Preceptor Workshop Transcript

Hello and thank you for joining our preceptor workshop here at Bowling Green State University. I am Dr. Shelly Bussard, I am the Director for the School of Nursing as well as an associate professor for the BSN and RN to BSN program. Welcome to our preceptor workshop, we are excited that you have joined us and have decided to be a preceptor for our nursing students. This workshop will go through kind of our nursing curriculum, what are the aspects of the program, some of the rules and regulations by the Ohio Board of Nursing, and how you as a preceptor can help our nursing students to prepare for their role that they will be transitioning into in the very near future. So, we'll go ahead and get started.

The objectives of the workshop- so there are eight objectives, and hopefully you will feel I get through these eight objectives. This is a one-hour presentation, and that allows you to get one contact hour through the Ohio Board of Nursing as well. So first off we will discuss the BSN program at BGSU, we will describe clinical judgement and its relevance to contemporary nursing practice. Describe the state of the science related to clinical judgement and teaching for it. Identify ways that educators and clinical partners can collaborate to foster clinical judgment development in students. Identify two ideas to promote clinical judgment development with precepted students. Discuss evaluation strategies of nursing students in the clinical setting. Evaluate OAC 4723-5 rules and regulations related to preceptors of pre-licensure nursing programs. Create a plan for implementing clinical judgement skills in the precepted clinical experience.

So as you can see, this is a lot about clinical judgment as well as the Board of Nursing rules and regulations. And we'll get into clinical judgment – why that's so important in today's curriculum and today's nursing field. And so let's go ahead and get started with that.

First, I do have to disclose that this presentation is free from bias and commercial support.

For continuing education requirement, you must compete the entire workshop, complete the post-test, and the course evaluation to receive one continuing education credit. Instructions for receiving the CE will be at the end of the workshop. Now, disclosure: the post-test is not hard. It is not a post-test where you have to answer 10 NCLEX-style questions. It's really more of a "will you attest to working with clinical judgement with the nursing students", "what couple things will you do to help foster clinical judgement in the nursing students". So, nothing that's hard, it's just really what I want you to do here is to pay attention, take some notes, hopefully learn some new aspects of clinical judgment that not only can you use for your precepted nursing students, but also for new graduates as you're orienting them to the role of a new registered nurse. So, I hope that you'll be able to gain some great insight on that as well.

So I'm going to start with a video of the School of Nursing so you can get an idea of what we are and where we have grown in such a short period of time.

Video: School of Nursing

> Bowling Green State University made a commitment to launch a School of Nursing to help meet workforce needs. As a public university for the public good, we hope to educate more students and increase the number of nurses available for Ohio and the nation.
>
> We are promoting excellence in nursing through our new Bachelor of Science in Nursing at BGSU. Our mission is to graduate nurses with excellent clinical judgement skills, ready to transition into the workforce throughout Ohio and the nation.
>
> It is important to have access to realistic manikins, as it helps our students learn how to care for patients prior to going into the hospital or community setting.

In the skills lab, students practice skills such as wound care, vital signs, health assessments, hygiene, administering medications, inserting catheters, and any other skill that a student would need prior to taking care of a patient. In our simulation lab, we provide students with actual patient care scenarios, which really help them to develop their clinical judgement skills. In our simulation center and skills lab, we have a variety of manikins, ranging from static manikins all the way up to highly computerized manikins. These computerized manikins can breathe, they have heart sounds, lung sounds, they can speak, they have pulses, and they can blink. We even have a pregnant mother, who is able to birth a baby.

After the simulation scenario, students go to a debriefing session with their faculty and peers. During this time, they reflect on their experience and discuss what went well, and what they will do differently in the future. We can also do live streaming of these scenarios from one station to another, where students are able to watch each other – and through this, they are able to grow in their learning process.

A unique benefit to our program at BGSU is our focus on clinical judgment. We are committed to providing our students with excellent education, where they can take clinical judgment skills, truly "think like a nurse", and enter the workforce prepared to care for all patients across the lifespan.

Well hopefully you enjoyed that video that took you for a tour around our school of nursing. The school of nursing opened in July of 2020, and our BSN program started in August of 2021. So you can see there we have a beautiful lab space, a 23-bed skills and simulation space that spans over 2 floors of Central Hall at Bowling Green State University Main Campus. And we have 7 high-fidelity manikins -which you saw the geriatric one there in the video- as well as birthing mom, we have a pediatric one that was also in the video, we have a newborn baby, we have 5 adult manikins, and they range. The high-fidelity manikins essentially, like the video said, they have vital signs, heart sounds, lung sounds, bowel sounds; they can blink, you can change pupils, they have pulses. From head to toe, they have pulses so we can alter the strength of the pulses, the location – if we're looking at a scenario where maybe there's compartment syndrome, we can change the pulse on one side of the body. So there's a lot of variety of things that we can do there, but ultimately the goal there is to make the fidelity a "realistic patient" scenario, where the students can go in, take care of the patient and learn to think like a nurse (learn to use interventions, prioritize care, notice what's happening, recognizing cues) and then really be able to focus on a scenario that perhaps they never get to see in the clinical setting. We might learn about ischemic strokes in the classroom, but we may get to clinical setting and only 5 out of the 40 or 80 students actually get to take care of ischemic stroke, or get to see a stroke in the early stages of care. So in these types of scenarios, we're able to give our students experiences, scenarios, that they will see in the real clinical setting but they may not get to see while they're in nursing school.

So that's one of our focuses there with the high-fidelity manikins. We also then have what's called moderate-fidelity, as well as low-fidelity.

Moderate fidelity is kind of a right-in-between the low and the high (that's why it's called moderate, right?) – but it has some heart sounds and some lung sounds. It's got – you're able to do blood pressures on it, and it's just got some minor vocal sounds with it. It might just be able to say "yes" or "no" or moan – so if you're doing a pain scenario, the manikin we can have it moan or something like that. So, minimal but yet it does have some heart sounds and lung sounds so students can practice those basic skills.

And then of course we have the static manikins, or low-fidelity manikins, which many, many of us are used to doing from nursing school and those are our test trainers. So the bathing, the wound care, the mobility, the transferring, things like that that we're able to do in those situations. That is what we have in our lab. The other thing that we do in our skills lab is we video record all skills check-offs as well as the simulation scenarios. So you saw in the one video we do a live streaming, so we have students in our simulation lab and we're live-streaming

the scenario to one of our classroom settings or our debriefing center. And we might have 4 students watching another 3-4 students in the simulation center – they're learning based off watching what those other students are doing. They're critiquing, they're analyzing, they're saying "wow, this is what the patient's saying but the students in there aren't reacting, why are they ignoring that patient who's yelling out in pain?". You know, because sometimes we get very focused on what we're trying to do and we forget about maybe some of those basic clues that the patient is giving us. So while some students are watching that live-streaming, they're able to recognize things, they're able to prioritize, they're able to say "you know what? In this situation this is what I would do…". And then they do a debriefing session afterwards, where the faculty is talking about everything that happened in the scenario: what was the scenario supposed to be, did the students recognize what it was supposed to be, what were the outcomes of the situation, what would they do differently, what would they do the same. So we'll go through a lot of what that means in the debriefing and how you can use debriefing in the clinical setting as a preceptor for the students.

So here is our mission statement for the school of nursing.

Slide: Mission Statement

It's the mission of the BSN Program at Bowling Green State University is to prepare registered nurses to provide safe and quality person-centered care to diverse populations across the lifespan using evidence-based practice. Graduates will use leadership and clinical judgment skills to improve the spectrum of complex healthcare issues throughout Ohio, the nation, the world.

So just as a fun picture here, you'll see this our ribbon-cutting ceremony that we did back on August 17 2021 within our school of nursing and this was just some of the faculty that was there at the time. We have grown tremendously since August 17 of 2021. We have Dean Ciesla in the background, we have our associate dean Dawn Anderson, several of our faculty, advisors, and so forth that are there as well.

So our conceptual model of the school of nursing. So these are things that I'm sure you've heard of through the years, but to kind of just put some actual terminology to it, the outside of the circle you'll see clinical judgment. There's four phases of clinical judgment that are wrapping around the circle, we're going to talk about those in this workshop. So there's noticing, interpreting, responding, and reflecting. Those are the four phases of clinical judgment that we are teaching our students here at the school of nursing in every single course throughout the curriculum, whether it's theory, skills lab, simulation, or clinical. And I will go through all those steps with you so you can also incorporate that in your preceptorship as well as when you're orienting new graduates.

In the center of our circle, these are our components of the philosophy of our school. So the individual, family, community, environment, health, and nurse. We focus on all of those within our curriculum.

Then the next things are the QSEN which is the tan color here. QSEN is quality and safety for education in nursing. And the spokes of that, that are orange and brown, those are the competencies of QSEN and so we have those all embedded throughout our curriculum. So patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, informatics. So those are the QSEN standards, those actually came out of Case Western Reserve University um several mm I would say, I'm going to guess around 2007-2008, is when they did some research, and Case Western Reserve University was kind of the spearhead of that project and came up with QSEN and all of the competencies associated with that. So all of these competencies are embedded throughout courses, it might be one course, it might be all courses, might be some courses – but in some fashion, all of these competencies are in the curriculum.

And then on the left-hand side, this is -you should be familiar with this – ANA, the American Nurses' Association, and these are the scope and standards of practice. We use the fourth edition, which is the newest edition of the ANA book, and this is kind of a summary of the ANA scope and standards of practice. So, again these are some

competencies or standards that are embedded within our curriculum. So, advocate, ethical standards and professionalism, health and wellness, community and public health, equity and social determinants, technology and innovation, economics. So again, all of those concepts are embedded in our curriculum through some of the courses, all of the courses- again: theory, clinical, simulation, skills lab, we have incorporated those.

So that's our conceptual model, that is what guides our entire curriculum.

So "why clinical judgment?" you ask. So, clinical judgment, you know, many of us remember back in school where we talked about the word "critical thinking". Everything was, "you have to use your critical thinking skills", but yet nobody really truly can define what the critical thinking was. We would say, "oh you'll learn that as you gain experience. You'll learn how to think when you gain experience"

The definition of critical thinking to this day, when I look at it, I'm like "what does that even mean?". What really truly does "critical thinking" mean? So as years have progressed, researchers have gone out and they've said "okay what really truly is the way that we think as a nurse". So Christine Tanner developed clinical judgment and did a huge research project, synthesis of literature that was available, and in 2006 published her clinical judgment model. So the Tanner's Clinical Judgement Model. And that's what I have there on our conceptual model. It's the noticing, interpreting, responding, reflecting – those four phases. I'll show you an image of that in a minute.

<u>Slide</u>: <u>Why Clinical Judgement?</u>

So why Clinical judgment? So what we have found is – I say "we" because I've noticed it throughout my 17 years of teaching – but also what the large, the folks that are really in the trenches, in the NCSBN that create the NCLEX, the higher leadership positions, really noticed that new graduates when they come out of school, were really unprepared to take care of patients. They're unprepared to prioritize the care, they're not prepared to take care of 4-5 patients, they're lacking communication skills, collaboration, they're maybe afraid to talk to physicians or they're afraid to say "you know what, I'm noticing something but I'm kind of unsure of myself so I'm afraid to tell anybody". And so, what we've noticed also is that students get through the NCLEX exam, they pass their license, but it's a minimal competency. And that is what NCLEX is measuring – it's measuring a minimal competency to practice as a licensed nurse. And so NCLEX in the past ten or so years has really been looking into clinical judgment. So Christine Tanner published in 2006 the clinical judgment model. Since then many, many schools, many many researchers, have really dug into clinical judgment – what does that mean, how do we apply it to schools, how do we apply it to students, what are strategies to teach this clinical judgment – rather than the term "critical thinking". So it's taken years – like I said, this has been 2006. So it's taken years and years to implement this fully. But the NCSBN, again the National Council of State Boards of Nursing, they're the ones that create the NCLEX exam, they've been working on research for well over ten years where they've been developing test questions, different ways of testing students, and kind of looking at the metrics and analysis of all of this data.

This new NCLEX test is called "Next Generation NCLEX", it's being implemented in April 2023. So ten years in the making and what they're doing is, they're changing the way they ask the test questions. So what you and I took: multiple choice, select all that apply, hot spots, that type of thing… those are still going to be there. But what they're now doing is they're adding clinical judgment questions. So what that looks like is they are going to ask, they're going to give a case scenario. And on one side of the computer screen will be a case scenario, and the other side of the screen there's going to be six questions associated with the scenario. The scenario is going to build – so they might only be given part of the scenario for question number one, when question number two comes, they might have to go a click on another tab of the scenario, almost like it's an electronic health record, they'll click on another tab it'll have lab data, they'll click on another tab it'll have physician notes, another one will have nurses' notes, might have some diagnostics. They'll click on another tab and there's gonna be a whole 'nother day's worth of data that has been included. So this is called a clinical judgment measurement model. That's what NCLEX is using, clinical judgment measurement model and they are they just developed different

varieties of questions to help measure clinical judgement better than what they were doing previously. So this kind of goes back to me being an educator, I've been an educator since 2004, I've gone through so many NCLEX test writing workshops. What they have told us year after year after year was make the questions, make the stem of the question, as very brief, very succinct, don't put in extra words, don't put in the he's and the she's and the they and the age and the sex of the patient and the ethnicity of the patient – get rid of all of that. Give the nuts and the bolts of what the question is. So, you know, maybe the patient is in with multiple sclerosis and you want to prioritize the care of the patient – that's it. Now they're saying, we're going to give you a whole case scenario. And this is a 55-year-old woman who has been admitted to the hospital with a diagnosis of exacerbation of her multiple sclerosis. She has a history of, blah blah blah blah blah. Current medications are, and they list the medications. Here are her labs, here are her diagnostics. Prior to this, NCLEX said "don't do that". They wanted just very brief "bam, here's the question, here's your choices" and go. Well obviously what they have found is, you know what, we walk into a patient room, that's not what we're presented with. We are presented with an array of information. We have to walk into a room, we have to dig through and figure out what is happening in this patient's room. You know, it's not just "a patient in a bed with MS, period" and I have to prioritize my care. I have to look at my surroundings, I have to talk to the family, I have to look at the medication list, I have to think at the orders the physician has written, I have to think about the testing that the patient has coming on in two hours from now, what medications am I going to give, are they NPO, are they going to allowed pureed diet, what is happening, what is their mobility status, so all of that array of what's going on with the patient. As we know, we walk in the room and we have to think through those things very quickly. We don't have time to sit there and sort through the data and say "this is what I'm going to do this particular second" because NCLEX only asked me to prioritize the care for that one diagnosis. So NCLEX has realized over the past 10 years that asking questions like that, it's kind of just making the student not recognize all of the surrounding information. And so now they gotten rid of that and they're saying "nope, we're going to ask these questions in case-scenario format". So again, that is starting April of 2023, it's been in development phases for over 10 years. They've been trialing questions. Every student who takes the NCLEX, they do at least 10 practice questions, research-type questions, at the end of their exam. So these are questions that have gone through the rigor and the analysis over the past ten years to be implemented.

So here at the school of nursing, we are already on board. We have clinical judgment as our model, we have next-generation NCLEX embedded throughout all of our testing, and our students are going to be prepared and ready to go for April '23.

So hopefully that gives you a little background as to "why clinical judgment". that's the terminology that we are using, and that's the terminology I would ask that all preceptors use as well when they're talking to students. Students are not using the term "critical thinking"-"clinical reasoning". It's always clinical judgment. That's what they're focused on, terminology they're focused on as well.

<u>Slide: **Science**</u>

So some of the science – sorry about this slide, it's a little blurry, at least on my end. Um but some of the science here for clinical judgment. In 2005, Dr. Del Bueno published an article that said 35% of new graduates had clinical judgment. 35%. Come fast forward to 2021, Kavanagh & Sharpnack – 8% of new graduates had clinical judgment skills upon graduation. 8. That's disgusting. That is upsetting – it's hard to believe that students can graduate after two years of nursing school and not be prepared to enter the workforce. Now with that being said, the workforce demand is much higher than what it was 20 years ago, we know the acuity of our patients is much higher than it used to be, um the demand on the nurses, the timing, the fast pace, the new orders, the new medications, it's just constant change that's happening in the workforce. And so education does need to catch up to that. And just as evidence-based practice takes years and years and years to do, so does changing curriculums in education. So, the NCSBN with changing that NCLEX exam to measuring clinical judgment is now

going to improve what schools of nursing are able to produce. Yet, now with that being said, we will never be able to graduate an expert nurse – ever. So um we are trying to figure out where have our graduates been, what are the employers expecting, and how do we come and merge a little bit in the middle. We cannot graduate experts, it's not possible. We have two years with them, our job is to graduate a general nurse. That "generalist" nurse – whether they go to med-surg, critical care, OR, home health care, hospice care, outpatient setting, whatever that case may be – we can only graduate the generalist nurse. And then once they get into the workforce and get into their specialty area, that's where they're really going to start to learn more, and really develop their skills and knowledge set. But we really want to come together a little bit closer together on how we are addressing this.

So, this is some data – this is from Cleveland Clinic, what they have found. They started collecting data of new graduates in 2015, you can see their sample size from 2015; they had over 1200 graduate new nurses in the Cleveland Clinic system up through 2020 and year-to-date in 2021. As you can see, they are pretty consistent on their new graduate numbers. Opportunity of growth, this is the third column here. This is where – this is the opportunity of growth of their new graduates. And both columns here have the opportunity for growth. These are things that I think we as a school, you as a preceptor, can help our students do. This is what the Cleveland Clinic noticed on their new graduates. So, "recognizing urgency/change in patient condition" and then "problem management". Those are the two opportunities that they have found, based off they type of testing, the simulation scenarios that they use at Cleveland Clinic. These are the areas they have found year after year after year are opportunities for growth. Problem management seems to be the highest area for opportunity for growth, but really in all reality what that means is that recognizing urgency: they're able to recognize there's a problem with a patient; problem management, how do they manage that problem? So if we haven't recognized the problem, we're not going to be able to manage it. How are we able to help our students recognize problems early, so we can identify and manage the problem? So again, this left-hand column – I'm sorry, this right hand column, what it is showing is in 2015, 23% of new graduates had acceptable clinical judgment. Every single year, it has gone down, and 8% as of 2021 is where it was considered acceptable clinical judgment of new graduates. So we have a lot of work to do, and I hope that through the next few years as this next generation NCLEX comes out, schools of nursing are starting to really grab onto this concept of clinical judgment. I hope that this is going to improve, but it starts with each of us. It starts with the curriculum students come from, it starts with faculty, and it starts with you.

Slide: NCSBN: NextGen NCLEX-RN 2023

Alright, so this is the NCSBN: Next Generation NCLEX exam clinical judgment measurement model. So you can see here at the top of the picture it's kind of hard model to follow to be honest. But I'm going to start. They have various layers, and layer zero, this is where they have client needs, decision making, and they have clinical judgment here in this layer zero. And layer one, they're forming hypotheses, they're refining hypotheses, and they're evaluating. Layer three is – it's kind of almost this layer 2/layer three - it's right in between. These are the ones that we're focusing on in the school of how to help our students get to the point of clinical judgment. The first one here, recognizing cues, analyzing cues, prioritizing hypotheses, generating solutions, taking action, evaluating outcomes. Think back to that slide that I just said about from the Cleveland Clinic – opportunity for growth: recognizing urgency and a change in patient condition. That is recognizing cues and analyzing cues. Then they said, other opportunity for growth is problem management. That is prioritizing hypotheses and generating the solution and taking action. That's how I'm going to manage my problems. I have to first recognize and analyze, then I need to prioritize and generate a solution, and take action. Once I take action, I need to evaluate. So, those are the main components of the NCSBN model. Layer 4, this is looking at environmental factors and individual factors that affect our ability to recognize, analyze, prioritize, generate. So the environment, client observation, resources, their medical records. "Individual skills" is my knowledge, my skills, my specialty area – things like that, that help me to get to that ability to use clinical judgment.

At the bottom of the model is the nursing process - that has not gone away. In fact, the Ohio Board of Nursing requires nursing programs to include nursing process in any curriculum. So, it's not going away, it's not replacing, this clinical judgment model is not replacing the nursing process. In fact, it's kind of very similar if you look at the bottom. Assessment and analysis; that goes hand-in-hand with recognizing cues and analyzing cues. Planning and implementation- that's prioritizing, generating and taking action. And then evaluate. Kind of hand-in-hand and the NCSBN really wanted to make that clear, that the nursing process did not go away. It's a component of clinical judgement. And like I said, the Ohio Board of Nursing requires that we teach that.

There is a link down here if you wanted to get more information for NCSBN. They have a ton of resources; monthly/quarterly newsletters I think it's every Fall, Winter, Spring type thing. Newletters that go through NCSBN, give examples of test questions that the students will see. So if you're very interested in that, here's one of the links to the Spring Edition. https://www.ncsbn.org/public-files/NGN_Spring20_Eng_02.pdf

Slide: Tanner's Clinical Judgment Model and NCSBN Clinical Judgment Measurement Model

Alright, so, here is Tanner's Clinical Judgment Model along with the NCSBN's Clinical Judgment Measurement Model, and how they kind of correlate together. So this is Tanner's model in the blue and the yellow. Her four phases: Noticing, Interpreting, Responding, and Reflecting, those are in the yellow. What's in the blue is maybe just a few definitions, a few words to help figure out "what is noticing", "what is interpreting".

So noticing are these first things here. You're looking at the context, the background, the relationship of the patient. What are your expectations and what is the initial grasp of the situation? NCSBN calls that "recognizing cues". So you can go look and think of at that as noticing and recognizing cues go hand-in-hand.

Noticing – I'm getting report, right? I'm getting report from the off-going nurse, I'm looking at the medical records, getting this initial grasp of the situation. You're gaining your expectations – how many times in report you're already thinking through what are the expectation that when I go into this patient's room, what am I expecting to see? Am I expecting to see a patient who's alert and oriented and sitting up on the side of the bed? Or am I expecting a comatose patient? What are you thinking in that moment? And you need to ask your student, after they've received report, "what are your expectations when you walk in this room? What did you hear the nurse say in report? What is your initial grasp of the situation?" So those are some questions to think about when you're receiving report with your student. So get report on your four or five patients and then stop with your student before you even walk in a patient room and just say "ok, let's talk about what you noticed here in this situation. What did you hear? What is the background -the context – of the situation?"

The next is interpreting, and interpreting has actually several of the NCSBN's measurements. So interpreting, according to Tanner, is the reasoning: our analytic, intuitive, and narrative. It's reasoning. It's making sense of our data. I've noticed all this stuff, I've recognized cues, now I need to make sense of it. It's not okay for me to just stop at noticing and recognizing information. Now I'm interpreting and I'm making sense of it. So in this orange box over here from NCSBN, that means I'm analyzing the cues, I'm prioritizing my hypotheses, and I'm generating solutions. So what you're going to do with your students is, you're going to say "great, now we've just sat, we've gone through this patient, we've talked about what you noticed; What are we going to do with it?" What does this mean to you? So let's analyze this information. So alright, prioritize what you're going to do when you walk into that room. And generate some solutions for what you might see.

Responding is taking action. Okay, so, Tanner calls that "action", NCSBN says "taking action". Then we're going to get in to reflecting, that's the fourth phase of Tanner – that's evaluation. Reflecting is evaluating our outcomes, it's evaluating patient outcomes, it's evaluating our own personal outcomes as well. And so we'll talk about reflecting and what you can do for your students.

Slide: BSN Curriculum End-of-Program Outcomes

Alright so BSN Curriculum. These are our end-of-program outcomes. I'm going to have you pause the screen, pause this video, and read these end-of-program outcomes. But essentially this means at the end of our two years with our nursing students, this is what they will achieve. So go ahead and press pause now, and when you're done reading, press play again.

(Upon completion of the Bachelor of Science in nursing program, students will be able to: 1. Integrate principles of liberal education in providing care for culturally diverse populations across the lifespan. 2. Analyze the role of the nurse leader in quality improvement, interdisciplinary collaboration, and communication within an organizational structure. 3. Apply evidence in decision-making to improve patient outcomes. 4. Use information and healthcare technologies to inform patients and support a safe practice environment. 5. Examine quality healthcare through policy, social justice, and collaboration with multiple disciplines across diverse populations. 6. Evaluate principles of health promotion and disease prevention for individuals, families, and communities. 7. Integrate professional standards, care, values, ethics, altruism, and integrity when managing care.)

Slide: Curriculum: Juniors

Our curriculum for our Juniors. So we have a four-year curriculum for BSN students; the first two years are pre-nursing coursework, the second two years is the nursing curriculum. So when they come to us as a nursing major, they've already finished all pre-nursing work. That's your A&P, Biology, Chemistry, English, Writing, Psychology, Lifespan Development, Humanities, any of the Liberal Arts education.

When they come to us these are the courses they will take as a junior. First column here is their very first semester. So, "Clinical Judgment I" is a course specifically for teaching clinical judgment, nothing else – we're only focused on clinical judgment. They also have a "Nursing Foundations" (lecture and lab), "Health Assessment & Health Promotion" (lecture, lab, simulation, and clinical), "Evidence-Based Practice", "Communication & Professionalism", and "Introduction to Pharmacology". So that's their very first semester as a junior.

Second semester as a junior they continue with "Clinical Judgment II" course, that's where we're finishing up and applying all of the concepts we learned about in clinical judgment into patient scenarios. "Nursing Concepts I" (lecture, lab, simulation and clinical) – I'm going to talk to you about a concept-based curriculum very soon- but this is where our concepts content starts. We have a "Population & Community Health", 'Transcultural Healthcare", "Mental Health Nursing" (lecture, simulation, clinical), and "Pharmacology I".

Slide: Curriculum: Seniors

Our senior curriculum- so this is their third semester of their nursing curriculum. "Nursing Leadership", "Healthcare Informatics", "Nursing Concepts II" (lecture, lab, simulation, clinical), "Pharmacology II", and "Maternal Child Nursing" (simulation and clinical). So this "Maternal Child Nursing" is one of our courses we will have preceptors in. And here you see one of our students with a "baby" manikin.

So the fourth semester our senior year: "Nursing Concepts III" (lecture, lab, simulation, clinical), "Pharmacology III", "Practicum" -this is where students will be with a precepted nurse in a field of interest to them, with the goal that they will find a preceptor in an area that they will, yknow, maybe when they graduate they want to get into a hospital that they might want to work in when they graduate. So really great time for them to focus in on maybe a specialty, maybe as critical care, O.R., community health, whatever the case might be that they really want to focus in on when they graduate, and hopefully at the hospital that they want to work at. It's a great time for orientation, you're helping them transition to practice, gain the skills that they need. So those are the two precepted courses: the maternal child nursing and then the practicum. There's a "Transition to Practice" course, as well as "NCLEX Prep".

Slide: Concept-Based Curriculum

Definition of concept-based curriculum. So most of use have gone through a traditional-based curriculum where we sit through class, we learn disease after disease after disease, we look at the PowerPoints or whatever, however the teacher teaches, and it's bullet point, bullet point, bullet point. Here is M.S., here's the signs and symptoms, here's the cause, here's the diagnostic, here's the treatment, here's the medications, here's your nursing interventions. Here is epilepsy, signs and symptoms, the types of epilepsy, and so forth.

Concept-based curriculum is a little bit different. This is where we're taking a concept and we're building on it throughout their two years. So the concept might be mobility, concept could be health & wellness, it could be mood & affect, it could be perfusion, oxygenation. It's an overall arching concept that can be applied to many different situations. So if you think of perfusion, obviously that's blood flow. But perfusion can be applied to just checking vital signs. It can be applied to congestive heart failure, to MI, post-partum hemorrhage, a GI bleed, it can applied to many different things. But once we learn the concept of perfusion, and what it means to the body, then I can help the student apply it to different exemplars.

So they may never see an ischemic stroke patient in their entire two years of school. But if they know the concept of perfusion and what perfusion means to the brain, they should be able to apply it to any patient and if they see an ischemic stroke come through the door, they should be able to apply that concept of perfusion to that patient.

They may never have taken care of a GI bleed patient. But if they know the concept of perfusion and what hypovolemia means, hypervolemia means for (stagia? 39:10), they should be able to apply it to the situation.

And we build on the concepts semester-after-semester. So we start off more simplistic with the concept and we might touch base on mobility on every single semester but we're going to keep building on the knowledge base throughout each semester. So it's just they're trying to say concept-based curriculum, with research that is out there, improves clinical judgment, helps prepare them to take the NCLEX, and helps prepare them to take care of a variety of patients across the lifespan no matter what the medical diagnosis is for that patient once they know the concept.

So with that being said, when they come to clinical, you are going to want to know what concept is that they're focusing on. Now by the time they get to you, they should be, they should have covered every single concept within the curriculum, or just about every concept. But you'll want to kind of focus in on that, and say "ok, where are you at, what have you learned, what are you focusing on in class?" so that you can help them maybe get to that point of concept. So maybe they're focusing on the concept of perfusion, but they're focusing on it in a very acute stage, maybe as an MI-type patient or an acute stroke patient, or maybe they're talking about perfusion and then they're talking about post-partum hemorrhage. Maybe they're talking about sensory perception, and you have a child in the school system and they're doing hearing and vision screening. So they learned sensory in the classroom as an over-arching concept but what does that now mean to individual students throughout the school system? What does sensory perception mean to a elderly client you may have who is blind or deaf? What does that mean to the student? How do they take care of that sensory patient in the clinical setting that's 90 years old versus the 10-year-old child in the school system? So that's kind of where we're going to be with concept-based. I hope that makes sense.

Slide: Exemplars

And these are some of what we call, exemplars. So this is an example of perfusion. So the first one here, we have a pulmonary embolism. So we've learned about perfusion, if we don't have good blood flow, right, there's going to cause damage to the organs. So this first one is pulmonary embolism. We've talked about perfusion,

students understand perfusion from the very first semester, now as we build semester after semester, we're going to start bringing in exemplars. So these are things that students can say "alright, I'm talking about PE this semester, yes it affects oxygenation, but today I'm talking about perfusion". Next is an MI. Here we've learned perfusion for three semesters in a row, I am now in my last semester of my curriculum, and I am learning about MIs and how perfusion affects the heart. This third picture here is that of a GI bleed, so this is I believe this is in our senior third semester the students are going to learn about GI bleeds, maybe esophageal varices. "what does the mean? I know about perfusion, I know what the blood has to do" but now we have the exemplar of the GI bleed.

So when you're in clinical with your precepted students, talk to them about this. "What concepts have you learned?" Maybe, "What concepts do you feel like you're struggling with?". Maybe they're struggling with perfusion, oxygenation, sensory, and you can help them identify those with patients in the patient load that you have. You can help kind of dig in to those different varieties of exemplars for them.

Slide: Teaching Strategies

Alright, teaching strategies. So we use theory, skills lab, simulation lab, and clinical to help guide our teaching and we again use the concepts across all four of those. So if I'm learning a concept in theory, I'm going to transfer that concept over to skills lab, and they're going to learn it at the same time. So Tuesday they might be learning the concept of perfusion and learning how to assess pulses. When they get to the skills lab, they're going to do the psychomotor portion of checking pulses. When they get to the simulation lab, they might do a scenario where it's a patient who has poor perfusion, and maybe they have decreased blood flow to the peripheral pulses. And so then students would recognize that. When they get to clinical, the clinical faculty want to help them to focus on the perfusion and checking the pulses. Maybe the student has a difficult time checking those pedal pulses - which we all do in the beginning, right – or maybe it's the apical pulse and they're having a difficult time because it's an obese patient and they can't get to that apical pulse. So we're going to transfer that concept from theory all the way through skills, simulation, and clinical, across the entire week or over the next couple of weeks through each of the semesters.

So it's really important to know what concept the student is on in the classroom, in the labs, so that when you are with them in clinical, you are able to help them to build that knowledge. It's called a "theory-practice gap" and we're trying to bring that gap in. So think about when you were in school. You might have learned about ischemic stroke in the classroom, but you came to clinical and you were taking care of a total knee replacement. Or you were taking care of someone going down for an EGD. So there is a gap, right? You're learning this in the classroom but you weren't able to apply it to the clinical setting. So what we're trying really to do here is apply what you learned in the classroom and the labs, and apply it to clinical, all at the same time. You hear it, you see it, you think it, you do it: it's going to help cement the information better.

Slide: Theory

So again theory: that's what we're doing in the classroom, that's where we're building on their knowledge, we're going to teach content -the concepts – in the classroom, we're going to build that, we're going to teach the clinical judgment and then pull that into the skills lab/sim/clinical

Slide: Teaching Clinical Judgment: Noticing

So, teaching clinical judgement like I said there is four phases. The first phase is noticing, and what we use with – let me rephrase that. The first phase is noticing of clinical judgment. That coordinates to the NCSBN

measurement model of recognizing cues. So how do I help my students get to that point of noticing? Number one, I said at the very beginning we've taught critical thinking but we never could tell the student how to get there. Well, what we can do now is tell the student how to get to clinical judgement. What are the steps for you to get there? Noticing – I'm recognizing cues. That's great, how do you recognize cues? So these are some thinking steps that we teach the students to notice and/or recognize cues. So if you want to pause the screen and write these down, these are the four things that we teach the students. So, identify signs and symptoms; assess systematically and comprehensively; gather accurate information; and predict potential complications. Ok, those are the four thinking steps for them to get to noticing.

Go ahead and pause that; when you're done writing them down, go ahead and press play.

<u>Slide: Teaching Clinical Judgment (2): Interpreting</u>

So the next is interpreting: that's the second phase. And that correlates to the measurement model of analyzing cues, prioritizing hypotheses, and generating solutions. There are ten thinking steps involved with the interpreting phase, and these are: clustering related information, recognizing inconsistencies, determining the important information, judging how much ambiguity is acceptable, compare and contrast, manage potential complications, identify assumptions, set priorities, and collaborate. The end goal of interpreting is development of a plan of care. So that "nursing process" piece. We've already assessed – that was noticing- now we need to start planning our care: looking at those goals and our outcomes of what we're going to be doing.

So, again, you can pause your screen and write these ten steps down.

But these ten steps – really think about this if you're working with your student and you've talked to them about their noticing and you've finished report, you're going to say to them, "okay what did you notice? What was some assessment data that *(we'll go back a screen)* with noticing – what was the assessment data that the nurse gave us in report? What were some signs and symptoms that brought this patient into the hospital or the outpatient setting? What brought them here?"

So they're gathering this data. You can go to the EHR, we can gather accurate data – look at the ER report, the progress notes, the lab data. And then we need to talk to them – "okay what kind of things do we predict as potential problems here?" So this patient came in with a total knee replacement. They aren't mobile – they will not get out of bed. They will not bend their knee. They won't do their physical therapy. "What are some potential complications? Let's talk about them"

(proceed to "teaching clinical judgment: interpreting" slide)

When we get into that interpreting phase, now we're going to say "ok, we're going in, we've assessed this patient. Let's cluster some information – what makes sense with this patient?" What is like "I was expecting all of this based off report but now I've came into this room and boy that is not what I'm seeing" -recognizing inconsistencies.

What's important versus not important. You know, we have all this information in our hands, but what's really important and what am I going to use to take care of that patient?

Judging how much ambiguity is acceptable – we know that some patients, it's okay. Stroke patients, they have a blood pressure of 160/80, that's okay. They need that for perfusion to the brain. But 160/80 might not be okay for that 30-year-old patient who has esophageal varices, or something like that. So how much ambiguity is acceptable? And the students don't understand this part – they look at the "the textbook tells me 120/80 is normal anything over, that's not 120/80" they think is abnormal, and they can't think past that. So you have to help them figure out what's acceptable for this patient and why, and what's not acceptable for this patient and why. So help them dig through that process.

Compare and contrast – you've got this 50 year old patient with a GI bleed and this 90 year old with this GI bleed. Compare and contrast the two – what makes them the same, what makes them different.

Manage potential complications – so back to that knee replacement patient, where I predicted a potential complication, now what am I going to do to manage it? I've got to talk to that patient about getting out of bed. I've got to talk to them – do they have anticoagulants on board? What are we doing for blood clot prevention for them? What are we doing about educating this patient?

Identifying assumptions – what are our biases going into this room? What kind of assumptions do I have? How many times have you received report and they tell you they're a drug seeking patient? You immediately have a bias walking into that room. And you're going to treat that patient a certain kind of way. So let's identify those assumption before we walk into the room, so we can go in on a clean slate, per se.

Help the students set priorities. They've noticed, they're now interpreting, let's set priorities. Prioritize hypotheses.

And collaborate. Collaborate is very important – we know that our new graduates lack this ability to collaborate well with others, and it's just from a lack of experience. When we're in nursing school, we get very focused with the teacher, the student, and the patient. So when they are with you: perfect time to collaborate with other disciplines. Let them talk to the physicians; stand there right with them. Help guide them if need be. Or if they get real stumbled up on their words, just help them. But let them do the talking, let them collaborate, so they can learn that and figure out how to talk to someone else in another discipline.

<u>Slide: Teaching Clinical Judgment (3): Responding</u>

Alright, next is the responding phase of Tanner's model. This is the taking action. Here are our thinking steps – so again, you can pause this video, write down these four steps, and then come on back to me when you're done writing them down.

So thinking steps: delegating, communicating, teaching others, and these are our nursing interventions.

Help them delegate. What does that mean? Who can they delegate to? They've learned this, they know this, this is part of our standards and scopes of practice. They know what they can delegate, we've taught this over and over. But help them – because in a real setting, it's different than being in a book setting.

Help them communicate. We've been working on the communication with our students, but help them. Again, whether they're with a patient, with a family, with other nurses, other disciplines, help them. Give them opportunities to communicate with others.

Part of responding is teaching others. So we know that part of our job is teaching – so help them teach their patients and their families to know "what is health promotion activities". They're going home on a new medication, a new diagnosis, help them. Let them teach, guide them in their teaching, but let them do that and just give them some guidance.

And then their nursing interventions, those are them taking actions. But with those nursing interventions, we want to make sure *(see previous slide)* that we prioritize.

(*return to "Teaching Clinical Judgement slide 3: responding")*

<u>Slide: Teaching Clinical Judgment (4): Reflection</u>

And then our reflection. Our reflecting piece - Tanner says this is the key to developing clinical judgment. I always thought reflecting was stupid, to be honest. But it turns out reflecting is the key to clinical judgment. And I think some of us will probably recognize that we do this, without ever having to put the word into our terminology.

But, reflecting… we all do this, at the end of the day. We drive home, and we sit there and we think through our day. "I did this, and this patient did this, and this person said this and this happened and now I got to go back tomorrow, and when I go back tomorrow I'm going to have this patient again, and I remember that this patient did this, and so you know what the next time I go to see that patient tomorrow, I'm going to start my day by doing such-and-such or, I'm going to let them eat breakfast first because they were really grumpy without breakfast, so I'm going to let them eat breakfast first before I start their med pass". Or things like that – we all do this, we think about our day, and how we want to do something differently or the same the next day we go to work.

So this is reflection. Thinking steps for reflection: Reflection-in-action. That's reflecting in the moment. Think about this: How many times have you gone to put a foley catheter in and you contaminate your gloves? You recognized that. That's reflecting in action. I contaminated my gloves, I'm going to change them.

Reflecting on action, that's after the fact. So we're done with the day, we're done with clinical, we're on our ride home, we're reflecting on our day, reflecting-on-action.

Anything that we evaluate when we evaluate our outcomes, evaluate our data, that's reflecting. So when we're thinking about our patient outcomes, we are reflecting.

When we evaluate, we want to correct our thinking. So it's not okay to just evaluate, we want to evaluate to help us improve and correct our thinking for the future.

How do we reflect on action? It's not just the ride home. It is for you and I, because that's typically what we do. But for the student, we call that debriefing. You and I, in nursing school, may have called that "post-conference" – same thing, same idea, but now the terminology used is "debriefing".

Debriefing is a time to reflect; think about what happened in the clinical. Let the student talk about their day. Let the student say, "okay, that patient we had in room 1. Why did they do this? Why did they say this? Why that medication? What happened there? Why did this patient just code in the middle of the day totally unexpectedly? What just happened?" Talk about those experiences; let them talk about what it made them feel like. Let them talk about how they want to maybe change in the future. Let them talk about how they prioritize their care. Maybe they can talk about those interpreting steps – what did they "I compared this patient but why did I have two patients with the same diagnoses but they totally did something different?" Their medications were different – okay, great, time to evaluate with the student. Compare and contrast the information.

So take that time every single clinical experience. Take time to debrief with your students. I would ask that commitment today, to say "Yes, I will debrief every single clinical experience with my student". Because debriefing is reflecting. Reflecting is the key to clinical judgment. And that is our goal – to help our students develop clinical judgment.

Slide: Skills Lab

Alright, for our skills lab here, this is a picture just to show you some students who are practicing hygiene skills on our manikins. We again, all of our skills labs, it's not just the psychomotor skill that they're learning, but we're putting thinking patterns in. So if they're doing hygiene, we might actually give them a scenario. So this is a 90-year-old -well, not this patient particularly- 50-year-old patient who came in and they are paralyzed from the waist down. Simple scenario, but now they have to think about what they need to do. They have to predict

potential complications: does this patient have bed sores, are we going to look for that when we're doing hygiene.

Slide: Sim Lab

Our simulation lab -I did talk a little about that earlier- this is our high-fidelity simulation center, where we're able to provide those high scenarios to really get the students to think. This top right picture, this is our debriefing room, where we can livestream scenarios in. The students are sitting here, and this is an example of debriefing and talking to our students and helping them to really reflect on the experience and evaluate their outcomes as well as the patient's outcomes.

Slide: Clinical

So clinical – you want to know end-of-course outcomes, so you're going to get the syllabus for the course, so that you can know what the end-of-course outcomes are: what we are expecting of our students at the end of the course.

Concept-based teaching – we've talked about that. You're going to want to know what concept is that the student is working on, what might they want to work on, especially when we get into the practicum course. They're going to be across the board. They would have learned almost everyone concept in the curriculum at that point. So how can help them with maybe a concept they struggled on. Just talk to them about a variety of concepts.

You want to be the best role model that you can be for these students. They will emulate you. So if you are very a negative person, or a nurse who you're really frustrated throughout your day, and complaining a lot because you're overwhelmed with the volume of patients coming in and out, and the procedures and the medication lists… that's going to come off onto that student. So anything that you can do as a role model to really promote the profession is going to help them feel better and less burned out and less afraid once they enter the workforce.

Again, you're going to want to debrief and reflect. So please make that commitment today that you will do that at the end of each clinical.

And making sure to collaborate with faculty. You will have a faculty member who is kind of the overarching faculty of the clinical experience, that you will have her or his contact information, that you will be able to contact them if need be. For any questions, for any evaluation methods, struggles that you're having.

You might have some challenges with your student – it may not be all peaches and cream for them, it may be that you're really struggling. May be a student that calls off all the time, they aren't coming to clinical, they're always coming in late, leaving early, they're coming unprepared, they don't want to learn, they don't want to go to the patients. You're trying to work with them and role model the profession, and this is a student that doesn't want to listen to you. If you're having problems like that, please contact your faculty in charge immediately. Don't let that linger on for week after week after week. Just contact immediately and tell the faculty "hey, this is what I'm experiencing, can we talk about this?" And then that faculty will make sure to talk with the student and figure out what we need to do to make it a better experience for all people involved.

Slide: Clinical Activities to Promote Clinical Judgment

So clinical activities to promote clinical judgment: assist the student with gathering data, conducting assessment, and predicting complications. So that was the noticing.

After the student has “noticed”, talk to the student through the interpretation skills. So these are the things we’ve talked about for interpretation. So ask them to identify relevant vs irrelevant information, compare and contrast different patients. Maybe you have five patients that are all 80 years old, but they have different diagnoses. Maybe they’re all on the same medication, but they’re using it for a different reason because they each have a different diagnosis or past medical history. Maybe you have a diabetic patient who’s on gabapentin, but you also have an epilepsy patient who’s on gabapentin. Why the difference? Compare and contrast. Ask them about managing potential complications. What are they going to do? They predicted it in noticing, now how are we going to manage it? Help them set priorities. Ask them “first, what are your priorities?”. Ask them explain the rationale – “why are you prioritizing this way” and then give them some feedback. Help them to collaborate with other disciplines. Help them determine how much ambiguity is acceptable.

Help the student respond through nursing interventions, communication, teaching, and delegating as appropriate. Remember to role model your thinking process. Not only your actions and professionalism, role model your thinking. So, we think automatically. We walk in a room, and we’re able to do what we do without -I don’t want to say without thought because there’s a thought there – but we just do. So role model that. Say to the student, “I’m going to walk in this room, and I want you just to watch me” and maybe just think out loud so that student can hear what you’re thinking while you’re doing. You can explain that to the patient first, of course: “I’m going to role model my thinking to the student so I’m going to be talking out loud and telling the student what I’m doing when I’m doing it” just so the patient is aware. But that is a great opportunity to role model what you’re thinking to help a student learn how to think.

Assist the student with reflecting-in-action.

And then, again, do the debriefing.

Slide: Preceptors

So preceptors: you will have to have a recommendation letter from your employer, there’s a preceptor application form, we will do a license verification, we will look at your qualifications, you will have complete this workshop, you will receive an acceptance letter, and then student evaluations and preceptor evaluation. So the students will evaluate you, and you will evaluate the student.

Slide: Maternal Child Nursing Practicum (1:02:21)

Maternal child nursing: this is the maternal child and the practicum are the two courses that we are using preceptors in. What I will do is say to you right now, go ahead and pause this video, read this course description and the end-of-course outcomes – this is what you’re going to help the student do. Once you’re finished reading all that, go ahead and press play and we’ll move on to the practicum.

Slide: Practicum (1:02:47)

Practicum: here is the course description. This practicum is 135 clinical hours. This student will be with you for 135 hours, in a variety of experiences, learning really how to transition to practice. This is their very last clinical before becoming licensed nurses. So go ahead take time to read the description and the end-of-course outcomes. Press pause, and press play when you’re ready.

Slide: Ohio Administrative Code (1:03:17)

Alright, I am going over my one-hour time frame – I apologize for that. There's just apparently a lot to talk about.

So I'm going to keep going and we're going to talk about the Ohio Administrative Code. These are the rules and regulations that regulate nursing programs – we have to follow these, word-for-word, step-by-step, in order to have a school of nursing, a BSN program. These are the rules and regulations, the end.

This is the rule 4723-5 – I gave you the link here, or if you want to go on you can even go on to google and type 4723-5 and then you can say "OAC" and you will be able to go through and see all of the rules and regulations. But what I gave here are some definitions. So this one, this is directly word-for-word from the OAC – what is a preceptor? And this is the definition of a preceptor. Again, press pause, read through that definition and come back when you are done.

Slide: Ohio Administrative Code (2) (1:04:57)

The next set of definitions – "clinical course" and "clinical experience". What do those mean? These are the exact definitions from the rules. Go ahead and press pause, and when you're done, come back.

Slide: Ohio Administrative Code (3) (1:04:38)

Alright, the next two definitions are "conceptual framework" and "course objectives or outcomes". So we've talked about these but I would love for you to press pause, read through those, and come back when you're done.

Slide: Ohio Administrative Code (4) (1:04:49)

The next two are "curriculum" and "supervision of a nursing student in a clinical setting". Go ahead, read through those, and come back when you're done.

Slide: OAC 4723-5-10 (1:05:04)

Alright, the next OAC rule is 4723-5-10.

This is for preceptors, so this is very important for you to read through the rules as what is your responsibility, by law, as a preceptor to complete.

So a lot of these things are what is in the preceptor application, the recommendation letter, my verification of your license, you completing this workshop. These are the things that are going to help us meet this rule, 4723-5-10. So go ahead a press pause, and start reading through this one, and when you're done, we'll move to the next slide.

Slide: Rule 4723-5-20 (1:05:45)

The next one is 4723-5-20: responsibilities of faculty, teaching assistants and preceptors in the clinical setting. Here is the rule – I'll have you go to that link. Again, you can just put in OAC in your google bar, 4723-5-20 and it will take you to this link, and you can read through your responsibilities. So if you need to press pause and go to that link to read through that and then come back to us.

Slide: Highlights from 4723-5-20 (1:06:13)

These are the highlights from that particular rule. So hopefully you did press pause and hopefully you did go into that particular rule and regulation, but here are the highlights for that.

Preceptors shall supervise student practice by providing guidance, direction, and support appropriate to the clinical situation.

Supervision of a nursing student shall be provided for each clinical experience involving the delivery of nursing care to an induvial or group of individuals. Supervision shall be provided only by a faculty member, teaching assistant, or preceptor who meets the qualifications set forth in rule 10, which we just went through.

Alright so, the preceptor providing supervision shall at least have competence in the area of clinical practice. Competence – it used to be that you had to have two years. Now it's just saying competence, and that's why it is a recommendation letter by your director or charge nurse or whoever your boss is. That recommendation is telling us that you have competence to be a preceptor.

You are going to design your clinical experiences with the guidance of your faculty member. So you are going to want to know those outcomes of the course. What are those competencies or concepts that are being taught, so you can help to create that experience for the student.

So clarify the role of your preceptor, clarify the responsibilities of the faculty member, know the course outcomes, and then also experience the evaluation tool. I'm just going to briefly talk about that – you really are just going to be doing an evaluation of the student. It's just going to be a document – you're going to say yes or no, you're going to rate the student, and the faculty member will do the true evaluation of the student based on the feedback that you give.

Very important – you do no more than two nursing students at one time. You cannot precept more than two students at one time, according to the OBN rules, or the OAC rules. If your organization says something differently – I know I worked at one organization where they said preceptors can only do one student at a time – that's very important to know. So if you are not allowed to do more than two at your organization, please make sure we are aware of that otherwise we are going under the assumption that the OAC says two, and that's what we are allowed to do. But again, you need to let us know if your organization says less than that.

Slide: Evaluating (1:08:47)

Alright, so, evaluation. We are evaluating the student's ability to notice, interpret, respond, and reflect. That's what we want to evaluate -we are evaluating their clinical judgment.

Slide: Lasater Clinical Judgment Rubric (1:08:58)

We at the School of Nursing use this beautiful tool called the Lasater Clinical Judgment rubric. If you notice in this grey column, it says: effective noticing, effective interpreting, effective responding, and effective reflecting.

At the very top, they are giving a rating of exemplary, accomplished, developing, or beginning. Or goal for our students is, when they graduate, they will be in this accomplished category. This means that they have accomplished clinical judgment. They've accomplished noticing, interpreting, responding, and reflecting. They're not exemplary – they're not experts – I don't expect them to get to exemplary in all of these sections. My goal is for them to be accomplished. And that's what the research – Kathy Lasater is the one who developed this rubric, and she based it off of Tanner's Clinical Judgment model, and when she did her research, that's where she did her focus. When they graduate, they're at the accomplished level. And so, that's where we expect our students to be upon graduation.

So you don't need to sit here and go through this – this is what the faculty will evaluate students. I just want you to see, this is how we've incorporated evaluating clinical judgment from clinical and simulation into the curriculum. But your job will just be to evaluate the student by giving a one-page document that's going to explain how the student is doing in clinical, and then the faculty will put that all information into this rubric.

Slide: Preceptor Role (1:10:39)

So I think that we've gone through this pretty thoroughly. So your preceptor role is to guide, communicate, educate, motivate, role model, prepare them for transition to practice, find experience related to course outcomes, ask students what concepts they're working on in class, help them develop clinical judgment skills, provide feedback to the student regarding strengths and weaknesses, and provide the weekly evaluation.

Slide: Evaluation (1:11:08)

Student evaluation by preceptor: this is what you're going to provide on a weekly basis. The student is going to submit this. So if you want to fill this out at the end of the day and give it to the student, you can do that. If you're not comfortable doing that, which if you have negative feedback or a negative evaluation, you may not feel comfortable giving that to the student, and that's okay – you can fill it out and email it to the faculty member that you will have a contact for, and then we can take it from there.

So if you're comfortable and you want to give it to the student, this is a really good time to provide the feedback to the student regarding their strengths and weaknesses. So through this evaluation, this is good time to do a debriefing, it's a good time to reflect on the week and say "okay, here this what we've done all week, this is your strengths or weaknesses, you're excellent here, you're satisfactory here, but we need to improve on this particular aspect". So this is a really good debriefing tool that you can use for the student. As long as you're comfortable doing this form and giving it to the student, that's what I would ask for. And then the student will upload it into their canvas, our learning management system, where it goes into their gradebook. If you don't feel comfortable, you can give it to the faculty.

Slide: Debriefing (1:12:30)

So Debriefing -we've talked about this – this is where I really hope that you will say "Yes at the end of every clinical day I will debrief with my student".

Reflect on their day.

Reflect on their decision making. Did they good decision making or not? And if not, why? And what are we going to do different? How are we going to learn from this?

Evaluate their thinking.

Reflect on the situation and how it was handled.

What lessons were learned?

Was thinking correct, or faulty?

Self evaluation.

So these are some questions or guides that you can use to help with your debriefing. So you can go ahead and press pause and write these down. And then, maybe use these to help you form your questions for the debriefing session. Debriefing is hard – I'm not going to lie, I struggled with debriefing in the beginning of time,

because sometimes students don't want to talk. And so, it was really a challenge to get them to talk with me, and so over time, using questions like this may help guide you until you really feel comfortable.

So if you want to press pause, write these down as your guide to debriefing, go ahead and do that, and then come back to us.

Slide: Stop (1:13:47)

Alright- so next thing we are going to do is STOP and we're going to create a plan for implementing clinical judgment skills with your students.

So I'm going to ask you to create your plan. At the end of this, what will you do for your plan? I would like you to write that down. And maybe it's going back through your notes and looking at all of those skills and those competencies for the noticing, interpreting, responding, reflecting. Maybe it's taking all of those and saying "based on my nursing unit that I work on, these are the things that I can do with my students". And make that plan of action for yourself – how will you help your student in your individual unit to develop clinical judgment.

So I just ask that you stop at this point, and create that. And when you're done, you can come back to us.

Slide: Post-Test (1:14:37)

Alright, so next thing we'll do is complete the post-test and evaluation of the workshop. On the next slide, I will have a QR code that you can do the post-test and the evaluation form. It should take about 5 minutes or so to complete that – if you don't have a phone and you don't have a QR, here is the link at the very bottom of this slide that you can type into your url address to complete the evaluation.

And here is the QR code – so you can press pause and take a picture of that QR and it will take you directly to the evaluation. And then the contact hour will be emailed to you upon completion of this course.

Slide: Conclusion (1:15:31)

Alright, so that is our workshop for preceptors. I hope that you enjoyed this. I hope that you learned a lot. I hope that these are skills that you can take not only with your preceptorship but also into orienting new faculty or nurses that come into your organization. I hope that you can take these ideas of clinical judgment and use that to help your new graduates as they progress. Because you're getting them in the end of their schooling, but this is exactly how they're still going to be as a registered nurse and transition to practice. So I hope you can take this and use this as you orient your new nurses on the floor.

Thank you very much – if you have any questions, please contact myself or AJ Wright. AJ is our clinical placement & partnership coordinator, so if you have any questions you can contact either me or him, and we would be happy to answer any questions that you have.

Thank you!