

CHAPTER THREE

INFLUENCING HEALTHCARE QUALITY: EDUCATING PATIENTS, NURSES, AND STUDENTS

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Education is a critically important enterprise to the healthcare system and is presumed to directly affect the quality of patient care, systems functions, and institutional efficiency. It can be expensive to develop quality education programs and also expensive to educate poorly. High costs associated with a failure to educate include the select liabilities associated with failures in practitioner competency, deteriorating health of patients unable to adequately manage self-care activities due to knowledge deficiencies, and poor publicity or civil suits associated with discriminatory practices or privacy violations in part based on underlying knowledge gaps.

Traditional modes of formal staff education and inservice programming include classroom lecture, continuing education articles with posttests, and unit-based workshops. For the most part, these learning opportunities are packaged in a one-size-fits-all format with little attention paid to experience, age, preferred learning style, culture, or gender. Learning disabilities are rarely, if ever, considered.

Staff is assigned or compelled to attend programs deemed as “mandatory.” Programs are offered while nurses have colleagues cover their patient assignment, and attendance is often poor. Educators, including CNSs, charged with providing these programs lament the poor participation and the low rate of return on the expensive investment of time while administrators insist on repeated program offerings to increase attendance figures and demonstrate competence to satisfy accrediting and regulatory agencies and to reduce liability exposure.

66 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

CNSs also teach patients and families, either directly or indirectly. Patient education concerns differ from those of staff, and yet there are commonalities. Classroom-based instructional programs for patients, families, and community residents are not uncommon. Teaching experiences often follow established routines, including the use of pamphlets, videotapes, and lecture with pretest/posttest evaluation designs. Attendance at post-discharge or preadmission programs is often sporadic, and healthcare professionals decry the perceived disinterest or other barriers to learning. Discharge teaching is offered quickly and supplemented by printed instructions, perhaps designed with grade-level readability in mind but perhaps without consideration of overall health literacy concerns.

Nursing students, particularly undergraduates, are taught in clinical settings and are influenced either directly or indirectly by CNSs, who facilitate a context of learning within the institution or who teach as adjunct faculty, instructors, or professors of nursing. CNSs may teach as they have been taught using traditional methods of instruction in tried-and-true formats. These teaching strategies may include preconferences, postconferences, or instructor-directed labs and lectures. CNSs are in an ideal position to teach nursing students because their advanced practice role ensures a current knowledge base and the wherewithal to recognize and promote safe clinical decision making. However, many CNSs are unfamiliar with the role of the adjunct faculty member and its associated responsibilities, including processes of student evaluation. They may also be unfamiliar with active teaching strategies, including problem-based learning. CNSs may also be unaware of the cutting-edge topics addressed in nursing education literature.

Relatively new computer technologies are affecting several of these scenarios in positive ways. Web-enhanced learning, intranet opportunities, and smart classrooms are enhancing the attractiveness of education programs by engaging learners in a variety of instructional modalities that appeal to multiple senses. The need for real-time education is minimized, and nurses can take advantage of learning at a time that suits individual schedules. The World Wide Web has dramatically increased the amount of information available to patients, families, and staff. While patients are satisfied with the easy information access, professionals worry about misinformation and overwhelming volumes of data. Many hospitals offer patients, families, and community residents opportunities to access health materials via learning laboratories and public computer stations.

This chapter addresses issues relevant to the education component of CNS practice. Many CNSs, prepared as such, are practicing in staff development roles within nursing education departments. CNSs working within a product line or Care Program practice arrangement also find themselves participating in or orchestrating programs for nursing staff, patients/family, community, multidisciplinary team members, and other individuals operating within the healthcare system. Many CNSs also teach undergraduate or graduate students of nursing. CNSs with doctoral preparation are often employed as professors of nursing, with some having opportunities to practice in joint arrangements with clinical affiliates.

Patient and Community Education

A Description of the Challenge: Literacy in the United States

Nurses are generally aware of the complexities of the English language and recognize that it is a difficult language to master, particularly once people have reached adulthood (Table 3-1). Becoming literate is a more challenging endeavor than the acquisition of conversation skills (Figure 3-1). Health literacy is related to language literacy but is different, both in its components and its usages. Health literacy is an important concern with significant implications for CNS practice.

Many CNSs are involved in patient education programs, either inpatient, outpatient, or through public health initiatives. This involvement requires CNSs to have a clear understanding of health literacy and its influence on patient education. CNSs are often familiar with literacy concerns specific to readability and grade level of written materials but may not have a clear grasp of the enormity of the literacy problem in the United States.

The National Assessment of Adult Literacy (NAAL) was conducted in 2003 to assess English literacy among a nationally representative probability sample of American adults age 16 and older. Data were collected from over 19,000 adults. Subjects were solicited from homes and prisons, both federal and state. NAAL results were compared to results of The National Adult Literacy Survey (NALS) conducted in 1992 by the Educational Testing Service (ETS) at the request of the U.S. Department of Education (USDOE) (The American Literacy Council [ALC], 2006).

68 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students***Table 3-1** REASONS WHY THE ENGLISH LANGUAGE IS HARD TO LEARN

1. The bandage was wound around the wound.
2. The farm was used to produce produce.
3. The dump was so full that it had to refuse more refuse.
4. We must polish the Polish furniture.
5. He could lead if he would get the lead out.
6. The soldier decided to desert his dessert in the desert.
7. Since there is no time like the present, he thought it was time to present the present.
8. A bass was painted on the head of the bass drum.
9. When shot at, the dove dove into the bushes.
10. I did not object to the object.
11. The insurance was invalid for the invalid.
12. There was a row among the oarsmen about how to row.
13. They were too close to the door to close it.
14. The buck does funny things when the does are present.
15. A seamstress and a sewer fell down into a sewer line.
16. To help with planting, the farmer taught his sow to sow.
17. The wind was too strong to wind the sail.
18. After a number of injections, my jaw got number.
19. Upon seeing the tear in the painting I shed a tear.
20. I had to subject the subject to a series of tests.
21. How can I intimate this to my most intimate friend?

Source: Plain Language Action and Information Network (PLAIN) (2006). www.plainlanguage.gov

NALS was conducted in three parts and included a national survey of 13,600 people, a 12-state survey of 1,000 people per state, and a prison survey of 1,100 inmates incarcerated in 80 federal and state prisons. Respondents were scored in three areas: prose, document, and quantitative literacy. The results were ranked into five levels ranging from least to most proficient as designated by Level 1 through 5 (ALC, 2006).

A comparison of NAAL to NALS results provides a decade point progress indicator for national adult literacy. CNSs should be aware of these results, as they provide a meaningful description of challenges specific to health literacy and support the need for professionals in the health-care system to carefully consider the average skill set of the nation that is dependent on it for services. The NAAL has several components that examine the breadth of adult literacy (NAAL, 2006a) (Table 3-2).

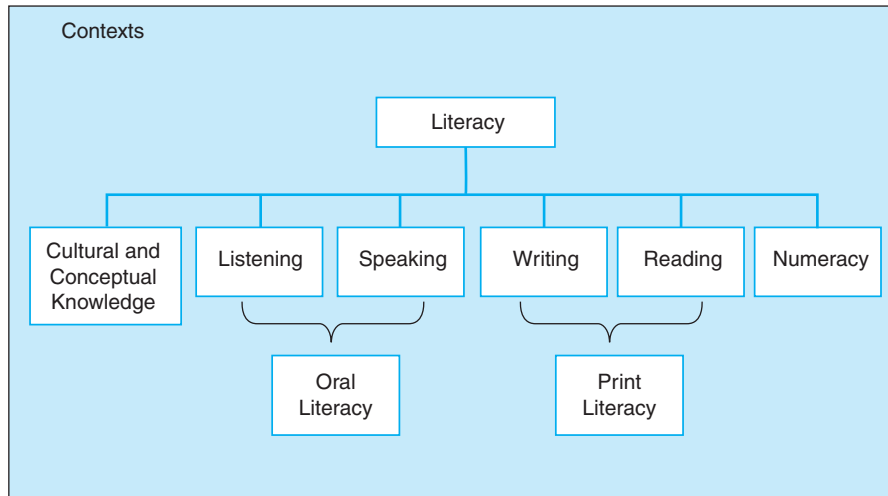


Figure 3-1 Literacy components. *Source:* ©2004. Reprinted with permission from *Health Literacy: A Prescription to End Confusion* by the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

Table 3-2 NAAL COMPONENTS

COMPONENT	DESCRIPTION
1. Background Questionnaire	Describes relationships between adult literacy and select respondent characteristics
2. Prison Component	Identifies literacy skills of incarcerated adults
3. State Assessment of Adult Literacy (SAAL)	Statewide literacy estimates for participating states
4. Health Literacy	Ability to use literacy skills in understanding health-related materials and forms
5. Fluency Addition	Measures basic reading skills by examining decoding ability, word recognition, and reading fluency
6. Adult Literacy Supplemental Assessment	Describes the ability of the least-literate adults to identify letters and numbers and to comprehend simple prose and documents

Source: NAAL. (2006).

70 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

The NAALS results are concerning, as they demonstrate no significant changes in prose and document literacy when compared to the NALS. There was some improvement in quantitative literacy. Literacy is currently ranked using levels ranging from Below Basic to Basic, Intermediate, and Proficient (Table 3-3) (ALC, 2006).

Findings reveal that 93 million Americans, or approximately 43%, are functioning at *Below Basic* or *Basic* levels of literacy (NAAL, 2006b) (Figure 3-2). These levels denote an ability to perform tasks at the most basic, un-

Table 3-3 LITERACY LEVELS

LITERACY LEVEL	SKILL SET
Below Basic	No more than the most simple and concrete literacy skills
Basic	Able to perform simple and everyday literacy activities
Intermediate	Can perform moderately challenging literacy activities
Proficient	Able to perform complex and challenging literacy activities

Source: (ALC, 2006)

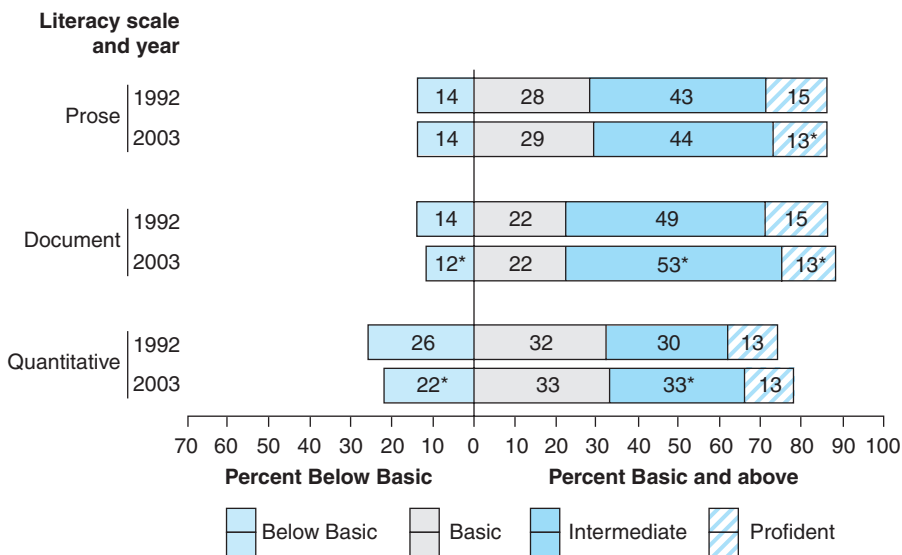


Figure 3-2 Number of Adults in Each Prose Literacy Level. Source: U.S. Department of Education. Institute of Education Sciences, National Center for Education Statistics. Retrieved on May 22, 2006, from <http://nces.ed.gov/NAAL/index.asp?file=KeyFindings/Demographics/Overall.asp&PageID>

complicated level. Tasks include locating information in a short news article or totaling the entry on a bank deposit slip. People with a basic level of literacy have considerable difficulty carrying out tasks requiring them to read and comprehend long texts, and two-step calculations may be beyond their capabilities. A worrisome finding related to the Below Basic in Prose group is that its members are also at greatest risk for compromised health status or societal disenfranchisement (Table 3-4).

Health Literacy: A Challenge within the Context of Literacy

Health literacy is a shared function of social and individual factors (Committee on Health Literacy, 2004) that influence the extent to which individuals are able to obtain, process, and understand basic health information and the services needed to make appropriate health decisions (Office of Disease Prevention and Health Promotion [ODPHP], 2000). It includes the ability to decode instructions, charts, and diagrams; analyze risks to benefits; and make decisions that lead to actions (National Institutes of Health, 2005).

The Institute of Medicine (IOM) of the National Academies convened the Committee on Health Literacy to examine the problem of health literacy. The committee report, *Health Literacy: A Prescription to End Confusion*, offers a comprehensive, detailed description of health literacy with potential interventions. The report is an excellent resource for CNSs who are interested in examining this problem and developing a better sense of the enormity of the challenge to design effective, targeted patient and family education programs.

The Committee on Health Literacy developed a framework that characterizes health literacy as a synergistic relationship between culture and society, health system, education system, and health outcomes and costs (Figure 3-3). During its work, the committee examined the customary measures of literacy and health literacy and found them lacking.

Responding to these deficiencies, the committee identified three potential points for intervening in the health literacy framework and potentially improving health literacy (Figure 3-4). The committee identified that the health system cannot bear full responsibility for health literacy and that efforts must include both culture and society. The health system and education system were also viewed as important partners in health

Table 3-4 CHARACTERISTICS OF ADULTS WITH BELOW BASIC PROSE LITERACY.

	PERCENT IN PROSE BELOW BASIC POPULATION	PERCENT IN TOTAL NAAL POPULATION
Did not graduate from high school	56	15
No English spoken before starting school	44	13
Hispanic adults	39	12
Black adults	20	12
Age 65+	26	15
Multiple disabilities	21	9

Source: U.S. Department of Education. Institute of Education Sciences, National Center for Education Statistics (Accessed on May 22, 2006).

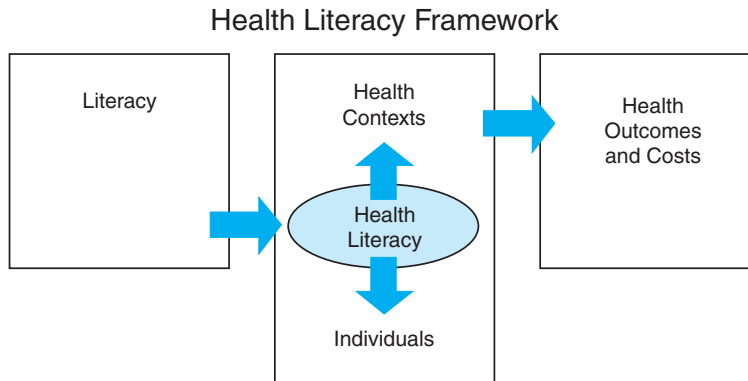


Figure 3-3 Health Literacy Framework. Source: ©2004. Reprinted with permission from *Health Literacy: A Prescription to End Confusion* by the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

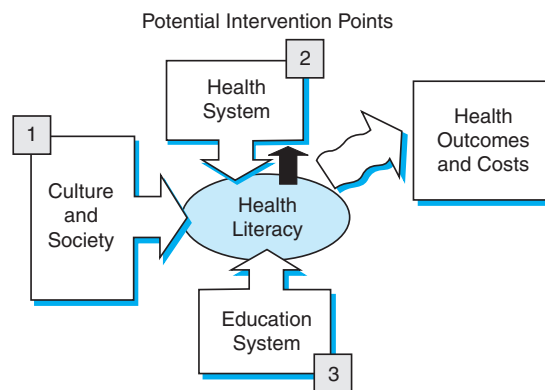


Figure 3-4 Potential points for intervention in the health literacy framework. Source: ©2004. Reprinted with permission from *Health Literacy: A Prescription to End Confusion* by the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

literacy. This finding needs to influence the ways that CNSs assess and address patient teaching.

Health literacy incorporates a variety of factors, not the least of which includes listening, speaking, writing, reading, cultural influences, conceptualizations, and arithmetic. When CNSs examine patient education materials, they typically use traditional readability measures, for example,

74 *Chapter 3* *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

SMOG or FOG. These measures are imprecise estimates that do not take into account the broad context of literacy. As a result, materials may seem suitable in terms of word usage and grade-level readability and yet may not affect patients' understanding of the essential truths necessary for health management.

Patients with English as a second language have additional challenges that may be compounded by limited education or age. The committee interpreted available data as suggesting that there is a relationship between health literacy, healthcare utilization, and healthcare costs. In other words, limited health literacy is expensive fiscally and personally. The Committee on Health Literacy recognized that shame and stigma related to limited literacy skills cause people to refrain from seeking resources to improve health literacy. As a result of limited health literacy, adults have less knowledge of health promotion, disease prevention, and disease management and utilize preventive services at a comparably lower rate.

The committee asserts that hundreds of studies have demonstrated that health information cannot be understood by most of the people for whom it was intended. The education system does not prepare people for a basic appreciation of anatomy and physiology. Therefore, when a patient experiences pathologies requiring self-management, they may not understand even the simple mechanics of functioning that are vital to making decisions about drug dosing, contacting a healthcare professional for follow-up, or returning to the hospital.

For example, a patient with congestive heart failure and coronary artery disease needs to understand the basic premise of coronary artery blood flow, ischemia, anticoagulation, heart rate, and pumping ability. This foundation informs self-management and facilitates recognition of the signs and symptoms that require medical and/or nursing review. Much of this information is couched in scientific terminologies that are not taught in basic education programs. This knowledge deficit worsens the challenges facing health professionals as they attempt to provide the education needed for self-care efficacy in a time frame that is constrained by inadequate personnel and fiscal resources.

Literacy Resources for CNSs

Health literacy is gaining a lot of attention from both private and public agencies and corporations. As a result, many Web-based resources are

available to CNSs at a low cost. These resources may be used to positively affect patient outcomes by influencing the expertise of health professionals within the healthcare system. Resources may also be used to empower patients by helping them to better understand and act on provided health information. CNSs should explore the many Web-based resources and keep in mind that most government sites allow for the free use of materials, providing that they are properly acknowledged.

A number of initiatives are focused on improving health communication and literacy. CNSs should consider exploring the resources available through these programs, as they are typically inexpensive and incorporate best practices using input from a variety of expert sources. A simple Web search using a popular search engine such as Google or Dogpile and the search term “health literacy” reveals a plethora of opportunities.

The *Ask Me 3* program was developed by the Partnership for Clear Health Communication to improve communication between providers and patients and to address the relationship between low health literacy and its negative impact on health status (Pfizer Clear Health Communication Initiative 2003–2004, 2006). *Ask Me 3* promotes three simple questions for patients to ask their healthcare provider during every encounter:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

The Web site, <http://www.askme3.org/>, offers a variety of resources for providers, patients, large-scale implementers, and media. The Partnership for Clear Health Communication makes available a variety of posters (Figure 3-5), brochures in both English and Spanish, teaching materials (Table 3-5), presentations, and the logo at no cost, stipulating that content of the written text cannot be changed, the materials must be appropriately credited, and the logo standards for graphics must be followed (<http://www.askme3.org/PFCHC/download.asp>). Funding for the *Ask Me 3* program is provided by Pfizer, Incorporated.

Another helpful Web-based resource is Plain Language.gov, a federal government employee initiative designed to facilitate the use of plain language to improve communication. In 1995, a group of federal employees joined together with an agenda to spread the use of plain language. The Plain Language Action and Information Network (PLAIN) created the Web site (<http://www.plainlanguage.gov/index.cfm>) to help people learn about

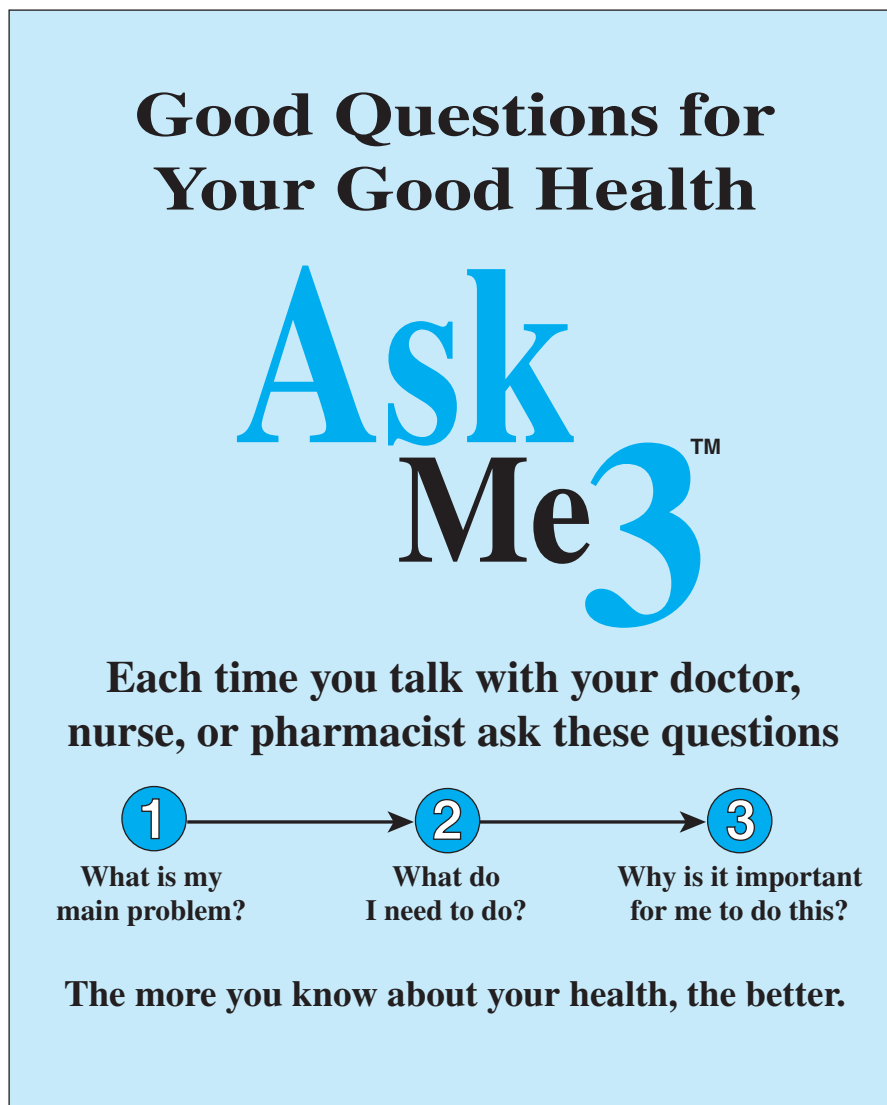


Figure 3-5 Sample Ask Me 3 poster. *Source:* Partnership for Clear Health Communication, 2006

Table 3-5 COMPARISON OF BREAST CANCER PATIENT INFORMATION AFTER REVISION USING PRINCIPLES FOR CLEAR HEALTH COMMUNICATION

AN EXTRA STEP: MAMMOGRAPHY

Women in the three high-risk categories—age 50 or more, 40 or more with a family history of breast cancer, age 35 or more with a personal history of breast cancer—may consider an additional routine screening method. This is x-ray mammography. Mammography uses radiation (x-rays) to create an image of the breast on film or paper called a mammogram. It can reveal tumors too small to be felt by palpation. It shows other changes in the structure of the breast, which doctors believe point to very early cancer. A mammographic examination usually consists of two x-rays of each breast, one taken from the top and one from the side. Exposure to x-rays should be carried out to ensure that the lowest possible dose will be absorbed by the body. Radiologists are not yet certain if there is any risk from one mammogram, although most studies indicate that the risk, if it does exist, is small relative to the benefit. Recent equipment modifications and improved techniques are reducing radiation absorption and thus the possible risk.

Original information based on the medical model. U.S. Department of Health and Human Services, National Cancer Institute/National Institutes of Health.

Breast Exams: What you should know. 1984. Readability: 12th grade. Retrieved May 28, 2006, from http://www.pfizerhealthliteracy.org/pdfs/Pfizers_Principles_for_Clear_Health_Communication.pdf

WHAT IS A MAMMOGRAM AND WHY SHOULD I HAVE ONE?

A mammogram is an x-ray picture of the breast. It can find breast cancer that is too small for you, your doctor, or nurse to feel. Studies show that if you are in your forties or older, having a mammogram every 1 to 2 years could save your life.

HOW DO I KNOW IF I NEED A MAMMOGRAM?

Talk with your doctor about your chances of getting breast cancer. Your doctor can help you decide when you should start having mammograms and how often you should have them.

WHY DO I NEED ONE EVERY 1 TO 2 YEARS?

As you get older, your chances of getting breast cancer get higher. Cancer can show up at any time—so one mammogram is not enough. Decide on a plan with your doctor and follow it for the rest of your life.

WHERE CAN I GET A MAMMOGRAM?

To find out where to get a mammogram:

- Ask your doctor or nurse
- Ask your local health department or clinic
- Call the National Cancer Institute's Concern Information Service at 1-800-4-CANCER

Revised information based on the Health Belief Model. U.S. Department of Health and Human Services, National Cancer Institute/National Institutes of Health. *Breast Exams: What you should know.* 1997. Readability: 5th grade. Retrieved May 28, 2006, from http://www.pfizerhealthliteracy.org/pdfs/Pfizers_Principles_for_Clear_Health_Communication.pdf

78 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

and use plain language. Wonderful tools are available via this Web site and health literacy is a popular topic. PLAIN offers a document checklist for plain language on the Web (Plain Language, 2006) (Table 3-6). Each item may be selected using the hyperlink to acquire additional details.

Pfizer, Incorporated also supports the Clear Health Communication Initiative (Pfizer, 2003) (<http://www.pfizerhealthliteracy.org/improving.html>) and offers a Patient Education Handbook (Doak & Doak, 2004) in PDF form and available as a free download. The handbook explores health literacy and offers suggestions, strategies, and examples in an easy-to-read format that exemplifies the simple yet meaningful recommendations it puts forth. This is an excellent resource for CNSs and may be useful to professionals in many disciplines.

The Agency for Healthcare Research and Quality (AHRQ) (Berkman, et al., 2004) has developed an evidence report/technology assessment on Literacy and Health Outcomes that is useful and informative. The review addressed two key questions: (a) Are literacy skills related to use of healthcare services, health outcomes, costs of healthcare, or disparities in health outcomes or healthcare service use according to race, ethnicity, culture, or age? (b) For individuals with low literacy skills, what are effective interventions to improve use of healthcare services, improve health outcomes, affect the costs of health care, and improve health outcomes and/or healthcare service use among different racial, ethnic, cultural, or age groups? Berkman, et al. (2004) concluded that low reading skill and poor health are related, thereby legitimizing health literacy and readability as real priorities for CNS practice. The full report is available as a free PDF download.

The Harvard School of Public Health offers a variety of health literacy resources (www.hsph.harvard.edu/healthliteracy/materials.html). The Web site provides information specific to health literacy, health literacy literature, research and policy, innovative materials, print materials resources (Rudd, 2005), health literacy curricula, links, contact information, and updated notifications of talks, presentations, and health literacy studies in the news. The Web site also offers a variety of teaching materials available for downloading, printing, and distributing.

A few of these selections include Plain Talk About Lupus and Key Words, Asthma Glossary Key Words in Plain Language, and Plain Talk About Arthritis and Key Words (<http://www.hsph.harvard.edu/healthliteracy/innovative.html>). A digital video disc (DVD), entitled *In Plain Language*, is available to purchase as well. This presentation lasts 15 minutes and

Table 3-6 DOCUMENT CHECKLIST FOR PLAIN LANGUAGE ON THE WEB**1. Written for the average reader**

Know the expertise and interest of your average reader, and write to that person. Don't write to the experts, the lawyers, or your management, unless they are your intended audience.

2. Organized to serve the reader's needs

Organize your content in the order the reader needs—the two most useful organization principles, which are not mutually exclusive, are to put the most important material first, exceptions last; or to organize material chronologically.

3. Has useful headings

Headings help the reader find the way through your material. Headings should capture the essence of all the material under the heading—if they don't, you need more headings! You should have one or more headings on each page.

4. Uses "you" and other pronouns to speak to the reader

Using pronouns pulls the reader into the document and makes it more meaningful to him. Use "you" for the reader ("I" when writing question headings from the reader's viewpoint) and "we" for your agency.

5. Uses active voice

Using active voice clarifies who is doing what; passive obscures it. Active voice is generally shorter, as well as clearer. Changing our writing to prefer active voice is the single most powerful change we can make in government writing. Active sentences are structured with the actor first (as the subject), then the verb, then the object of the action.

6. Uses short sections and sentences

Using short sentences, paragraphs, and sections helps your reader get through your material. Readers get lost in long dense text with few headings. Chunking your material also inserts white space, opening your document visually and making it more appealing.

7. Uses the simplest tense possible—simple present is best

The simplest verb tense is the clearest and strongest. Use simple present whenever possible—say, "We issue a report every quarter," not "We will be issuing a report every quarter."

8. Uses base verbs, not nominalizations (hidden verbs)

Use base verbs, not nominalizations—also called "hidden verbs." Government writing is full of hidden verbs. They make our writing weak and longer than necessary. Say "we manage the program" and "we analyze data" not "we are responsible for management of the program" or "we conduct an analysis of the data."

(continued)

80 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students***Table 3-6** (continued)**9. Omits excess words**

Eliminate excess words. Challenge every word—do you need it? Pronouns, active voice, and base verbs help eliminate excess words. So does eliminating unnecessary modifiers—in “HUD and FAA issued a joint report” you don’t need “joint.” In “this information is really critical” you don’t need “really.”

10. Uses concrete, familiar words

You don’t impress people by using big words, you just confuse them. Define (and limit!) your abbreviations. Avoid jargon, foreign terms, Latin terms, legal terms. Avoid noun strings. See our alphabetized list of complex words and simple subjects in the “word suggestions” page on this Web site.

11. Uses “must” to express requirements; avoids the ambiguous word “shall”

Use “must” not “shall” to impose requirements. “Shall” is ambiguous and rarely occurs in everyday conversation. The legal community is moving to a strong preference for “must” as the clearest way to express a requirement or obligation.

12. Places words carefully (avoids large gaps between the subject, the verb, and the object; puts exceptions last; places modifiers correctly)

Placing words carefully within a sentence is as important as organizing your document effectively. Keep subject, verb, and object close together. Put exceptions at the end. Place modifiers correctly—“We want only the best” not “We only want the best.”

13. Uses lists and tables to simplify complex material

You can shorten and clarify complex material by using lists and tables. And these features give your document more white space, making it more appealing to the reader.

14. Uses no more than two or three subordinate levels

Readers get lost when you use more than two or three levels in a document. If you find you need more levels, consider subdividing your top level into more parts.

Source: PLAIN (2006). Reprinted with permission. PlainLanguage.gov

was developed for health professionals who are interested in learning about adult literacy and implications for medicine and public health. The DVD/videotape recording is available for \$10 and may be an interesting addition to the CNS's health literacy repertoire, particularly when working with nurses and other health professionals interested in improving patient education within a healthcare organization (http://ncsall.gse.harvard.edu/order_video.html).

EthnoMed (<http://ethnomed.org/ethnomed/>) offers patient education materials tailored to diverse cultures including Amheric, Cambodian, Chinese, Entrean, Hispanic, Somali, and others (University of Washington, Harborview Medical Center, 2006). The groups represent immigrant groups living in Seattle and other parts of the United States. Cross-cultural links are available. The EthnoMed project began in 1994 with the goal of bridging cultural and language barriers during medical encounters. The project's objective is to make information about culture, language, health, illness, and local resources readily available to healthcare providers working with diverse ethnic groups.

EthnoMed offers CNSs a menu of various cultures. The CNS selects the culture of interest and is presented with options for a cultural profile, clinical topics, or patient education materials. As an example, if a CNS is working with a Vietnamese patient with a cancer diagnosis but the CNS has no experience with this cultural group, the EthnoMed site will provide a detailed overview of the Vietnamese culture. A symptom list of common Vietnamese symptoms is offered as well as health and illness topics. If the CNS is looking for education materials for this patient, the link to "Patient Education" reveals many resources written in Vietnamese, including a "What Is Cancer?" document available in both Vietnamese and English. The site is an ongoing activity and encourages providers to share information about treatments, resources, and cultural perspectives with the EthnoMed group.

An additional resource is fee-based patient education materials. Some vendors create patient education materials for purchase. Many hospitals and other health organizations choose to purchase patient education materials in the form of text pamphlets with visual aids, Web site development, and specialty program development. These types of products may be useful for streamlining education material resources and protecting the accuracy and consistency of the information provided during healthcare encounters.

Other vendors also provide databases that may be used to develop individualized discharge instructions for a variety of settings, including emergency departments. If this option is interesting, the CNS should

82 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

request a vendor list from the purchasing expert at the healthcare institution. Vendor information is also available at professional nursing conferences, particularly the larger regional, national, and international conference venues.

Levels of Literacy

Managed care requires people to be increasingly more autonomous in self-care practices. Ownership of self-care responsibilities demands health literacy. Many areas of health management are connected to health literacy (Table 3-7).

Levels of literacy are described by fairly common terms. CNSs should think about these descriptive terms and consider the demographics of the CNS practice within the context of these literacy levels. Low literacy is also referred to as marginally literate or marginally illiterate and designates individuals who are able to read, write, and comprehend information at the fifth through eighth-grade level of difficulty (Bastable, 2003). Functional literacy describes adults with reading, writing, and comprehension skills that are below the fifth-grade level. Literacy categorizations should not be interpreted as akin to intelligence.

Health literacy is one of the Health Communication objectives in Healthy People 2010 (HP 2010). Objective 11-2 is to “improve the health

Table 3-7 HEALTH LITERACY SELF-CARE IMPACT AREAS

1. Patient–care provider communication: health histories, advanced directives, untoward drug reactions, discharge instructions
 2. Medication labeling: prescription drug dosing and scheduling, empty stomach instructions, drug interaction precautions
 3. Equipment labeling: using durable medical equipment safely and correctly
 4. Health information publications and other resources: self-care pamphlets, public health precautions, hazardous materials warnings, household items warnings concerning mixing materials
 5. Informed consent
 6. Responding to medical and insurance forms
 7. Nutrition: food labeling, avoiding allergens, proper food storage, expiration dates, handling instructions
-

literacy of persons with inadequate or marginal literacy skills” (NIH, 2005). To effect change in literacy, HP 2010 emphasizes the crucial need to develop appropriate written materials for audiences with limited literacy and to improve the reading skills of individuals with limited literacy.

Assessing Patient Education Materials

CNSs should be aware of screening instruments used to determine a patient’s literacy and to ascertain the readability and appropriateness of available teaching materials. It is important for CNSs to be comfortable selecting the best-fit instruments and using these tools. Readability is frequently discussed in nursing textbooks, and most nurses are familiar with issues specific to the level of difficulty of materials; however, they may be less familiar with the concept of health literacy. Both measures should be carefully examined when planning patient education.

Readability CNSs may be familiar with readability tools including Flesch–Kinkaid Grade Level score, and the Flesch Reading Ease score, as these options are available in the Readability scores feature of Microsoft Word. Other popular readability measures include the SMOG formula and Fog formula.

The SMOG (Simple Measure of Gobbledygook) Index is based on average sentence length and the number of words with three or more syllables in a total of 30 sentences (Potter & Martin, 2006). The SMOG is fast and easy to use and has well-established validity. The SMOG is based on 100% comprehension of material read, so if the index calculates the readability level at grade 6, it means that 100% of readers able to read at the sixth-grade level should fully comprehend the material. Other formulas rely on 50% to 75% of all persons reading at the sixth-grade level, which explains why the SMOG results are often about two grade levels higher than those determined by other indices (Bastable, 2003). The SMOG index follows simple calculation steps (Table 3-8) that may be cumbersome when applied to lengthy documents. Resources are available for passages longer and shorter than 30 sentences that offer conversion tables for ease of use (Bastable, 2003, pp. 523–525).

The Fog Index or the Gunning–Fog Index (Wikipedia, 2006) measures readability of print materials from a range of fourth-grade to college level. The formula calculates grade level based on average sentence length and

84 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students***Table 3-8** SMOG INDEX

To calculate the SMOG Index:

1. Count the number of complex words (words containing 3 or more syllables).
2. Multiply the number of complex words by a factor of (30/number of sentences).
3. Take the square root of the resultant number.
4. Add 3 to the resultant number.

the percentage of multisyllabic words in a 100-word passage. It is an easy formula to use, and the resulting number indicates the number of years of formal education that a person needs to easily understand the text on the first reading (Wikipedia).

The Flesch Reading Ease score rates the text on a 100-point scale, with a high score indicating greater understandability. Microsoft recommends a target score of approximately 60 to 70 for standard documents (Table 3-9). The Flesch–Kincaid Grade Level score rates text on a U.S. grade-school level. A score of 8 indicates that the text can be understood by an individual with the skill set of an eighth grader. For a standard document, the recommended grade level is between seven and eight (Table 3-10). This recommended grade level should be determined by the average reading level of the typical patient with whom the CNS practices.

Readability scores in Microsoft Word are not provided as a default function. To take advantage of this feature, it must be selected. Given its usefulness, CNSs should consider adding the feature to the spelling check function to verify the grade level of written work that directly affects pa-

Table 3-9 FLESCH READING EASE SCORE FORMULA

The formula for the Flesch Reading Ease score is

$$206.835 - (1.015 \times ASL) - (84.6 \times ASW)$$

where:

ASL = average sentence length (the number of words divided by the number of sentences)

ASW = average number of syllables per word (the number of syllables divided by the number of words)

Source: Microsoft Office Word (2003).

Table 3-10 FLESCH–KINCAID GRADE LEVEL SCORE FORMULA

The formula for the Flesch–Kincaid Grade Level score is

$$(.39 \times \text{ASL}) + (11.8 \times \text{ASW}) - 15.59$$

where:

ASL = average sentence length (the number of words divided by the number of sentences)

ASW = average number of syllables per word (the number of syllables divided by the number of words)

Source: Microsoft Office Word (2003).

tients, families, or staff. To turn on this function in Word, select “Tools” from the tool bar. Select “Options” and then select “Spelling and grammar.” There is a box next to “Readability statistics.” Check this box and select “OK.” Readability statistics will now present with completed spell-checks.

Understanding how the reading ease and grade level scores are calculated will assist the CNS in improving the appropriateness of word documents by reducing the grade level or enhancing the understandability of the document. In general, a sixth-grade level may be more appropriate for a large patient audience, depending on the typical demographic profile of patient group (rather than an eighth-grade level). If needed, consider a fourth-grade level.

The readability tools in software programs may be inaccurate and underestimate the level of text difficulty (Pfizer, 2003). Pfizer recommends using the manual Fry formula because it is not copyrighted, uses a reasonably small sample size of 100 words, has respectability within the reading community, and takes only 15 to 20 minutes to obtain results. The Pfizer Principles for Clear Health Communication (1994) manual offers step-by-step instructions for using the Fry formula and provides the Fry Chart for ease of use.

There are also online resources that enable the CNS to cut and paste text into text boxes and have the selection evaluated for readability. Wikipedia.com, a free online encyclopedia, provides external links to tools that evaluate the Fog index, Flesch–Kincaid scores, and other readability measures and offers suggestions for enhancing readability (http://en.wikipedia.org/wiki/Fog_index#Calculating_the_Gunning-Fog_Index).

Formatting for Appeal and Impact In addition to grade level and understandability, CNSs should consider the overall look of printed materials. Graphics can be important visual cues that enhance learning. Elderly

86 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

patients provided with a leaflet that included graphics were five times more likely to receive a pneumococcal vaccine than were those elders in a control group who received a test-only brochure. They were also more likely to speak with their physicians about receiving the immunization (Jacobson et al., 1999).

CNSs should keep in mind that the average patient is probably a poor reader. Clear headings, bullets rather than full paragraphs, and ample white space are important. Short sentences, active voice, and familiar language with pictures and examples also facilitate engagement and learning (Potter & Martin, 2006). When developing critical materials, it may be useful to consider bringing together a group of intended audience members and field testing materials to solicit feedback about the effectiveness and appeal of the written product.

Assessing the Learner Two validated measures for ascertaining health literacy are the Rapid Estimate of Adult Literacy in Medicine (REALM) and the Test of Functional Health Literacy in Adults (TOFHLA). The REALM measures a person's ability to recognize and pronounce common health and medical terms (Potter & Martin, 2006). The REALM does not measure understanding but can be used to assist health professionals in selecting appropriate educational materials and instructions.

The REALM is currently comprised of 66 items and takes 2 to 3 minutes to administer and score (Measurement Excellence and Training Resource Information Center [METRIC], 2006). Subjects read from a list of 66 medical words arranged in order of complexity as determined by the number of syllables and pronunciation difficulty. Patients read aloud as many words as they can from the first word and continue until they reach words that they cannot pronounce correctly.

The REALM yields a score that estimates a grade level for reading (Weiss, 2003). A sample kit and pricing information can be obtained by writing to the developer (METRIC, 2006). The REALM has established validity and reliability (Davis, Crouch, et al., 1991; Davis, Long, et al., 1993) and is available only in English.

The TOFHLA is available in both English and Spanish (Weiss, 2003). It measures the functional literacy of patients using real-to-life healthcare materials. Examples of these materials include prescription bottle labels, diagnostic test instructions, and patient education information (METRIC, 2006).

The TOFHLA has 67 items and measures numeracy and reading comprehension. This instrument costs approximately \$50 and is available for

purchase (METRIC, 2006). Scores categorize patients into low, marginal, or adequate health literacy skill groups. It takes 22 minutes to complete both constructs. A short form is available, and a shorter form is under development (Weiss, 2003). METRIC (2006) suggests that the TOFHLA may be too long in its more commonly used form and that the tool requires additional validation and prediction studies. However, the tool is available in Spanish, and this is an important consideration when examining health literacy.

Culturally and Linguistically Appropriate Health Care

The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) views culturally and linguistically appropriate health services as critical to quality and safety (JCAHO, 2006a). Many Joint Commission standards support this requirement, including interpreter and translation services, food preferences, equal standard of care, informed consent, and many others.

Standard R1.2.100 calls for the organization to respect the patient's right to and need for effective communication (Table 3-11). The rationale for this

Table 3-11 JCAHO STANDARD R1.2.100

Standard R1.2.100 The organization respects the [patient's/resident's/client's] right to and need for effective communication.

Rationale for R1.2.100 The [patient/resident/client] has the right to receive information in a manner that he or she understands. This includes communication between the organization and the [patient/resident/client], as well as communication between the [patient/resident/client] and others outside the organization.

EP.2 Written information provided is appropriate to the age, understanding, and as appropriate to the population served, the language of the [patient/resident/client].

EP.3 The organization facilitates the patient in the provision of interpretation (including translation services) as necessary.

EP.4 The organization addresses the needs of those with vision, speech, hearing, language, and cognitive impairments.

Source: © Joint Commission Resources: 2006 *comprehensive accreditation manual for hospitals*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2006, p. 3. Reprinted with permission.

88 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

standard includes concerns with the appropriateness of the selected communication modality as well as the appropriateness of the language (JCAHO, 2006a). Interpretation, including translation services, as well as communication aids for patients with vision, speech, hearing, language, and cognitive impairments create significant challenges for CNSs.

Staff Education: Influencing Staff via Educational Programming

Education Programs: Not a Cure-All

CNSs are frequently charged with creating educational programs that will correct an identified patient care or indirect care problem. These program requests are often the result of a need to respond to a situation that is viewed as threatening to quality patient care outcomes. Concerns may also be related to institutional liability, patient satisfaction, or safety, among others. Although education *may* be the correct remedy, it should not always be the only or even the first proposed solution to a concern of interest. Many times practice problems are unrelated to knowledge deficits, but rather are related to competing priorities, workload challenges, or an employee's free will (Exemplar 3-1).

Exemplar 3-1 Free Will and Missed Opportunities: A Management Consideration

Nurse Robinson, RN, has been employed on South Bay Hospital's telemetry unit for 6 years on 12-hour night shifts. Nurse Robinson is regarded as a competent nurse who works very well under pressure. He is well liked by his coworkers, but supervisors find that he can be a negative influence on the work group when he is dissatisfied with staffing levels or new policies and procedures.

South Bay Hospital has attracted a nationally known bariatric surgeon and intends to develop a bariatric surgery service. Some of the nurses, including Nurse Robinson, are concerned about the impact that this service will have on the telemetry unit. These concerns have been shared and discussed during a variety of unit and department meetings.

In preparation for this new program, the hospital purchased several new patient lifts and bariatric-specific beds. The equipment is not sophisticated but does require staff to learn how to adjust the equipment for emergency procedures and transports. In-services are arranged across all shifts. Educational posters are developed with posttest questions, and access to a Web-based educational module is purchased for a 4-week period. There is also an option of reading a continuing education article and completing the posttest.

Staff is required to select the teaching modality that is most convenient for them. Following this educational session, each nurse must demonstrate correct use of the lift and the specialty bed. The staff has 1 month to complete this educational module and to demonstrate competence with the equipment.

Nurse Robinson fails to complete the education stating, "There is no way I'm coming in on my day off and the other times I've been too busy to leave my patients for an in-service on a bed!" Other nurses agree, resulting in a program completion rate of 60%.

During a meeting with the Director of Nursing Education (DONE), the topic of the bariatric education program is raised. The nurse manager requests that the CNS schedule additional in-services to accommodate the staff that had not elected to attend the previous programs. The bariatric program is progressing quickly, and staff will soon need to use the equipment. The CNS agrees to offer three more sessions. Again, turnout is poor.

Two days following the final education session, an obese woman suffers from respiratory distress. She is in a specialized bariatric bed. The emergency team arrives to intubate the patient but the nurse, Nurse Robinson, is unable to position the bed flat. Other nurses come to the room to assist. After a period of 5 minutes, the patient is successfully intubated. As the team attempts to transport the patient to the intensive care unit, more difficulties arise when they realize that the bed will not fit through the door frame. After a lengthy discussion and several attempts, the nursing team successfully removes the bedrails and transports the patient.

The following morning, the DONE is contacted by the bariatric surgeon regarding the nurses' ineptitude with the bariatric equipment. Although the patient did not suffer harm, the potential for injury was high. He insists that the nursing staff requires education.

The DONE meets with the CNS and nurse manager of the unit. The nurse manager's initial response is, "We'll have to set up more in-services right away. Staff have shared with me that they could not attend the in-services because they were too busy taking care of patients. We'll set up mandatory inservices immediately."

90 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

The CNS is asked to respond. After thoughtful consideration, the CNS summarizes the problem:

1. Education programs were offered over a 3-week period on a variety of shifts and a variety of days, including weekends. Attendance was poor.
2. Staff unable to attend the education sessions were encouraged to review the poster information and complete a posttest. Fifty percent of nurses who completed the skills demonstration acquired the necessary information via the poster opportunity.
3. Staff interested in a Web-based learning module were able to access the materials through the vendor's Web site. The posttest used for the poster session was available for these nurses. Forty percent of the nurses who completed the skills demonstration chose this education pathway.
4. Staff were permitted to read a continuing education article, self-study through the instruction booklet, and complete the posttest. Ten percent of staff who completed the skills demonstration acquired the necessary information using this selection.

The CNS identified that the problem was no longer a knowledge deficit but rather was a commitment issue. The CNS worked with the management team to design a strategy. Two nurses, both of whom had completed the education program, were asked for input. The action plan was as follows:

1. Staff who had completed the program and the skills assessment were recognized during a staff meeting.
2. Staff who had not completed the program and the skills assessment were identified as "not yet competent" (Wright, 2005) specific to the bariatric bed and lift. They were not permitted to use this equipment until competency was established. Charge nurses were notified as were the individual nurses.
3. Staff were given 1 week to complete the education program and the skills assessment. The only options for learning were numbers 2–4 noted earlier. No further in-service sessions were available. Self-study time was not paid beyond the shift pay.
4. Evaluative feedback was documented and placed in files to inform

upcoming performance evaluations.

5. Staff choosing to not participate in the education opportunities were given the option to meet with the nurse manager to discuss other unit assignments that did not require bariatric equipment skills, given the hospital's decision to prioritize this particular program.
6. Staff discussions during meetings and individual conversations reinforced the new perspective on competency demonstrations. Staff participated in identifying convenient and effective teaching and learning strategies and were encouraged to contribute to competency identification for the upcoming year.

Within the week, each nurse had completed the education program and demonstrated competence with the equipment. Nurse Robinson was reluctant to attend the program; however, alternate assignments within the hospital were unappealing. Nurse Robinson completed the program within the required time frame.

Organizations are responsible for providing opportunities for education so that employees can achieve and maintain the skill set necessary for safe, quality practice. These educational opportunities are *opportunities* or chances to learn. Employees are obliged to take advantage of these chances to meet their contractual obligation to provide safe care.

It is reasonable for employees to expect that educational programs will be offered on more than one occasion and in a scheduling pattern that accommodates more than one shift. It also makes sense for educational formats to vary and to include flexible options such as computer-assisted instruction, self-study modules, workshops, poster board formats, or Web-based instruction. These expectations are realistic and may even be obligatory on the part of the employing institution.

Employees have concurrent obligations. They are obliged to make themselves available to educational programs. Nurses are responsible for acquiring and maintaining the skills necessary for the level of practice expected of them by the employing institution and for which they accept

92 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

compensation. Wright (2005) commented that the organization needs to recognize that employees may not be interested in the direction the organization is moving. If this is the case and the employee is not interested in availing himself or herself of the provided educational opportunities, then the employee should find a different organization in which to practice.

This stance is not threatening; rather, it is an honest appraisal of the situation. As noted by Wright (2005), “employees should periodically reflect on their commitment to their organization’s evolution, and if that commitment is not strong, find an organization to work for that is better aligned with his or her personal philosophies and goals” (p. 3).

Nursing administrators may find this position disconcerting. Anecdotal evidence suggests that when systems problems arise, education is often offered as a first-line response. When attendance is poor and nurses’ skill sets remain amiss, CNSs or educators are charged with providing more teaching sessions. When low attendance rates persist, nurses are reminded of their responsibility to attend and then cajoled, implored, and threatened.

CNSs may need to consider this loop and more carefully examine the linkages that reinforce the negative behaviors. Could it be that low attendance is the result of two or more influences: an incorrect assumption that education is needed to correct this particular clinical problem, and nurses’ realizations that “mandatory” in-services are not truly mandated when there are no clear consequences associated with absences? In fact, employees may have become conditioned to believe that it is the responsibility of organizations to provide *carte blanche* programming and that this responsibility supersedes the obligation of the nurse to take advantage of the education.

The key point is that a root cause analysis is sometimes needed to identify whether the particular problem is actually related to a knowledge deficit. There are many times when nurses know the correct action or behavior but choose to not act as per policy stipulations or, in the case of equipment, per manufacturer’s directions. Understanding the reasons why compromised practice standards or processes occur is important to correctly remedy the situation.

At times, the remedy is education. At other times, the solution relates to management interventions. This sort of analysis may be more time consuming than the typical “let’s teach—that will fix the problem” reaction but will save money and needless effort by targeting interventions that will

correct the underlying problem. The challenge may lie in changing the culture of nursing to one that views competence as radically different from education program attendance.

The Creating and Recognizing Excellence (CARE) Program of Albert Einstein Healthcare Network (AEHN) is a unique strategy for rewarding desirable nurse behaviors and promoting professionalism (Exemplar 3-2). This program offers a good example of a program that was initiated by administrators to specifically reinforce employee behaviors that were important to the organization. Rather than providing monetary incentives for overtime or bonuses, a strategy that perpetuated a work culture motivated by pay incentives for time, the program financially recognizes nurses who demonstrate professional excellence. The impetus for this program was similar to the challenges currently faced by many CNSs when trying to ensure competence in a work environment that devalues educational programming. There may be lessons learned from AEHN's Care Program exemplar that are applicable to other types of organizational challenges.

Exemplar 3-2 Creating and Recognizing Excellence (CARE) Program

Jill Stunkard, MSN, RN, CCRN, CNAA-BC

The CARE Program, Creating and Recognizing Excellence, was developed at Albert Einstein Healthcare Network (AEHN), Philadelphia, Pennsylvania, as a joint venture between Nursing and Human Resources. AEHN was responding to a regional and national nursing shortage and the additional challenge of attracting nurses to an inner-city location. The intent of the program is to improve patient and employee satisfaction, as well as to promote teamwork and improve quality of care.

Program objectives specifically include:

- 1) differentiate the organization as an employer of choice,
- 2) reward behaviors that are most beneficial in helping to achieve the institution's mission and goals,
- 3) retain and attract talented employees in hard to recruit areas,
- 4) promote career development, and

94 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

- 5) provide excellent clinical service.

Specific activities of nurses and both individual and team goals that should be rewarded were identified. Rather than continually offering bonuses for working long hours, this program financially recognizes steps nurses take to foster professionalism in their own practice and the organization in which they work. The organization's Chief Executive Officer (CEO) and senior leadership team show commitment to the program by providing financial incentives to frontline employees who achieve measurable results that are aligned with the organizational goals of the institution.

The CARE Program consists of four main components, all of which are aimed at retaining registered nurses and other direct patient care providers. Most offer rewards for achievements. The components are an RN Excellence program, Medical/Surgical Team Incentive, Loan Repayment and Leadership Incentive, a program rewarding managers.

- 1) One component offered to RNs throughout the Network is the RN Excellence Incentive Program. Initially developed by the Network Nursing Council, this program most importantly promotes development and personal growth of direct patient care RNs. Financial incentives are awarded for achieving excellence in one or more of three areas: Clinical Practice, Leadership/Citizenship, and/or Education/Professional Growth.
- 2) The Medical/Surgical Care Team Incentive is an innovative program, which focuses on rewards for multidisciplinary teamwork. In addition to RNs, other members of the team may include LPNs, Patient Care Associates, medical clerks, Environmental Service workers, Food and Nutrition staff, physical therapists, and pharmacists. Team members set targets that are reviewed monthly. Assuming the unit meets their target, the reward is divided among the unit members. The three metrics targeted in the first year of this program included patient satisfaction, turnover of licensed staff, and a quality measure. Many units chose decreasing the patient fall index because it was something on which each team member could have an impact.
- 3) As a method of enhancing educational benefits to RNs, Loan Repayment is offered for RNs employed in Medical/Surgical areas. These RNs are eligible for up to a \$10,000 lifetime benefit to be used for repayment of nursing school loans.

- 4) The final program is a leadership incentive, which is based on five key areas or indicators. These include quality of care, patient satisfaction, staffing, fiscal performance, and professional development. The financial award varies, depending on an eligible leader's role and success in achieving the mutually agreed upon target goals.

Program requirements for CARE were developed collaboratively among nursing managers, staff nurses, and Human Resources (HR). Through AEHN's nursing shared governance model, staff nurse councils assembled members from each specialty area to assist in development of the program. Members of care teams, administration, and HR met to discuss what aspects should be rewarded. The facility also held focus groups to gauge interest in the program and determine what the staff found motivational.

Metrics required within each category often deliberately overlap, so that managers and staff are working toward a goal collectively. RN Excellence, the Medical/Surgical Care Team incentive, and the leadership incentive are all aligned with the goals of the nursing department and the organization as a whole. The monetary reward notwithstanding, active participation in these programs contributes to individual growth and development that benefits not only the individual, but the organization as a whole. After a year of planning, the program was launched in the summer of 2004.

Initially meetings were held with nursing management and education to provide them with specific information about the CARE Programs. Subsequently in July 2004, there were presentations to staff by nursing leadership via Town Meetings, unit staff meetings, and publishing of the "RN Excellence Resource Kit." Nurse managers, Clinical Nurse Specialists, and educators have proven to be significant resources for RNs aspiring to meet the criteria defined in the RN Excellence program. At first glance many people find the requirements overwhelming and value input from nursing leadership.

In order to qualify a nurse must be employed at AEHN for at least 1 year, have no active disciplinary action, and meet baseline criteria on their annual performance review. The plan is for an interested RN to meet with their manager to determine appropriate projects, which would both fulfill the established criteria and be of benefit to the nursing unit where the RN is employed. Nurses must meet various criteria within a category to fulfill requirements, which may include: being a preceptor, acquiring a determined number of continuing education credits, spearheading a performance improvement activity, or attaining certification (Figure 3-10). All three categories of practice (Clinical Excellence, Education/Professional Growth,

96 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

and Leadership/Citizenship) are valued the same and have similar intensity of criteria. An applicant may select any or all of the three categories in any order they desire, however a monetary award can be earned only once for each category per fiscal year.

The nurse is responsible for creating a portfolio highlighting his/her achievements thereby demonstrating fulfillment of the criteria selected. Once reviewed by the RN's manager, the portfolio is evaluated by the RN Excellence Review Committee. This group of ten is comprised of staff nurses, a nurse manager, a nursing director, the Nursing Career Specialist, and a Human Resources representative. When a nurse's portfolio is approved in one of the categories, he/she receives a \$4,000 bonus. Approval in subsequent areas can earn \$2,000 for each category. Individuals whose portfolios are not approved are provided with feedback, which almost all have utilized in revising and resubmitting their work.

In March 2005, the "RN Excellence Resource Toolkit" was placed on AEHN's intranet to provide convenient access. A Portfolio Development Seminar was held in April 2005, at which time mentoring by Review Committee membership and RN Excellence Award recipients was initiated. There has been periodic education regarding the program at nursing management meetings.

Nurses are acknowledged for involvement in a variety of projects including inservices, committees, and research. The program has encouraged nurses to think about ways of improving their workplace and their practice. In the first year of the program, \$142,000 was paid to 29 nurses who submitted a total of 43 portfolios. Year to date March FY06 there have been 30 portfolio submissions by 26 RNs. The number of certified RNs has increased in the past year, anecdotally attributable to the RN Excellence Program.

The RN Excellence Committee is in the process of attempting to determine measurable indicators of the success of the program. They are also making minor adjustments to make some of the criterion more understandable. Plans are underway to create pins, which will be presented to award recipients at a program where nurses will be asked to present some of their projects to their colleagues. Modifications to the program are being considered to include smaller monetary rewards for individuals who finish a project, but feel overwhelmed at the prospect of completing an entire category.

Clinicians are embarking on endeavors that will undoubtedly have an impact on nursing practice and patient outcomes. Continuing evaluation is needed to determine if rewarding professionalism and professional growth contribute to desired outcomes.

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Staff Education: Influencing Staff via Educational Programming 97

MANDATORY REQUIREMENTS FOR THIS CATEGORY:			
Candidate is required to attain 12 contact hours or one (1) college credit in nursing (or related area) in the 12 months prior to submission of their portfolio. Copies of contact hours or proof of a grade of C or above must be provided. Candidate is required to provide evidence of effective utilization of the nursing process — assessment, planning, intervention, and evaluation. Provide evidence of twelve (12) randomly selected charts/year (3 per quarter) that appropriately document all the above stated components of the nursing process. See attached evaluations completed by 1) Nurse Manager, 2) peer (selected by Nurse Manager), and 3) candidate selected peer, manager, or educator (approved by Nurse Manager). The RN must also submit documentation of attainment of three (3) other of the following criteria:			
Criteria:	Met	Unmet	Comments
1. National certification in the specialty in which the RN currently practices, as recognized by an accepted organization.			
2. Teach a structured educational offering to staff, patients, family, or community a minimum of twice a year (such as BLS, ACLS, PALS, diabetic class, spinal cord injury class, NRP instructor, "Handle with Care," specialty "core," or unit-based in-service). Copies of course coordinator/nurse manager evaluation and attendance sheet must be provided.			
3. Participate in writing and/or revising patient education materials, documentation tools, protocols, policies, and/or procedures. Must be able to demonstrate an evidence-based approach. Provide written documentation signed by a nurse manager.			
4. Be a primary preceptor/mentor for new hires/less-experienced team members a minimum of twice/year. Meet criteria for goal setting, evaluation of goal attainment, collaboration with management and/or CNS as appropriate, and completion of all required documentation. May include coordination/facilitation of student rotations depending on complexity. Evidence of preceptor workshop or "refresher course" completion required. See attached evaluations completed by: 1) manager, 2) CNS/Clinical Educator, and 3) orientee [must have a total rating of ≥ 39 with no "1" (never) rating].			
5. Poster or oral presentation at a professional conference. Copy of program brochure must be provided.			
6. Completion of a quality improvement or process improvement initiative. (May include oversight of the entire project, writing abstract, presenting at PIC (Process Improvement Council), and/or relaying information to the staff via a report, bulletin board, or poster presentation.) <i>Please note: identification of a problem and/or data collection alone does not qualify to meet these criteria.</i>			
7. Active participation in Nursing Shared Governance or other entity network committees or councils. Attendance records and minutes must be provided. Attendance records (showing attendance at 80% of meetings) and minutes must be provided.			
8. Author or coauthor of an article in a nursing focused media (e.g., professional journal or magazine, chapter in a book). If the publication is a peer-reviewed journal, the date of the letter of acceptance will be utilized (not the date of publication).			

Nurse Manager/Clinical Director and/or Clinical Nurse Specialist must initial Met/Unmet in each category

Initials: _____ Signature: _____

Initials: _____ Signature: _____

Figure 3-10 RN Excellence Criteria: RN Clinical Excellence. *Source:* ©2004 Albert Einstein Healthcare Network. Reprinted with permission.

Developing Competence with Competencies There is confusion surrounding the definition of competence and many problems with its measurement (Watson, Stimpson, Topping, & Porock, 2002). The root of this confusion may relate to the lack of a conceptual definition of nursing competence, making it difficult to establish measurable operational definitions (Waddell, 2001). Cowan, Norman, and Coopamah (2005) suggested that nursing requires complex combinations of knowledge, performance, skills, and attitudes, and this complexity necessitates consensus on a conceptual and operational definition.

Identifying domains of competence may be useful, as domains offer possibilities for practical evaluation strategies. Lyon and Boland (2002) suggested that competence domains may include knowledge, technical, cultural, and communication. Del Bueno (2001; del Bueno, Barker, & Christmyer, 1980) offered technical, critical thinking, and interpersonal domains as a model of competence. These domain models are consistent and may be useful to the CNS when developing multifaceted strategies for developing nursing competencies and assessing nurse competence.

The terms *competence* and *competency* also require definition, as they are often used interchangeably and may, in fact, be unique but related entities. *Competence* is often defined as a capacity to perform based on knowledge, whereas *competency* is the actual performance (Nolan, 1998; McConnell, 2001).

Distinguishing competence from performance is also challenging, and there is no clearly established link from these two concepts to capability and expertise (Watson et al., 2002). Although the notion of protecting the public by ensuring competent practitioners makes sense, the level of performance that actually demonstrates competence in practice has not been determined. An example of this concern is illustrated by a scenario in which an RN completes a medication administration examination for a critical care unit position. The RN scores a 90%. Does this score reflect medication administration competence, or is competence demonstrated only by a 100% score? If the RN scores an 85%, does this score indicate incompetence? Competence may seem simple, but it is a sophisticated issue.

Many healthcare agencies are investing time and money into systems to assess competency of nursing professionals. One example of such a system is the Performance Based Development System (PBDS). This particular system uses video simulations, written out-of-context exercises, and visual out-of-context exercises to evaluate critical thinking manifested primarily as clinical judgment (del Bueno, 2005).

Aggregate results for competency assessment of new RNs using PBDS indicates that clinical judgment abilities are lacking. Del Bueno (2005) sug-

gested that clinical judgment may be best promoted by asking questions and inquiring as to the evidence available or needed to evaluate the effectiveness of nursing interventions. These strategies promote judgment building more effectively than multiple-choice exams offering a choice of written potential solutions (del Bueno, 2005).

Del Bueno's (2005) findings and suggestions should be carefully considered by CNSs as they work with newly graduated RNs and as they coach and educate more experienced staff. Assessing competence must be through more than multiple-choice tests offered immediately following an educational program. This evaluation strategy may be appropriate in certain situations but does not provide credible evidence that a nurse is competent.

In addition, CNSs must remember that attendance at an educational program does not ensure competence with the particular topic or skill. It is probably also true that demonstrating a performance in a controlled laboratory situation with a single skill in a simple environment as compared to a complex, stressful, real-world environment also does not denote competence. Of course, the more sophisticated and labor intensive the competency assessment, the more the activity costs. This is a legitimate concern that cannot be easily dismissed.

Competence assessment involves some form of evaluation by one person of another (Watson et al., 2002). When human interaction is involved in competence assessment, reliability is a potential concern due to the influence of social processes on the consistency of evaluative scores (McMullan et al., 2003; Watson et al., 2002). Validity is also a problem related to the lack of psychometrically established instruments used to establish competence. Reliability concerns are not often raised when CNSs are planning skills labs assessments. Validity is discussed even less frequently. Both of these topics are critically important to the notion of competent practice (Exemplar 3-3).

Exemplar 3-3 Validity and Reliability as Applied to Competencies

A CNS identifies a need for professional nurses to improve their recognition of acute myocardial infarction (AMI) electrocardiogram (ECG) patterns after a potentially serious clinical event in the telemetry unit during which several nurses failed to recognize AMI ECG changes in a 52-year-old fe-

male patient. The CNS designs a program to develop competence in AMI ECG interpretations and creates outcomes measures to ascertain competency. The CNS selects a posttest and case study exercise as strategies for verifying competency. In addition, a mock clinical scenario using a simulation model is developed. This simulation experience will take place 2 weeks after the program and will be scored by one of two CNSs. The experience will consist of acute myocardial infarction electrocardiogram recognition and three associated scenarios: (a) acute destabilization with dysrhythmias, pulmonary edema, and hypotension; (b) preparation for and administration of thrombolytic therapy; and, (c) immediate preparation for cardiac interventional therapy.

The CNS conducts a literature search and software search to locate an infarct pattern test. None is located, and the CNS creates an examination. The case study exercises are actual 12-lead ECGs from patients who have had a variety of cardiac events and nonevents, including infarcts and angina episodes. Several staff nurses have agreed to supervise small groups of case study sessions and grade the tools.

Reflection Questions

1. Reliable measures are *consistent* measures. Where are the potential measurement problems specific to reliability?
2. Valid measures accurately reflect the true nature of what is being measured. A valid measure is a *truthful* measure. What validity concerns are associated with this competency program?
3. How might the CNS improve the reliability and validity of this competency program?
4. Why do the posttest, case study, and clinical simulation work well together to evaluate competence with AMI ECG interpretation and treatment? What does each single evaluation strategy evaluate?

Skillful Nurses and Competency Assessment

Wright (2005) offers very specific, practical suggestions for competency assessment. She asserted that competency assessment follows a continuum that evolves as the requirements of the nurses' jobs evolve (Figure 3-6). Competency assessment for the new hiree should differ from that of the established RN. Wright suggested that competency assessment must be

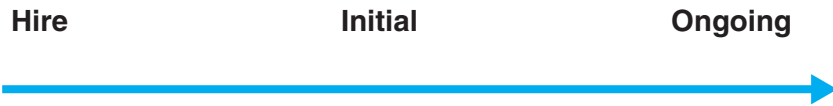


Figure 3-6 Competency continuum. *Source:* From *The ultimate guide to competency assessment in health care* (3rd ed.) by Donna Wright. ©2005 Creative Health Care Management. Used with permission.

perceived by staff as a valuable process, or it will be perceived as a time waster.

One strategy for competency assessment is to engage staff in identifying the competencies that are required for safe and professional practice. Once the competency is determined, verification strategies should match the competency categories. Nurse leaders need to support and sustain a culture of success by promoting, nurturing, and rewarding positive employee performance related to competency assessment (Figure 3-7).

This suggested model is quite different from the traditional competency assessments used in many healthcare organizations (Figure 3-8). Wright's Competency Assessment Model is outcome focused and holds employees accountable for managing their competency verifications. Competency as-

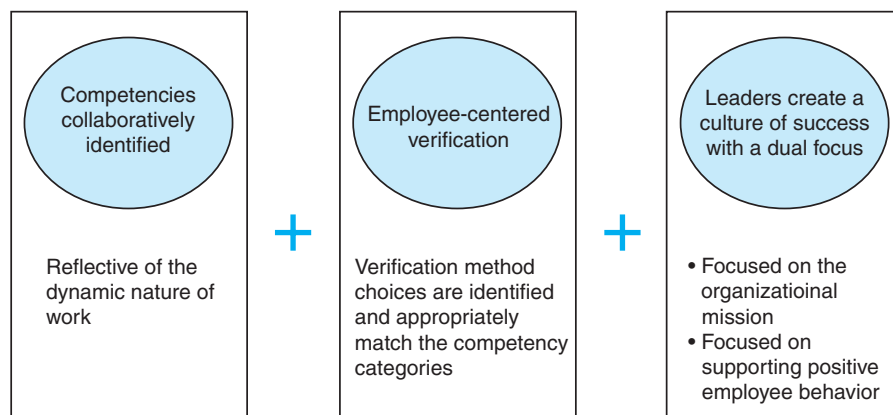


Figure 3-7 Donna Wright's Competency Assessment Model. *Source:* From *The ultimate guide to competency assessment in health care* (3rd ed.) by Donna Wright. ©2005 Creative Health Care Management. Used with permission.

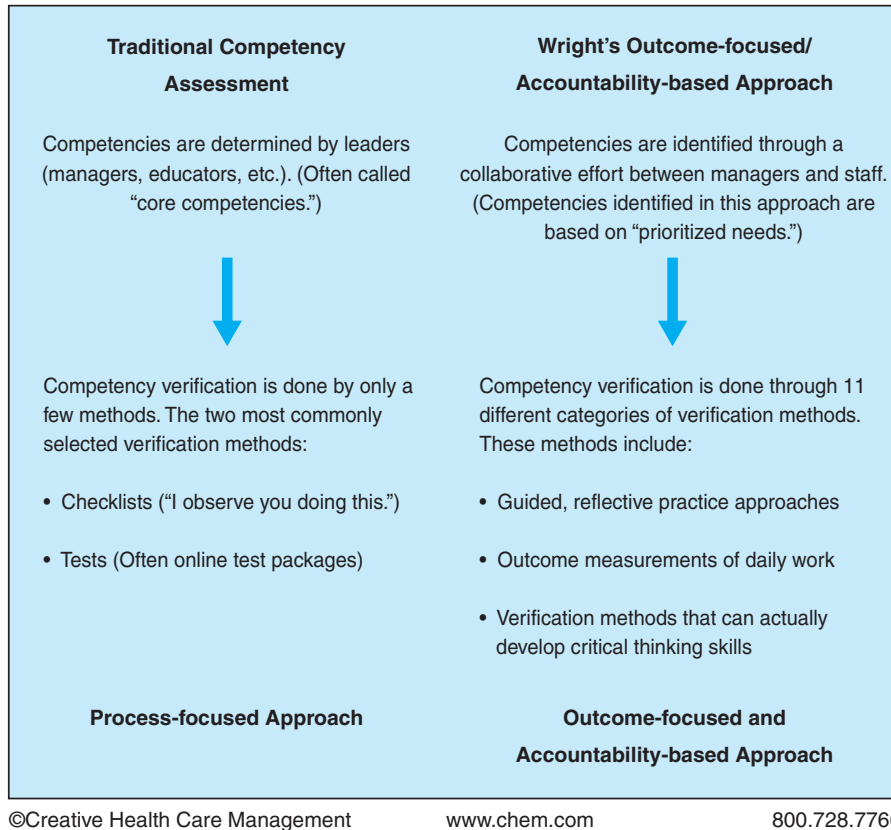


Figure 3-8 Traditional competency assessment versus Wright's Competency Assessment Model. *Source:* From *The ultimate guide to competency assessment in health care* (3rd ed.) by Donna Wright. ©2005 Creative Health Care Management. Used with permission.

assessment forms are useful as documentation templates for competency identification, verification methodologies, and action planning (Table 3-12).

Regulating Competency Assessment

External agencies like JCAHO provide powerful motivation for competency development and implementation. Wright (2005) observed that many times organizations are cited as deficient on a particular standard by an external agency because of an internal policy. For example, JCAHO (2006b) requires that organizations ensure that staff abilities meet the require-

Table 3-12 COMPETENCY ASSESSMENT FORM

Competency Assessment Form for _____ through _____
(job title) (competency assessment period)

Name: _____ Job Class _____ Work Area: _____

This form is to be completed by the employee. For each of the competency statements listed below, the employee may select which method of verification he or she would like to use for validation of his or her skill in that area. See the method of verification for details. When this form is complete, submit it to the area supervisor as indicated.

COMPETENCY	METHOD OF VERIFICATION	DATE COMPLETED

For added effect, this form can be categorized into three domains of skill (technical, critical thinking, and interpersonal).

The following is a list of organizational activities required for this job. Select the method of education/verification that you prefer.

ORGANIZATIONAL EDUCATION AND OTHER REQUIREMENTS	METHOD OF EDUCATION/ VERIFICATION	DATE COMPLETED

This section to be completed by the supervisor:

With consideration of the employee's performance and competency assessment, this employee is competent to perform as a/an:

_____ on/in _____ YES NO (Not yet deemed competent)
(job class) (work area)

Action Plan:

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

Source: From *The ultimate guide to competency assessment in health care* (3rd ed.) by Donna Wright. ©2005 Creative Health Care Management. Used with permission.

104 *Chapter 3* *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

ments of the job. The Behavioral Health Care—Management of Human Resources Standard prepublication copy identifies Standard HR.1.20 as: Staff qualifications are consistent with his or her job responsibilities.

The elements of performance specific to this standard are variable and include elements related to nonemployees, students, and employees. One of the JCAHO (2006b) elements is “Staff supervises students when they provide client care, treatment, and services as part of their training” (p. 4). This element is written in a general way that is open for interpretation by the individual organizations.

When the organization is crafting policy that meets this external agency standard, the organization must give careful thought to the best policy for its particular circumstances and design the policy parameters to be reasonable and consistent with its operations and resources. If the organization drafts a policy mandating that each student have an RN assigned for direct supervision and that the assigned RN will be designated on the daily assignment sheet, then this is what JCAHO will expect to find. Wright (2005) cautioned that external agencies can cite organizations for noncompliance with the organizations’ established internal policies. It is very important for institutions to craft policies and standards that are realistic, reasonable, and effective within its particular practice setting.

Essentials for Educating with Excellence: Academic Teaching and the CNS

Many CNSs are interested in teaching undergraduate nursing students, whereas others find that precepting graduate students is more to their liking. There are many opportunities to participate in nursing education at both the undergraduate and graduate levels. The nursing profession and the healthcare system are challenged by the shortage of professional nurses, including advanced practice nurses. Faculty shortages are contributing to this nursing shortage because baccalaureate program enrollment figures cannot exceed the availability of nurse educators.

The American Association of Colleges of Nursing (AACN) has identified that budget constraints, an aging faculty, and increasing competition from clinical agencies for graduate-degree nurses have contributed to the nursing faculty shortage (AACN, 2005). In 2004, nursing schools in the United States turned away 32,797 qualified applicants from college/university un-

dergraduate and graduate programs due to insufficient resources, including faculty and clinical preceptors. A July 2004 AACN report revealed that 717 faculty vacancies were identified at 395 nursing schools with baccalaureate and/or graduate programs.

The shortage of formally prepared nurse educators coupled with the need for clinical experts puts CNSs in an ideal position to consider opportunities in clinical instruction, professorships, and part-time employment as adjunct faculty members. CNSs need to have a clear understanding of the differences between these roles, the expectations of each, a general sense of the right questions to ask, and a handle on the responsibilities and challenges associated with the teaching role.

Undergraduate Clinical Teaching

There are a number of ways for CNSs to become involved in basic nursing education. In general, most nursing programs require a masters of science in nursing (MSN) degree of faculty. Although some individuals using the title “CNS” or “CS” do not have an MSN, specifically in those states that do not protect the title “CNS,” most CNSs do hold an MSN degree, usually from a graduate program providing CNS preparation. Specialty certification is not usually required for clinical teaching, although it may be desirable to demonstrate expertise within a particular specialty area.

Some nurses prefer to work as a CNS on a full-time or part-time basis and to teach as an adjunct faculty member for a university, four-year college (baccalaureate program), or community college (Associate of Arts/Science Degree of Nursing [ADN]). This type of teaching position is referred to as “adjunct” because the clinical instructor is a supplemental teaching resource that contributes to the overall education of the students and the quality of the program but does not have the responsibilities of a full-time faculty member.

Other CNSs may prefer to teach on a full-time basis while practicing clinically on a part-time basis. This clinical practice may be in the form of agency or per diem work, part-time employment, or in a joint appointment. A joint appointment is a combined position that links academic work to clinical practice. The CNS holding a joint appointment position typically straddles both worlds, academic and service, with varying accountabilities to administrators in each setting. This type of role can be challenging in its duality but is also stimulating. Challenges associated with joint positions include a high workload, lower salaries as compared to clinical practice alone, and role conflicts (Lewallen, 2002).

106 *Chapter 3* *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

Adjunct or part-time clinical instructor positions are also available in basic nursing programs at the diploma (hospital-based) level. The more typical terminology is “part-time” clinical instructor rather than “adjunct” faculty and probably relates to the historical differences between the hospital-based and university-based programs. There are also fewer diploma programs in the United States than other types and, therefore, fewer opportunities for CNSs. For the purpose of this chapter, academic opportunities will relate to college or university settings.

What Are Creative Teaching Strategies?

The descriptive phrase “creative teaching strategies” is commonly used by nurse educators. Some institutions of higher education use this phrase on evaluation forms as an aspect of teacher evaluations. In general, this phrase is a catch-all term for a variety of teaching methods that are designed to engage the student in the process of learning as an active participant rather than as a passive receptacle of information.

Creative teaching or active learning strategies may include concept mapping (Billings & Halstead, 2005; Hsu & Hsieh, 2005), problem-based learning activities (Zuzelo, Inverso, & Linkewich, 2001), case studies, simulation exercises, games, logs, journals, and role playing, as well as others. Billings and Halstead (2005) provide helpful descriptive summaries for multiple teaching strategies. These descriptions, as well as the identified supplemental resources, may be very useful to the novice CNS educator.

Clinical Teaching Versus Clinical Practice: Duality and Harmony

It is common for CNSs to express an interest in teaching nursing students. Many CNSs have an interest in education and a commitment to clinical practice excellence. Clinical expertise is an advantage to nursing students as CNSs’ expertise contributes to the overall quality and relevance of the educational experience.

CNSs may find that their expertise is associated with unique challenges. It can be difficult to instruct students in settings that are challenged by a lack of experienced staff or a culture of mediocrity. Staff may approach the CNS for advice, assistance, or troubleshooting. CNSs may feel inclined to participate in decision making and care provision that is not within their

purview as nursing instructors but, rather, belongs with the RN employees of the host institution.

CNSs may also find it difficult to teach at a rudimentary level when their usual practice is much more advanced. It can be tempting to launch into a discussion of abnormal physical assessment findings, complex pharmacology, or advanced pathology topics with students who are eager to learn and interested in everything and anything that the CNS may be willing to share! At the same time, these students may not have had a pharmacology course or medical–surgical content or have practiced beyond providing fundamental care to a single patient assignment. Although the instructional conversations may be interesting, CNSs teaching as academic instructors need to stay focused on facilitating progression toward the final course objectives. This duality as educator and clinician can work in harmony if the CNS is clear about the responsibilities and focus of clinical teaching experiences.

Exploring the Possibilities of Teaching Gathering information about clinical and classroom teaching is a good first step for the CNS interested in nursing education. Lewallen (2002) provides an excellent overview of academic nursing and tailors this discussion to CNSs. Lewallen suggests that there are questions that CNSs should ask when considering an academic position (Table 3-13). These questions are an excellent starting point, but other preparatory questions may also be useful.

The school of nursing's philosophy is an important consideration, as the philosophy should provide a context for educational experiences. The school's philosophy must be congruent with the philosophy of the larger

Table 3-13 ACADEMIC POSITION CONSIDERATIONS AND QUERIES

1. What is the school's philosophy?
2. What does the job description say?
3. What about tenure?
4. How are the courses sequenced?
5. How do I begin to prepare for classroom teaching?
6. How do I make the transition from clinical nursing to clinical teaching?
7. What regulatory and accreditation issues will I face?
8. What will my students be like?

Source: Lewallen (2002). Using your clinical expertise in nursing education. *Clinical Nurse Specialist*, 16(5), 242–246.

108 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

university or college in which it exists. The university's philosophy and mission relate to the ways in which nursing education is provided.

As an example, a university dedicated in the traditions of the Christian Brothers and a Roman Catholic, private, urban institution may have a different perspective on faculty obligations and student-to-faculty relationships than a large, publicly funded state university located in a rural region. Students may also have differing expectations of their selected program, depending on school type. The school of nursing exists within the confines of the university's mission. CNSs need to consider the university's philosophy and make certain that it is compatible to their personal philosophy of education.

Reviewing the position's job description is important to understand the responsibilities of clinical instructors. Job descriptions may be written in broad terms to address the generic responsibilities associated with any type of nursing course. CNSs need to be aware of the different responsibilities associated with the different teaching roles within the school.

For example, the responsibilities of a clinical instructor, classroom teacher working in a team, and course coordinator or single classroom professor are markedly different. These differences may not be clearly articulated in a job description. CNSs should review the syllabi for their course assignment and discuss the responsibilities of the course specific to clinical faculty or assistant classroom faculty. It is often helpful to construct questions specific to clinical (Table 3-14) and classroom (Table 3-15) teaching responsibilities to assist in developing a very clear understanding of the commitments and expectations of each type of position.

CNSs considering an opportunity to take responsibility for coordinating and teaching a course may find that they have additional obligations including communicating with clinical instructors, arranging student experiences at affiliating agencies, and organizing paperwork, evaluations, and documentation specific to student performance issues. Differentiating between these roles and asking appropriate questions prior to accepting the position may help the CNS avoid problems or surprises during the semester.

Many CNSs become initially involved in nursing education as part-time clinical instructors. Be aware that the responsibilities of clinical instructors can vary between schools and/or within schools. As an example, some programs will require clinical instructors to participate in grading student assignments. CNSs need to seek information specific to the turnaround time for grading assignments as well as any opportunities for asking questions

Table 3-14 SAMPLE QUERY PATH FOR FLEDGLING CLINICAL INSTRUCTORS**QUESTIONS TO ASK:**

1. How large is a typical clinical group?
2. How does the instructor become familiar with the clinical setting? Is there an orientation program, and if so, who arranges this orientation?
3. The name, job title, credentials, electronic mail address, and telephone number of the clinical agency contact person.
4. How are the students oriented to the agency?
5. What is the appropriate dress, including identification, for clinical faculty?
6. Is there a student handbook that describes policies and procedures for medication administration, charting, student illness, absenteeism and lateness, dress code, and clinical preparation requirements?
7. How long is the clinical day? What is the typical schedule?
8. How are assignments shared with students? Are they posted at the clinical agency, and if so, when should they be posted?
9. What is the required student preparation for clinical, and when should this preparation occur?
10. How should an instructor respond to the poorly prepared student?
11. Secure a copy of the required clinical paperwork. What criteria are used to evaluate the preparatory work? When should the work be returned to the student? How does the clinical instructor respond to inadequately completed paperwork?
12. When are students evaluated? Secure a copy of the evaluation tool.
13. What resources are available to assist the student who is performing poorly or unsafely in the clinical setting?
14. What is the policy for office hours?
15. Is parking available at the clinical agency?
16. Is a preconference session required?
17. Is a postconference session required?
18. Are clinical activities scheduled solely at the clinical agency, or are there required activities that are scheduled for additional, outside sites?
19. How does inclement weather affect the clinical learning experience, and who makes decisions regarding early dismissal or clinical experience cancellations?
20. Are phone chains required? What is the expected mode of communication between the clinical instructor and the students?

(continued)

110 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students***Table 3-14** (continued)

21. What circumstances should be described and forwarded to the immediate course supervisor?
22. What are the clinical expectations for students specific to numbers of patients, intravenous and medication therapies, discharge planning, teaching, physical assessment, and charting?
23. How will course content and concerns be communicated to the clinical instructors to connect clinical and classroom learning activities?
24. How are instructors addressed in the clinical setting? Are formal titles required, or do instructors work with students on a first-name basis?

Table 3-15 QUESTIONS TO ASK WHEN CONSIDERING CLASSROOM TEACHING OPPORTUNITIES**DIDACTIC INSTRUCTION**

1. How large is a typical classroom group?
2. Is there a general orientation to the university?
3. Is there an orientation to the school?
4. Copy of the academic calendar including withdrawal dates, semester holidays, examination schedules at midsemester and final-semester.
5. What is the policy and procedure for printed materials?
6. What resources are typically used for testing (e.g., test scoring equipment, Scantron sheets, pencils, laptops), and how are arrangements made for secure testing?
7. What is the policy and procedure for missing or making up a class due to attendance at a professional conference or illness?
8. Are guest speakers encouraged, and if so, are they paid? How is this pay generated? Is there a resource list of speakers?
9. What is the process for textbook selection?
10. How are texts secured for faculty?
11. Is there a notification process to alert students when their academic progress is below the required passing mark?
12. What is the policy for office hours?
13. Is there a platform for Web-based/computer-based instruction as a supplement to the course? If so, how does the professor access this resource?

(continued)

Table 3-15 (continued)

14. How is the instructor addressed by the students? First-name basis or formal titles?
15. Who is responsible for developing and updating the course syllabus? Is it an individualized activity or a group activity with other faculty members?
16. How are final grades entered into the university system? What are the reporting mechanisms associated with all grades? Failing grades?
17. Is there a policy for missed examinations?
18. Is there an honesty code, and if so, how is this policy enforced?
19. Are professors required to tutor, and if so, how are rooms reserved?
20. Explore the availability of office space and secretarial support.
21. Is there a required format for course syllabi? What topics are included on the syllabus? What other additional forms should be generated for a course?

and seeking validation from more experienced colleagues that grades have been correctly assigned.

Difficulties associated with grading tend to relate to the clarity and detail of the assignment flyers. If grading activities rely on the subjective evaluation of the clinical instructor, the CNS may find it helpful to ask that the instructor group meet to share insights and critiques prior to returning grades to students. This activity promotes interrater reliability and prevents the variability in grading that students perceive as unfair. Some programs will not require clinical instructors to grade assignments but may require paperwork evaluations using satisfactory versus unsatisfactory criteria. Again, this is an important area to explore prior to signing a contract.

Clinical Instruction: Control the Urge to Nurse New clinical instructors often find it difficult to establish boundaries with the staff on the assigned nursing unit. CNSs are accustomed to serving as the clinical expert and typically enjoy interacting with staff and troubleshooting patient care dilemmas. As a result, the CNS may feel conflicted when a situation develops on the assigned unit that appears to require the expertise of the CNS.

Although it may be tempting to fully participate in the problem-solving activities of staff, the CNS is on the unit in the capacity of a nurse educator. Within this capacity, the instructor must attend to the learning needs of the

112 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

students rather than the unit activities. CNSs need to remember that each student is relying on the instructor to make certain that learning is occurring and that patients are safe. If the instructor becomes too involved in isolated patient care situations or practice dilemmas, students are left unsupervised, and patients are receiving care from individuals who are not licensed or prepared to practice with autonomy.

Another boundary challenge relates to complex patient care scenarios. There are times when patients' conditions deteriorate. Depending on the academic standing of the nursing student and the responsibilities and activities of the other students in the clinical group cohort, the CNS instructor may be able to engage in prioritizing and intervening in the complex patient care situation with the intent of promoting student learning.

However, the reality of this type of situation is that deteriorating patient circumstances demand time and attention. Acute instability may require medication orders, initiating a rapid response team consult, and, perhaps, verbal orders. These responsibilities are more appropriately met by the employed RN. It may be possible for a student to work closely with the RN and either assist or observe; however, the CNS must step out and focus on the learning experiences of the remaining students.

Lewallen (2002) cautioned that clinical instructors need to realize that they are not on the unit as direct care providers. Instructors are on the unit to teach. There are times when students will be unable to accomplish the tasks of patient care. These activities will need to be turned back to the staff. The CNS clinical instructor cannot perform nursing care outside the purview of teaching students. It is difficult to acknowledge that total care has not been completed and to return these responsibilities to the staff; however, clear communication processes and ongoing updates assist in preventing misunderstandings.

Another potential problem area relates to the relationship between ancillary staff members and students. This relationship is a frequent "hot button" and has been known to create much stress for clinical instructors. It may be helpful to meet with the nurse manager and/or charge nurses prior to beginning the clinical experience to establish rules and procedures prior to the first day of clinical.

In general, it is important to recognize that neither the students nor the instructor are agency employees. In fact, the clinical learning group is a guest to the institution. Ancillary staff members are paid employees. As such, certain responsibilities and tasks are assigned to them, for which

they are paid. The employed RNs are responsible for assigning work to the ancillary staff members and for supervising this work.

Within this context, it is useful to explain to students and reinforce to staff that ancillary staff assigned to patients are required to meet the needs of the patients. If a student is also assigned to the patient, the student is responsible for completing assigned patient care activities as demanded by their learning needs. These needs are delineated on the course syllabus.

In other words, students are at the clinical agency to learn, whereas ancillary staff members are at the agency as employees. When a nursing assistant (NA) receives a patient care assignment, the NA is responsible to the employed RN assigned to the particular patient. The NA is not accountable to the student; however, the student is also not accountable to the NA.

Rather, NAs should go about their work as they are paid to do within the confines of the usual practice patterns on the unit. If a nursing student is assigned to the same patient, the NA should not abdicate responsibility for patient care because "the patient has a student today." The student may or may not have responsibility for learning and practicing fundamental skills.

If a student is required to learn discharge teaching and planning, physical assessment, or other aspects of professional nursing care, the morning care routines of beds, baths, and weights may or may not be required of the student. Communication is absolutely critical in these scenarios. The clinical instructor needs to recognize that tact, kindness, and respect for others should be paramount in the interactions with staff members. Otherwise, issues with ancillary staff and professional staff may negatively affect student learning experiences. Instructors should view these interactions as opportunities to role model professional communication processes.

This same rationale explains why students should not be inappropriately used for patient transport, pharmacy pickups, and other routine tasks. When students spend too much time in these activities, they become resentful and frustrated because these activities take time away from critical experiences, thereby undermining the educational value of the day. Of course, in the event of a true patient care emergency, students may need to be flexible and assist as team members. It is important for the clinical instructor to recognize what sorts of situations are emergencies as

114 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

compared to situations that are predictable and related to short staffing, sick calls, or poor planning.

Typically Atypical Nursing Students

Nurse demographics are changing, and the profession is welcoming, even encouraging, these changes. Society needs an increased number of nurses, and both society and the profession need these nurses to reflect the richly diverse cultural montage of the country. These needs are encouraging professional nursing organizations and foundations to increase recruitment efforts directed toward diverse students, including people from low socioeconomic backgrounds (Zuzelo, 2005).

The aging nursing workforce is also a concern and provides additional incentives for recruiting potential nurses from underrepresented groups. It is anticipated that by 2010, the average age of nurses will be 45.4 years, with approximately 40% of the workforce beyond age 50 (U.S. General Accounting Office [GAO], 2001). These concerns, coupled with the desires of disadvantaged and disenfranchised people to improve their quality of life, are changing the demographics of the nursing classroom. CNSs working in academic nursing need to be prepared for the joys and challenges of a student body that includes people of all ages, even those near retirement age, races, religions, and socioeconomic backgrounds.

Zuzelo (2005) asserted that disadvantaged students present challenges to nurse educators who may be unprepared to identify and respond to the unique needs and characteristics of this group. Disadvantaged students come to higher education programs with different background experiences than do advantaged students. These past experiences may affect the ways that the student engages with classmates and faculty.

When an instructor values a consistent approach to students, there may be a tendency to use a “one-size-fits-all” teaching style. The problem with this approach is that it discounts the differences in the opportunities to learn. In other words, disadvantaged students may not have the same real-life opportunities to learn as a student who is academically and psychologically ready to learn at the college level. Educators need to keep these differences in mind as they work with clinical groups and classroom sections and strategize appropriately to meet the needs of these students, within reason (Table 3-16). It is important for faculty to be fair and rigorous

Table 3-16 STRATEGIES FOR AFFIRMING DISADVANTAGED STUDENTS

1. Recognize the lack of role models for disadvantaged students and fill the void by personally reaching out.
2. Evaluate reading assignments, class activities, patient care assignments, and speakers to ensure that they reflect pluralism and diversity and are relevant to the experiences of students from a variety of backgrounds, including disadvantaged backgrounds.
3. Recognize that self-confidence, assertiveness, and teamwork are part of the hidden yet important curriculum of nursing education programs.
4. Counter student hostility with calm, quiet, and immediate discussion.
5. Offer additional supports to disadvantaged students, including students who are disadvantaged within the university setting because of minority status.
6. Consider joint projects between instructors and disadvantaged students, remembering that these particular students may be less likely to volunteer or ask for such experiences.

Source: Zuzelo (2005).

in expectations while simultaneously assisting students from all types of backgrounds to be as successful as their skills and abilities permit.

Handling the Angry Student

CNSs may also find it important to note that there is an increasing body of published literature suggesting that student incivility is a significant problem in nursing education. Whether described as “attitude” (Zuzelo, 2005, p. 29) or categorized as incivility, aggression (Luparell, 2005), or “maladaptive anger behavior” (Thomas, 2003, p. 17), hostile and aggressive behaviors are increasingly witnessed in nursing education settings. Incivility and threatening behaviors may be viewed as manifestations of a more aggressive society; however, nurse educators need to have a ready repertoire of strategies for dealing with student behaviors that may be unpredictable, uncivil, offensive, or even dangerous (Table 3-17).

Although incivility is not a hallmark of nursing students in general, it is a phenomenon that is increasingly worrisome and should be not unexpected. There have been incidents of fatal violence directed at professors from students as well as stalking incidences and assault (Thomas, 2003).

Table 3-17 STRATEGIES FOR RESPONDING TO INCIVILITY, THREATS, OR DANGER**Recommended Strategy**

1. Clearly describe behavioral expectations using both verbal and written instructions (Luparell, 2005).
2. Explain the purpose and necessity of constructive criticism (Luparell, 2005).
3. Engage in circumspective self-evaluation and consider personal behaviors and teaching strategies that may be perceived as disrespectful by students (Luparell, 2005).
4. Anticipate the possibility of an uncivil response from students (Luparell, 2005). Keep office doors open without violating student privacy. Meet in common rooms rather than in an isolated office.
5. Prepare for occasions when negative feedback needs to be delivered to a student (Luparell, 2005).
6. Respond promptly to incivilities and disruptive behaviors—mediate the form of the response based on the severity of the behavior (Luparell, 2005).
7. Establish a zero-tolerance policy for violent behavior.
8. Avoid appointments with students in isolated settings during off-business hours.
9. Establish a security or alert system to intervene when student behaviors are threatening.
10. Utilize safety and security services on campus or at clinical affiliates as appropriate.

Student anger may be triggered when students feel “different” or isolated from the normative group (Zuzelo, 2005), feel the perceived pressures associated with constructive criticism (Luparell, 2005), or experience one of five common triggers (Thomas, 2003). Thomas noted that there are five common causes of nursing students’ anger, including (a) perceptions of teacher unfairness, discrimination, or rigidity; (b) unreasonable expectations of faculty; (c) overly critical instructors; (d) reactions to unanticipated changes; and (e) unresolved family issues that influence and inform reactions to situations in the educational setting. CNSs considering educator roles should think about these triggers and contemplate strategies to minimize the likelihood of evoking an unreasonably angry student response to an unreasonable teacher behavior (Table 3-18).

Table 3-18 ANGER TRIGGERS FOR STUDENTS

1. Receiving only negative feedback without recognition of jobs well done.
2. Treating students differently based upon sex. Avoid making gender-based requests such as, "I need one of the male students to assist with a transport."
3. Criticizing students for their opinions or feelings when honesty is requested.
4. Insulting or criticizing students in public forums including nursing stations, patient rooms, or during clinical conferences.
5. Making unexpected changes to clinical schedules, assignments, or locations and providing little to no notice.

Source: Adapted from Thomas, 2003.

Evaluating Students

Setting the tone for the clinical learning experience is important and should be carefully contemplated prior to the first day of clinical. The CNS instructor should develop a loose script for the orientation day and make clear the behaviors required for satisfactory performance. The tone of the initial meeting and the clarity of shared information affects students' perceptions of the rigor associated with the clinical experience. Ultimately, these perceptions influence student behaviors and affect student performance evaluations.

A word of caution. Clinical instructors occasionally confuse rigor with meanness. Students should not feel threatened, bullied, or diminished by instructors. High expectations are able to coexist with warmth, friendliness, and genuine concern. Reading the riot act to students as a method of ensuring hard work and discipline is not an effective teaching method. Rather, it may perpetuate itself in practice when nurses "beat up" new colleagues or are intolerant of the needs of colleagues.

Clinical instructors are responsible for evaluating students' performance. This may be one of the more difficult aspects of academic nursing. CNSs may have experience with evaluating the performance of new or established employees; however, evaluating students is somewhat different. The Clinical Instruction Algorithm (Figure 3-9) (Zuzelo, 2005) is a useful pictorial representation of clinical instruction and evaluation processes. Instructor feedback suggests that it is easy to follow and a rapid way to understand the larger context of clinical instruction.

118 Chapter 3 Influencing Healthcare Quality: Educating Patients, Nurses, and Students

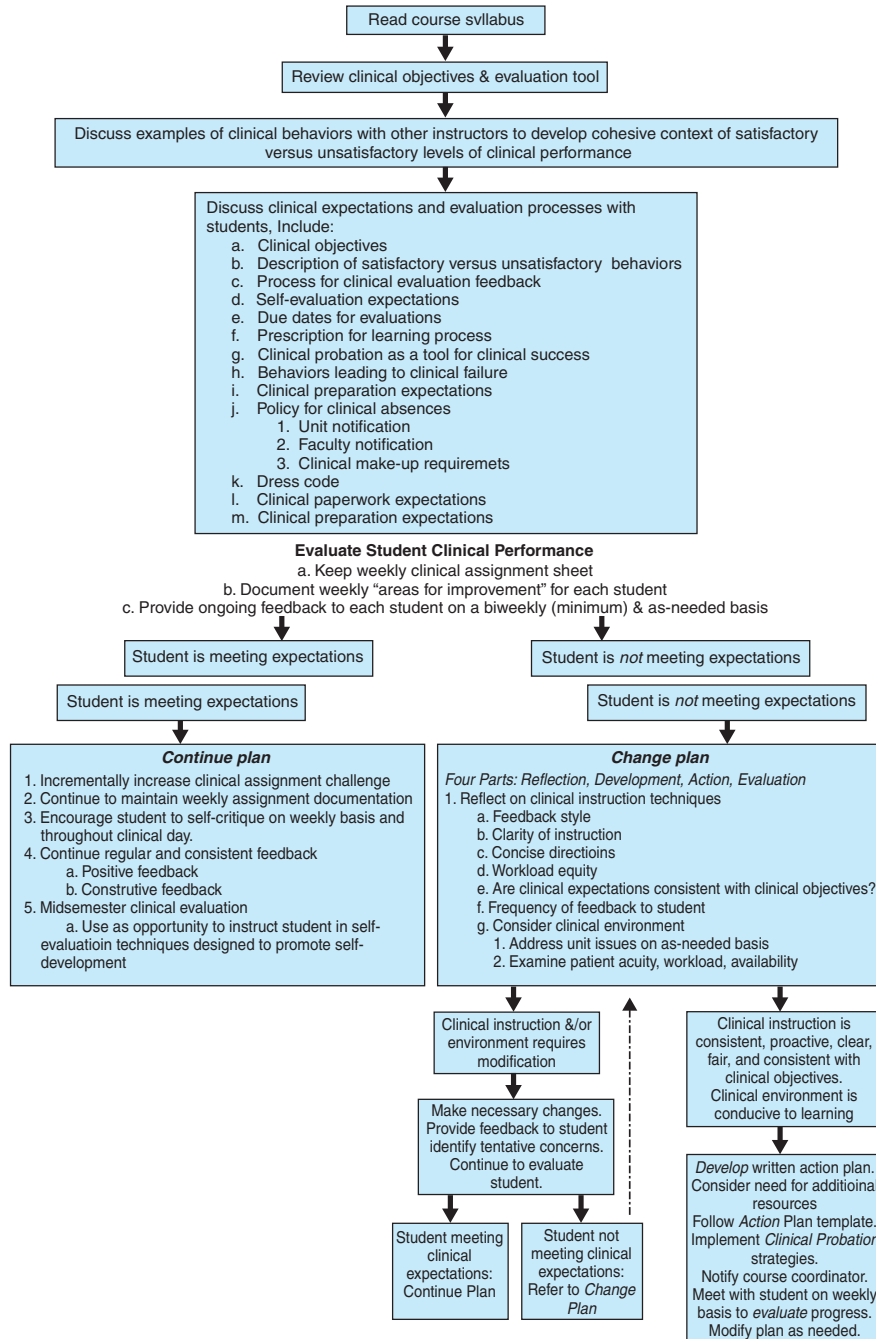


Figure 3-9 Clinical Evaluation Algorithm. Source: ©2006 Patti R. Zuzelo. Reprinted with permission.

Students should be evaluated on an ongoing basis. The clinical instructor should be making conclusions based on patterns of behavior with the purpose of developing students and assisting them in their efforts to become proficient beginner clinicians. If a student is performing at an unsatisfactory level, inform the student immediately and follow an organized process for supporting the student in attempts to improve and develop competence (Table 3-19). There are strategies and guidelines available to assist the instructor with meeting the needs of the struggling student

Table 3-19 CHECKLIST FOR CLINICAL ADVISEMENT

1. Has the student received a written copy of the clinical objectives/requirements? This includes a copy of the clinical evaluation tool, written criteria from the clinical instructor, course syllabus criteria.
 2. Has the student participated in the action plan?
 3. Is the action plan signed and dated by each party with each meeting?
 4. Are copies being kept of the student's written work?
 5. Do you have copies of the weekly assignments?
 6. Keep objective anecdotal records. Are these records available for all students in the clinical group cohort, or is excessive rigor being applied to the poorly performing student?
 7. Review school policies and follow.
 8. Better to use clinical probation early than late. Remember, student success is the goal; therefore, as early a notice as is realistic is best for the student.
 9. Think about support services. What else can be offered to the student, and who else can be involved?
 10. If meetings are uncomfortable or angry, bring in a consistent third party.
 11. Are other students asking questions? Firmly but kindly assure them that their concerns are understood, but one student's issues cannot be discussed with other students.
 12. Is staff curious? Do not share information. Reassure staff that the student is supported in the learning process.
 13. Are parents calling? Do not discuss the student with them. Rather, suggest that they come in with their child to discuss the concerns. Remember, the student controls this interaction, and the student needs to speak with his/her parents and arrange the meeting at the mutual convenience of all parties.
 14. Was written notice regarding the particular student's performance issues provided to the course coordinator?
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120 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

(Zuzelo, 2000), including probationary processes, remedial supports, or systematized warnings.

Most institutions require a midsemester and end-semester clinical evaluation. A general guideline to consider is that students should not be surprised by the contents of their performance evaluation. Ideally, students should have an ongoing sense of how they are performing as measured against the clinical objectives (Zuzelo, 2000).

The Unprepared Student When students arrive for clinical in an unprepared state (Exemplar 3-4), the instructor should immediately address this issue and provide feedback. The student may have experienced a personal crisis that impeded clinical preparation, or the student may be demonstrating poor work habits and a lackadaisical approach to learning. Explore this issue and intervene immediately. Early, consistent, feedback is critical to the quality of the clinical learning experience.

Exemplar 3-4 The Unprepared Student

Background:

Suzanne Perkins is a 21-year old junior nursing student entering her second semester of nursing courses. She has completed the Fundamentals of Nursing course as well as the Health Assessment and Health Promotion course. Suzanne is presently enrolled in a Medical–Surgical Nursing course that focuses on the adult client. Her clinical experience takes place at a local university hospital on a busy medical unit. The clinical instructor is responsible for a total of eight nursing students. The instructor reviewed the clinical objectives with the students during the first week of class. The evaluation tool was carefully reviewed with the students and questions were encouraged. The students were informed that the following week, they needed to be prepared to provide comprehensive nursing care to one patient. This assignment would include medication administration, with the exception of intermittent intravenous medications. Clinical paperwork would be collected at the end of the clinical day. Students who attended preconference without satisfactory evidence of clinical preparation would be sent off the clinical unit for the day. The instructor made

certain that the students had her office phone number and electronic mail address. Policies for absences and lateness were reviewed.

Week One:

Suzanne presented to preconference on time and adequately discussed her nursing plan of care for the day. She claimed to have had difficulty finding two of her assigned clients' medications and was unaware of the patient's bladder irrigation therapy required for hemorrhagic cystitis (she had not yet had this topic in nursing class). Her care provision for the day was organized, and she was professional and friendly on the unit. When dispensing medications, Suzanne was able to identify Digoxin as a "cardiac glycoside" but was unable to relate the Digoxin to the patient's long history of atrial fibrillation. Additionally, she identified Capoten as an "ACE inhibitor" but was unaware of what this term meant and believed that her patient required such for hypertension, despite the fact that her patient had no such history noted on his record. The instructor reviewed these concerns with Suzanne and related these issues to inadequate clinical preparation. Suzanne's comment to these concerns was, "I spent four hours getting ready for clinical! It's unrealistic to expect me to spend more time!" The instructor discussed strategies for clinical preparation with Suzanne and made certain that the student knew how to find information in the chart, how to prioritize multiple diagnoses, and how to fine-tune her medication preparation. The student expressed understanding and appreciation.

Week Two:

Suzanne was assigned two patients; one patient required partial assistance with care, whereas the other required minimal assistance. The first patient was in the hospital with the diagnosis of deep vein thrombosis (DVT) and was receiving concurrent heparin and Coumadin therapy. Suzanne was able to discuss DVT and the nursing care associated with such. She was unable to identify signs and symptoms of pulmonary embolus. Suzanne also was unable to explain why the patient was receiving both heparin and Coumadin. Suzanne did adequately discuss the nursing care associated with anticoagulation therapy in general. After preconference, the instructor approached Suzanne about her inadequate preparation. Suzanne stated, "We haven't had any of this in class yet. You can't

122 Chapter 3 *Influencing Healthcare Quality: Educating Patients, Nurses, and Students*

expect me to learn all of this the night before clinical. Besides, I think my preparation was as good as anyone else's!" After further discussion, Suzanne reluctantly acknowledged that her preparation was superficial and vowed to be more focused the following week.

Week Three:

Suzanne was assigned one patient with total care needs. The patient was receiving continuous enteral feedings via a PEG tube. The patient had a Stage III decubitus ulcer on her left hip requiring dressing changes twice daily. Additionally, she was receiving intravenous fluid at 80 cc/hour. The patient was alert and oriented to person and place with a diagnosis of hemiplegia secondary to an embolic cerebral vascular accident (CVA). Suzanne satisfactorily discussed the physical care needs of this patient. She was unable to relate the patient's CVA to her atrial fibrillation despite the fact that this information was noted in the chart on several occasions. Additionally, although she was aware of the patient's diarrhea, she was unaware of the patient's diagnosis of *Clostridium difficile* and treatment with Flagyl.

Reflection Questions

1. Was this student's clinical preparation satisfactory? How do you determine whether a student has "adequately" prepared for the clinical day?
2. Is information not yet covered in the classroom fair game for clinical?
3. How would you respond to Suzanne's comment, "Besides, I think my preparation was as good as anyone else's"?
4. In what ways could this performance issue with Suzanne affect the rest of the clinical group?
5. What types of documentation should the instructor maintain as she works with Suzanne?
6. What is the role of the course coordinator in this situation?
7. Identify your concerns when you place yourself in this scenario as the instructor.
8. Identify your concerns when you place yourself in this scenario as the student.
9. Develop a possible action plan for Suzanne.

The Contractual Obligations of a Syllabus Students should be evaluated against the clinical objectives of the course, and these objectives should be theoretically consistent with the overall course objectives delineated on the syllabus. This syllabus is a contract that instructors and students are obliged to follow.

CNSs need to appreciate the serious nature of contract obligations and rights established through school and course policies and procedures to avoid misunderstandings related to compromised due process requirements stemming from property rights (Exemplar 3-5). The clinical instructor is obliged to provide feedback, both positive and negative, to students on a regular basis through informal communication or in brief, written comments.

Exemplar 3-5 Critical Thinking Question: CNS as Clinical Instructor

Due process rights emanate from the ideas of a property right or a liberty interest. They are constitutional rights. The Fourteenth Amendment protects citizens from having property denied without due process of law. Public universities must protect these rights. Private universities do not have to protect constitutional rights, but they must fulfill their contractual obligations with students. Of course, the private institution cannot make a mistake by protecting due process rights, so it is always best to keep due process in mind when making student decisions.

Property is defined as “anything that one possesses.” A contract is property. Students have a contractual relationship with the college/university. A contract is a promise or a set of promises obligating parties, student and school, to perform or behave in certain ways.

Contracts may be written or oral, expressed or implied. The academic handbook is an example of a written, expressed contract. The course syllabus or clinical guidelines are also examples of written contracts.

When students are admitted to programs of study, certain contractual obligations follow. Private institutions, although not governed by constitutional obligations, are governed by the terms of the contracts.

Source: Adapted from Hendrickson, R. M. (1999). The colleges, their constituencies and the courts.

Reflection Questions

1. What are the implications of contract law and constitutional requirements for the clinical instructor teaching at a public university? How do these obligations differ from those associated with teaching at a private college or university?
2. How should these constitutional and contractual protections inform and influence the clinical instructor who is evaluating the poorly performing student at risk of failing the course and, potentially, needing to leave the nursing program?

Discussion Points

1. Follow the course guidelines and the school guidelines for academic/clinical advisement, support, disciplinary proceedings, and failure.
2. Make certain that the student has been clearly informed of the criteria required for clinical success.
3. Document required outcomes and the ramifications of unsatisfactory performance.
4. Make certain to keep ongoing records documenting exchanges.
5. Be objective. Although it can be difficult, do not perceive the probationary student as an “adversary.”
6. The obligations may be daunting, but at stake is patient safety, the reputation of the program, and an obligation to the public and profession that graduates of nursing programs are prepared for entry into practice. Evaluations must be honest, well documented, and fair and follow the established policies and procedures.

Communicating with Students

CNSs should give careful thought to the method of shared communication. Some instructors prefer to distribute their personal cell phone numbers or home numbers, whereas others prefer electronic mail and voice mail messages in the event of missed experiences. Many professors have experienced problems with students lacking a clear understanding of boundaries and telephoning faculty at inappropriate times of day, calling about minu-

tiae, or to engage in general conversation. Clinical instructors subjected to these demanding telephone conversations need to set immediate limits and expeditiously end the call with a reminder to the student that electronic mail may be a more reasonable mode of communication for nonessential concerns.

In addition to inappropriate student calls, clinical instructors may also experience family calls. It is not uncommon for unsatisfactorily performing students to share the instructor's cell phone number with family members, including parents. Not only are these particular calls uncomfortable and surprising, they also place the instructor in an awkward position. Students over the age of 18 are entitled to privacy. Their scholastic performance is considered private information, regardless of who is paying the tuition bills.

Parents are occasionally frustrated by the privacy restriction, but instructors cannot share information about a student's performance with family, friends, or acquaintances unless the student has granted permission. In general, it may be wise to provide students with contact numbers and addresses that are solely work related rather than home phone numbers, addresses, or personal electronic mail addresses.

Fitting into the Academic Environment

Many faculty organizations encourage adjunct faculty members to attend meetings and contribute (Lewallen, 2002) through voice but restrict voting to the full-time professoriate. If a CNS is working as an adjunct or part-time instructor, it is important to share the "adjunct point of view" during faculty meetings. Today's educator shortage frequently creates a dichotomy of classroom faculty and clinical faculty. At times, this relationship is cantankerous as educators struggle with resource and workload challenges that are not much different from those experienced in service settings! Full-time faculty members highly regard clinical instructors who attend meetings, communicate regularly with course faculty, offer well-written and organized evaluation data, and exert positive influences on students. Highly regarded instructors usually enjoy long-term relationships with professor colleagues and have opportunities for participating in academic research, mentoring, and other types of support.

Conclusion

CNSs enjoy teaching and tend to be effective educators. There are many opportunities to teach in nursing, and it is not uncommon to find CNSs participating in educational activities across many venues, including hospitals, universities, and public agencies. First teaching occasions can be nerve-racking as the CNS attempts to learn the ropes and develop a teaching plan that is appropriate for the particular learner.

Most nursing programs address the basics of teaching and learning at the undergraduate level. As a result, the majority of CNSs are comfortable with creating a teaching plan that is based on learner assessment and framed by measurable objectives and goals that are evaluated using outcome-driven data. CNSs are less likely to understand health literacy. They may not appreciate the wealth of materials that are freely available in electronic form. CNSs may also not appreciate the complexity of student teaching and learning or the practical challenges associated with teaching nursing students.

Teaching can be an exciting enterprise, and excellent educators are needed in so many areas within and outside healthcare organizations that CNSs can have their pick of opportunities. It is rewarding to facilitate growth in others, and the teaching role, when satisfied with excellence, is satisfying personally and professionally. The skills that distinguish the expert CNS are readily transferable to and sorely needed in all types of education venues.

References

- Agency for Healthcare Research and Quality (2004). *New Evidence Report Illustrates Links Between Health Literacy and Health Care Use and Outcomes*. Press Release, April 8, 2004. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved September 10, 2006, from www.ahrq.gov/news/press/pr2004/litpr.htm.
- American Association of Colleges of Nursing (AACN). (2005). *Nursing faculty shortage fact sheet*. Retrieved May 11, 2006, from www.aacn.nche.edu/Media/Backgrounders/facultyshortage.htm
- American Literacy Council (ALC). (2006). *Literacy figures. Literacy statistics from the National Adult Literacy Survey*. Retrieved May 10, 2006, from http://www.americanliteracy.com/literacy_figures.htm

- Bastable, S. B. (2003). *Nurse as educator. Principles of teaching and learning for nursing practice* (2nd ed.). Boston: Jones and Bartlett.
- Berkman, N. D., DeWalt, D. W., Pignone, M. P., Sheridan, S. L., Lohr, K. N., Lux, L., Sutton, S. F., Swinson, T., & Bonito, A. J. (2004). *Literacy and Health Outcomes. Summary, Evidence Report/Technology Assessment No. 87* (Prepared by RTI International—University of North Carolina Evidence-based Practice Center under Contract No. 290-02-0016). AHRQ Publication No. 04-E007-1. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved September 10, 2006, from <http://www.ahrq.gov/clinic/epcsums/litsum.htm>.
- Billings, D., & Halstead, J. (2005). *Teaching in nursing: A guide for faculty*. St. Louis, MO: Elsevier Saunders.
- Committee on Health Literacy, Board on Neuroscience and Behavioral Health, Institute of Medicine. (2004). *Health literacy: A prescription to end confusion*. Washington, DC: National Academies Press.
- Cowan, D., Norman, I., & Coopamah, V. (2005). Competence in nursing practice: A controversial concept. A focused review of the literature. *Nurse Education Today*, 25, 355–362.
- Davis, T. C., Crouch, M. A., Long, S. W., Jackson, R. H., Bates, P., George, R. B., & Bairnsfather, L. E. (1991). Rapid assessment of literacy levels of adult primary care patients. *Family Medicine*, 23(6), 433–435.
- Davis, T. C., Long, S. W., Jackson, R. H., Mayeaux, E. J., George, R. B., Murphy, P. W., & Crouch, M. A. (1993). Rapid estimate of adult literacy in medicine: A shortened screening instrument. *Family Medicine*, 25(6), 391–395.
- del Bueno, D. (2001). Buyer beware: The cost of competence. *Nursing Economics*, 19(6), 250–257.
- del Bueno, D. (2005). A crisis in critical thinking. *Nursing Education Perspectives*, 26(5), 278–282.
- del Bueno, D., Barker, F., & Christmyer, C. (1980). Implementing a competency-based orientation program. *Nurse Educator*, 5(3), 16–20.
- Doak, L. G., & Doak, C. C. (Eds). (2004). *Pfizer principles for clear health communication* (2nd ed.). Potomac, MD. Retrieved May 11, 2006, from http://www.pfizer-healthliteracy.org/pdfs/Pfizers_Principles_for_Clear_Health_Communication.pdf
- Hendrickson, R. L. (1999). *The colleges, their constituencies, and the courts* (2nd ed.). No. 64 Monograph series. Dayton, OH: Education Law Association.
- Hsu, L., & Hsieh, S. (2005). Concept maps as an assessment tool in a nursing course. *Journal of Professional Nursing*, 21(3), 141–149.
- Jacobson, T. A., Thomas, D. M., Morton, F. J., Offutt, G., Shevlin, G., & Ray, S. (1999). Use of a low-literacy patient education tool to enhance pneumococcal vaccination rates. A randomized controlled trial. *JAMA: Journal of the American Medical Association*, 282(7), 646–50. Retrieved September 10, 2006, from EBSCO host Electronic Journals Service.

128 Chapter 3 Influencing Healthcare Quality: Educating Patients, Nurses, and Students

- JCAHO. (2006a). *2006 comprehensive accreditation manual for hospitals*. Oakbrook Terrace, IL: Author.
- JCAHO. (2006b). *Behavioral health care—management of human resources standards*. Retrieved on June 15, 2006, from http://www.jointcommission.org/NR/rdonlyres/9F45B1F6-45E6-4D01-9DE4-62AF056ACDD7/0/bhc_hr_07.pdf
- Lewallen, L. P. (2002). Using your clinical expertise in nursing education. *Clinical Nurse Specialist*, 16(5), 242–246.
- Luparell, S. (2005). Why and how we should address student incivility in nursing programs. In M. H. Oermann & K. T. Heinrich (Eds.), *Annual review of nursing education: Strategies for teaching, assessment, and program planning* (pp. 23–36). New York: Springer.
- Lyon, B. L., & Boland, D. L. (2002). Demonstration of continued competence: A complex challenge. *Clinical Nurse Specialist*, 16(3), 155–156.
- McConnell, E. (2001). Competence vs. competency. *Nursing Management*, 32(5), 14–15.
- McMullan, M., Endacott, R., Gray, M. A., Jasper, M., Miller, C., Scholes, J., & Webb, C. (2003). Portfolios and assessment of competence: A review of the literature. *Journal of Advanced Nursing*, 41(3), 283–294.
- Measurement Excellence and Training Resource Information Center (METRIC). (2006). *Critical review of Rapid Estimate of Adult Literacy in Medicine (REALM)*. Retrieved June 2, 2006, from http://www.measurementexperts.org/instrument/instrument_reviews.asp?detail=58
- National Assessment of Adult Literacy (NAAL). (2006a). *What is NAAL?* Retrieved May 22, 2006, from <http://nces.ed.gov/NAAL/index.asp?file=AboutNAAL/WhatIsNAAL.asp&PageId=2>
- National Assessment of Adult Literacy (NAAL). (2006b). *National Assessment of Adult Literacy—Overall. Demographics*. Retrieved May 22, 2006, from <http://nces.ed.gov/NAAL/index.asp?file=KeyFindings/Demographics/Overall.asp&PageId>
- National Institutes of Health. (2005). *Improving health literacy*. Retrieved May 10, 2006, from <http://www.nih.gov/icd/od/ocpl/resources/improvinghealthliteracy.htm>
- Nolan, P. (1998). Competencies drive decision making. *Nursing Management*, 29(3), 27–29.
- Office of Disease Prevention and Health Promotion (ODPHP). (2000). *Healthy people 2010: Terminology*. Retrieved on May 9, 2006, from http://www.healthypeople.gov/document/html/volume1/11healthcom.htm#_Toc490471359
- Pfizer, Incorporated. (2003). *Clear health communication. Improving health literacy*. Retrieved May 18, 2006, from <http://www.pfizerhealthliteracy.org/improving.html>
- Plain Language. (2006). *Document checklist for plain language on the web*. Retrieved May 28, 2006, from <http://www.plainlanguage.gov/howto/quickreference/checklist.cfm>
- Potter, L., & Martin, C. (2006). *Health literacy fact sheets. Fact sheets 6 & 7 of 9*. Center for Health Care Strategies, Inc. Retrieved May 12, 2006, from http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711

- Rudd, R. E. (2005). *How to create and assess printed materials*. Harvard School of Public Health: Health Literacy Studies. Retrieved May 26, 2006, from <http://www.hsph.harvard.edu/healthliteracy/materials.html#two>
- Thomas, S. P. (2003). Handling anger in the teacher–student relationship. *Nursing Education Perspectives*, 24(1), 17. CINAHL-Database of Nursing and Allied Health Literature.
- U.S. General Accounting Office. (2001). *Nursing workforce. Emerging nurse shortages due to multiple factors*. GAO 01-944. Washington, DC: Author. Retrieved July 2, 2006, from <http://www.gao.gov/new.items/d01944.pdf>
- University of Washington. Harborview Medical Center. (2006). *Ethnomed home page*. Retrieved June 3, 2006, from <http://ethnomed.org/ethnomed/>
- Waddell, D. (2001). Measurement issues in promoting continued competence. *JCEN*, 32(3), 102–106.
- Watson, R., Stimpson, A., Topping, A., & Porock, D. (2002). Clinical competence assessment in nursing: A systematic review of the literature. *Journal of Advanced Nursing*, 39(5), 421–431.
- Weiss, B. (2003). *AMA literacy manual*. Retrieved March 18, 2006, from <http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf>
- Wikipedia. (2006). *SMOG Index*. Retrieved May 27, 2006, from http://en.wikipedia.org/w/index.php?title=SMOG_Index&oldid=54693668
- Wright, D. (2005). *The ultimate guide to competency assessment in health care* (3rd ed.). Minneapolis, MN: Creative Health Care Management, Inc.
- Zuzelo, P. (2005). Affirming the disadvantaged student. *Nurse Educator*, 30, 27–31.
- Zuzelo, P. (2000). Clinical probation: A supportive process for the at-risk student. *Nurse Educator*, 25, 216–218.
- Zuzelo, P., Inverso, T., & Linkewich, K. (2001). Content validation of the Medication Error Worksheet. *Clinical Nurse Specialist*, 15(6), 253–259.

Supplemental Resources

- McKeachie, W. J. (2002). *McKeachie's teaching tips*. Boston, MA: Houghton Mifflin.
- Stevens, B. (2003). How seniors learn. *Center for Medicare Education*, 4(9), 3. Retrieved May 18, 2006, from <http://medicareed.org/PublicationFiles/V4N9.pdf>

