

Governor's Committee on Nursing Workforce  
Subcommittee on Alternative Educational Opportunities

1/11/08

The subcommittee met on December 13th with the following members and guests present. Claudine Buettner, Bob VandeMerwe, Karen Hodge, Steve Frei and Noreen Davis. Guests included Dessa Lagerstrom and Lucy Tait, SLRMC and SARMC staff responsible for coordinating student rotations.

**Questions that need to be considered include:**

1. What organizations are currently being used for clinical rotations of students? Are all used to capacity?
2. What is the number of student occurrences that are provided by the current clinical sites including hospitals, clinics etc.?
3. How many qualified students were denied admission in Idaho Nursing programs in each of the last three years? Are those students tracked to see if they are accepted at a later date?
4. How long do colleges and universities track students after graduation? Where are the students currently working that have graduated over the last 3-5 years? Are we losing students to other states?
5. What are the barriers for colleges and universities to work together more collaboratively in scheduling clinical rotations of students?
6. What are some of the creative solutions being used and how are they shared with other colleges and universities?
7. Are health provider organizations willing to partner with colleges and universities to change the way student rotations are currently staffed and scheduled?

**Dessa Lagerstrom and Lucy Tait shared with the group the following challenges that are currently experienced in scheduling student rotations.**

1. Awkward clinical scheduling due to mandatory University schedules resulting in clinical rotations predominately being held Monday through Friday on the day shift. (Usually four hour shifts)
2. Fatigue factor hospital staff have as a result of having different universities and different students every day. It is not unusual for a nurse to have two different nursing students during one eight hour shift.
3. Constant requests for more clinical rotations in the acute care settings. In academic year of '08 there are an additional 540 nursing students scheduled for clinical rotations at SARMC and SLRMC.
4. Out of state schools and multiple new programs are requesting time for clinical rotations often with little or no advanced planning.
5. The current practice for pediatric experience results in inadequate pediatric availability for students.
6. On a day to day basis there is often capacity for additional students on a clinical unit, however the academic facility scheduled to use the unit for the day do not have additional students scheduled or in that specific rotation.
7. It is difficult to find faculty that enjoy working in or feel comfortable working in multiple clinical sites.
8. The current technology utilized in acute care settings and regulatory requirements make it difficult for an instructor to be effective at multiple sites.
9. Rural facilities are not presently being used for clinical rotations by all academic programs.

### **Alternatives to consider:**

1. Schools and Universities spread clinical experience over the entire year vs. using only the academic year. Schedules to be expanded to include all shifts and all days of the week vs. the current Monday-Friday day shift.
2. The use of other sites providing health related services should be considered for clinical rotations as appropriate during the beginning of the students' introduction to patient care. This would expand the availability of acute care hospitals for students beyond the beginning phase of patient care. Other sites could be LTC centers, SNF, clinics, outpatient centers, physician offices, day care centers etc. Nursing homes could be utilized for students learning about multi system failures.
3. Schools and Universities share grant writers to seek funding to financially support new alternatives in providing clinical education and experience. Explore the feasibility of including other health providers in the grant process.
4. Investigate more efficient ways of providing clinical instructors in the health care settings. For example partner with the facilities to have facility staff function as a clinical instructor (with proper preparation). This would reduce the time required for multiple individuals from the colleges and universities to become familiar with complex equipment, procedures and protocols.
5. Evaluate the effectiveness of alternative schedules with different start times during the year. For example 12-14 week schedules vs. the traditional 16 weeks and starting students three times a year vs. the traditional one/sometimes two.
6. Investigate the use of more simulation with equipment shared between educational facilities and possibly with other health providers.
7. Explore an additional way to provide BSN education including a combination of on line/ face to face and simulation with the possibility of students obtaining the necessary courses from more than one educational facility.
8. Identify what is necessary for rural hospitals to be effectively used as clinical sites for students. Consider the preceptor model or other alternatives that allow students, instructors and staff from the facilities to maximize learning opportunities.
9. Encourage the teaching of health occupation classes in high schools giving dual credits. This would result in students being able to begin CNA, EMT, pharmacy tech and other health related programs in an advanced placement.
10. Identify how multiple entries for students can be achieved.
11. Investigate alternatives on how faculty can be supported while they are finishing a Masters or Doctoral program while teaching.
12. Consider placing students from more than one educational facility together in clinical rotations so that each site is utilized to its maximum capacity. This could include sharing faculty between educational facilities.
13. Educational facilities and health care organizations partner together to provide reference materials and equipment for labs etc.
14. Create incentives for staff working in health care facilities to consider affiliate faculty status with all educational program working together to make certain there is consistency and standardization.

It is imperative that health care providers work closely with educational facilities to identify what education is needed; and for educational facilities to look at different ways of providing the needed education for students, to ensure the demands of the future are met. It is imperative that we have true partnership and collaboration across all boundaries and that we all plan together to make certain the way we educate the health care providers of the future is effective and efficient.