Dial-In Instructions

Conference Name: Developing Critical Thinking Skills in New Graduate Nurses

Scheduled Conference Date: Wednesday, May 31st, 2006

Scheduled Conference Time: 1:00 p.m.–2:30 p.m. (Eastern), 12:00 p.m.–1:30 p.m. (Central), 11:00 a.m.–12:30 p.m. (Mountain), 10:00 a.m.–11:30 a.m (Pacific)

Scheduled Conference Duration: 90 Minutes

PLEASE NOTE: If the audioconference occurs April through October, the time reflects daylight savings. If your area does NOT observe daylight savings, times will be one hour earlier.

Your registration entitles you to ONE telephone connection to the audioconference. Invite as many people as you wish to listen to the audioconference on your speakerphone. Permission is given to make copies of the written materials for anyone else who is listening.

In order to avoid delays in connecting to the conference, we recommend that you dial into the audioconference 15 minutes prior to the start time.

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2. You will be greeted by an operator
3. Give the operator your pass code 053106 and the last name of the person who registered for the audioconference.
4. The operator will verify the name of your facility.
5. You will then be placed into the conference.

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1. If you experience any difficulties with the dial-in process, please call the conference center reservation line at 877/407-7177.
2. If you should need technical assistance during the audio portion of the program, please press the star (*) key followed by the 0 key on your touch-tone phone and an operator will assist you. If you are disconnected during the conference, dial 877/407-2989.

Q&A Session
1. To enter the questioning queue during the Q&A session, callers need to push the star (*) key followed by the 1 key on their touch-tone phones. Note: For most programs, this portion of the program generally falls after the first hour of presentation. Please do not try to enter the queue before this portion of the program.
2. If you prefer not to ask your question on the air, you can fax your question to 877/808-1533 or 201/612-8027. However, note that you can only fax your question during the program.

Prior to the Program
If you prefer not to ask your question on the air, you can send your questions via email to stierney@hcpro.com. The deadline for questions is 05/30/06 @ 5:30 PM EST. Please note that it is likely that not all questions will be answered.

Program Evaluation Survey
In your materials on page 2, we have included a Program evaluation letter that has the URL link to our program survey. We would appreciate it if when you return to your office you would go to the link provided and complete the survey.

Continuing Education Documentation
If CE’s are offered with this program, a separate link containing important information will be provided along with the program materials. Please follow the instructions in the CE Documentation.
Dear Audioconference Participant,

Thank you for attending the HCPro audioconference today. We hope that you find the information provided valuable.

In our effort to ensure that our customers have a positive experience when taking part in our audioconferences we are requesting your feedback. We would also like to request that you forward the link to others in your facility who attended the audioconference.

We realize that your time is valuable, so we’ve limited the evaluation to a few brief questions. Please click on the link below.

http://www.zoomerang.com/survey.zgi?p=WEB2258Y6TL64F

The information provided from the evaluation is crucial towards our goal of delivering the best possible products and services. To insure that your completed form receives our attention, please return to us within six days from the date of this audioconference.

We appreciate your time and suggestions. We hope that you will continue to rely on HCPro audioconferences as an important resource for pertinent and timely information.

PLEASE NOTE:
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http://www.zoomerang.com/survey.zgi?p=WEB2255LZ3JPZP

within 30 days of the program in order to receive your credits. After 30 days, the evaluation for this activity will be closed and the certificate of completion will be sent to you by email.

Sincerely,

Frank Morello
Director of Multimedia
HCPro, Inc.
Developing Critical Thinking Skills in New Graduate Nurses

A 90-minute interactive audioconference

Wednesday, May 31, 2006

1 p.m.–2:30 p.m. (Eastern)
12 p.m.–1:30 p.m. (Central)
11 a.m.–12:30 p.m. (Mountain)
10 a.m.–11:30 a.m. (Pacific)
In our materials, we strive to provide our audience with useful, timely information. The live audioconference will follow the enclosed agenda. Occasionally, our speakers will refer to the materials enclosed. We have noticed that other non-HCPro audioconference materials follow the speaker’s presentation bullet-by-bullet, page-by-page. Because our presentations are less rigid and rely more on speaker interaction, we do not include each speaker’s entire presentation. The materials contain helpful forms, crosswalks, policies, charts, and graphs. We hope that you find this information useful in the future.

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E-mail: customerservice@hcpro.com
Web site: www.hcpro.com
Dear colleague,

Thank you for participating in our “Developing Critical Thinking Skills in New Graduate Nurses” audioconference with Shelley Cohen, RN, BS, CEN, and Polly Gerber Zimmermann, RN, MS, MBA, CEN, moderated by Rebecca Hendren. We are excited about the opportunity to interact with you directly, and we encourage you to take advantage of the opportunity to ask our experts your questions during the audioconference. If you would like to submit a question before the audioconference, please send it to stierney@hcpro.com and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to take a good cross section of questions.

If at any time you have comments, suggestions, or ideas about how we might improve our audioconference, or if you have any questions about the audioconference itself, please do not hesitate to contact me. If you would like any additional information about other products and services, please contact our Customer Service Department at 800/650-6787.

Along with these audioconference materials, we have enclosed a fax evaluation. After the audioconference, please take a minute to complete the evaluation to let us know what you think. We value your opinion.

Thanks again for working with us.

Best regards,

Shannon Tierney
Audioconference Producer
Fax: 781/639-2982
E-mail: stierney@hcpro.com
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Polly Gerber Zimmermann, RN, MS, MBA, CEN, resources

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Agenda

I. What is critical thinking?
   A. Defining expectations
   B. Principles of critical thinking
      1. Del Bueno’s four components for clinical judgement/critical thinking
      2. Prioritization principles and the need to teach them

II. Classroom skills for teaching critical thinking
   A. Cooperative learning
   B. Multisensory learning
   C. Unfolding case studies
   D. Orientation guides/brains in the pocket

III. Critical thinking skills in everyday practice
   A. Examples of teaching moments that ignite critical thinking
   B. Role of preceptor
   C. Role of nurse manager

IV. Retention strategies
   A. Encouraging the new graduate nurse’s sense of accomplishment
   B. Relationship of critical thinking skills to improved patient outcomes and less errors in judgment

Live Q&A
Speaker profiles

Rebecca Hendren, Moderator

Rebecca Hendren is a managing editor at HCPro. She edits Recruitment & Retention Monthly, a newsletter for recruiting, motivating, and retaining health care staff, and helps research and develop training products within the nursing group.

Shelley Cohen, RN, BS, CEN

Shelley Cohen is the educator and consultant for Health Resources Unlimited, a company that she founded in 1997. Her humorous approach to problem-solving has captivated audiences nationwide. She brings 30 years of experience into the classroom and is nationally known as an author, speaker, and coach.

Currently active in patient care, her timely experiences are relevant to the issues at hand, which allows her to understand the perspectives from both the staff nurse as well as the administrative team. Her Web-based Tips of The Month and her publications through HCPRO have had a positive effect on healthcare workers by empowering them with knowledge. With a focus on triage and leadership development, she is committed to the mission of Health Resources Unlimited by offering reality-based, timely programs.

Polly Gerber Zimmermann, RN, MS, MBA, CEN

Polly Gerber Zimmermann has been in active clinical practice for more than 28 years and involved with educating adults for more than 10 years. She was the senior course manager for the nursing division of the National Center for Advanced Medical Education and is a tenured assistant professor in the department of nursing at Harry S. Truman College in Chicago. Under her guidance, the school’s curriculum instituted an integration of prioritization principles and critical thinking that resulted in the school’s students improving from below to above national average results in these areas on standardized test scores.

She is a frequent national speaker and has published more than 200 times about topics including prioritization, improving clinical critical thinking, enhancing staff learning, effective staff teaching, precepting nursing students, and writing effective test items. She also writes test items that score high in critical thinking for national standardized tests, including HESI, NLN, NCLEX, and Excelsior College (Regents).

Ms. Zimmermann is also an associate editor and section editor of Managers Forum for the Journal of Emergency Nursing and a contributing and section editor for the emergency section for the American Journal of Nursing. She has also served as a legal expert/consultant in more than 35 cases.
Exhibit A

Presentation by Shelley Cohen, RN, BS, CEN, and Polly Gerber Zimmermann, RN, MS, MBA, CEN
Developing Critical Thinking Skills in New Graduate Nurses

Presented by:
Shelley Cohen, RN, BS, CEN
Polly Gerber Zimmermann, RN, MS, MBA, CEN

Expectations

Graduates:
- Are not taught by pathophysiology.
- Struggle most with prioritization, evaluating outcomes, evaluating lab results, performing accurate physical assessments.
- Tend to be most concerned about skills, handling emergencies, and having multiple patients.
- Have not had much IV teaching, particularly starting IVs.
- Have minimal clinical exposure. Relate all teaching to clinical application. They already know the textbook.
Developing Critical Thinking Skills in New Graduate Nurses

Expectations (cont’d)

Give them rules

- Aim for them to recognize something is wrong and to “tell somebody”
- They were typically told for NCLEX test questions that “Call the doctor” was not the right answer.
- Need exposure. One of the most common methods of decision-making is pattern recognition. Information is pieced together in an analytical way and compared with relationships and conditions from previous cases. Need experience to develop and becomes instinctive.

What is Competency?
Dorthey Del Bueno

- Technical Skills
  - Common New Grad Focus
- IPR Relations
- Clinical Thinking
  - Essential for Safety
What is Critical Thinking?

For Clinical Judgment
- Can the nurse recognize the patient’s problem?
- Can the nurse safely and effectively manage the problem?
- Does the nurse have a relative sense of urgency?
- Does the nurse do the right thing for the right reason?

Prioritization Principles

New Grads know ABCD and Maslow
- A severe C goes before a mild B.

Acute over chronic usually more serious

Onset
- Sudden tends to be more serious than gradual
- Symptoms that reach maximum intensity in less than one minute are an ominous sign

Actual over Potential
Prioritization Principles (cont’d)

Trends
- Symptoms associated with other definitive changes (especially systemic, VS, etc.)
- Minor symptoms that tend to recur repeatedly or to increase in severity
- Progressive decline
- How does this compare to the patient’s normal?

Life before Limb (Systemic before Local)
R/o the worse-case scenario, most lethal outcome that the patient could have with this complaint

Prioritization Principles (cont’d)

When you hear hoof beats, think horses, not zebras... (but there are some zebras out there)

Patient demographics
- Very young/very old
- Immunocompromised
  - Drugs, such as steroids, chemotherapy
  - Conditions, such as HIV+, DM, spleenectomy, organ transplant
- Co-morbidities
- Experienced worse-case scenario before with these complaints
Prioritization Principles (cont’d)

Remember
- Patients before paperwork
- Known conditions can develop a new problem

Avoid
- The red herring (“Oh my GOD!”) distracter
- WHO rather than what

Effective Teaching
Too much thought on “what” rather than “how”

Cooperative Learning
“He who teaches learns the most.”
- Think, pair, and share
- Sample test questions—voting
  - Choose between multiple needs
  - Good distracters (pain, high glucose, numbers “close to the border,” abnormal findings typical for the named condition, common misconceptions (e.g. elderly are confused)
- New style: sequential
Effective Teaching (cont’d)
Too much thought on “what” rather than “how”

- Ask good questions
  - Wait 10 seconds (make them commit)
  - Do not agree with immediately, even if right
  - Defend answer, indicate why others wrong
- Pass the folder, Pass the notebook

Multisensory Learning

Use Auditory, Visual, Kinesthetic

1/2 - 1/3 of oral communication is forgotten in 8 hours

Environment

- Color, music, peripheral learning (Use sight for 75% of learning)
- Exercise break every 40-50 minutes (primacy/recency)
- Repetition is the mother of learning; stories
- Pull names from a jar—“summarize what I just said” (can pass)
- FUN (Hot Potato, Jeopardy)
Multisensory Learning (cont’d)

Tricks

- Turn and repeat it to someone else
- Tap temple 5 times (rub fingernails) while saying it.

Seek to give it organization and meaning

Rhythm

- When you are clammy, you need some candy
  When you are dry, your sugar is high

Mnemonic

- 3,4,6 Make My Eyes Do Tricks
- 3,4,6,8 How Do We Accommodate

Developing Critical Thinking Skills in New Graduate Nurses

### Exhibit A

#### ANTICOAGULANTS

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td>193</td>
<td>70-190 mg/dL</td>
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<tr>
<td>BUN</td>
<td>8</td>
<td>7-17 mg/dL</td>
</tr>
<tr>
<td>Cr</td>
<td>0.7</td>
<td>0.7-1.2 mg/dL</td>
</tr>
<tr>
<td>Sodium</td>
<td>131</td>
<td>136-145 mEq/L</td>
</tr>
<tr>
<td>Potassium</td>
<td>3.2</td>
<td>3.5-5.0 mEq/L</td>
</tr>
<tr>
<td>SGOT</td>
<td>1932</td>
<td>13-40 IU/L</td>
</tr>
<tr>
<td>SGPT</td>
<td>2360</td>
<td>7-60 IU/L</td>
</tr>
<tr>
<td>Bilirubin Total</td>
<td>2.9</td>
<td>0.2-1.2 mg/dL</td>
</tr>
</tbody>
</table>

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#### BELL'S PALSY

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Unfolding Case Study

Italics—instructor states

- 46-year-old brought to ED from outpatient OR
- Undergoing conscious sedation with midazolam (Versed) and morphine for port insertion for chemotherapy for pancreatic cancer
  - *What class of drugs are these?*
- Became unconscious & diaphoretic
- 96, 108/70,16, 96% (same as baseline)
- Already given O₂ and IV fluid bolus

Unfolding Case Study

*Italics—instructor states*

- *What do you want to do?*
  - *If someone immediately says check glucose, don’t respond...others will probably say some of those below*

| Repeat VS | Same, Afebrile |
| Neuro assessment | GCS 7 (SUCTION) |
| Give Flumazenil (Romazicon) | Can ask worried about what s/e No change |
| Give naloxone (Narcan) | Can ask dosing, administration No change |

Blood glucose: 35mg; responds to D₅₀
“6th VS” for acute LOC: glucose
Comprehension-Based Concept Mapping

Critical Thinking Skills in Everyday Practice

Concepts/Tips For Success
Teaching Moments

- Assignment preparation/organization
- Change of shift reporting
- Skills/ competency check offs
- Case scenarios

The Preceptor

- Coaching the transition from student to nurse
  - Clarifying and setting realistic expectations
  - Mutual respect
  - Flexibility in using adult teaching methods
  - Goal setting
The Nurse Manager

- Job descriptions that are reality based
- Orientation goals that are realistic
- Coaching staff through accountabilities as a team
- Recognition of preceptors

Retention

- Identifying strengths
- Sharing accomplishments with team
- Manual system to visualize progress
- Emotional component of gaining respect
- Setting goals for growth with a time-line
Patient Outcomes

• Patient case reviews
• Pertinent questions
• Minimizing fear of errors
• Performance improvement involvement

Train Them To Retain Them!
Relating Patient Care To Critical Thinking

- Intravenous
- Catheters
- Tubes
- Colostomy
- Dressings
- Wounds
- Orthopedic devices

*What does the nurse need to consider with a patient having any of the above devices?*

Keep Asking The Questions

*WHY?*  *HOW?*  *WHAT?*  *WHEN?*
Attributes of the Critical Thinker

- Asks pertinent questions
- Assesses statements/arguments
- Is curious about things
- Listens to others and gives feedback
- Looks for evidence or proof
- Examines problems closely
- Can reject incorrect information
- Wants to find the solution

Strategies of the Critical Thinker

- Thinks independently
- Confident in their rationale for actions
- Analyzes arguments
- Evaluates evidence and facts
- Explores consequences before taking action
- Recognizes a contradiction
- Evaluates policy
EXHIBIT A

When To Call The Provider

- Perfusion Problem
- Pain Issue
- Standing Order Concern
- Atypical Presentation Complaints

When To Call The Provider

- Risk Management Potentials
- What’s Going In Isn’t Coming Out
- Negative Response To Intervention
- Social Concerns/Family Issues Affecting Patient Care
A critical thinker is able to reject
Information that is incorrect or irrelevant”
S. Ferrett

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Temperature</td>
<td>97.4</td>
</tr>
<tr>
<td>Pulse</td>
<td>118</td>
</tr>
<tr>
<td>Respiration</td>
<td>26</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>128/72</td>
</tr>
</tbody>
</table>

ADULT PATIENT

What information do you need to know about this patient
To determine if any of the vital signs are relevant to the care
You are giving to this patient?

Ask The Right Question

How would you respond to the following
patient statement?

That doesn’t look like the pill I take at home!
Exhibit B

Sample orientation classroom agenda

Source: Shelley Cohen, RN, BS, CEN. Reprinted with permission.
Your facility
Critical thinking skills
Date of program

Agenda

9:00-9:15
Introduction to critical thinking and course overview

9:15-10:00
Patient assessments
- Anatomy/Physiology review
- Establishing the baseline
- Reassessments

10:00-10:15
Stretch Break

10:15-11:30
Age Specific Patients
*Include here on the agenda pediatric and/or geriatric specifics*
- Geriatric
- Polypharmacy issue
- Atypical presentations
- Elder misuse and reporting
- Pediatric
- Social challenges
- Children as victims and reporting suspicion
- Medication specifics for children

11:30-12:15
Lunch

12:15-1:15
Red flags
- Patient statements/comments
- Family input
- Documentation specifics
- Case scenarios

1:15-1:30
Stretch break

1:30-2:30
Applying the knowledge
- When to call the doctor
- More case scenarios

2:30
Course evaluations
Exhibit C

Critical thinking skills course handouts

Source: Shelley Cohen, RN, BS, CEN. Reprinted with permission.
Critical thinking skills handouts

Shelley Cohen RN BS CEN
Health Resources Unlimited
www.hru.net educate@hru.net
888/654-3363

Course objectives:

1. Relate critical thinking skills to delivering patient care
2. Identify three essential elements for educating staff about critical thinking
3. Identify resources for critical thinking

Resources:


www.enchantedlearning.com Anatomy diagrams/glossaries and more
www.ncrel.org North Central Regional Educational Laboratory (NCREL®)
www.advisory.com Multiple resources: search under new graduate nurse
www.ncsbn.org Access to all State Board of Nursing Rules/Regulations

Critical thinking skills

The development of cohesive and logical reasoning patterns
Stahl and Stahl, 1991

Careful and deliberate determination of whether to accept, reject, or suspend judgment
Moore and Parker, 1994

Examination and testing of suggested solutions to see whether they will work
Lindzey, Hall, and Thompson, 1978

Sample laminated pocket card for participants

When to call the provider

Perfusion problem
Pain issue
Standing order concern
Atypical presentation complaints
Risk management potentials
What’s going in isn’t coming out!
Negative response to intervention
Social concerns/family issues affecting patient care
Exhibit D


*Source: Polly Gerber Zimmermann, RN, MS, MBA, CEN. Reprinted with permission.*
Developing Critical Thinking Skills in New Graduate Nurses
Guiding Principles at Triage: Advice for New Triage Nurses

Author: Polly Gerber Zimmermann, RN, MS, MBA, CEN, Chicago, Ill

Polly Gerber Zimmermann, *Illinois ENA*, is Instructor, Department of Nursing, Harry S Truman College, and Associate Nurse, American Airlines, Chicago O’Hare International Airport, Chicago, Ill. For reprints, write: Polly Gerber Zimmermann, RN, MS, MBA, CEN, 4200 North Francisco, Chicago, IL 60618; E-mail: pzimmermann@ccc.edu.


An ED triage nurse has the following patients waiting to see the treating physician. Which patient has the highest priority?

- **Patient A:** A 70-year-old with Alzheimer’s disease who started constant pacing today.
- **Patient B:** An 8-year-old with a known seizure disorder who had a seizure at school today.
- **Patient C:** A 20-year-old who is 8 weeks pregnant and has a cough with yellow phlegm.
- **Patient D:** A 40-year-old with a fractured arm whose circulation, movement, and sensation are normal and who rates his pain as an “8.”

The answer is “A.” A sudden onset of new behaviors such as pacing are “mental status changes” and are often the only symptom of illness for an elderly patient with dementia. Patient B is currently stable. Patient C is stable as well—she is not in labor. Giving priority to patient D could be tempting in a real-life triage situation because he might be more articulate and persistent in seeking care.

**Triage is a skill**

ED comprehensive triage, endorsed by ENA and most often practiced in the United States, involves assessment, history taking, and some data gathering (eg, obtaining vital signs) before deciding on a triage acuity level. Triage is a unique skill that requires elements of problem identification and prioritizing that are different from those used in direct patient care.

Effective triaging identifies not only patients who are obviously gravely ill but patients who might be seriously ill. The fact that patients seek care at various stages of the
course of their condition makes determining triage acuity even more difficult. The following universal considerations can help with the triage decision.

**Physical**

Independent of the presenting complaint, triage always begins with an assessment of the stability of the patient’s airway, breathing, circulation, and disability (ABCDs), in that order. Triage nurses must avoid the temptation to be drawn away from this basic principle by the “Oh, my God!” distraction, such as a deformed, bloody extremity.

*A higher acuity should be suspected for patients who complain about tightness in the throat or state that they came to the emergency department because their respiratory symptoms are worsening. The CTAS indicates that they should be seen within 30 minutes.*

However, within the ABCDs, severity should be considered. Treating a patient with a spurting laceration (circulation) is more important than treating a patient with asthma who reports feeling short of breath but speaks in complete sentences and has a \( \text{pO}_2 \) of 97% on room air (breathing).

**AIRWAY AND BREATHING**

Foundational assessments regarding airway and breathing should be made as objectively as possible. It is now the standard to use an objective number or a key word to rate pain assessment. Similarly, objective numerical criteria, such as the peak expiratory flow rate and oxygen saturation values, should be used to assess the patient’s oxygenation status.

The Canadian Emergency Department Triage and Acuity Scale (CTAS) is the standardized, statistically supported 5-level triage scale (Table 1) endorsed by both the Canadian Association of Emergency Physicians (CAEP) and the National Emergency Nurses Affiliation of Canada (NENA). The collective wisdom of another system can help guide our determinations. The CTAS implementation guidelines recommend a combination of objective findings to determine the triage level. The best guide to therapy of patients with respiratory problems is some form of spirometric testing, such as forced expiratory volume or peak expiratory flow rate. For instance, >40% predicted or previous best indicates “severe” respiratory problems or emergent level 2 (out of 5 levels). If a patient, particularly a child younger than 6 years, cannot complete an accurate spirometry test, then oxygen saturation and clinical features should be used. For instance, a \( \text{pO}_2 \) of <92% on room air also places the patient at level 2; that is, he or she should be seen by a physician within 15 minutes.1,2

The modified Borg scale is a quick, valid, and reliable assessment tool for dyspnea that correlates well with other clinical parameters. Patients rate their breathlessness on a scale of 1 to 10 to illuminate the amount of effort and energy they are expending to maintain their current oxygenation. One patient with asthma likened a high rating to breathing through a tiny hollow of a small coffee stirrer.3,4

A higher acuity should be given for patients who complain about tightness in the throat or state that they came to the emergency department because their respiratory symptoms are worsening. The CTAS indicates that they should be seen within 30 minutes.1

**CIRCULATION**

Circulation (perfusion) alteration should be considered both for local and systemic manifestations. Early signs are subtle. An elderly patient who "fell" may have a dysrhythmia,
a child lying quietly may have poor cerebral perfusion, or mild tachycardia may be the first sign of hypovolemia, not stress. Hypotension is sometimes not evident until an adult loses approximately 1500 mL of blood or a child loses about 25% of his or her circulating blood volume.\textsuperscript{5,6} A quick check for a strong radial pulse reassures the nurse that the systolic blood pressure is at least 80 mm Hg.

**DISABILITY**

Disability assessment includes noting mental status, neuromuscular function evaluation, and the patient's pain status.

**Mental status:** Traditional evaluation includes checking to make sure the patient is alert and oriented × 3. Standardized tests require correctly naming all items (year, season, date, day, and month for time; state, county, town, hospital, and unit for place) to receive full credit. It is not enough for the patient to forget the US president's name but state, “It's that stupid guy; his Dad was president too.” An adult fully oriented to person, living in our society, should be able to recall the president's name.\textsuperscript{7,8}

*A rapid blood glucose test and pulse oximeter triage screening should be performed to determine whether the need exists for immediate sugar or oxygen.*

A fourth criterion, recent events, should be included because some elderly persons know the classic person, place, and time answers by rote. Asking a question about an event from today, such as “What did you eat for breakfast?” can help assess frontal lobe function.

Standardized assessment scales are available, but they can take up to 10 minutes to administer and are not practical for use in triage. A basic functional limitation, sometimes hidden by patients from their families, can be determined quickly by other means. Gerontology expert Karen Rice, MSN, RN, APRN, recommends the clock test: While the patient is waiting, give him or her a blank sheet of paper and request that he or she draw the face of a clock.\textsuperscript{9} Some patients cannot accurately perform this task. This request reminds me of the case of an elderly woman, brought in by her family for anorexia, who held up the dinner tray's spoon and asked, “What is this?”

**Elderly patients with dementia are undertreated for pain even though their reports of pain are as valid as those of patients without cognitive impairment.**

A change in mental status can indicate anything from sleep deprivation to an intracranial bleed to drug toxicity. A rapid blood glucose test and pulse oximeter triage screening should be performed to determine whether the need exists for immediate sugar or oxygen.

**Neuromuscular function:** Priority should be given to any new neurologic sign or symptom, such as a change or loss of sensation, weakness of the limbs, or alteration in bowel or bladder function.\textsuperscript{9}

**Pain assessment:** Patients experiencing severe pain should be moved up in priority. Severe pain is defined as a patient's self-rating of “8 to 10” on a 1 to 10 rating scale (with “0” being no pain and “10” being the worst pain in life) or pain described with foreboding words, such as “unbearable,” “excruciating,” or “disabling.”

The Manchester Triage Group developed Britain's 5-level statistically validated triage system, which is endorsed by the Royal College of Nursing Accident and Emergency Association and the British Association for Accident & Emergency Medicine (Table 2). It suggests also considering the disruption to a patient's usual activities on
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FIGURE 1

a continuum from doing normal activities (1 to 2) to having to stop all normal functions (9 to 10). The pain ruler tool coordinates descriptors, numerical rating, and function (Figure 1).10

If a patient states that his or her pain intensity is a “10” but looks comfortable, or if he or she has a minor condition (e.g., a sore throat), the triage nurse should ask about the worst pain the patient has previously experienced. By definition, pain anyone has for the first time is the “worst ever” or a 10 on a scale of 10. Comparing the current pain to an incident such as childbirth, renal colic, or a fracture indicates that the patient's pain truly is severe.1 Patients who are unable to rate their pain but would be expected to have severe pain, such as a young child or with a fracture, should be treated as though they have a score of 8 to 10 on a score of 10.

Triage nurses must be careful not to make wrong assumptions when evaluating the pain level for minorities and patients with dementia. In one study of male patients with isolated long bone fractures, Hispanic male patients received pain medication in the emergency department only half as often as did the non-Hispanic white male patients. Research findings indicate that elderly patients with dementia are undertreated for pain even though their reports of current pain experienced are as valid as those of patients without cognitive impairment.11-14

History

The typical triage challenge is the ranking of everyone who is not critically unstable. To accomplish this task, triage relies on a good history of the patients' current complaints, as well as their demographics and general health. Many mnemonic guides aid in consistently and thoroughly obtaining that information (Table 3). The following aspects should be considered when making triage decisions.
### TABLE 3

Mnemonics

**PQRST:** Chief complaint
- **P** Provokes  What provokes the symptoms?
- **Q** Quality  What makes it better/worse?
- **R** Radiation  What does it feel like?
- **S** Severity  Where is it? Where does it radiate?
- **T** Time  Rate on a scale of 1 to 10?
- **Treatment**  How long?

**OLD CART:** Chief complaint
- **O** Onset of symptoms
- **L** Location of problem
- **D** Duration of symptoms
- **C** Characteristics of the symptoms described
- **A** Aggravating factors
- **R** Relieving factors
- **T** Treatment administered before arrival

**POSHIPATE:** Chief complaint
- **P** Problem
- **O** Onset
- **S** Associated Symptoms
- **H** Previous History
- **I** Inciting event
- **P** Precipitating factors
- **A** Allaying/Aggravating factors
- **T** Timing
- **E** Etiology

**TICOSMO:** Have I overlooked anything?
- **T** Trauma
- **I** Infection
- **C** Chemical
- **O** Organs
- **S** Stress
- **M** Musculoskeletal
- **O** Other

**MIVTS:** Report from prehospital provider
- **M** Mechanism of injury
- **I** Injuries sustained
- **V** Vital signs
- **T** Treatment

**AVPU:** Disability Assessment for Pediatrics
- **A** Alert
- **V** Verbal
- **P** Painful stimuli
- **U** Unresponsive

**CIAMPEDS:** Pediatric history
- **C** Chief complaint
- **I** Immunizations
- **A** Allergies
- **M** Medications
- **P** Past medical history
- **E** Events surrounding the illness or injury

**SAVE A CHILD:** Pediatric
- **S** SAVE Observation made prior to touching the patient
- **A** CHILD: History, brief examination
- **V** Skin (moist, petechiae, pallor)
- **E** Activity (responsive)
- **A** Ventilation (respirations, rate, stridor)
- **V** Eye contact (glassy stare, fails to engage)
- **E** Abuse (unexplained bruising, inappropriate parent)
- **A** Crying (high pitched, inconsolable)
- **V** Heat (fever)
- **E** Immune system (sickle cell, corticosteroids)
- **A** Level of consciousness (irritable, lethargic)
- **V** Dehydration (capillary refill, severe vomiting/diarrhea)

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CURRENT SCENARIO

Acute versus chronic condition: A recent condition or exacerbation is a concern because of the potential of a more lethal cause. The Manchester Triage Group defines a “recent onset” as within the past 7 days.\textsuperscript{1,10}

Sudden, abrupt versus gradual onset of symptoms: True “sudden” onset of symptoms can signal a catastrophic event. Establishing what the patient means by “sudden onset” is necessary because, in one sense, most complaints of people who come to the emergency department are “sudden” rather than “long-term.”

It is significant if (1) the exact time or activity of the onset is remembered and (2) the maximum intensity is reached immediately (in less than 1 minute), rather than gradually, during a 30-minute period. For patients with a headache, this could mean cerebral bleed. Those with back pain could have a disk involvement (vs a muscle spasm).

Trends: A trend, versus just an isolated incident, could be an indication that something more serious is happening. Trends include the following:

- Steady progressive decline
- Minor symptoms that recur repeatedly or increase in severity
- A symptom that is associated with other definitive (especially systemic) changes

Compare the patient’s current condition with their normal state: The patient should be asked about his or her normal state. Recognition of previous symptoms (“This is like the last time I had kidney stones”) or identification of a new distinction (“This is different than any other headache I had before”) can help guide the triage nurse’s perception of the seriousness of the event that is occurring. I have often had concern for a patient with chronic obstructive pulmonary disease (COPD) who had labored respiration, only to have the patient state, “Oh, this breathing is good for me! I came today about something else.”

Most triage nurses are attuned to parents’ impressions of the condition of their child. Considering caregivers’ perceptions of patients with dementia is just as helpful. The sudden onset of confusion or behavior changes may be the only sign of a new condition for elderly or demented patients. Even if they have a history of inappropriate behavior, behaving more strangely is a significant change for them.

Recent related history: Recent events related to the current episode can signal an increased risk for severity. These events include the following:

- Recent discharge from the hospital and/or medication changes. With the rapid patient turnover in today’s acute care settings, opportunities to reinforce instructions are limited. The likelihood that error will occur increases with any change. One elderly man returned to the emergency department 3 days after his hospitalization because of dizziness. He had a severe heart block as a result of mistakenly taking his new prescribed nitrroglycerin once a day and the Lanoxin (digoxin) as needed.

- The patient received treatment prior to arrival without improvement and/or was seen by a physician prior to arrival. These patients already had some ineffective interventions or an initial screening by a health care provider. Their need for additional, more intensive workup and medical care is a given.

- Foreign travel. Montezuma’s revenge, the traveler’s diarrhea from water contaminated by \textit{Escherichia coli} in developing countries, is a well-known tourist hazard.\textsuperscript{15} However, even a patient who is only “unwell” can be quite ill after being in an area with endemic diseases that are rare in the United States. Initially, malaria often masks as the “flu.”\textsuperscript{16} A sore throat could be the start of diphtheria (especially if immunizations are not up-to-date), which is a concern because its classic exudative membrane can lead to life-threatening airway complications.\textsuperscript{17} The Manchester Triage Group defines “recent travel” as within the past 3 months and recommends that patients fitting this criteria be seen within 1 hour.\textsuperscript{10}

- Previous serious etiology for the same complaints. The same risk factors are still there for a repeat incident. The CTAS guidelines are that patients experiencing any chest pain (regardless of the characteristics of this episode’s pain) should be seen by a physician within 10 minutes if they have a prior history of myocardial infarction, angina, or pulmonary embolus.\textsuperscript{9} Similarly, a history of intubation or frequent ICU admissions for a
patient with an asthma attack would raise the acuity rating. A patient’s evaluation of this episode’s severity should be listened to. In one publicized case, an athlete told the trainer, “I can’t breathe…I’m dying.” A trainer mistakenly handled the athlete in a routine manner precisely because of his history of frequent previous asthma attacks, and tragically, the athlete died.

**Potential of worsening:** When a patient has taken an unknown substance, the progression of the patient’s condition is unpredictable. Reports of intentional overdoses are particularly unreliable because the patient may not provide an accurate history. Any substance that causes stinging, burning, or pain should be considered capable of causing a chemical burn. A patient with an allergic reaction must be watched for rapid deterioration. An urgent priority should be assigned to these types of patients so that appropriate treatment can be initiated before the patient starts to decline.

Any woman of childbearing age who is having unprotected sex should be considered pregnant until there is evidence to the contrary.

**SPECIFIC HIGH-RISK CONDITIONS**

**Pregnancy:** Overall, with a pregnant patient, the potential exists for unknown effects on the fetus, and thus pregnant patients usually receive a higher priority. The Manchester Triage Group indicates that, for triage purposes, any woman of childbearing age who is having unprotected sex should be considered pregnant until there is evidence to the contrary.

Presenting complaints that are of specific concern in pregnant patients include trauma (including rule-out abuse), hypertension (≥140/90), history of a seizure (rule out preeclampsia/eclampsia), dribbling “urine” (rule out bag of water leaking), heavy blood loss after 24 weeks (rule out placenta previa), or back pain (rule out labor). Placenta previa causes painless vaginal bleeding with bright red discharge; placental abruption usually causes severe pain and vaginal bleeding, if present, is usually dark red.

**Abuse/neglect:** The CTAS recommends that a stable patient with suspected (e.g., the history does not match the injuries) or known abuse or neglect be seen within 30 minutes. The Manchester Triage Group recommends that such a patient be seen within 60 minutes. Such patients have a higher priority than the injury alone would warrant because the victim and/or family are at a high risk of leaving the emergency department, the injuries may be more extensive than readily apparent, and the patient often has specialized emotional needs. If the incident occurred within 4 hours before the ED presentation, CTAS indicates that the patient is to be seen within 15 minutes for enhanced evidence collection.

The patient’s physiologic capacity to adapt to his or her new medical problem will be strained whenever he or she has another chronic, systemic illness, such as diabetes mellitus, sickle cell disease, or hypertension.

**Psychiatric:** Considerations for a higher triage acuity level should include the current state of the patient’s level of agitation, self-control, willingness to stay, significant psychiatric history, and the presence of a responsible person who can stay with the patient.

When extreme agitation is present, as indicated by tone of voice, statements, or nonverbal behaviors, the CTAS indicates that such a patient should be seen within 15 minutes. The Manchester Triage Group recommends that if any doubt exists about the potential of the patient to actively attempt to harm others or himself or herself, a high risk should be assumed and the patient should be seen within 10 minutes.

**PATIENT DEMOGRAPHICS**

**Very young and very old patients:** Very young and very old patients are more susceptible and often have atypical responses because of their depressed immune systems. Any infant 7 days of age or younger should be seen within 10 minutes.
In addition, very young and very old patients often lack the coping skills to deal with extended waits. The additional stress of fatigue and increasing anxiety only clouds the assessment of their medical condition. The Manchester Triage Group recommends that, later in the evening or at night, consideration be given to increasing the priority of these patients.10

Any immunosuppressed patient, such as a patient with AIDS or one who has undergone long-term administration of systemic steroids, a splenectomy, or chemotherapy, should be considered a significant risk for having a serious infectious episode because of the possibility of a blunted response.

Co-morbidity/multiple systems involved: The patient's physiologic capacity to adapt to his or her new medical problem will be strained whenever he or she has another chronic, systemic illness, such as diabetes mellitus, sickle cell disease, or hypertension. CTAS indicates that a patient undergoing dialysis or with a history of having an organ transplant should be seen within 30 minutes because of the potential fluid and electrolyte imbalance.1

Conditions/medications that suppress immunity: Any immunosuppressed patient, such as a patient with AIDS or one who has undergone long-term administration of systemic steroids, a splenectomy, or chemotherapy, should be considered a significant risk for having a serious infectious episode because of the possibility of a blunted response. Isolation from other infectious patients in the waiting room should be initiated, either by (preferably) physical separation or use of a face mask.1

Difficulty discerning the situation

VAGUE, GENERAL HISTORIES
Some patients' "chief complaint" is a rambling, vague history about multiple problems. The complaint can be brought into focus by asking: "What is different today that made you come in?" You can feel reassured that you are not missing some subtle cue when the answer is related to convenience (eg, "I had a ride"), rather than symptoms (eg, "I can't take it anymore").

On the other hand, sometimes patients give a "yes" answer to every single triage question, even when it would seem incongruent with their presentation. If you think another issue may be involved, such as a language problem, ask, "Do your toenails itch?" This can be a discriminating question because it is not possible for nails to have that sensation. A "yes" answer here can help confirm your suspicions. However, when the patient thoughtfully replies "no," then I truly believe all of the previous multiple "yes" answers and move him or her up in priority.

Sometimes I directly ask, "Is there anything else going on in your life that you think could be contributing to this problem?" Often, an informative answer is given about a stressor, such as the first anniversary of a spouse's death or a recent divorce. I have never had a patient appear offended by this inquiry even if nothing significant is revealed.

SUSPICIONS OF EXCESSIVE ALCOHOL INTAKE
When a patient calmly describes a loss of consciousness (blackout!) during the weekend, having an accurate history of the patient's alcohol intake could be a significant discriminator in determining the patient's acuity and treatment.

Sometimes obtaining accurate answers is difficult because patients know what is "acceptable" drinking. Questions should be phrased so that a quantitative answer is expected. Ask, "When did you have your last alcoholic drink?" rather than "Do you drink?" Also ask what is normally consumed and how much.

Try overestimating: "Do you drink 2 cases of beer a day?" The patient is more likely to be honest in "correcting" the by saying something like "Oh no, I only drink one case a day," whereas he or she probably would not initially volunteer that he or she consumes such a large amount.

Another technique is to feign surprise if a doubtful answer if given: "Really??! Is that all??" Sometimes the patient will then sheepishly "correct the answer. The key is to remain matter-of-fact during this assessment.
Determining the presence of chronic alcoholism can be important because benzodiazepines are used to treat the agitation that can accompany alcohol withdrawal, but they are not used in elderly patients who do not abuse alcohol. Two laboratory tests can help. Look for a low mean corpuscular volume in the complete blood cell count (which is related to patient’s nutritional status). (It will be normally low in patients with COPD, pernicious anemia, and B12 deficiency.) In addition, the liver enzyme γ-glutamyl transferase (GGT) will be elevated while the other liver enzymes are normal.

Remember that airway obstruction is as much a risk for the patient who is unconscious as a result of intoxication as from any other cause. The risk for symptoms of alcohol withdrawal typically begins around 6 to 8 hours (peaking at 24 to 48 hours) after the last drink or rapid reduction of the alcohol intake. Stage 1 includes symptoms of dehydration, irritability/anxiety, hypertension, and tremors. A rising pulse is an indicator that the patient is progressing into withdrawal.

PATIENTS RETURNING TO THE EMERGENCY DEPARTMENT
The official or unofficial policy of many emergency departments is that patients who return within 24 hours should receive a higher priority. The fact that they felt a need to return so soon could indicate that something is wrong. This could include an oversight in their initial assessment and diagnosis, a worsening of their physical condition, or a lack of understanding or coping with their discharge teaching. If nothing else, there is a risk of litigation resulting from the patient’s perception that something is amiss.

“MYSTERY” PATIENT
When a patient’s symptoms do not add up to any recognizable common presentation, I assign the patient a higher acuity. Triage has only limited resources and data; let a conclusion be made after a more in-depth workup.

FAKING PATIENT?
Sometimes the triage nurse might suspect that a patient’s unresponsiveness or weakness is a pseudoseizure, such as a history of a “seizure” right before it is time to pay the bill in a restaurant. As a Navajo proverb says, “You can’t wake up a man pretending to be asleep.”

Watch for telltale signs such as peeking, nonrhythmic seizure activity, or a response to calculated statements, such as “We’ll need to insert a large urinary catheter if he doesn’t wake up.” One patient, in my experience, would literally stand and stop “seizing” on command.

Other “tricks of the trade” include instilling natural tear eyedrops (and watching for resistance when the patient is “unconscious”), introducing noxious stimuli (such as ammonia), or placing the patient’s hand directly above his or her face and allowing the hand to drop (protecting the patient’s face with your hand). If there is a physiologic reason for the patient’s condition, the hand will smash the patient’s face/your hand (because of gravity); if the reason is psychogenic, the patient lets the hand drift to the side. One patient’s only complaint was weakness; she wouldn’t even help herself get on the cart. However, when her dropped hand went directly towards her face, I made her “emergent.” Her serum potassium level, as it turned out, was 2.6 mEq!

“KNOWN” PATIENT
Every emergency department has patients who are “frequent flyers.” Triage nurses must resist the temptation to treat these patients casually; they need the same quality of triage assessment each time. Patients with old complaints can have new complaints or an exacerbation of their problem.

Summary
“When you hear hoof beats, think horses, not zebras.” This familiar phrase means that the overarching principle is to first consider the most common causes for a patient’s presentation. However, there are some zebras. Eliminate the worst, emergent etiologies, such as a cerebellar bleed after a head trauma, by assessing if a loss of consciousness occurred. Then follow the given standard recommendations to guide the prioritization.

Posttest
NOW who would you assign the highest priority?
• Patient A: A 40-year-old with nonradiating low back pain that is slowly getting worse; the patient rates the pain as a “9.”
Patient B: A 25-year-old with a history of a kidney transplant who complains of "flu" and has a temperature of 100.4°F (38°C).

Patient C: A 9-month-old who is tugging on his ear and has a temperature of 102°F (38.9°C).

Patient D: A 60-year-old with COPD who has a fractured ankle; his respirations are 20 and room air po2 is 92%.

Choose patient B. He is probably immunosuppressed from steroids, so his low-grade fever is a blunted response to infection. He has systemic symptoms and is at risk for more serious problems such as fluid and electrolyte imbalance or organ rejection.

The gradual onset of pain, without cauda equina syndrome, in patient A points to a muscular problem. This patient could lie down and receive analgesics in triage.

Patient C is alert and can receive antipyretic medication in triage. Patient D is at the emergency department for a local complaint. The lower pulse oximetry reading is probably his normal reading resulting from his COPD, because he has no other signs of respiratory distress.

Now you are ready for the real test: the 4 real patients waiting in your triage area!

REFERENCES

Developing Critical Thinking Skills in New Graduate Nurses
Exhibit E


Source: Polly Gerber Zimmermann, RN, MS, MBA, CEN. Reprinted with permission.
Some Practical Tips for More Effective Teaching

The speaker concludes and the audience is on their feet, applauding enthusiastically. “This was the most meaningful presentation I have ever heard,” gushes one attendee.

Everyone who teaches in any form has probably had at least some version of this fantasy. The silent cry behind all teaching, be it one-on-one interactions, staff mentoring, inservice programs, or formal lectures, is “May it be effective.”

What determines if teaching accomplishes the desired outcome? Effort and desire alone will not guarantee results. The following is a collection of tips, principles, and techniques, based on the wisdom of expert teachers and some schools of thought about education, that work for me.

**Learning Situation**

**FOCUS ON THE LEARNER**

Consider yourself a guide for active participants through the learning experience, rather than a vessel pouring wisdom into passive listeners. It is tempting for the teacher to focus on his or her prepared words and content instead of watching and responding to the audience’s response to the presented material. Plan not so much on “What am I going to say today?” but “What are my listeners going to learn today?” Otherwise, you miss perceiving the need to repeat the material, vary the presentation, or illustrate the content’s application.

**HANDOUTS**

Including written material reinforces the content. Most people prefer easy-to-read handouts, independent of their reading ability. This is best accomplished through the use of short sentences with easily understood words and phrases.
Helpful tips include using:

- short sentences (no more than 15 words per sentence).
- active rather than passive voice (eg, “Do x,” rather than “X should be done.”)
- lists rather than paragraph format, with accompanying pictures and adequate white space.
- *boldface* or underlining for emphasis rather than all CAPITAL LETTERS, which is more difficult to read.
- a 12-point or larger type size with a serif font (such as Times New Roman).

**CREATE A SAFE LEARNING ENVIRONMENT**

Learning inherently involves vulnerability because a lack of knowledge may be exposed or a risk might be taken to alter one’s thinking about a subject. Make it a safe place with your personal warmth. Humor helps release tension, but be careful to avoid sarcasm. No one ever wants to feel like a fool.¹

The room itself can be made safe and warm through the use of visual and auditory tools. National education expert Sylvia Rayfield suggests adding warm, colorful banners and music. Baroque classical music correlates with the body’s breathing and heart rates and prepares the brain to learn. Play it before a class begins to signal a welcoming atmosphere.²

**CONSIDER SEATING ARRANGEMENTS**

The goal is for all learners to feel included, without any “hiders.” Students in the first row learn best, probably because they are more psychologically engaged in the process.³ National organizational behavior expert and education consultant Michael Lavin recommends using a circle to encourage an exchange of ideas because there are no positions of power. This seating arrangement conveys the sense that everyone’s input is equal. A half-circle is equally effective for a smaller group, but avoid creating a distinction by having the instructor positioned at the front of the half-circle.⁴

In larger rooms or with large groups, a fishbone arrangement works well. Tables and chairs are placed in angled rows on either side of a center aisle or “backbone.” This design allows interactions between the instructor and participants as the instructor walks down the center “backbone” aisle. Even when the seating arrangement cannot be modified, the instructor can still foster an interactive environment by leaving the lectern and moving among the learners.⁴

**Presentation method**

**SIMPLIFY THE CONTENT**

Ralph Waldo Emerson said, “A great teacher makes hard things easy.” Taking this edict to heart keeps the presentation’s focus on simplicity. Even the most difficult material can be understood when it is broken down into what is essential, and when it is compared with any similarities or differences with other known concepts.

**ASK GOOD QUESTIONS**

A common adage in teaching is to ask critical thinking questions. Questions such as “How does that work?” “What does that mean?” or “Why?” help the learner try a different logical path and integrate key data. Playing the devil’s advocate, even when a correct answer is given, can promote a deeper understanding.¹

**USE SILENCE**

After asking a question, it is tempting to jump in with the answer to fill the resulting quiet, perhaps awkward, moments that follow. Yet educators know that is when the most productive thinking occurs.¹

Train yourself to wait 10 seconds so participants have time to process the question and their responses. I literally have to count off my fingers because that time period can seem like an eternity. Tell them why you are deliberately waiting. When learners understand the process, they become more willing to actively mentally work towards an answer, rather than passively wait for it to be provided.¹

It can also be particularly effective to wait and not respond, even when given the right answer. Initially, students often assume they are wrong and change their response. This practice of sometimes waiting trains the learner(s) to think about the justification of the answer rather than just trying to “read” the teacher. Another trick of the trade is to confirm an answer involving application is correct, but then ask the student to defend it.
PROMOTE CRITICAL THINKING WITH CONTEXTUAL APPLICATION

Noted competency authority Dorothy del Bueno administers competency testing for new registered nurses (RNs). Her Performance Based Development System video scenario testing found that 15% of experienced ED RNs and 70% to 75% of new graduate nurses initially do not indicate a response that demonstrates safe, competent care. Yet, 65% to 70% improve after 6 to 12 weeks of working with the recommended critical thinking material.6

Del Bueno advocates critical thinking for health care workers that involves application of concepts within a clinical context. She identifies 4 key attributes: 6,7

1. Can the learner recognize the patient's problem?
2. Can the learner safely and effectively manage the problem within their scope of practice?
3. Does the learner have a relative sense of urgency?
4. Does the learner know why he or she is doing the actions indicated? In other words, does the learner do the right thing for the right reason?

Unfolding case scenarios can be an effective way to incorporate this process of clinical critical thinking in a classroom setting.8 This technique provides the information in staggered amounts, punctuated with questions such as “What else do you want to do?” or “What do you want to do now?” Use case studies or triage scenarios from journals for patient examples of atypical presentations or unusual clinical diagnoses when you do not have any relevant personal anecdotes.

USE A VARIETY OF METHODS

Learning occurs through auditory, visual, and kinesthetic approaches. Each person has a preferred major learning style, but everyone uses some of each. Accelerated learning occurs when there is a multisensory mix of all 3, activating both the logical left side of the brain with the artistic right side of the brain.4

For instance, lecturers rely heavily on the learner's hearing, but incorporating visual aids, with color and symbols, increases long-term retention by 14% to 38%.4 Include constant “peripheral” visual learning opportunities by placing wall posters wherever learners’ eyes might gaze.

Bring in “doing” by asking a sample group quiz question for which you throw a squishy ball when the right answer is given.4 I review material by playing the childhood game of “hot potato” with a balloon. When the music stops, the person holding the balloon must give a related assessment/nursing action or pick someone else to answer.

REPETITION IS THE MOTHER OF ALL LEARNING

New material needs reinforcement. Say something again, in a slightly different way. People need to hear things more than once. Repeat it again. After all, isn’t frequency a factor for why we remember our mother’s favorite sayings?

Instructional approach

HAVE STUDENTS TEACH STUDENTS

It can be tempting to believe that all learning will come from the “expert” instructor’s teaching. Yet educators know that he who teaches learns the most. Using small groups for directed sharing makes everyone a teacher and enhances learning.

Structured versions of this are the cooperative learning “think-pair-and-share” exercises.9 Learners are given the general concept and one minute to think and write down their thoughts about it. The posed task could be anything from “What will improve the care of cardiac patients in our emergency department?” to “What are the 3 most important things to assess (or do) for a patient with abdominal pain?”

Participants are then paired to share; each is required to verbalize their thoughts to the other person rather than just agree with the first person’s statements. After this time (so they both pay attention during the sharing), one is chosen as the spokesperson for the pair by a random selector, such as the one with the earliest birthday in the year. Spokespeople stand and then some are randomly selected to repeat information from the paired sharing.

There are multiple benefits from this method that result in everyone participating. It accommodates those learners who initially need more time to think or have trouble speaking before others. (They “rehearse” what they will say, usually with positive feedback and can choose to “enhance” their response with their partner’s comments.) Interaction with the material is accomplished as participants must conceive it, write it down, teach it to another, hear both what they and their partners say about it, and consider another
Developing Critical Thinking Skills in New Graduate Nurses

PERSON'S PERSPECTIVE ON IT. THE REPEITION AND VARIETY OF METHODS ARE PENETRATING.

TAKE FREQUENT BREAKS
Lavin recommends having a break every 40 to 50 minutes of class.1 I set a ringing kitchen timer (if I don't, I tend to lose track of the time). I announce "Time for exercise!" as I play a tape of lively music for 1 to 2 minutes and lead minor exercises (e.g., lifting arms up and down, twirling at the waist). It has become an anticipated, delightful trademark.

The interruption pulls in the kinesthetic learners and individuals with attention deficit disorders. More importantly, it improves retention because learners remember the first and last material covered (educators call it the primary and recency effect). Multiple short breaks create more beginnings and endings.2

THE USE OF SELF

EXUDE PASSION AS WELL AS PURPOSE
William Arthur Ward said, "The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires."3 The difference between good and great teaching usually isn't expertise. It involves a genuine passion for the material and for teaching. That comes from the heart and is contagious. Emphasize what already interests you. Your excitement about the material will be infectious and the learner will catch it (or at least respect it).1

PRACTICE VULNERABILITY
While it is assumed as a speaker that you have some knowledge to share (why else are you teaching?), people don't trust someone who is always a know-it-all. Honestly admit it when you occasionally don't know. With professional groups, I will offer up the question so audience members can respond. Admitting you don't know something doesn't cause you to lose credibility, but rather models that you, too, are a life-long learner.1

USE EMOTION
Leon Lessinger said, "Human beings are full of emotion, and the teacher who knows how to use it will have dedicated learners."4 Humans often forget something that makes us think, but we almost always remember how something makes us feel. It is the emotions attached to a particular event that help us remember the details of a high school graduation, a first date, or casual insult, just like it was yesterday. I use anecdotal stories or legal cases to portray the emotions, as well as consequences, of what I want the learner to remember.

TEACH THROUGH YOUR EVERYDAY EXAMPLE
In all you do, people are watching and learning. As the saying goes, "I'd rather see a sermon than hear one."5 People are more willing to learn from someone they respect.

SUMMARY
Henry B. Adams said, "A teacher affects eternity; he can never tell where his influence stops."6 It is a high calling to be in a position of imparting knowledge to anyone. Manipulating your learning environment, instructional approach, presentation method, and effective use of self can aid your successful presentation of any content.

REFERENCES

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Exhibit F


*Source: Polly Gerber Zimmermann, RN, MS, MBA, CEN. Reprinted with permission.*
Orienting ED Nurses to Triage: Using Scenario-based Test-style Questions to Promote Critical Thinking

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Triage is a unique skill, essential to emergency nursing, but not easy to learn. ED nurse educators can use scenarios with test questions as an effective tool to help teach or reinforce principles behind good triage decisions. Who doesn't play along when watching the television quiz show JEPARDY? Also, with case-based scenarios, the "story" element, game premise, and the challenge entice everyone to get involved. Get started with the lessons in these illustrative scenarios.

Obtaining the history
A common medical adage is that 90% of the information needed to make a diagnosis is contained within the patient's history. Asking the right questions and follow-up questions is vital. Sections of the chart's format often guide the triage nurse through the standard categories of a history, such as allergies, last menstrual period, or current medications. A thorough description of the chief complaint and related history, however, is often where the omission of key information can have a significant impact.

Lesson 1: The importance of obtaining the complete history of the chief complaint

A 26-year-old woman is brought to the emergency department after fainting while visiting her mother in ICU. There is no seizure activity or head trauma. In triage, her finger-stick glucose is 76 mg/dL and partial pressure of oxygen is 99% room air. The patient denies drug and alcohol use, pregnancy, or other medical conditions. Which information is now a priority for the triage nurse to obtain?
A. What she felt just before she fainted.
B. Her stress related to her mother’s hospitalization.
C. What food she had eaten that day.
D. How much sleep she has been getting.

Answer A
The most important clue in a loss of consciousness is the patient’s recollection of the event just before it happened or the “onset.” When there is a true loss of consciousness, or syncope, patients will say that “everything went black” with a rapid recovery (compared with postictal). It is important to rule out a cardiac origin when “fainting” occurs without warning; ask about palpitations and check for pulse irregularity. Vasovagal syncope, in comparison, often has premonitory symptoms that make the patient dizzy, nauseated, or diaphoretic.¹

The fact that it is a younger woman, rather than an older obese man with a pacemaker, might tempt a triage nurse to focus initially on emotional distress instead of a cardiac etiology. Food intake, while appropriate in some circumstances, is not that significant for her since it is already known that the glucose level is adequate. In this true case, the woman had a previously undiagnosed cardiac condition and anemia and did well with treatment.

Lesson 2: Do not assume that patients tell you what is most important
The presenting physical complaint may not be the only thing, or the worse thing, that’s wrong with the patient. Similarly, the most obvious etiology for a complaint may not be the right one. Patients often give an explanation for their problem. While some patients may have correct insights, avoid automatically accepting their assessment of the problem.

In one case, an elderly woman complained of abdominal pain and said, “I think my bowels are acting up.” She was triaged to fast track for constipation, but was found to have a drug-induced hepatitis with whitish stool.

In another case, a young, robust man, with a low-grade fever, presented requesting antibiotics because he had the “flu that is going around.” It was only after further probing by the triage nurse that he revealed he had a transplanted kidney and was on prednisone. He could have early signs of rejection or a blunted response to a more serious infection.

A 64-year-old man presents complaining that his leg “is not working right” after he fell 4 days ago. He cut his knee but did not seek medical care. The triage nurse notes a scabbed, wide, jagged area on the right knee, without red streaks, warmth, or drainage. The nurse should next:

A. verify his tetanus immunization status.
B. teach the time frame for suturing and signs of infection.
C. clarify what is meant by "not working right."
D. assess his pain level.

Answer C
The patient implies this is just a minor case of an old local injury, with a possible lingering infection or musculoskeletal injury. However, the atypical description and lack of infection should prompt further questioning. In this case, the nurse elicited that there was weakness in the patient’s leg and, incidentally, his arm on that side was a little weak, too. In the end, it was discovered that this man had actually experienced a minor stroke that caused his fall.

Lesson 3: Rule out serious systemic etiology first
An important principle related to the triage process is to rule out the worse-case scenario for a symptom and then work backwards toward less ominous etiologies. For example, with a complaint of “chest pain,” eliminate the possibility of a cardiac etiology before considering less ominous causes, such as costochondritis or herpes zoster (shingles).²

An 80-year-old woman presents with a noticeable left-sided facial droop, complaining of facial pain. What is most important for the triage nurse to do next?

A. Evaluate cranial nerve III (oculomotor).
B. Determine the presence of the palmar drift.
C. Ask the patient to squeeze the nurse’s hands.
D. Assess if there is a history of facial trauma.

Answer B
Rule out a systemic neurological cause, such as a brain attack (stroke), by first checking for extremity movement and strength. Most nurses do this by evaluating bilateral hand grasps for extremity strength, but this finding can be affected by forearm or hand afflictions, such as arthritis.
Use the palmar drift instead. Have patients close their eyes and stretch their arms out straight (palm side up) for 15 seconds. A weak side will drift down and turn medially. An alternative version is determining if the patient can hold their arms straight up (palm side forward) for 15 seconds (without drifting) and then resist against the nurse’s efforts to push the arms down. Alternative causes for this patient’s symptoms, such as Bell’s palsy (peripheral facial paralysis) or local trauma, can be considered afterwards (options A and D).

Lesson 4: Avoid stereotypes and assumptions

Popular generalizations can subconsciously lead to wrong decisions. For example: “all cocaine abusers are inner-city teenagers,” “all Asians are stoic,” or “patients with a psychiatric disorder do not develop medical problems.” One 24-year-old Hispanic woman was triaged as a patient experiencing a “hysterical” panic reaction, when she actually had epiglottis and eventually was intubated. Of course she was exhibiting severe anxiety in triage; she couldn’t breathe!

A 70-year-old woman has a known history of Alzheimer’s disease, hypertension, and diabetes. She is brought to the emergency department by her son because of new, nonstop verbal rambling and pacing today. What is the best response for the triage nurse to do next?

A. Ask about her other typical dementia-related behavior.
B. Assess the caregiver’s stress and ability to cope.
C. Inquire if anything upset the patient emotionally today.
D. Classify this as a “change in mental status.”

Answer D

A sudden change in behavior is a change in mental status, regardless of the patient’s baseline cognitive status. It is an adage that can be forgotten when patients are elderly, have dementia, or have a history of a psychiatric disorder. Start further assessment by obtaining a pulse oximeter and fingerstick glucose reading.

Sudden cognitive changes are the most common manifestation of illness in the elderly (with or without dementia). As much credence and attention should be given to the geriatric caregiver who recognizes a change in this patient’s “normal” condition as is traditionally given to the parents’ evaluation of their children.

Delay providing answers

When the correct response to a test question is immediately available, it is human nature to just passively agree with it. Learning takes place when the participant commits to a choice, and then seeks to understand why it is the best answer (or why not). So consciously delay your answer to help orientees learn the most.

Summary

Instructors describe test taking as a learning opportunity, particularly from the individual’s missed questions. While few warmly welcome that “educational experience,” the technique does work. Using the test question format in a non-threatening way can promote emergency nurses’ growth in obtaining an essential triage history and applying critical thinking triage and prioritization skills.

REFERENCES

Send descriptions of procedures in emergency care and/or quick-reference charts suitable for placing in a reference file or notebook to:

Gail Pisarcik Lenehan, RN, EdD, FAAN
c/o Managing Editor, PO Box 489, Downers Grove, IL 60515
800 900-9659, ext 4044 • karen.halm@artbi.com
Exhibit G

*Journal of Emergency Nursing*, December 2002, volume 28, number 6, “The Difference Between Teaching Nursing Students and Registered Nurses”

*Source: Polly Gerber Zimmermann, RN, MS, MBA, CEN. Reprinted with permission.*
The Difference
Between Teaching Nursing Students
and Registered Nurses

Author: Polly Gerber Zimmermann, RN, MS, MBA, CEN,
Chicago, Ill

Section Editor: Faye Everson, RN

An accomplished, experienced lecturer began his presentation on ethics to nursing students. He painted the following scenario: “You have a COPDer with sats of 70. Do you tube him? Would your answer be different if you knew he was gorked out?” The students were confused about what was happening and looked alarmed that it was up to them to make this important decision.

A respected researcher began her conference talk on advances in asthma interventions to an audience of experienced ED nurses. In the first 5 minutes, she explained the anatomy and physiology of the lungs. A mass attendee exodus ensued.

What went wrong? Both presenters failed to recognize and plan for the differences between nursing students and experienced registered nurses. Nursing students are not “experienced” nurses; they still lack knowledge and exposure to clinical reality. On the other hand, experienced nurses want new information for their practice, not a basic concept review.

The best presentations are tailored to the audience. Consider the following distinctions to customize presentations for these 2 groups of learners.

Who are the people?

LEARNER CHARACTERISTICS

Students: Students are really unlicensed assistive personnel with some additional education and background. Their view of patient care is still pure.

Students freely admit (and assume you know) that they do not know everything. For example, they freely admit they will be afraid of defibrillating a patient in ventricular
fibrillation because “they might do it wrong.” They need confidence to do what nurses must do.

Nurses: A nursing audience has an assumed competency, “lived” experience, and internalized professional socialization. Nurses automatically assume a sense of control and responsibility for their own practice and its impact on others.

Nurses are reluctant to admit they do not know everything because they do not want to look stupid. They have seen questionable scenarios for which they wonder if there should have been a different course of action.

TEACHER CHARACTERISTICS

Students: Students assume their instructor is an “expert” who knows everything. However, nursing faculty are required to have a broad, superficial awareness in every area. For instance, although I am an ED nurse, my teaching assignments include postoperative hip replacement, tube feedings, and bladder retraining programs.

Nurses: At least subconsciously, nurses want their presenters to “prove” they know what they are talking about and are not “educated dummies.” There are still some believers in George Bernard Shaw’s maxim, “Those who can, do; those who can’t, teach.” Toward this end, many persons making a presentation to nurses will mention their previous or current related nursing roles or experience.

Presenters are expected to have an in-depth expertise in a limited area. Nurses want pearls of wisdom that illustrate lessons learned from the “school of hard knocks” with clinical and technical know-how.

WHY DID THE LEARNERS COME? OR “WHAT’S IN IT FOR ME?”

Students: Attendance for students is a requirement. Besides, intellectual stimulation, whether or not it is useful in the job, is considered an acceptable outcome in academia.

Nurses: Nurses, as professional learners, “volunteer” to participate in most educational activities. They expect (demand!) a demonstrable, practical difference in their practice as a result of this investment of time, money, and energy. They need the instructor to help them do or be something better.

What is the content?

DEPTH

Students: Generic nursing students need “classic” theoretic concepts at a broad, skimming level. Their goal is to learn enough essential information on many topics, including areas they will never practice, to pass the comprehensive National Council of State Boards Licensing Exam (NCLEX) and become a registered nurse. They are learning the rules and processes of nursing practice.

Nurses: For nurses, the basics are known; their focus has been selected. Nurses now want a mixture of disease theory, research, updates, practical reality, and tips for this specific area. Instructors should offer in-depth understanding, unique cases that illustrate the interesting variances, and detailed information nurses can apply today.

STARTING POINT

Students: With students, instructors should start at the beginning and not make assumptions. For example, after a lengthy, clear explanation of the syndrome of inappropriate antidiuretic hormone, the students had only one question: “What does the word ‘diuretic’ mean?”

Nurses: For nurses, only a brief review of the basics is needed (if a review is needed at all) before moving on to the latest and greatest in this area. Lectures often are expected to be a shortcut for nurses to acquire this new material.

THOROUGHNESS

Students: Students initially have difficulty focusing; they consider everything equally important. They often ask questions about obscure, insignificant material, such as how to determine if a skull fracture is a simple or compound break without having to take a radiograph.

Nurses: Nurses possess a vague understanding that is good enough for most concepts, especially within nursing’s jurisdiction. They want to know what they should do about it. Besides, nurses have the background to figure out things on their own. It is like being able to navigate within a strange new city as long as you know where you are at, can read a map, and determine which direction is north.
PATHOPHYSIOLOGY

Students: Today the focus of basic nursing programs is recognition of normal versus abnormal conditions and nursing interventions. Anatomy and physiology for a sign or symptom are not emphasized because the NCLEX does not test that information. What is tested is need states, nursing diagnoses, what is important to report or act on, and patient teaching/prevention. The instructor should paint dramatic pictures of the “worse case scenario” so an impression is made of the importance of this symptom. For example, “When you hear a new onset of rales (make a mimicking sound), tell somebody!”

Nurses: “Seasoned” nurses were often trained under a pathophysiology and disease model and seek to fit new information within that framework. Even nurses without prescriptive authority like the inclusion of the differential medical diagnosis distinguishes and “anticipated” medical treatment. This helps them better understand what they have witnessed in their work. For example, when you have a new onset of congestive heart failure, what drug, dose, and response should one expect?

SOURCE OF INFORMATION

Students: For students, textbooks are the ultimate authority. Only current universal practice (not new innovations) is taught because that is what NCLEX will test.

Nurses: Experienced nurses appreciate “war stories,” an intriguing isolated research study result, an illustrative legal case, use of cutting-edge advances, and current nursing and physician practices. They value the integral role of “on-the-job” learning and real patient scenarios.

BASIS OF ACTION

Students: Students believe that decisions are made by the rules. Initially, their mantra is, “If I just memorize everything, I will be fine.”

Nurses: Nurses may not always recall all the in-depth rationales behind something, but the application of key concepts and actions are inherent in their thinking. It is obvious to them.

The testing scenario situation is that a patient, after blunt head trauma, is found with new-onset extreme restlessness. One third of the students would continue to monitor, perform a cranial nerve assessment, or discuss his feelings because “these are important nursing functions.” Nurses would automatically, and correctly, call a doctor now.

AMOUNT OF MATERIAL

Students: Students are irritated with “interesting” tidbits; they only want a memorable spotlight on the crucial information. Their silent cry is “Tell me only what I have to know.” They are already overwhelmed with the sheer quantity and complexity of the material they need to learn.

Nurses: Instructors should give nurses more material than they can use. Nurses want to be able to sort through the abundance to pick out what they need at this time. Their silent cry is, “Give me something that will solve my problem.” They enjoy material set a higher level because it forces development of new intellectual muscle.

TEACHING SKILLS

Students: Tell students the one perfect right way to do the skill. They deteriorate on their own to a “practical” level after graduation. Stylistic options confuse them.

Nurses: Nurses like to hear about variances, tricks of the trade, and tips about various product brands. They are enlarging their repertoire of options to try in their real-life encounters.

THE ROLE OF HISTORY

Students: Students do not want to hear about the outdated, “irrelevant” past. Just teach current practice.

Nurses: Instructors can bridge the new changes in current practice by recalling episodes from the past. The average nurse is in the mid-40 age range; most graduated from basic training many years ago. Even if they obtained an advanced degree, the rapid turnover makes it difficult to keep up. Deliberately pointing out and recognizing changes helps the “seasoned” nurse understand what to change in their practice and why.
Developing Critical Thinking Skills in New Graduate Nurses

How

SPEED OF SPEECH

Students: For students, most content is unfamiliar; it is like listening to a foreign language. Things must be said slowly in an expansive manner. New material is heard the first time, recognized the second time, and learned the third time. Repetition is the mother of learning.

Nurses: ED nurses are used to a fast pace. Instructors should be concise with a quick tempo. If you need to reinforce the information, use a different method, such as an illustrative story.

TERMINOLOGY

Students: With students, use precise, proper terminology and explanations. A student literally believes it when the nurse says that the patient "has no veins." For example, explain that "the client is in danger of a life-threatening systemic condition because the kidneys are in danger of permanent damage when they are not filtering properly. This is a result of low pressure from the septic shock's vasodilatation, causing inadequate blood perfusion through the kidneys' tubules."

Nurses: Abbreviated shortcut slang terms are used universally among nurses. It is part of how we know who belongs to the "club." Nurses say, and expect the presenter to say, that the patient is "crashing from renal shutdown."

HUMOR

Students: Because students lack exposure to real-life nursing situations, they think concretely in black and white. I once used a joke that "cost-effective cardiopulmonary resuscitation begins with shaking the patient and shouting 'Annie, Annie, are you insured?'" The students took note! Students enjoy jokes, but not ones based on patient behavior.

Nurses: Having lived through enough bizarre instances in the course of their professional life, nurses appreciate a little earthy irreverence or "black" humor. It is a coping mechanism used to deal with the inherent ED weirdness. It also is a way of sublimating frustration over issues that affect nursing but seem beyond immediate control. Nurses enjoy jokes about "stupid patient tricks," ridiculous bureaucratic paperwork, or universal staffing problems. For example, how do you know you have a cheap health maintenance organization? You ask for Viagra but they give a popsicle stick and duct tape instead. Nurses laugh at this joke; students look appalled.

MOTIVATION

Students: When instructors tell students they need to know this "for the test" or clinical practice, they will seek to learn it. Studying high-risk situations inspires them that they can save lives!

Nurses: Instructors should tell nurses why they should change their practice. Nurses can be motivated by the threat of a legal action, loss of license, regulatory agency requirements (Joint Commission on Accreditation of Healthcare Organizations, Board of Health), or an example of making a difference in one person's life. Nurses love personal anecdotes, especially when a nurse triumphs over an egotistical physician.

BLUNTNESS

Students: Students need to be corrected in a direct manner. They do not know the safeguards or perceive what might be wrong. This approach can seem "rude" to the uninitiated. However, when I "suggested" a student take the temperature of a chilling postoperative patient who was diabetic and taking steroids, she deferred because "it was normal only 3 hours ago."

Nurses: With nurses, suggestions usually work: professional nurses do not want to be ordered around. There are disciplinary exceptions, of course, but a gentle hint will nudge most nurses to do what they know they should be doing. After all, they successfully completed nursing school and NCLEX.

WHO ELSE—NETWORKING

Students: Many students do not perceive the potential of learning from others. Their nursing education is viewed as an individualistic endeavor. Students often get upset if other students interrupt the teacher's instruction.

Nurses: Professionals overwhelmingly participate in an educational offering because they want access to people. Program participants love to share and, in turn, learn from each other. Instructors should build in networking opportunities or audience involvement.
Summary

Teaching what you know and understand in any format is uplifting and rewarding. As the Israeli saying goes, "More than the calf wants to suck its mother's milk, the mother wants to impart the milk to the calf."

Anyone can effectively transition teaching between nursing students and registered nurses. All it takes is recognition and deliberate modifications to accommodate the distinct needs in content and technique.

REFERENCES
2. Saltzer C. Sixteen ways to be a smarter teacher. The Fast Company 2001(December);No. 53:114-26.

Submissions to this column are welcomed and encouraged. Contributions may be sent to:

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Correction

Developing Critical Thinking Skills in New Graduate Nurses

Resources

1. www.guidelines.gov

2. University Of New Mexico School of Nursing
   http://hsc.unm.edu/consn/conct/whatis.shtml

3. National League For Nursing

4. Links to various related articles
   http://nursing.about.com/od/glossary/g/criticalthinkin.htm


Exhibit I

Polly Gerber Zimmermann, RN, MS, MBA, CEN, resources
Resources

Dorthey Del Bueno’s article about critical thinking in the nurses:

American Association of Critical-Care Nursing (AACN) decision-tree for delegation decisions,
101 Columbia, Alisa Viejo, CA 92656-1491, 1-800-899-2226

Give new graduates “rules” for “telling somebody” by using the criteria developed for Rapid Response Team Activation (a concept introduced by the Institute for Healthcare Improvement (IHI) as part of the 100,000 Lives campaign.

IHI’s recommendation:
• Mean arterial pressure < 70 or >130 mmHg
• Heart rate < 45 or >125
• Respiratory rate < 10 or > 30
• Complaints of chest pain
• Change in mental status (lasting more than 10 minutes)

UPMC Shadyside and UPMC Presby Signs and Symptoms
• Chest pain unrelieved by nitroglycerin
• Sudden loss of movement or weakness of face, arm, or leg
• Change in color of central or peripheral skin (pale, dusky, gray, or blue)
• Unexplained agitation lasting >10 minutes
• Bleeding into the Airway

Durkin, S. Implementing a Rapid Response Team. Good Samaritan Hospital, Downers Grove, IL, *American Journal of Nursing*, in press.
• Staff concern about the patient, something is “just not right”
• Acute change in heart rate, blood pressure, respiratory status
• Acute change in oxygen saturation
• Acute mental status changes

According to one study, 66% of patients had signs of instability for up to eight hours prior to the event. Studies have shown that up to 70% of the calls to a rapid response team were based on concerns about the patient’s respiratory status, accompanies by staff concern about a patient’s deteriorating condition.

“Brains in our Pocket” Resources for Nurses
• PDA programs
  - “Homemade” Versions—
    - Peg McBee, 246 Brickworks Lane, Severna Park, MD 21146, EDPegMcBee@aol.com
      Written up in Nursing 2003, July, 32cc1, 2. “…was originally developed to help recruit and retain new
EXHIBIT I

Developing Critical Thinking Skills in New Graduate Nurses; however, it also exemplifies how one unit can pull together to ensure the delivery of first-rate patient care."

- Laura Criddle, 28384 Hafferman Road, Scappoose, OR  97056-9109, criddle@ohsu.edu

Written up in the June 2004 *Journal of Emergency Nursing* 30:3, pg 212 Created an institution-specific pock-sized guide of department/specialty-specific source for commonly used standards, protocols, procedures, medication data, polices and guidelines. It allows you to standardize and simplify information access rather than every nurse creating their own version.

My favorite sources of test questions


Sylvia Rayfield’s books of pictures and mnemonics including *Nursing Made Insanely Easy* and *Pharmacology Made Insanely Easy*. www.icanpublishing.com

Aids for Writing Better Test Questions


Aids specific for triage/ED nursing


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773/593-1048 phone/fax
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54 Developing Critical Thinking Skills in New Graduate Nurses
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April 20–21, 2006, The Ritz-Carlton Golf Resort, Naples, FL

Advanced Medical Staff Leadership Retreat: Where today’s leaders come to solve their toughest medical staff problems

Get an in-depth look at the six toughest challenges faced by medical staff leaders today: ED coverage, disruptive physician behavior, physician/hospital collaboration and competition, matching proven competency with clinical privileges, physician/physician and physician/hospital conflict, lack of effective physician leaders.

Early-Bird Discount: Register by February 16 to save $100!

April 21–22, 2006, The Ritz-Carlton Golf Resort, Naples, FL

Surgical Team Summit: Bringing together chiefs of surgery, chiefs of anesthesia, and surgical services leadership to tackle the toughest OR challenges

Surgical teams can bring in some of the highest revenue for your facility. However, stress-free, efficient operating-room (OR) management is difficult to attain. Improve revenue and reduce inefficiencies while getting practical strategies for OR management, regulatory compliance, turf-battle resolution, credentialing, and patient flow.

Early-Bird Discount: Register by February 16 to save $100!

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To register, or for continuing education credit opportunities for these seminars, call 800/801-6661 or visit www.greeley.com.
Spring 2006 Seminar Calendar

MAY

May 17, 2006, Mandalay Bay Resort & Casino, Las Vegas, NV
**NEW! Core Privileging Advanced Course: Design and implementation**
Are you charged with the job of reviewing and recommending a redesign to core privileging? Where do you start, and how can you avoid the roadblocks that can hamper smooth implementation of core privileges? A pre-conference to the 9th Annual Credentialing Resource Center Symposium, this full-day offering will take participants through the key steps needed to design, modify, and implement core privileges.
Ask about additional discounts!

May 18–19, 2006, Mandalay Bay Resort & Casino, Las Vegas, NV
**UPDATED! The 9th Annual Credentialing Resource Center Symposium**
Learn practical and innovative approaches to solving your toughest credentialing and medical staff challenges. For the past nine years, experts from The Greeley Company have offered medical staff and credentialing professionals nationwide seminars on credentialing hot topics. Past topics have included low-volume/no-volume providers, core privileging, physician performance profiles, new technology, and much more.
**Early-Bird Discount:** Register by March 16 to save $100!

May 18–19, 2006, Mandalay Bay Resort & Casino, Las Vegas, NV
**UPDATED! Achieving Continuous Survey Readiness Through Patient Tracers: A practical 5-step model to compliance**
On January 1, 2006, the unannounced survey process goes into effect. Prepare now with the 5-step model to continuous survey readiness, a look at JCAHO hot spots, what’s new for 2006.
**Early-Bird Discount:** Register by March 16 to save $100!

May 18–19, 2006, Mandalay Bay Resort & Casino, Las Vegas, NV
**Magnet Resource Center Advanced Workshop**
Confused and overwhelmed by how to achieve Magnet status—the highest seal of nursing excellence? Then attend this seminar to work one-on-one with the elite few nursing professionals who have already achieved Magnet status. These experts will outline clear action plans toward successful completion of your Magnet application.
Register early for team discounts!

May 20, 2006, Mandalay Bay Resort & Casino, Las Vegas, NV
**NEW! Physician Performance Profile Course: Quality data and current competence**
Understand the collection and use of quality data to improve physician performance and appraise the ongoing competence of your medical staff. Topics include the domains of physician performance, the use and application of rule, rate and review indicators, and gaining physician buy-in.
Ask about additional discounts!

JUNE

June 1–2, 2006, The Ritz-Carlton, Amelia Island, Amelia Island, FL
**Medical Executive Committee Institute: The essential training program for all medical staff leaders**
Gain skills never taught in medical school. Topics include how to solve MEC challenges (turf battles, disruptive physicians, ED coverage, impaired physicians, conflict of interest, medical records completion, external peer reviews, fair hearings, physician apathy) and improve performance for medical staff leaders.
**Early-Bird Discount:** Register by March 30 to save $100!

Coming Soon (June date and location to be announced)
**Public Accountability for Quality**
Hospital and physician data is being measured and reported publicly with consequences for marketing, reimbursement and accreditation. This program will teach hospital teams responsible for improving performance on publicly reported data how to gather data, interpret data, train management on how to use data, and much more.
Ask about additional discounts!

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