UNIVERSITY OF NEBRASKA MEDICAL CENTER

COLLEGE OF NURSING

CLINICAL FACULTY HANDBOOK

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UNIVERSITY OF NEBRASKA MEDICAL CENTER
COLLEGE OF NURSING

1. POSITION GUIDELINES

Position Title: Clinical Teaching Faculty

Position Description: This position is to assist in the guidance and evaluation of nursing students in a selected clinical agency. The Clinical Teaching Faculty member is responsible for the guidance and evaluation of the clinical experiences of a group of nursing students in a selected clinical setting, and is expected to work the same academic calendar as other faculty.

Position Qualifications: Masters of Science in Nursing is the minimal educational expectation. Must have a minimum of one year of staff nursing experience in the clinical area in which teaching will be conducted. Must be eligible to work in the U.S. and must have current RN licensure in Nebraska.

Position Responsibilities:

1. Communicate, as required, student learning objectives and planned activities to agency staff.
2. Assume overall responsibility for the instruction, supervision and evaluation of clinical learning experiences of assigned students.
3. In conjunction with the nurse in charge of the clinical unit, select appropriate patients and learning experiences to facilitate achievement of course/class and clinical objectives, weekly clinical focus, student competencies and learning needs.
4. Challenge the students' clinical reasoning skills and foster the application of skill and knowledge development.
5. Encourage students to be involved in the selection of appropriate patients that will meet student learning needs and course objectives.
6. Guide students with development of their nursing process, assessing students' clinical performance and knowledge development.
7. Provide students with constructive weekly, mid-semester, and final feedback regarding their clinical performance to assist students in further growth and skill development.
8. Evaluate the performance of each student according to evaluation criteria provided.
9. Provide opportunities for students to evaluate their own performance (e.g. mid-semester and final).
10. Maintain records of all students' performance associated with clinical experiences.
11. Notify the course coordinator as soon as possible of poor student performance, student injury, and/or clinical incident involving a student or to discuss any uncertainties regarding student(s) or agency.
12. Adhere to agency policies, procedures and regulations and those governing professional practice.
13. Ensure that students wear the appropriate attire for the clinical experience.

Position Accountabilities:

1. Attend the orientation program and subsequent information sessions as required by the course to which he or he is assigned.
2. Adhere to UNMC College of Nursing's Policies and Procedures governing clinical.
3. Adhere to agency policies, procedures and regulations and those governing professional practice.
4. Maintain regular and frequent contact with the course coordinator (or faculty to whom you are assigned) to discuss student progress, teaching issues, and other concerns. Contact the course coordinator as soon as possible of own unavoidable absence from clinical teaching and any concerns related to students.
5. Be aware of content being studied in accompanying theoretical nursing courses, what has been taught in previous nursing courses and what will be taught in future nursing courses.
6. Provide opportunity for students to evaluate the clinical teaching faculty as a clinical instructor (each semester).
7. Evaluate self as clinical teaching faculty member each semester.
8. Submit all student evaluation forms to the course coordinator within one week of completion of clinical experience.
9. Complete additional clinical or related activities as directed by the course coordinator.
10. Adhere to CON, course, and clinical agency policies regarding appropriate attire in the clinical area.

*Note : If you are a Graduate Assistant for Clinical Teaching (GACT), please review the GACT Position Guidelines as well.

2. GIDDEN'S CONCEPT- BASED NURSING CURRICULUM

As the body of nursing content increases exponentially, it is no longer possible to learn all nursing content as in the past. Instead, a new approach with our nursing curriculum is warranted. UNMC, College of Nursing organizes their BSN curriculum around Gidden's Concept Based Curriculum. This involves a shift from the traditional methods of teaching health and illness content areas. Now, concepts are presented across the life span and across clinical settings in both didactic and clinical courses. Exemplars are used to teach the concepts, but not all content is addressed. Instead, student learning is interactive; evidence based, focused on critical thinking and using additional resources as needed.

Please read the article by Drs. Jean Gidden's and Debra Brady in the *Journal of Nursing Education* (2007).

http://nursingisfabulous.wikispaces.com/file/view/Concept-based+Curriculum.pdf

View the brief, two-minute YouTube, *Gidden's: Concepts of Nursing Practice* for additional insights.

http://www.youtube.com/watch?v=QykYlyXveVA

You will also want to contact Elsevier Publishing and obtain a link to PAGEBURST which has added on –line features to teach concept based techniques. Our contact person is Audra Ostergard at Elsevier (phone: 402-617-1236; email: a.ostergard@elsevier.com).

References

Giddens, J. F. (2012). Concepts for Nursing Practice. St. Louis: Mosby Elsevier.

Giddens, J.F. & Brady, D.P. (2007). Rescuing nursing education from content saturation: The case for a concept –based curriculum. *Journal of Nursing Education, (46)*2, 55-69.

3. CLINICAL INSTRUCTOR RESPONSIBILITIES

A. Clinical Teaching Tips

Student-Focused Behaviors:

1. Assess learning needs of students, recognizing and accepting individual differences.
2. Communicate objectives and expectations clearly to students.
3. Clearly explain concepts and theories applicable to patient care.
4. Ask higher level questions that assist students in thinking through complex clinical situations and cases requiring critical thinking.
5. Encourage students through teaching and evaluation to think independently and beyond accepted practices and to try out new interventions.
6. Use reflective questioning for the student to evaluate their own performance.
   a. What key learning occurred today?
   b. What learning needs can the student identify for the next clinical experience?

Teacher-Focused Behaviors:

1. Be well prepared for the skills and learning needs for the clinical teaching day.
2. Develop clinical teaching strategies that encourage students to problem solve, arrive at clinical decisions, and think critically in a clinical situation.
3. Vary clinical teaching methods to stimulate student interest and meet individual needs of students.
4. Guide learning and students' use of resources for learning.
5. Be available to students in clinical settings when they need assistance.
6. Serve as a positive role model for students.

References:

Billings, D.M. (2009). Story Telling: An Adjunct to Learning. *The Journal of Continuing Education in Nursing*, 40(7), 296-297.

Carlson, E., Wann-Hansson, C, and Pilhammer, E. (2009). Teaching during clinical practice: Strategies and techniques used by preceptors in nursing education*. Nurse Education Today*, 29, 522-526.

Stokes, L. G., & Kost, G. C. (2009). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead, *Teaching in nursing: A guide for faculty* (3rd ed., pp. 283-299). St. Louis: Saunders Elsevier.

Giddens, J. F. (2012). *Concepts for nursing practice*. St. Louis: Mosby Elsevier.

B. Making Clinical Assignments

Curriculum Considerations:

1. Consider placement of the clinical course in the curriculum. This should include understanding the skill and content that will be introduced in this course, reinforced from previous coursework, and what should be mastered for the next level.
2. Review objectives of the course in order to provide experiences that will help meet them. Senior level students should also be meeting program objectives.
3. When possible, correlate assignments to the content being discussed in the class room to allow students to apply theory material in a timely manner. Or be able to discuss when this content be presented and how it can be integrated into the current clinical day.

Student-Focused Considerations:

1. Recognize each student as an individual and understand the skill level and learning needs of each student.
2. Determine if the traditional individual assignment is best or the use of dual or multiple assignment to enhance the experience.
3. Allow for collaboration with the student for assignments to meet individual interest and learning opportunity. Student self-assignment should be approved by instructor.
4. Consider student goals and needs during planning of clinical experience.
5. Provide opportunities for practice of clinical skills, procedures, and technology. This does not have to be with the assigned patient.
6. Recognize the different skill level among the students and incorporate the appropriate level of practice to enhance and improve skills.
7. Choose assignments that will provide a diverse experience for the students. This could include diverse cultural background, gender, medical and nursing diagnosis, healthcare needs, and age groups.

Teacher-Focused Considerations:

1. Involve the staff when preparing for clinical assignment when possible to get better insight on issues that might benefit or hinder learning.
2. Structure clinical assignments and activities to build on one another.
3. Give assignments that you know that you would be able to handle.
4. Be aware of the skill sets required by the overall patient load of the clinical group for your time management of the clinical day. Too many skills that require supervision leads to students waiting around and a chaotic day.
5. Plan assignments that help in transfer of learning in the clinical setting, meet learning needs, and promote acquisition of knowledge and development of competencies.
6. Look for opportunities for student collaboration and interaction with other health disciplines. Foster appreciation of inter-professional relationships to enhance understanding and appreciation of each role in the healthcare system.

References:

Cederbaum, J., Klusaritz, H. (2009). Clinical Instruction: Using the Strengths-Based Approach with Nursing Students. *Journal of Nursing Education,* 48(8), 422-428.

Stokes, L. G., & Kost, G. C. (2009). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead, *Teaching in nursing: A guide for faculty* (3rd ed., pp. 283-299). St. Louis: Saunders Elsevier.

C. Faculty Concerns about Students

Some common questions faculty have during their work with students involve the following:

1. Students sometimes seem to desire to tell faculty about their personal problems. How should faculty handle this? It often makes faculty uncomfortable.

   According to Stokes, Valencia-Go, and Fisher (2000), this problem arises when students perceive faculty as approachable. These authors advise caution, however, and recommend stopping these revelations as gently as possible so as not to seem unresponsive to the student. Acknowledge that the problem is real and of concern to the student, and refer the student to appropriate counseling/referral services on campus or relevant information about other resources the student might find useful. If the student is in a crisis state, do not leave the student alone, but accompany the student to the counselor's office or call security to have them do so (particularly if the student seems potentially harmful to self or others). It may be helpful to you to consult with your college administrative person about specific procedures you should be aware of in these types of situations.

2. How should faculty maintain appropriate boundaries with students? Often it is difficult to determine when being approachable could be construed as too friendly; conversely, maintaining boundaries may make the faculty appear intimidating to students.

   The authors mentioned above state that the relationship between student and faculty is a professional one. If faculty demeanor is perceived by students as threatening or remote, students may believe that the faculty member is disinterested in them. Probably the key is to maintain professional boundaries so that the faculty member does not divulge too much information about personal life or engage in social activities with the student. It is fine at the beginning of the semester to ask students and faculty to share interest in hobbies and extracurricular activities in order to become more familiar with one another, but then move on to discussion of course-related material. Certainly, students need to have the faculty member's telephone number(s) and work email address in order to communicate effectively.

Reference:

Stokes, E. N., Valencia-Go, G., & Fisher, K. (2000). Concerns of and about students. In L. J. Scheetz, *Nursing faculty secrets.* Philadelphia: Hanley & Belfus, Inc.

D. Clinical Supervision of Students

1. Determine the policy of the facility in regards to patient care and interventions performed by students.
2. Decrease the numbers of students to supervise directly by rotating students to a related area.
3. Review interventions and procedures with students prior to performance as needed and dependent upon level of student ability and knowledge.
4. Observe student for competency level in safety, teamwork, patient centered care, evidenced-based practice, and informatics).
5. Assess student level of anxiety, provide support and give ongoing feedback.
6. Mistakes are part of learning. Be sure to correct students in private, but ask for permission to discuss with the group to enhance learning for all.
7. The instructor does not have all the answers. Role model by using available resources to help find answers. Discuss how resources are found and utilized.
8. Assist students as needed with planning and organizing care. Provide tips on organization.
9. Keep notes for evaluation of the students that include strengths and weaknesses, type of care provided to what type of patient, agency, skills learned, etc.
10. Allow the student to work as independently as possible unless there is a safety issue.
11. Be available for questions and to provide assistance.
12. Determine a time management style to be available for medication administration and other supervised procedures.
13. When possible, seek feedback from staff that have observed student-patient interactions.

References:

Carlson, E., Wann-Hansson, C, and Pilhammer, E. (2009). Teaching during clinical practice: Strategies and techniques used by preceptors in nursing education. *Nurse Education Today*, 29, 522-526.

Cronenwett, L, Sherwood, G, Barnsteiner, J, Disch, J, Johnson, J., Mitchell, P., Sullivan, D. T., Warren, J. (2007). Quality and safety education for nurses. *Nusing Outlook 55*: 122-131.

Stokes, L. G., & Kost, G. C. (2009). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead, *Teaching in nursing: A guide for faculty* (3rd ed., pp. 283-299). St. Louis: Saunders Elsevier.

E. Conducting Pre- and Post-Conferences

Pre- and post-conferences are group learning experiences that should bridge the gap between classroom learning experiences and clinical experiences. Well-developed conferences focus the learning experience and provide opportunities for students to critically apply concepts discussed in class to patient situations. In addition, students should have the opportunity to examine issues that have arisen during the clinical experience (e.g., ethical, legal), not to introduce new didactic content. Both students and staff should be informed where and when these conferences will be scheduled (in case staff needs to locate instructor or students during conference). **All students should be expected to attend and participate in pre- and post-conferences.**

Pre-Conferences:

1. Pre-conferences precede the clinical experience and can be used to assess the student's goals and for preparatory guidance to assist the student in clarifying questions and preparing and identifying priorities for their care. Concepts that will be the focus for the day should be identified for the students ahead of time; pre-conference is a good time to remind students of them.
2. During pre-conference, each student may briefly share their goals for patient care with the total group. Goal-oriented pre-conferences can be efficiently conducted with the entire clinical group, but individual student concerns may need to be discussed one-on-one after pre-conference between the student and faculty. Some instructors use this time to provide students with patient status report from the off-going nurse or the nurse they will work with that day.

Post-Conferences:

1. Post-conferences allow students to critically reflect upon their clinical experiences, learn from others in the group, and assist the students to develop more in-depth learning related to the clinical objectives. Patient-centered care for particular concepts, comparing across the all students' patients should frequently provide the focus of post-conferences.
2. Allow the students to direct the post-conference discussion. Faculty may encourage further elaboration of important aspects of the students' discussions by raising high-level questions, suggesting relationships, and facilitating all students' participation in the topic.
3. Students can also participate in "grand rounds" in which (with patient/parent permission) the student group and faculty member make rounds to demonstrate patient characteristics and nursing care related to the selected concept(s) that provided the focus for care that day. Focused topics should be guided by the clinical objectives and reinforce class content using specific patient care examples, but should NOT replace or repeat content taught in class. Preparation could include asking the students to bring articles (research or nursing care), standards of practice, or other published nursing literature to supplement ideas used for clinical topics. Medication math exercises can also be discussed in post-conferences if students have sufficient time to work problems prior to their discussion.

References:

Hsu, L. (2007). Conducting clinical post-conference in clinical teaching: A qualitative study. *Journal of Clinical Nursing, 16*, 1525-1533. doi:10.1111/j.1365-2702.2006.01751.x

Letizia, M. & Jennrich, J. (1998). Development and testing of the clinical post-conference learning environment survey. *Journal of Professional Nursing, 14*(4), 206-213.

Nielsen, A. (2009). Concept-based learning activities using the clinical judgment model as a foundation for clinical learning. *Journal of Nursing Education, 48*(6), 350-354.

O'Connor, A. B. (2006). *Clinical instruction and evaluation: A teaching resource.* Boston: Jones & Bartlett.

Stokes, L. G., & Kost, G. C. (2009). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead, *Teaching in nursing: A guide for faculty* (3rd ed., pp. 283-299). St. Louis: Saunders Elsevier.

F. Using Critical Thinking Exercises in Clinical and Post-Conferences

What is critical thinking? According to Alfaro-LeFevre (2004), **critical thinking in nursing** "refers to purposeful, informed reasoning both *in* and *outside* the clinical setting" whereas "**clinical judgment and clinical reasoning** refer to using critical thinking in the clinical setting…" Both involve "purposeful, informed, outcome-focused (results-oriented) thinking that requires careful identification of key problems, issues, and risks involved." (p. 3) Both logic and intuition can be used, and the nurse's knowledge and experience, as well as nursing process and the scientific method, are essential in contributing to reasoned, evidence-based practice.

You can help students use critical thinking during clinical practice as well as in post-conference by raising some of the following questions to guide the students' thinking. Feel free to add your own questions to this list as you find those that seem best for you to use, but try to be gentle and avoid interrogating the students. It may be difficult for them to think critically if they are overly anxious. Sometimes asking the student to "think out loud" can be useful in tracking their thought processes.

1. What symptoms or patient/family characteristics are apparent related to the physiologic or psychosocial concept(s) that may be the focus of the clinical experience?
2. What outcomes or goals are appropriate related to the goals the client/family desire to achieve? When is a reasonable time to expect that the outcome can be achieved?
3. What nursing diagnoses can you identify based on the patient/family data available to you? Why are the diagnoses you selected the best in this situation? Are the diagnoses actual or is the patient at risk for some? How do you decide? What additional data do you <u>really</u> need? Why? Where/how can you obtain the data most quickly? What outcomes would be appropriate to expect and what criteria will you use to evaluate them?
4. What knowledge is necessary to provide best practice in this situation? This can range from pathophysiology or pharmacology to policies/procedures, the patient/family's culture, and knowledge of the nurse's scope of practice. What resources will help you obtain this knowledge and where are they?
5. What has the patient tried to do about the problem (What is the patient's "story")? What is the rationale for planned or provided nursing interventions? How effective were these in achieving the desired outcomes? If the attempt was unsuccessful, why do you think so? What else should be done to achieve the desired outcome safely and efficiently? Why? What evidence supports your recommended action? What is the source of the evidence? What is your patient's opinion of your actions/recommendations? Do you have the knowledge, skills, and attitudes to do what you are recommending? If not, what help is needed?
6. When you reflect on your time with the patient/family today and the outcome you wanted to achieve, contemplate whether or not you were successful in achieving the goals/outcomes. If not, what knowledge, skills, or attitudes need to change? What are the risks and benefits to your suggested changes? If you make no changes, what do you think the patient/family's condition or situation might be tomorrow?

<u>References</u>:

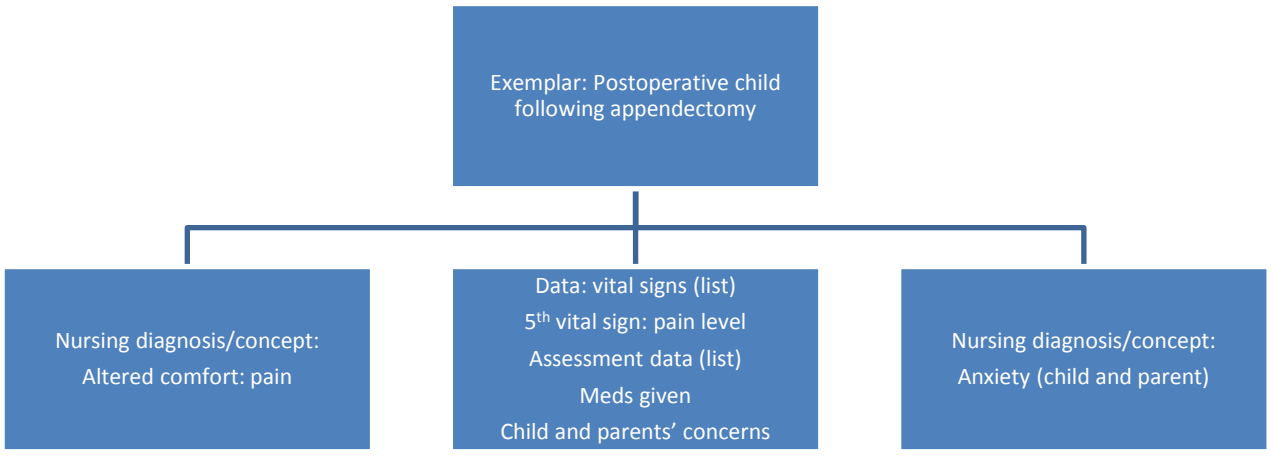
Alfaro-LeFevre, R. (2004). *Critical thinking and clinical judgment,* 3rd ed. Philadelphia: Saunders.

Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education, 45*(6), 204-211.

G. Using Concept Maps

Concept mapping is a critical thinking exercise that can be used in both classroom and clinical situations. In the classroom, concept mapping can be an exercise to stimulate students' thinking about a particular case study, for example. In clinical, the students would use their own patients for this exercise. It can be completed by an individual student to replace or supplement the written nursing process for a particular patient, or conducted in post-conference using group dialogue applied to a particular patient care situation. Concept maps have been found to improve non-linear thinking to identify relationships among concepts and foster critical thinking (Abel & Freeze, 2006; Hicks-Moore & Pastirik, 2006). Concept map care planning is an innovative technique for understanding the patient's condition and problems as well as planning interventions. According to Schuster (2002), the concept map is a diagrammatic representation that can be used to "organize patient data, analyze relationships in the data, establish priorities, build on previous knowledge, identify what you do not understand, and enable you to take a holistic view of the patient's situation." (p. 2)

As shown in the chart below, begin with a central or top circle or box to begin the process of the concept map. This could be the reason for admission or home care referral, or for being seen in the clinic (presenting complaint or medical diagnoses). Begin listing data in boxes below that relate to this. Data can be moved back and forth but eventually the data should lead to the establishment of as many nursing diagnoses as the data support. Below is an example of a beginning map. The data should be very specific, and include the patient's actual pain levels, electrolyte values, temperature, etc. Add boxes or bubbles while continuing to list data and develop nursing diagnoses until all data and diagnoses have been exhausted. Then connect the diagnoses with lines to show relationships. Which diagnoses are connected in some way, or flow from one another? When all the lines have been drawn, look at the diagnoses and the relationships. Do the lines assist in assigning priorities? At this point, the students should assign priorities to the identified nursing diagnoses and dialogue about their reasoning.



Another concept map can be developed to devise interventions or evaluate outcomes for the priority nursing concepts/diagnoses, following the process outlined above. If this exercise is being conducted in post-conference, students may have actual data to include in a concept map of the outcome/evaluation of their care and begin revising the map to improve care, as well. It may be useful to have the student draw the map on a black or white board in the conference room, so all students can see it and participate in developing and modifying the map.

The same process can be useful to examine ethical dilemmas, community care, management issues, and other types of clinical problems.

References:

Abel, W. M., & Freeze, M. (2006). Evaluation of concept mapping in an Associate Degree nursing program. *Journal of Nursing Education, 45*(9), 356-364.

Hicks-Moore, S. L., & Pastirik, P. J. (2006). Evaluating critical thinking in clinical concept maps: A pilot study. *International journal of nursing education scholarship, 3*(1). Retrieved from https://library1.unmc.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&jid=YRZ&loginpage=Login.asp&site=ehost-live

Schuster, P. M. (2002). *Concept mapping: A critical-thinking approach to care planning*. Philadelphia: F. A. Davis.

H. Evaluation of Students

Data sources contributing to the evaluation of clinical experience include observation of student-patient interactions, actual care provided by students as well as their written plans of care, verbal report of their interactions with patients from students and staff, and students' performance during laboratory activities or simulations. Faculty responsibilities include the following:

1. Evaluation of critical thinking by asking open-ended higher level questions (why and why not?) for which several answers are possible. In the evaluation process, ask:
- A. How does the student develop answers to problems?
- B. What does the student do when s/he doesn't know the answer?
- C. What are the student's reasons? Sources of information?
- D. Does the student ask reasons why things occur? Why some interventions are better? Know how to locate valid and reliable evidence?
- E. Are many alternatives generated by the student in choosing a solution?
- F. What discrepancies in the environment are the students able to identify that may affect the client's health, access to care, and outcomes?

2. Formative evaluation (ongoing evaluation that occurs throughout the clinical experience). Formative evaluation provides:
- A. Ongoing, specific, timely, and constructive feedback regarding clinical experiences to assist students' further growth and skill development.
- B. Insight into students' preferred learning styles, readiness to learn, learning needs, levels of ability and aptitude to develop at progressively more advanced levels. For example, have assignments been too basic for the student? Is the student ready to care for more than one patient? Are the instructor's expectations appropriate and realistic?
- C. Feedback to student about where they stand relative to achievement of course objectives and what might be necessary areas of improvement in order to successfully pass clinical.

3. Regular and frequent documentation (sampling of students' knowledge, skills, and attitudes) of care in anecdotal notes or evaluation forms that describe the patient/client situation and the student's action in relation to patient needs. This is helpful since the faculty member is not able to observe all students during their entire clinical experience.
- A. Episodes of care provided by each student should involve a range of patient situations and include both positive and negative observations. Students should be informed about what they did well, as well as the areas that need to be improved.
- B. An equivalent number of episodes in some detail should be recorded for each student to adequately assess each student's performance and to avoid charges of discrimination in evaluation should the student appeal the grade.
- C. Formative evaluation should occur as close in time to the stimulating incident as possible, so that the student can connect faculty comments to events that occurred.

4. Mid-Semester Clinical Evaluations*:
- A. Formalize a summary of evaluation comments at mid-semester that reflects student progress thus far and provides positive feedback as well as suggested areas for continued effort on the student's part.

B. Correct students' performance without shaming or belittling them.
C. Exhibit fairness in evaluation.
D. Maintain confidentiality; never compare this student's performance with others in the clinical group. Provide feedback that identifies student deficiencies away from the bedside, staff, and other students.
E. Provide opportunity for students to evaluate their own performance and include this written document as part of the evaluation materials that remain in the student's file.
F. Share any/all evaluative data, verbally and in written form, ONLY with the involved student.
G. Decline parental requests to discuss the performance of a student who is in danger of failing. Consult with the appropriate administrator and course coordinator and meet with the student and course coordinator if requested.

5. Summative evaluation is provided when the clinical rotation has been completed. At this point, the students must be informed whether or not they have met the course/clinical objectives. Students need to be informed if there is a certain point at which observations of their performance will begin to contribute to the final/summative clinical evaluation. Performance achieved at the end of the clinical experience matters most. Ultimately the instructor must decide if the student has met the course/clinical objectives, if the student is safe to provide care, and whether or not the instructor has clear evidence that supports these judgments.
A. Indicate the level of the student's performance during the final conference.
B. Include a brief narrative note describing the student's overall performance relative to each objective for the clinical experience. It may be useful to include examples of student behaviors that support the rating achieved (satisfactory, needs improvement, unsatisfactory).
C. If the student does not achieve the clinical objectives, the student deserves to be informed in private. The course coordinator may need to conduct this conversation or be present for it.
i. **Due process** means that the student has the right to know what s/he must do to successfully complete the expectations of the clinical experience; all instructors have the responsibility to communicate these clearly to the student. Students must receive regular written and timely feedback on their performance, especially if it fails to meet expectations; be told the consequences of their continued failure to meet expectations and what they must to do meet them; and have the opportunity to remediate and improve.

References:

Bonnel, W. (2009). Clinical performance evaluation. In B. M. Billings & D. A. Halstead, *Teaching in nursing: A guide for faculty (pp. 449-466, 3rd ed.).* St. Louis: Saunders Elsevier.

O'Connor, A. B. (2006). *Clinical instruction and evaluation: A teaching resource.* Boston, MA: Jones & Bartlett Publishers. See Chapter 9, Theoretical approaches to the evaluation of learning in the laboratory and clinical practice settings, pp. 201-216, and Chapter 10, Evaluation strategies for the laboratory and clinical practice settings, pp. 217-244.

I. Clinical Simulation Experiences

Advantages of Using Clinical Simulation:

1. Provides a controlled environment.
2. Allows all students to experience the same type of patient.
3. Creates events that may not occur in clinical.
4. Allows room for student error without harm to the patient.
5. Increases student competence and confidence.
6. Provides alternate method of learning.
7. Promotes student interaction and learner-centered experience.

Disadvantages:

1. SimMan is not a real person.
2. Students are required to role play or "act" to an extent.
3. Limits number of student participants to each encounter.
4. Considerable amount of faculty time involved in development and update of material.
5. Possible equipment failure.

Clinical uses for simulation:

1. Orientation to skills or patient population.
2. Make-up clinical day.
3. Remediation or improvement of skills seen at clinical site.
4. Testing student competencies.

Resources for simulation development:

1. Learning Resources Center: Connie Miller – Omaha
    a. Kendra Knox – Lincoln
    b. Diane Feldman- Kearney
    c. Jerry Schledewitz- Scottsbluff
    d. Tom Gaffney - Norfolk
2. Sorrell Center: Patricia Carstens

References:

Cronenwett, L, Sherwood, G, Barnsteiner, J, Disch, J, Johnson, J., Mitchell, P., Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook 55*, 122-131.

Jeffries, P. R. (2007). *Simulation in nursing education: From conceptualization to evaluation.* New York: National League for Nursing.

Wagner, D., Bear, M., & Sander, J. (2009). Turning simulation into reality: Increasing student competence and confidence. *Journal of Nursing Education, 48*(8), 465-467.