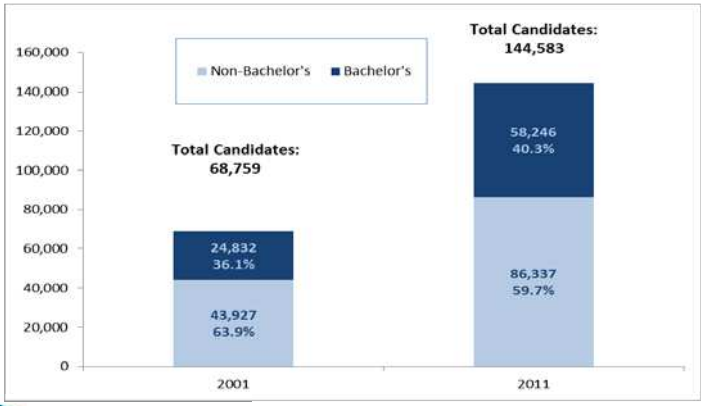
AARP'S CAMPAIGN FOR ACTION

- National initiative to guide implementation of the recommendations in *The Future of Nursing: Leading Change, Advancing Health*

- 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

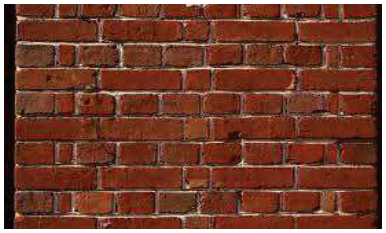
- Promising Solutions
  - Shared statewide or regional curriculum
  - Seamless progression
  - Community colleges granting BSN degrees
  - RN-to-MSN programs

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 SCHOOL

- Personal Barriers
  - Advancing age
  - Multiple role strain
  - Limited resources
  - Lack of confidence
  - Low expectations

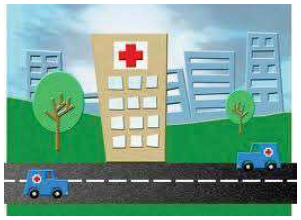


DISINCENTIVES TO RETURN TO SCHOOL

- Academic Institutional Barriers
  - Cost of education
  - Redundant curriculum
  - Not counting previous learning or experience
  - Lack of flexibility with scheduling
  - Faculty not responsive to needs of adult learner
  - 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
  - Lack of incentives to earn BSN
  - Lack of effective partnering with academic institution
  - Unsupportive institutional culture

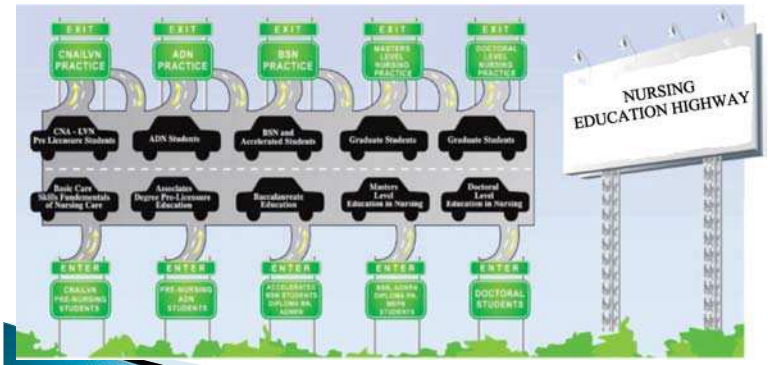


ISSUES RELATED TO THE 80/20

- 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 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
  - Can students be dual-enrolled?
  - Do all the pre-requisites align?
  - Are ADN/diploma students required to take more units?
  - Are students appropriately counseled?
  - 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 degree in nursing
    - Pay differential
    - Clinical ladder
    - Up front tuition reimbursement & stipends to reduce work hours
- Make it Possible
  - 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
  - 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.

INSTITUTE OF MEDICINE GLOBAL FORUM ON INNOVATION IN HEALTH PROFESSIONAL EDUCATION

- 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.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

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.

JOINING FORCES
TAKING ACTION TO SERVE AMERICA'S MILITARY FAMILIES

OADN President Donna Meyer invited to attend to represent Associate Degree Nursing at April 11, 2012, Joining Forces kick off in Philadelphia.

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

Robert Wood Johnson Foundation

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
  - Webinars
  - Guest Conference Attendee
- National League for Nursing
  - 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

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
- Nursing Organization Alliance Member

NURSING ASSOCIATION PARTNERSHIPS

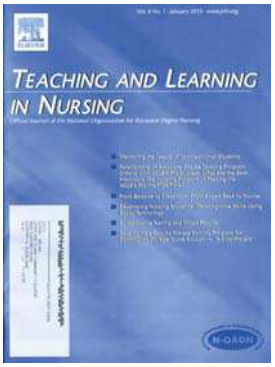
- American Association of Community Colleges
  - Affiliated Council
  - Workforce Commission
  - Presentation National AACC Conference
- Association of Community College Trustees
  - Presentation at National Conference

Alpha Delta Nu
Nursing Honor Society

Recognizing the Excellence of
Associate Degree Nursing Students

OADN Offers Many Benefits

- Teaching Learning Journal
- Webinars
- List Serve for Networking



MAKE PLANS
NOW!

CONTACT INFORMATION

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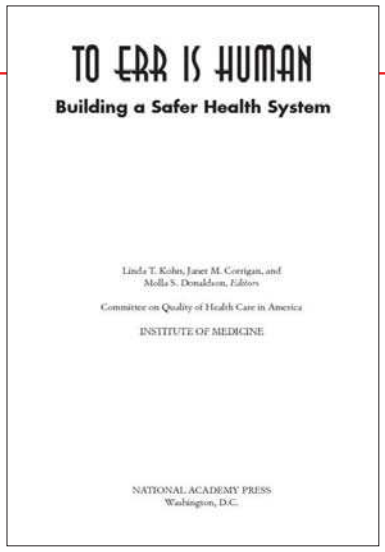
President, OADN
dmeyer@lc.edu

Transformation Realized!

Prepare Your Students for Practice by Bringing Clinical Reasoning to Your Classroom

Keith Rischer, RN, MA, CEN, CCRN
email: Keith@KeithRN.com
Website: KeithRN.com

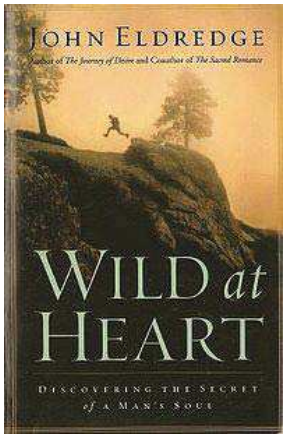
What Do You See…



My Journey…

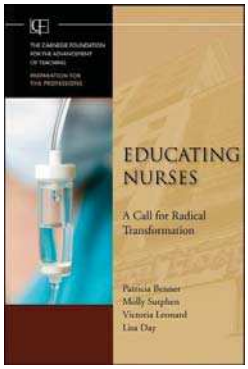
"Don't ask yourself what the world needs. Ask yourself what makes you come alive, and do that.

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 extreme changes in existing views, practices, or institutions



How do you Define…

- TRANSFORMATION
  - Complete or major change in 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

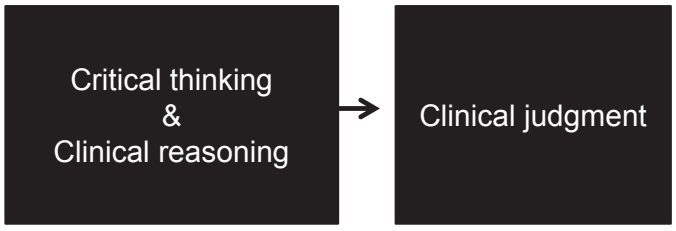
- CONNECT classroom & clinical
  - ✓ Make classroom rich, ACTIVE learning
- Decrease current fragmentation
  - ✓ BRIDGE current clinical/theory divide

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 **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?*

Clinical Reasoning Template: Providing Care

*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?*

"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 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."

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:

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:
RELEVANT Data from Social History:	**Clinical Significance:**

I. Fundamental Reasoning

I. Developing Nurse Thinking by Identifying Clinical Relevance/Significance

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:
RELEVANT Data from Social History:	**Clinical Significance:**

Lab/diagnostic Results:

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?
Sodium (135-145 mEq/L)		
Potassium (3.5-5.0 mEq/L)		
Glucose (70-110 mg/dL)		
Creatinine (0.6-1.2 mg/dL)		
Complete Blood Count (CBC):	**Current:**	**High/Low/WNL?**
WBC (4.5-11.0 mm 3)		
Hgb (13-16 g/dL)		
Platelets (150-450K 103/µl)		
Neutrophil % (45-75)		

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

RELEVANT Lab(s):	Clinical Significance:

II. Nurse Collected Clinical Data:

Current VS:	WILBA Pain Scale (0-10):
T:	Where:
P:	Intensity:
R:	Location:
BP:	Duration:
O2 sat:	Appearance:
	Alleviate:

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

RELEVANT VS Data:	Clinical Significance:

Current Assessment:	
GENERAL APPEARANCE	Resting comfortably; appears at no acute distress
RESP:	Breath sounds clear with equal air motion bilaterally, unobstructed respiratory effort
CARDIAC:	Peak, 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?

RELEVANT Assessment Data:	Clinical Significance:

III. Developing Nurse Thinking by APPLICATION of the Applied Sciences

Fluid & Electrolytes:

Lab:	Normal Value:	Clinical Significance:	Nursing Assessments/Interventions Required:
Value:	Critical value:		

Lab:	Normal Value:	Clinical Significance:	Nursing Assessments/Interventions Required:
Value:	Critical value:		

I. Fundamental Reasoning

Pharmacology:

Home Med:	Classification:	Mechanism of Action:	Nursing Considerations:

Dosage Calculation:

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

IV. Developing Nurse Thinking by Identifying Clinical RELATIONSHIPS

1. What is the RELATIONSHIP of the past medical history and current medications?
(Which medication treats which condition? Draw lines to connect)

Past Medical History/PMH:	Home Meds:

2. Is there a RELATIONSHIP between any disease in PMH that may have contributed to the development of the current problem? (Which disease likely developed FIRST that then began a "domino effect")

PMH:	What Came FIRST:
	What Then Followed:

3. Is there a RELATIONSHIP of a problem in your patient's PMH that contributed to the current primary problem?

Primary Contributing Problem:	Pathophysiologic Cause/Relationship to Present Problem:

4. What is the RELATIONSHIP between the primary care provider's orders and primary problem?

Care Provider Orders:	How it Will Resolve Primary Problem/Nursing Priority:

V. Developing Nurse Thinking by Identifying Clinical PRIORITIES

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

6. What nursing priority will guide your plan of care?

7. What interventions will you initiate based on this priority?

Nursing Interventions:	Rationale:	Expected Outcome:

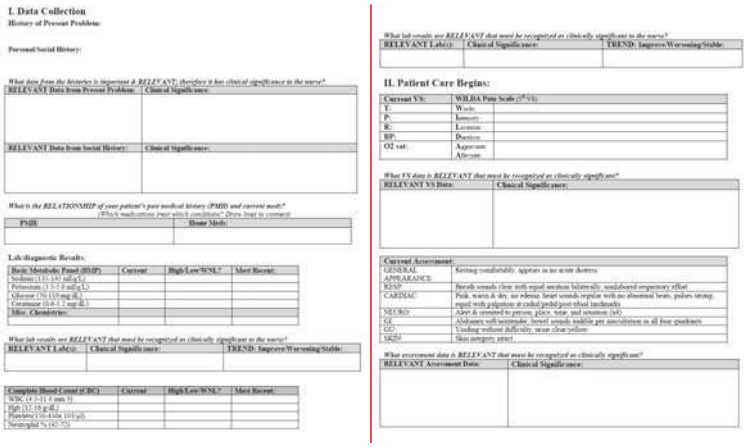
8. What educational discharge priorities have you identified and how will you address them?

VI. 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?

II. Rapid Reasoning



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:
RELEVANT Data from Social History:	**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:

Basic Metabolic Panel (BMP)	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:			

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

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

Complete Blood Count (CBC):	Current	High/Low/WNL?	Most Recent:
WBC (4.3-11.0 cmm !)			
Hgb (12-16 g/dL)			
Platelets (150-450x 103/ul)			
Neutrophil % (42-75)			

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

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

II. Patient Care Begins:

Current VS:	WILDA Pain Scale (0-10 VS):
T: (oral)	Words:
P: (regular)	Intensity:
R: (regular)	Location:
BP:	Duration:
O2 sat:	Aggravate:
	Alleviate:

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

RELEVANT VS Data:	Clinical Significance:

Current Assessment:	
GENERAL APPEARANCE:	Resting comfortably; appears in no acute distress
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?

RELEVANT Assessment Data:	Clinical Significance:

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

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

II. Patient Care Begins:

Current VS:	WILDA Pain Scale (0-10 VS):
T:	Words:
P:	Intensity:
R:	Location:
BP:	Duration:
O2 sat:	Aggravate:
	Alleviate:

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

RELEVANT VS Data:	Clinical Significance:

Current Assessment:	
GENERAL APPEARANCE:	Resting comfortably; appears in no acute distress
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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?

RELEVANT Assessment Data:	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

Care Provider Orders:	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:
Normal Range: (high/low/avg?)		Hourly rate IVPB: IV Push Rate Every 15-30 Seconds?	

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

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:

S ituation	
B ackground	
A ssessment	
R ecommendation	

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?

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

Care Provider Orders:	Rationale:	Expected Outcome:

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

Care Provider Orders:	Order of Priority:	Rationale:
	1 2 3 4 5 6	

Medication Dosage Calculation:

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Normal Range: (high/low/avg?)		Hourly rate IVPB: IV Push: Volume every 15 sec?	

Radiology Reports:

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

RELEVANT Results:	Clinical Significance:

Lab Results:

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

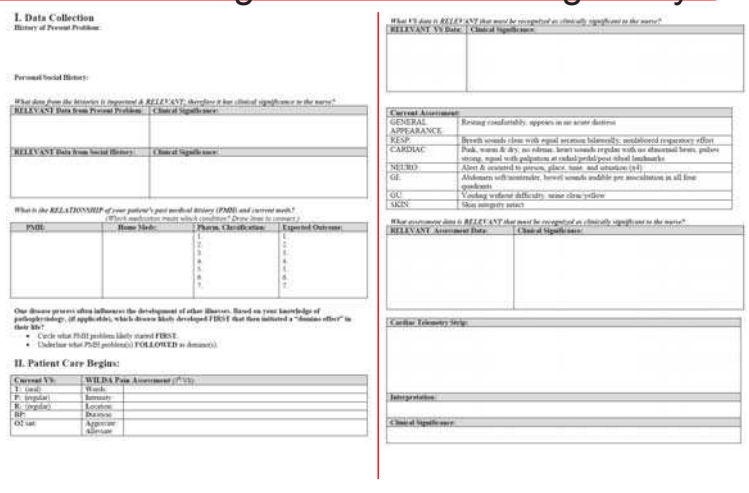
Complete Blood Count (CBC):	Current:	High/Low/WNL?	Most Recent:
WBC (4.3-11.0 cmm !)			
Hgb (12-16 g/dL)			
Platelets (150-450 x10x/ul)			
Neutrophil % (42-75)			
Band forms (3-5%)			

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

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

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?	Most Recent:
Sodium (135-145 mEq/L)			
Potassium (3.5-5.0 mEq/L)			
Chloride (97-105 mEq/L)			
CO2 (Breath) (21-31 mmol/L)			
Anion Gap (Adj) (7-16 mEq/L)			
Glucose (70-110 mg/dL)			
Calcium (8.4-10.2 mg/dL)			
BUN (7-25 mg/dL)			
Creatinine (0.6-1.2 mg/dL)			

III. Unfolding Clinical Reasoning Study:



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:
RELEVANT Data from Social History:	**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:	Pharm. Classification:	Expected Outcome:
		1 2 3 4 5 6 7	1 2 3 4 5 6 7

One disease process often influences the development of other illnesses. Based on your knowledge of pathophysiology, (if applicable), which disease likely developed FIRST that then initiated a "domino effect" in their life?

- Circle what PMH problem likely started **FIRST.**
- Underline what PMH problem(s) **FOLLOWED** as domino(s).

II. Patient Care Begins:

Current VS:	WILDA Pain Assessment (0-10 VS):
T: (oral)	Words:
P: (regular)	Intensity:
R: (regular)	Location:
BP:	Duration:
O2 sat:	Aggravate:
	Alleviate:

What VS data is RELEVANT that must be recognized as clinically significant to the nurse?

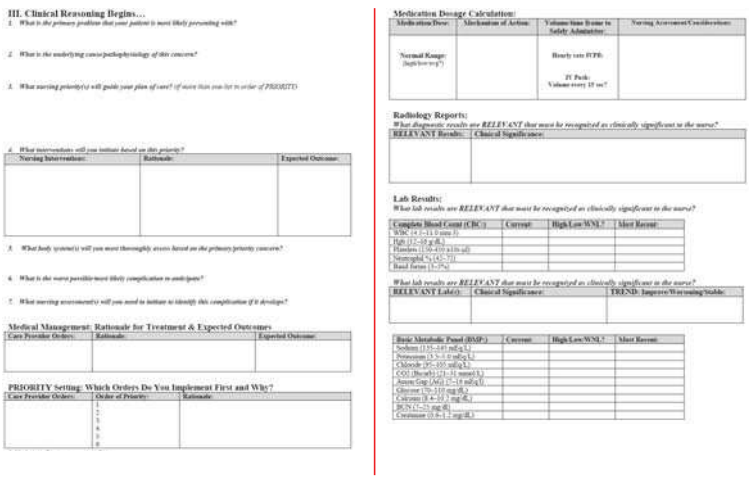
RELEVANT VS Data:	Clinical Significance:

Current Assessment:	
GENERAL 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 to the nurse?

RELEVANT Assessment Data:	Clinical Significance:

Cardiac Telemetry Strip:
Interpretation:
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

Care Provider Orders:	Rationale:	Expected Outcome:

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

Care Provider Orders:	Order of Priority:	Rationale:
	1 2 3 4 5 6	

Medication Dosage Calculation:

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Normal Range: (high/low/avg?)		Hourly rate IVPB: IV Push: Volume every 15 sec?	

Radiology Reports:

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

RELEVANT Results:	Clinical Significance:

Lab Results:

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

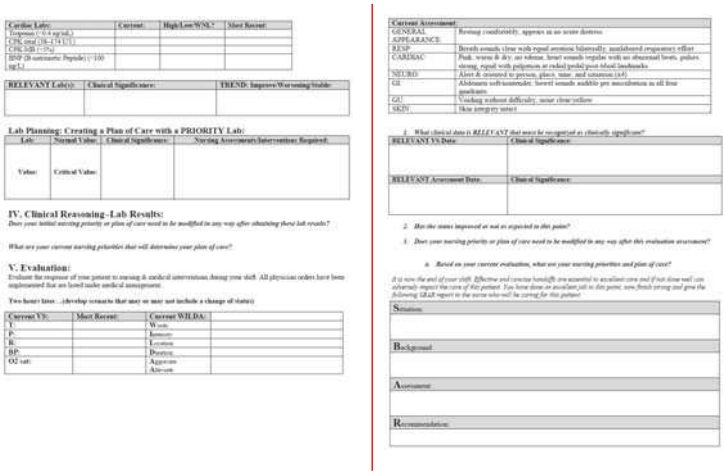
Complete Blood Count (CBC):	Current:	High/Low/WNL?	Most Recent:
WBC (4.3-11.0 cmm !)			
Hgb (12-16 g/dL)			
Platelets (150-450 x10x/ul)			
Neutrophil % (42-75)			
Band forms (3-5%)			

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

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

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?	Most Recent:
Sodium (135-145 mEq/L)			
Potassium (3.5-5.0 mEq/L)			
Chloride (97-105 mEq/L)			
CO2 (Breath) (21-31 mmol/L)			
Anion Gap (Adj) (7-16 mEq/L)			
Glucose (70-110 mg/dL)			
Calcium (8.4-10.2 mg/dL)			
BUN (7-25 mg/dL)			
Creatinine (0.6-1.2 mg/dL)			

III. Unfolding Clinical Reasoning Study:



Cardiac Labs:	Current:	High/Low/WNL?	Most Recent:
Troponin (< 0.4 ng/mL)			
CPK, total (38–174 U/L)			
CPK-MB (< 5%)			
BNP (B-natriuretic Peptide) (< 100 ng/L)			

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

Lab Planning: Creating a Plan of Care with a PRIORITY Lab:

Lab:	Normal Value:	Clinical Significance:	Nursing Assessments/Interventions Required:
Value:	Critical Value:		

IV. Clinical Reasoning–Lab Results:

Does your initial nursing priority or plan of care need to be modified in any way after obtaining these lab results?

What are your current nursing priorities that will determine your plan of care?

V. Evaluation:

Evaluate the response of your patient to nursing & medical interventions during your shift. All physician orders have been implemented that are listed under medical management.

Two hours later…(develop scenario that may or may not include a change of status)

Current VS:	Most Recent:	Current WILDA:	
T:		Words	
P:		Interact	
R:		Location	
BP:		Position	
O2 sat:		Aggress	
		Attitude	

Current Assessment:	
GENERAL APPEARANCE	Resting comfortably, appears in no acute distress
RESP	Breath sounds clear with equal aeration bilaterally; nonlabored respiratory effort
CARDIAC	Peak, 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

1. What clinical data is RELEVANT that must be recognized as clinically significant?

RELEVANT VS Data:	Clinical Significance:
RELEVANT Assessment Data:	**Clinical Significance:**

2. Has the status improved or not as expected to this point?

3. Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment?

a. Based on your current evaluation, what are your nursing priorities and plan of care?

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 in this game, now finish strong and give the following SBAR report to the nurse who will be caring for this patient:

Situation:
Background:
Assessment:
Recommendation:

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?*

2. *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 questions to situate this content/concepts to any case studies you build on your own!

Patient-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 this clinical presentation?
(QSEN-Patient-Centered care)

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?
(QSEN-Patient-Centered care)

How can you ensure that your patient is an active partner while under your care and promote self-care once they are discharged?
(QSEN-Patient-Centered care)

Teamwork and Collaboration:
What can you do to facilitate a safe and effective update/report to the physician or oncoming nurse?
(QSEN-Teamwork and Collaboration)

What would you do if you were not comfortable performing any new skill that was required to take care of this patient?
(QSEN-Teamwork and Collaboration)

Evidence-Based Practice:
As a new nurse, what resources could you utilize to provide current, evidence-based, and individualized care planning based on the needs of this patient?
(QSEN-Evidence-Based Practice)

Safety/Quality Improvement:
What would you as the nurse do if 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?
(QSEN-Safety/Quality Improvement)

Informatics:
What medical-electronic data bases 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 illness/surgery you have never seen before?
(QSEN-Informatics)

Optional 2012 National Patient Safety Goals Questions to Incorporate into Case Study

Identify Patients Correctly:
What are the two patient identifiers that I must use at my clinical site each time I administer medications?
(2012 National Patient Safety Goals—Identify patients correctly)

When should lab specimens that are collected by the nurse be labeled?
(2012 National Patient Safety Goals—Identify patients correctly)

Improve Staff Communication:
If any of my patient's lab results were "critical" or "panic values" what is the policy at my clinical site that guides me as to how quickly the physician must be notified?
(2012 National Patient Safety Goals—Improve staff communication)

Use Medicines Safely:
What can I do with my patient to promote and ensure that they take their anti-coagulants such as Warfarin safely and with no harmful consequences?
(2012 National Patient Safety Goals—Use medicines safely)

What are my responsibilities as a primary nurse when my patient is admitted to ensure that all of their home medications, dosages, and when last taken are accurate for the physician?
(2012 National Patient Safety Goals—Use medicines safely)

What are my responsibilities as a primary nurse when my patient is discharged to ensure that they are knowledgeable and compliant with their ordered home medications?
(2012 National Patient Safety Goals—Use medicines safely)

Prevent Infection:
What can I do before I go into my patient's room and before I leave that will dramatically decrease the risk/rate of infection?
(2012 National Patient Safety Goals—Prevent infections)

What are some practical, evidence-based practices I can implement to prevent infection due to multidrug-resistant organisms such as MRSA or VRE?
(2012 National Patient Safety Goals— Prevent infections)

What are some practical, evidence-based practices I can implement to prevent bloodstream infection due to central lines, including PICC?
(2012 National Patient Safety Goals— Prevent infections)

What are some practical, evidence-based practices I can implement to prevent surgical site infections?
(2012 National Patient Safety Goals— Prevent infections)

What are some practical, evidence-based practices I can implement to prevent indwelling urinary catheter infections?
(2012 National Patient Safety Goals— Prevent infections)

Universal Protocol for Any Invasive Procedure:
What is a "timeout" and what does it consist of that must be done before starting any invasive procedure?
(2012 National Patient Safety Goals— 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
  - **WBC**
  - 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
    - ✓ 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

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 painful, burning sensation when she urinates as well as frequency of urination the last week. It has been >90 degrees this past week. She usually drinks 2-3 glasses of liquid 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:

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 tub 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 lost 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:
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 prn
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:	TREND: Improve/Worsening/Stable:

Labs: UA

Urine Analysis (UA):	Current:	High/Low/WNL?	Most Recent:
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
Ketones (neg)	Neg		Neg
Bilirubin (neg)	Neg		Neg
Blood (neg)	Neg		Neg
Nitrite (neg)	Pos		Pos
LET (Leukocyte Esterase) (neg)	Pos		Pos
MICRO:			
RBC's (<5)	1		0
WBC's (<5)	>100		3
Bacteria (neg)	Large		Few
Epithelial (neg)	Few		Few

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

Vital Signs

II. Patient Care Begins:

Current VS:	WILDA Pain Assessment (5^{th} VS):	
T: 101.8 (oral)	**W**ords:	Ache
P: 110 (regular)	**I**ntensity:	5/10
R: 24 (regular)	**L**ocation:	Right flank
BP: 102/50	**D**uration:	Continuous/ongoing
O2 sat: 98% room air	Aggravate: Alleviate:	Nothing 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 APPEARANCE:	Resting comfortably, appears in no acute distress
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 tenderness to gentle palpation
SKIN:	Skin integrity intact

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

RELEVANT Assessment Data:	Clinical Significance:

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 IVPB…after blood/urine cultures obtained Morphine 2 mg IV push every 2 hours prn-pain		

PRIORITY Setting: Which Orders Do You Implement First and 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 IVPB…after blood/urine cultures obtained 5. Morphine 2 mg IV push every 2 hours prn-pain		

Pharm. & Dosage Calc

Medication Dosage Calculation:

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Morphine Sulfate **2 mg IV push** 4 mg/1 mL Tubex vial **Normal Range:** (high/low/avg?)		**IV Push Rate Every 15-30 Seconds?**	

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?

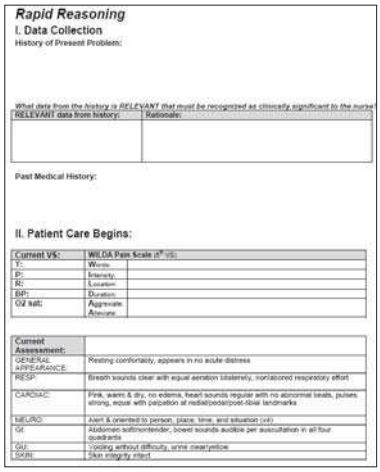
10. What can I do to engage myself with this patient's experience, and show that she matters to me as a person?

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 caring for this patient.

Situation:
Background:
Assessment:
Recommendation:

Time to Build Your Own…



Rapid Reasoning

I. Data Collection

History of Present Problem:

What data from the history is RELEVANT that must be recognized as clinically significant to the nurse

RELEVANT data from history:	Rationale:

Past Medical History:

II. Patient Care Begins:

Current VS:	WILDA Pain Scale (if VS)
T:	Words:
P:	Intensity:
R:	Location:
BP:	Duration:
O2 sat:	Aggravate Alleviate

Current Assessment:	
GENERAL APPEARANCE:	Resting comfortably, appears in no acute distress
RESP:	Breath sounds clear with equal aeration bilaterally, normalcored 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

One Student's Perspective…

"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."

Educator's Perspective…

- *"This format helps students to apply information 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.

1. 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
5. 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<u>. Fundamental Reasoning Activity</u>: 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:

No Student will **RISE** to **low** expectations. 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, not one 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.

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4. Hampton Robb, E. (1900). *Nursing ethics*. Cleveland, OH: E.C. Koeckert.

Notes/Reflections

Keith Rischer, RN, MA, CEN, CCRN

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?*

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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*_____

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RAPID Reasoning Case Study-STUDENT

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:**
RELEVANT Data from Social History:	**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:

Basic Metabolic Panel (BMP)	**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:			

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

RELEVANT Lab(s):	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?

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

II. Patient Care Begins:

Current VS:	WILDA Pain Scale (5th VS)	
T:	**W**ords:	
P:	**I**ntensity:	
R:	**L**ocation:	
BP:	**D**uration:	
O2 sat:	**A**ggreviate: **A**lleviate:	

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

RELEVANT VS Data:	Clinical Significance:

Current Assessment:	
GENERAL APPEARANCE:	Resting comfortably, appears in no acute distress
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?

RELEVANT Assessment Data:	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

Care Provider Orders:	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:
Normal Range: (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?

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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: