The Future of Nursing in Texas: Stakeholders Moving Towards Alignment

February 24-25, 2020
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The Future of Nursing in Texas

Executive Summary

In 2019, through deliberative alignment strategies, the Texas Board of Nursing (TBON) and the Texas Organization for Nursing Leadership (TONL) joined together to convene a Summit designed to engage conversations between academia and practice to improve the readiness of new graduates to transition into practice. The result was the Invitational Nursing Summit, The Future of Nursing in Texas: Stakeholders Moving Towards Alignment.

The purpose of this statewide Summit hosted by the Texas Board of Nursing and the Texas Organization for Nursing Leadership was to develop a coordinated approach to address gaps between and within academia and practice and optimize clinical learning experiences for the future of nursing in Texas. Stakeholders from various national and state nursing organizations were invited to nominate member participants.

Over 130 nurses from academia and practice settings across Texas attended the two-day Summit, engaging in open discussion and problem solving. The results of the Summit and the subsequent recommendations for moving towards alignment are detailed in this report. This report was delayed due to a worldwide pandemic which took place immediately after the Summit.
Acknowledgments

The Texas Board of Nursing (TBON) and the Texas Organization for Nursing Leadership (TONL) would like to thank the members of the Summit Planning Committee for their expertise, time, and commitment to the success of the Summit.

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Support

The Summit Planning Committee acknowledges the generous support offered toward the Summit event and report production by:

- AMN Healthcare,
- Texas Organization for Nursing Leadership, and
- Texas Tech University Health Sciences Center School of Nursing.

The committee also acknowledges Beth Ulrich, EdD, RN, FACHE, FAONL, FAAN, for compiling and editing the report, and Leslie Norman, DNP, RN, NEA-BC, FACHE and Brandy Wells, DNP, APRN, NNP-BC for analyzing the Summit results.

Finally, the committee would like to thank the staff of the Texas Board of Nursing and Texas Organization for Nursing Leadership for coordinating and recording the Summit.
# Table of Contents

Executive Summary .................................................................................................................. 3  
Acknowledgements .................................................................................................................. 4  
Background ............................................................................................................................... 7  
  Approach in Texas .................................................................................................................. 7  
  Summit Objectives ............................................................................................................... 9  
  World Café Concept .......................................................................................................... 10  
World Café – Topics and Guiding Questions ........................................................................... 12  
World Café Results .................................................................................................................. 16  
Analysis and Themes .............................................................................................................. 22  
Overall Recommendations and Action Plans ......................................................................... 29  
Summit Evaluation .................................................................................................................. 33  
Moving Towards Alignment .................................................................................................... 37  
References ............................................................................................................................... 38  
Appendices .............................................................................................................................. 39  
  Appendix A: Summit Attendees/Organizations .................................................................. 40  
  Appendix B: Invitation to the Summit ............................................................................... 43  
  Appendix C: Summit Agenda ............................................................................................. 44  
  Appendix D: Summit Speaker Bios .................................................................................... 46  
  Appendix E: Summit Suggested Readings and Resources ................................................ 55  
  Appendix F: World Café 101 ............................................................................................... 65  
  Appendix G: Summit World Café Table Topics and Facilitators ....................................... 68  
  Appendix H: World Café Facilitator Reports ..................................................................... 69  
  Appendix I: Post-Summit Evaluations .............................................................................. 113
Background

Health care today is experiencing a rapidly evolving agenda requiring new and innovative methods of communication and collaboration. The nursing profession is well positioned at the forefront of this revolution to create one united voice for change.

The passing of the Patient Protection and Affordable Care Act (ACA) in 2010 created new challenges for the delivery of health care; particularly how to meet a significant increase in demands for services while maintaining quality and safety. The Institute of Medicine (IOM) and the Robert Woods Johnson Foundation (RWJF) created the Future of Nursing Campaign with nursing at the helm of individual state coalitions. The IOM published the landmark report, “The Future of Nursing: Leading Change, Advancing Health” (FON) in 2010. The report outlined eight key recommendations for action including:

- Removing scope of practice barriers;
- Expanding opportunities for nursing to lead and diffuse collaborative improvement efforts;
- Implementing nurse residency programs;
- Increasing the proportion of nurses with a baccalaureate degree to 80% by 2020;
- Doubling the number of nurses with a doctorate by 2020;
- Ensuring that nurses engage in lifelong learning;
- Preparing and enabling nurses to lead change to advance health;
- Building an infrastructure for the collection and analysis of interprofessional health care workforce data. (FON, 2010)

The state and national coalitions created the first major partnerships between nursing and community stakeholders which opened the door to academic and community collaboration.

In 2012, the American Association of Colleges of Nurses (AACN) developed a joint task force with the American Organization of Nurse Executives (AONE) (now the American Organization for Nursing Leadership) and created guiding principles for academic-practice partnerships that include setting recommendations for developing mutual respect, shared goals, and knowledge (AACN, 2020). These partnerships are vital to position nurses in both academic settings and practice settings to work together to carry out the FON report’s call to action.

Approach in Texas

Two major nursing groups in Texas had been working separately for several years on related tasks. Beginning in 2012, as an outgrowth of two prior task force groups addressing clinical education in prelicensure programs and transition to practice, the Texas Board of Nursing appointed a task force, the Texas Board of Nursing (TBON) Task Force to Study Implications of Growth in Nursing Education Programs, to consider how to work effectively with leaders in nursing practice to address these issues. This work produced two prior reports and the third effort began in 2018.
In 2017, the Texas Organization for Nursing Leadership (TONL) began its work by convening chief nursing officers (CNOs) and Deans/Directors of baccalaureate-level nursing schools to discuss clinical placements and transition to practice for newly licensed nursing graduates. In late 2017, TONL conducted a survey of CNOs from health care organizations and deans of baccalaureate nursing programs in the state to identify the challenges facing both groups. The top three challenges identified included: workforce shortages (nurses and qualified faculty), education gaps for new nurses, and transition of newly licensed registered nurses (RNs) into practice. Their interest in meeting to discuss strategies to address those challenges led to TONL convening the two groups for the first meeting in February of 2018. Subsequent meetings occurred in July 2018, February 2019, and July 2019.

In March 2019, the TBON Task Force to Study Implications of the Growth in Nursing Education Programs began discussions regarding enhancing collaboration and partnerships between academia and practice to meet its charge to create a dialogue between nursing education and clinical partners to facilitate optimal clinical learning experiences for all constituents. TONL was an invited participant on the Task Force.

In essence, both the TBON and TONL groups had the intention of strengthening relationships between academia and practice in order to create graduates who were increasingly practice-ready and to enhance the potential for a smooth transition from the role of student to the role of practitioner. Additionally, both groups were planning meetings for the Spring of 2020 that would have invited essentially the same stakeholders. The potential to align interested stakeholders culminated in TONL and TBON co-hosting an Invitational Nursing Summit, The Future of Nursing in Texas: Stakeholders Moving Towards Alignment. With this commitment to work together, the two groups identified some individuals with overlapping involvement. For example, Dr. Paula Webb, then President of TONL, was also a member of the TBON task force.

A small group, representative of TBON and TONL met to identify how the Summit might unfold. Two major outcomes resulted. First, a broader based Summit Planning Committee (identified in the Acknowledgements) was created. Second, both TONL and TBON acknowledged the need to deliberately structure the attendance at the Summit to represent both practice and education, and within education, the various educational programs, which ranged from vocational education through graduate programs preparing advanced practice registered nurses (APRNs). This group was committed to working through existing organizations to identify the selected participants. As a result, the Texas Organization of Baccalaureate and Graduate Nursing Education (TOBGNE), the Texas Organization of Associate Degree Nursing (TOADN), the Texas Association of Vocational Nurse Educators (TAVNE), the Texas Nurse Practitioners (TNP), and the Texas Nurses Association (TNA) were asked to identify a given number of Summit participants to share their perspectives about the issues from the viewpoint of their respective programs, organizations, and practice settings. Additionally, specific groups and individuals were invited to represent specific vested interests. For example, the Texas Center for Nursing Workforce Studies and DNP students representative of Texas programs were invited. A
complete list of Summit attendees can be found in Appendix A and a copy of the Summit invitation is available in Appendix B.

**Summit Agenda and Objectives**

The Summit was designed as a two-day event.

Day 1 of the Summit set the context with presentations from national and state experts on relevant topics including: social determinants of health, the Future of Nursing 2030, nursing workforce trends, transition to practice, nursing education essentials, and current issues in advanced practice nursing education (see Appendices C & D).

Day 2 included the patient’s perspective on the work to be done and prepared participants to engage in meaningful discussions using the World Café meeting format. Discussions were designed to facilitate recommendations for schools of nursing and practice/service partners to:

- Develop innovative approaches to address gaps between and within academic and practice settings
- Identify optimal clinical learning experiences for the benefit of students, nurses, and patients
- Incorporate social determinants of health concepts
- Incorporate the anticipated National Academy of Medicine recommendations regarding the Future of Nursing 2020-2030*
- Disseminate recommendations generated at this Summit widely.

*The anticipated report was not released prior to/during the Summit.

In preparation for the Summit, attendees were provided with suggested readings and resources (see Appendix E).
World Café Concept

In 1995, a small group of academic leaders created a new social interactive method by introducing new strategies to facilitate open, strategic dialogue called the World Café (The World Café Community Foundation, 2015, see Appendix F). The World Café process uses a structured, yet simple, methodology for conducting group discussion activities. The assumption is that participants are subject matter experts who can conduct professional and productive dialogues. The methodology is built on seven design principles, which guide the process and include: setting the context for the meeting, creating a comfortable and approachable environment, exploring compelling questions, encouragement of participation, connecting diverse perspectives, active listening for themes, and harvesting collective discoveries. The process includes individuals rotating tables to discuss pre-determined questions in small groups.

The TBON Task Force used this process at one of its meetings to test this approach and help create/refine critical issues to be discussed during the Summit. During this meeting, small elephants were used to identify the person who was to speak. The elephant was a deliberate choice to symbolize the “elephant in the room,” a term often used to indicate critical issues people do not address. This strategy was highly effective and prompted the Summit Planning Committee to adopt The World Café as the process to generate discussion and an elephant to symbolize topics seldom discussed openly.
For the Summit, the small elephants were retired in favor of Talking Sticks to honor the Native American tradition of using a talking stick in councils to respect each individual's potential contribution. The Talking Stick allows all council members to present their Sacred Point of View, encourages everyone to listen carefully, reduces competition for time and attention, builds trust and safety in community, and emphasizes respect for the ideas and contribution of others (Educators for Peaceful Classrooms and Communities, Inc., 2020). The Talking Stick is passed from person to person. Only the person holding the stick is allowed to talk during that time period. All others must listen quietly and respectfully.
World Café - Topics and Guiding Questions

The Summit utilized the World Café process for the work of Summit participants. There were 12 topics for discussion at the Summit. Each topic was discussed at a specific table with an assigned facilitator (see Appendix G). In addition, “floaters” were available during the World Café meetings to support the facilitators.

Topics

The topics of the World Café discussions included:

- Academic Clinical Placement
- APRN Clinical Placement & Precepting
- APRN Scope of Practice
- APRN Transition to Practice
- Creating a Healthy Workplace Environment
- Customer Service Competencies
- Differentiated Essential Competencies*
- Healthcare Organization Placement
- Opportunities to Practice Clinical Judgment & Skills
- Precepting (pre-licensure)
- Social Determinants of Health
- Student Access to Electronic Healthcare Records

* The differentiated essential competencies (DECs) are a statewide set of competencies for vocational and professional nursing program graduates originated by a Texas Legislature mandate in 1988. All programs include the DECs in their curriculum and many base their course and clinical objectives on the DECs. The DECs provide a common standard for nursing program outcomes and graduate preparation. The DECs also establish the expected competencies for employers of new graduates. Four nursing roles are identified in the DECs: member of the profession, provider of patient-centered care, patient safety advocate, and member of the health care team.

Questions

Questions were provided for each topic to stimulate and guide discussion.

Academic Clinical Placement

- What are the barriers experienced by schools of nursing in obtaining clinical placements for large groups of students?
- What alternatives exist to clinical placement in acute care facilities and what barriers exist to implementing them?
- Are there creative partnerships that can be formed to diminish the barriers to clinical placement?
APRN Clinical Placement & Precepting
- What policy initiatives would assist with promoting quality clinical learning experiences for APRN students?
- What barriers exist in promoting a quality clinical learning experience for advanced practice registered nursing (APRN) students?
- What can be done to facilitate a positive precepted clinical learning experience for APRN students?

APRN Scope of Practice
- What challenges exist in practicing within a defined APRN role and population focus?
- How can APRN educators and clinical partners facilitate students’ understanding of APRN scope of practice?

APRN Transition to Practice
- What challenges exist for a successful transition to advanced practice nursing for new APRN graduates?
- How can APRN educators and clinical partners assist with preparing students for transition to APRN practice?

Creating a Healthy Workplace Environment
- How do students and staff work synergistically to produce a healthy nursing work environment?
- What are possible actions to improve the nursing work environment?
- How does nursing education prepare graduates to address these elements?
- How do we create more conversation together to improve the nursing work environment?

Customer Service Competencies
- How is customer service relevant to nursing practice?
- What aspects of customer service do you expect from students entering practice?
- What can be done to teach customer service?

Differentiated Essential Competencies (DECs)
- Considering the four nursing roles in the DECs, what competencies should be taught to nursing students that will help them transition to practice?
- What teaching strategies can be used to help students learn one of the four nursing roles?
• What should employers expect from graduates in one of the four roles?

Healthcare Organization Clinical Placement
• What are the barriers organizations face when supporting the large volume of students needing placement?
• What can be done to facilitate a smooth process for students looking to gain access to preferred clinical sites?
• What barriers are experienced by students who wish to gain access to clinical sites?
• What can be done to facilitate positive experiences for students at their clinical sites?

Opportunities to Practice Clinical Judgment and Skills
• What can education programs teach/do to help students develop clinical judgment?
• How can clinical partners assist nursing education programs to develop clinical judgment skills in nursing students?
• What would a student demonstrate to faculty, or a new grad to their employer, that would indicate they have good clinical judgment?

Precepting (pre-licensure)
• What are barriers to promoting a positive precepted experience?
• What can be done to facilitate a positive precepted experience?
• What do students need to learn in their education that would better prepare them for a precepted experience?

Social Determinants of Health
• What are the prominent factors (social determinants) that impact the health and well-being of people living in Texas?
• What are ways health care professionals can address our most pressing social determinants of health?
• What needs to be developed in educational and health care institutions to help future and current practitioners incorporate these factors into their care?

Student Access to the Electronic Healthcare Records (EHR)
• What solutions have been implemented at the practice level to ensure students have access to the EHR in their clinical settings?
• What factors/barriers have led to limited EHR access for nursing students in their clinical settings?
The Future of Nursing in Texas

- What strategies will need to be in place at the education level to promote EHR competency, thereby ensuring readiness for practice?

These questions were assigned to various tables. Participants were deliberately pre-assigned to tables for repeated sessions to assure a balance among perspectives. Additionally, participants could review the work at any table to add comments or add questions during breaks between rotations.
World Café Results

At the end of the second day of the Summit, the participants convened to share the results of the World Café discussions. Overall, the participants identified the following results of the Summit:

- Examined current state of affairs;
- Identified the need to innovate and to expect innovation;
- Worked together (academia, practice, and regulation) on a common goal;
- Provided validation of shared issues, needs, and frustrations; and
- Provided a chance to be honest and to openly address the elephants in the room.

Facilitators reported the results of the World Café discussions by topic. The following are highlights of the discussions in each of the areas.

Academic Clinical Placement

- Programs compete for limited acute care clinical placements, especially pediatrics, obstetrics, and psychiatry.
- Nurses have competing priorities.
- Programs should utilize all shifts 24/7.
- Programs should increase the use of simulation.
- Programs should consider expanding placements to other sites, for example, long-term care, maternal-child clinics, and school health.
- A specific effort should be made to develop preceptors statewide.
- Education advisory councils should include practice partners.
- Academia and practice should increase communication.
- Education programs should partner with hospitals to create dedicated education units.

APRN Clinical Placement & Precepting

- Competition for placements exists throughout the state.
- Graduate Medical Education supports medicine; graduate nursing education needs comparable support.
- Clinical placement options are insufficient.
- Faculty should decide the benefits of APRN students having the same preceptor rather than multiple preceptors.
- Clinical placement sites should be evaluated periodically.
- Participants expressed concerns related to the financial burden to some students having to pay preceptors.
• Evaluate potential preceptor incentives from organizations/programs to precept.
• Standards for precepted clinical learning experiences should be established.
• Consider the development of APRN-driven clinics to achieve two goals: serving underserved populations and clinical placement for students.

APRN Scope of Practice
• Education is not meeting the market need (e.g., acute care).
• Education on scope of practice needs to start on day one.
• Clinical partners need to understand educational practices and expectations.
• Financial burden for students should be explored.
• Consider options for how preceptors are affiliated with the program, for example, as adjunct faculty.
• Lack of full practice authority can limit clinical learning experiences.
• Challenges exist with understanding scope of practice for various APRN roles.
• Employers of APRNs, including physicians, need to be aware of the Board of Nursing rules related to APRN practice as they relate to APRN roles and population foci.
• Large numbers of students enter Family Nurse Practitioner (FNP) programs without a full understanding of the FNP scope of practice with the appropriate patient populations.
• Differences exist in how facilities and the Texas Board of Nursing define scope of practice.

APRN Transition to Practice
• No formal residency or fellowships exist.
• Preceptors are needed for APRN transition to practice.
• Core competencies need to be defined.
• Schools need to have clinics for clinical learning experiences.
• Roles including qualifications need to be clarified.
• Concerns exist about number of out of state programs.
• Virtual mentors could be used for transition to practice.
• What comprises a quality APRN program?
• Transitioning APRNs need supervision.
• APRN educator shortage is a concern.
• RNs need experience before becoming APRNs.
• A statewide model is needed to standardize transition to practice.

Creating a Healthy Work Environment
• Clinical sites and education programs need to further develop true partnerships and build relationships.
• Concerns about staffing exist.
• There need to be mechanisms in place for dialogue.
• Academia and practice need to begin education early about civility, violence, crucial conversations, including addressing bullying or uncivil behavior in real time.
• Students need to have faculty skilled in debriefing.
• Nurses are seen as stereotypes.
• Preceptors need to be deliberately selected.
• A healthy work environment includes an understanding of generational issues and self-care.

Customer Service Competencies
• Prepare students for communication strategies, customer service, and building relationships prior to clinicals.
• Students need to be held to the same customer service standards as clinical staff.
• Instructors, faculty, and hospital staff should:
  • Be role models for customer service competencies
  • Use simulation including role playing to teach customer service competencies prior to clinicals.
  • Understand cultural and generational diversity.
  • Practice with presence and mindfulness.
  • Orient students on how patients are to be treated.

Differentiated Essential Competencies (DECs)
• Patient safety, empathy, and critical thinking are essential competencies.
• Faculty work more intensely with students whose performance is subpar.
• Students should be encouraged to become involved in professional associations.
• Simulations should include interprofessional practice when possible.
• Psych/mental health skills can be practiced in many settings.
• Students need support from their first year to post graduation.
Students need to know and value their professional responsibilities.
The Board of Nursing needs to increase communication about the DECs.
Delegation is a challenging skill to learn.
Most new grads do not know cost factors related to care.
Practice partners can enrich student understanding of the DECs.
Transition to practice programs should be required.
Students need to know how to have a voice, advocate for patients, and be team members and leaders.
Case studies should include common ethical situations.

Health Care Organization Placement

- A sufficient number of preceptors is unavailable.
- Faculty who orient to a unit ahead of time have the opportunity to share the DECs.
- Using the DECs can help build relationships through this common language.
- The DECs help establish and manage expectations and responsibilities of students and their faculty.
- Sharing the DECs allows for buy-in by frontline nurse managers.
- Preceptor preparation should include the DECs.
- Preceptors should be selected based on their interest and abilities not assigned.
- Placement contracts take too long and have to be redone too often.
- Some schools are paying for preceptors.
- To increase the number of clinical placements, hospitals should be used 24/7.
- Preceptors experience fatigue/burnout.
- Academia and practice can partner to create dedicated education units.

Opportunities to Practice Clinical Judgment & Skills

- Case scenarios (to answer why and what comes next) including interdisciplinary scenarios and disruptions can be created to enhance students’ abilities to exercise clinical judgment.
- Simulation situations need to emphasize two things: it’s okay to make mistakes. Debriefing is critical.
- Before developing and assigning a preceptor, the employer should make sure the clinical preceptor wants to precept.
Students who excel in clinical judgment could be rewarded in some manner.

Practice experiences must allow for students to practice skills, not just observe.

Having a consistent preceptor is important

Collaboration between academia and practice can enhance case scenarios and simulations related to clinical judgment.

**Precepting**

- Make needed changes to ensure units are welcome to students.
- Preceptor burnout is an issue.
- Preceptors require role preparation.
- A staff liaison for students and faculty at the facility should serve as a contact for faculty or student issues.
- Staff need to know student expectations.
- An educational institution quality report card would be useful.
- Programs should teach students flexibility and resilience.
- Employers should consider modifying patient care assignments for preceptors.
- Preceptors foster professionalism through appearance, communication, and confidence.
- Implement communication strategies among faculty, student, preceptor, and hospital nursing leadership.

**Social Determinants of Health (SDOH)**

- Education programs should increase undergraduate and graduate nursing students' knowledge of SDOH.
- Advocacy and grassroots level involvement should be taught.
- Teaching SDOH should include increasing care access, cultural awareness and economic factors impacting health.
- School nurses could be mobilized to care for uninsured children.
- More community centers are needed in uninsured areas.
- Collaborate with city officials to care for indigent population.
- Emphasize the importance of applying Maslow's hierarchy of needs in practice.

**Student Access to EHRs**

- Students need access to patient data to provide quality patient care, and to develop documentation skills.
Access to the EHR by students is either restricted or limited by clinical sites.

Orientation to various EHR platforms is time consuming for both the students and the organizations.

Expectations related to access, performance, and liability between the organization and student is not congruent.

Faculty require orientation to the various EHRs to assist students in the clinical environment.

Students must have a clear understanding of the information that should be documented related to patient care.

Student documentation options are available in some EHRs.

Programs should incorporate documentation in the EHR in simulation scenarios.

Programs should teach students HIPPA and ethics related to patient information.
The Future of Nursing in Texas

Analysis and Themes

The input from the World Café discussions was analyzed. The themes and sub-themes are shown in Figure 1. The themes included clinical placement/scheduling, work environment, quality, and APRNs.

Figure 1. Initial Themes and Sub-themes

The discussion of each theme generated sub-themes and related issues and ideas. In the following figures, the size of the shape is an indicator of frequency of occurrence. Each thematic area is presented with the issues and ideas generated from the work during the Summit. Recommendations for action extrapolated from the work follow.
Theme: Clinical Placement/Scheduling

The clinical placement/scheduling theme included the sub-themes of collaborative partnerships, communication, and technology. The issues and ideas are shown in Figure 2.

Figure 2. Clinical Placement/Scheduling

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Lead Action Group</th>
<th>Priority/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hold statewide collaboratives among nursing stakeholders biennially (even number years) using the World Café approach.</td>
<td>TBON TONL</td>
<td>1 2022</td>
</tr>
<tr>
<td>2. Create academic-practice partnerships for ongoing dialogue.</td>
<td>TAVNE TONL TOADN TOBGNE TNP</td>
<td>1 2023</td>
</tr>
</tbody>
</table>
3. Develop a statewide core orientation for preceptors that includes content re: negotiating clinical experiences, customer service, and DECs.

<table>
<thead>
<tr>
<th></th>
<th>TBON</th>
<th>TONL</th>
<th>TOADN</th>
<th>TOBGNE</th>
<th>2</th>
<th>2022</th>
</tr>
</thead>
</table>

4. Survey students of nursing education programs to determine their expectations for preceptors and discuss clinical experiences.

<table>
<thead>
<tr>
<th></th>
<th>TAVNE</th>
<th>TOADN</th>
<th>TOBGNE</th>
<th>TNSA*</th>
<th>3</th>
<th>2022</th>
</tr>
</thead>
</table>

5. Explore regional clinical placement committees to assist with allocating clinical spaces.

<table>
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<th>2022</th>
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*Awaiting response from organization
Theme: Work Environment

The sub-themes for the Work Environment theme included behavioral expectations and self-care (see Figure 3).

Figure 3. Work Environment

<table>
<thead>
<tr>
<th>The Issues</th>
<th>The Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support new nurses</td>
<td>Deploy civility expectations</td>
</tr>
<tr>
<td>Change culture of having students</td>
<td>Teach customer service skills to students</td>
</tr>
<tr>
<td>Preceptors have “Student Fatigue” and burnout</td>
<td>Address bullying or uncivil behavior real time</td>
</tr>
<tr>
<td>Preceptors and staff need to role model expected behavior</td>
<td>Create meditation rooms/spaces</td>
</tr>
<tr>
<td>Customer Service skills [mitigate litigation]</td>
<td>Staff nurses and preceptors: Communicate expectations for students</td>
</tr>
<tr>
<td>Staff Nurse civility towards students</td>
<td>Deploy modules in school with communication strategies prior to clinicals: include respect, empathy training, conflict resolution; active listening</td>
</tr>
<tr>
<td>Preceptor incentives needed (Clinical ladder, library access)</td>
<td>Emphasize self care in academia &amp; practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations</th>
<th><strong>Lead Action Group</strong></th>
<th><strong>Priority/Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Create a standardized clinical orientation applicable to all comparable type settings to be used by all students.</td>
<td>TONL</td>
<td>1 2021</td>
</tr>
<tr>
<td>2. Develop or locate a core statewide short course, from existing materials, for students and faculty related to incivility, workplace violence practices and patient experience satisfaction.</td>
<td>TNA</td>
<td>2 2022</td>
</tr>
<tr>
<td>3. Add “soft skills” to the DECs.</td>
<td>TBON</td>
<td>1 2021</td>
</tr>
</tbody>
</table>
 Schools of nursing  
 2022

5. Explore options to offer preceptors incentives such as library access, professional development, and recognition programs.
 Schools of nursing  
 2022

*Awaiting response from organization*
Theme: Quality
The quality theme had three sub-themes: expected competencies, customer expectations, and financial needs (see Figure 4).

Figure 4. Quality

<table>
<thead>
<tr>
<th>The Issues</th>
<th>The Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of state programs: Do they meet TX standards?</td>
<td>Provide preceptor incentives</td>
</tr>
<tr>
<td>Excessive push for enrollment: How maintain quality?</td>
<td>Use scenarios, simulation, and case studies</td>
</tr>
<tr>
<td>Short cuts from out of state organizations</td>
<td>Provide preceptor education</td>
</tr>
<tr>
<td>Reduction in litigation</td>
<td>Build a standardized Transition to Practice (TTP) modules and share statewide</td>
</tr>
<tr>
<td>Patients/consumers expect great service</td>
<td>Need high quality clinical experiences</td>
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<tr>
<td>Economic concerns (Transportation, cost of care, competing priorities)</td>
<td>How do we compensate for social determinate issues?</td>
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<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Lead Action Group</th>
<th>Priority/Date</th>
</tr>
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<tbody>
<tr>
<td>1. Use simulated and virtual real-world scenarios, developed collaboratively between academia and practice, to support clinical learning with opportunities to demonstrate clinical judgment and competencies.</td>
<td>Schools of Nursing</td>
<td>1 2021</td>
</tr>
<tr>
<td>2. Disseminate the DECs to academia and practice (once revised) through webinars.</td>
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<td>2 2021</td>
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</tbody>
</table>

*Awaiting response from organization
The Future of Nursing in Texas

**Theme: Advanced Practice Registered Nurses (APRNs)**

The theme of APRNs had three sub-themes: placement, policy, and ethics (see Figure 5).

**Figure 5. APRNs**

<table>
<thead>
<tr>
<th>The Issues</th>
<th>The Ideas</th>
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<tr>
<td>APRN role varies among facility as facility defines it</td>
<td>CCNE regulations</td>
</tr>
<tr>
<td>Students often pay preceptors out of their own pocket to be precepted</td>
<td>Policy to prohibit students from having to pay for preceptor</td>
</tr>
<tr>
<td>TBON – Needs more emphasis on APRN regulation</td>
<td>Set standards for clinical experiences</td>
</tr>
<tr>
<td>Onus often on students to find preceptors (Pay search firm)</td>
<td>Formal residency or fellowship for APRNs</td>
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<tr>
<td>Nurses who go back to school for APRN – need more prior experience</td>
<td>State regulation over standardized APRN hours/programs</td>
</tr>
<tr>
<td>Lack of preceptors to educate and transition APRNs</td>
<td>Policy surrounding obtaining care/ upstream policy</td>
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</table>

<table>
<thead>
<tr>
<th>The Themes: APRNs</th>
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<tbody>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>1. Healthcare organizations should consider cost effective ways to implement precepted APRN clinical learning experiences.</td>
</tr>
<tr>
<td>2. Explore the implications of state regulation of APRN education.</td>
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</tbody>
</table>

*Awaiting response from organization*
OVERALL Summit Recommendations and Action Plans

Subsequent to the Summit and the initial report, members of the planning group reviewed the entire work and created overall recommendations important to address the issue of clinical experiences in the State of Texas. These OVERALL recommendations were then reviewed and an action plan was created. The action plan identified at least one logical group to be the lead organization(s). These action groups represent a logical group(s) to discuss the recommendation and initiate further work to achieve the recommendation. The action group is not expected to be the solely responsible group for further work. Rather that group is the initiator, convener, delegator, actor or facilitator to create a desired outcome.
### Global Recommendations

<table>
<thead>
<tr>
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| 1. Utilize the World Café concept, talking sticks, and “elephant in the room” for future collaborative summits to be held biennially in even numbered years. | TBON  
TONL |
| 2. Explore ways to resolve the issues of students using EHRs. | TONL |
| 3. Explore the Transition to Practice (TTP) model from NCSBN, consistent with accreditation standards, and introduce it with clinical partners. | Health Care Organizations |
| 4. Hold a statewide conference related to social determinants of health and how to incorporate them into the curricula. | TAVNE  
Texas Team  
TNA |
| 5. Integrate social determinants of health into health policy. | TNA  
APRN Alliance* |
| 6. Develop clinical judgment modules related to greatest population health and disease condition needs. | Schools of Nursing |
| 7. Explore a standard clinical placement agreement for use in any facility by any school in the state of Texas. | TBON  
TONL |
| 8. Hold a statewide collaborative with APRN stakeholders to review Board Rule requirements, based on the national standards of the Consensus Model for APRN Regulation, Licensure, Accreditation, Certification and Education (LACE). | TBON  
TONL  
Schools of Nursing  
Health Care Organizations |

**GLOBAL RECOMMENDATIONS**

*Awaiting response from organization*
## OTHER RECOMMENDATIONS

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<td>1. Expand the use of experiences and settings for clinical opportunities.</td>
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<tr>
<td>2. Explore the use of dedicated education units to improve clinical learning experiences.</td>
<td>Health Care Organizations</td>
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</table>
Summit Evaluation

Participants were asked to evaluate the Summit. Sixty-five of the attendees completed the evaluation. There were four Likert scale items regarding the Summit (see Table 1) and three open-ended items. The five-point Likert Scale ranged from Strongly Disagree (1) to Strongly Agree (5). The average Likert rating is shown for each item.

Table 1. Evaluation Items

<table>
<thead>
<tr>
<th>Items</th>
<th>Average Likert Rating</th>
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<tr>
<td>This Summit helped you to discuss innovative approaches to address gaps between and within academic and practice settings.</td>
<td>4.71</td>
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<tr>
<td>This Summit helped you to discuss ways to incorporate social determinants of health into nursing practice education.</td>
<td>4.54</td>
</tr>
<tr>
<td>The presentations on Day 1 set the context for dialogue during the World Café.</td>
<td>4.72</td>
</tr>
<tr>
<td>The presentations on Day 2 set the context for dialogue during the World Café.</td>
<td>4.82</td>
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Open-Ended Evaluation Items

There were three open-ended items:

- Please list two ways you will integrate any of the ideas discussed during the World Café discussions at this Summit into your practice.
- Is there anything else you would like to say that you did not get a chance to?
- Thank you for attending the Summit and providing constructive feedback. Please feel free to provide any additional comments.

Summaries of the responses to the open-ended items are provided here. A representative sample of the detailed responses is available in Appendix I.
Please list two ways you will integrate any of the ideas discussed during the World Café discussions at this Summit into your practice.

The responses to the request to participants to list two ways they would integrate any of the ideas discussed during the World Café at this Summit into their practice clearly indicated their intent and enthusiasm to disseminate what they had learned, share the discussions they had experienced, develop partnerships, and improve practices in their organizations. The word cloud above shows the most common words used to describe how participants would integrate the ideas. Specific comments included:

- I will discuss possibilities to improve transition to practice...
- I will use the ideas...
- I will take our discussion back to my school...
- I am going to use some of the [World Café] questions from the round table with my students...
- I will encourage...
- I will incorporate the innovative strategies to improve...
- I will advocate for...

Representatives from both academia and practice expressed their satisfaction with participating in engaging discussions with each other and their intent to collaborate more effectively with each other when they returned home.
Is there anything else you would like to say that you did not get a chance to?

The word cloud above shows the most common words used to identify additional ideas.

Overall, participants described the Summit as a very positive experience. Specific comments included:

- Outstanding conference
- Thank you for a wonderful experience
- Perhaps the best meeting I have ever attended
- Good opportunity to start open communications
- Amazing
- The mix of participants was great
- Found the information to be eye-opening
Thank you for attending the Summit and providing constructive feedback. Please feel free to provide any additional comments.

The final open-ended question provided for any other comments participants wanted to make. The word cloud above shows the most common words used to identify additional ideas.

Additional comments reiterated the participants' previously stated positive statements about the conference. Specific comments included:

- The opportunity to interact across the spectrum of nursing had tremendous value.
- Thank you for the attention to detail to ensure all stakeholders were 'at the table' and we had an avenue to voice ideas.
- Thank you for the excellent Summit.
- I look forward to another Summit.
- This was a very thoughtful and well-organized Summit.
- The World Café was the perfect method.
- I loved the ability to network with a variety of fellow nurse professionals.

The participants also encouraged having a similar Summit periodically and wanted to be invited when that occurred.
Moving Towards Alignment

In order for the work of the Summit to have meaning for nursing education, the State of Texas, and the ultimate recipient of our efforts, the patients, global recommendations were created by synthesizing the work during the Summit, the comments on the evaluations, and the materials sent to the participants prior to the Summit.

Everyone involved in the Summit and nursing education and practice has the potential to make a difference in addressing the issues that were discussed. The following statements identify the actions with the greatest priority for making a difference:

- Utilize the World Café concept, talking sticks, and “elephant in the room” for future collaborative summits to be held biennially in even numbered years.
- Explore ways to resolve the issues of students using EHRs.
- Explore the Transition to Practice (TTP) model from NCSBN, consistent with accreditation standards, and introduce it with clinical partners.
- Hold a statewide conference related to social determinants of health and how to incorporate them into the curricula.
- Integrate social determinants of health into health policy.
- Develop clinical judgment modules related to greatest population health and disease condition needs.
- Explore a standard clinical placement agreement for use in any facility by any school in the state of Texas.
- Hold a statewide collaborative with APRN stakeholders to review Board Rule requirements, based on the national standards of the Consensus Model for APRN Regulation, Licensure, Accreditation, Certification and Education (LACE).

As mentioned at the beginning of this report, health care is experiencing a rapidly evolving agenda requiring new and innovative methods of communication and collaboration. The intent of this Summit was to identify key issues and create strategies to promote communication and collaboration to resolve today’s and tomorrow’s critical issues.
References

Educators for Peaceful Classrooms and Communities, Inc. (2020). *The story of the talking stick.*
https://www.educatorsforpeacefulclassroomsandcommunities.org/resources/peace-tools/the-story-of-the-talking-stick/

Texas Board of Nursing. (2010). *Differentiated essential competencies (DECs) of graduates of Texas nursing.*
https://www.bon.texas.gov/pdfs/differentiated_essential_competencies-2010.pdf

Appendices

Appendix A: Summit Attendees/Organizations
Appendix B: Invitation to the Summit
Appendix C: Summit Agenda
Appendix D: Summit Speaker Bios
Appendix E: Summit Suggested Readings and Resources
Appendix F: World Café 101
Appendix G: Summit World Café Table Topics and Facilitators
Appendix H: World Café Facilitator Reports
Appendix I: Post-Summit Evaluations
## Appendix A: Summit Attendees/Organization

<table>
<thead>
<tr>
<th>Attendee Name</th>
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<tbody>
<tr>
<td>Gail Acuna</td>
<td>TBON Education Task Force</td>
</tr>
<tr>
<td>Kristy Aleman</td>
<td>DNP Student</td>
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<tr>
<td>Karen Alexander</td>
<td>Texas Organization of Baccalaureate and Graduate Nursing Education (TOBGNE)</td>
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<tr>
<td>Nina Almasy</td>
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<tr>
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<tr>
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<td>American Association of Colleges of Nursing</td>
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<tr>
<td>Joan Becker</td>
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<tr>
<td>Kim Belcik</td>
<td>Texas Nurses Association (TNA)</td>
</tr>
<tr>
<td>Kristin Benton</td>
<td>TBON Staff, Summit Coordinator, Editorial Team Member</td>
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<tr>
<td>Christy Blanco</td>
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<tr>
<td>Paula Webb</td>
<td>TONL, Summit Co-Chair, Editorial Team Member</td>
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<tr>
<td>Brandy Wells</td>
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<td>Jolene Zych</td>
<td>TBON Staff</td>
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Appendix B: Invitation To The Summit

Subject: FW: Texas Board of Nursing and Texas Organization for Nursing Leadership Summit: The Future of Nursing in Texas

Dear Future of Nursing in Texas Stakeholder,

On behalf of the Texas Board of Nursing and the Texas Organization for Nursing Leadership, we are delighted to invite your participation in the Statewide Summit entitled, The Future of Nursing in Texas: Stakeholders Moving Towards Alignment on February 24-25, 2020 in Austin at the University of Texas Commons Conference Center.

The purpose of this Invitational Statewide Summit is to develop a coordinated approach to address gaps between, and within, academia and practice and optimize clinical learning experiences for the future of nursing in Texas. Representatives from various national and state nursing organizations representing academia and practice will participate in this Summit. Participants will hear updates from experts and have the opportunity to engage in rich discussions about the future of nursing in Texas in an innovative world café meeting format. The Summit agenda is attached.

To register, please visit this link: https://www.bon.texas.gov/catalog/product/#bon-wks-futureofnursing. The non-refundable registration fee is $150. Only a few seats remain, so please register as soon as possible! Seats will be issued on a first-come, first-served basis.

We hope that you can make it as your perspective is vital to shaping the future of nursing in Texas! If you do not plan to attend, please rsvp to: workshops@bon.texas.gov.

Sincerely,

Summit Planning Committee
Appendix C: Summit Agenda

The Future of Nursing in Texas: Stakeholders Moving Towards Alignment

Agenda

Day One

12:00 p.m. Registration Opens

12:30 – 12:45 p.m. Welcome
   Patricia Yoder-Wise, RN, EdD, NEA-BC, ANEF, FAONL, FAAN
   Paula Webb, DNP, RN, NEA-BC, FAONL

12:45 – 1:05 p.m. National Academy of Medicine 2020-2030 (video)
   Sue Hassmiller, RN, PhD, FAAN

1:05 – 1:25 p.m. Social Determinants of Health
   Lisa Campbell, DNP, RN, PHNA-BC

1:25 – 1:45 p.m. State of the State in Nursing (TX Center for Nursing Workforce Studies)
   Pamela Lauer, MPH, Program Director

1:45 – 2:00 p.m. Break

2:00 – 3:00 p.m. APRN Panel:
   Preceptor/clinical placement
      Emily Merrill, PhD, APRN, FNP-BC, CNE, FAANP
   Transition to practice
      Jan Sumner, PhD, RN
   Scope of practice
      Jolene Zych, PhD, APRN, WHNP-BC

3:00 – 3:20 p.m. American Association of Colleges of Nursing (video)
   Joan M. Stanley, PhD, CRNP, FAAN, FAANP

3:20 – 4:00 p.m. The Gap/Transition to Practice (World Café Concept)
   Nancy Spector, PhD, RN, FAAN

4:00 – 4:30 p.m. Student perspective on clinical experiences
   Rachel Barbey – BSN Nursing Student and TSNA President

4:30 – 5:00 p.m. Day One Wrap-Up/Day Two Plan
Day Two

9:00 – 9:15 a.m. Welcome (Auditorium)
    Paula Webb, DNP, RN, NEA-BC, FAONL
    Patricia Yoder-Wise, RN, EdD, NEA-BC, ANEF, FAONL, FAAN

9:15 – 9:30 a.m. Patient Perspective
    David Saucedo, BON Vice President, Consumer Representative

9:30 – 9:40 a.m. World Café Instructions (Auditorium)
    Kristin Benton, DNP, RN

9:40 – 10:20 a.m. World Café Model Panel Demonstration (Auditorium)
    Janice I. Hooper, PhD, RN, FRE, CNE, FAAN, ANEF
    Jane McCurley, DNP, MBA, RN, NEA-BC, FACHE
    Nancy Spector, PhD, RN, FAAN
    Sarah Towery, MS, BSN, RN, NEA-BC
    Brandy Wells, APRN, MSN, NNP-BC

10:30 – 10:55 a.m. Discussion Circle #1

10:55 – 11:10 p.m. Break

11:10 – 11:35 p.m. Discussion Circle #2

11:35 – 12:00 p.m. Discussion Circle #3

12:00 – 1:00 p.m. Lunch

1:00 – 1:25 p.m. Discussion Circle #4

1:25 – 1:50 p.m. Discussion Circle #5

1:50 – 2:10 p.m. Break

2:10 – 3:25 p.m. Harvest Time: Debriefing (Auditorium)

3:25 – 3:50 p.m. Closing Remarks/Next Steps
    Paula Webb, DNP, RN, NEA-BC, FAONL
    Patricia Yoder-Wise, RN, EdD, NEA-BC, ANEF, FAONL, FAAN
Appendix D: Summit Speaker Bios

**Rachel Barbey** is approaching the beginning of her nursing career. She is graduating with her Bachelor of Science in Nursing in May 2020. She plans to begin a nurse residency in Neonatal ICU, Labor and Delivery, or Emergency Care. In her college career, she has served in many ways to the fellow students of her school and to NSNA. She’s currently the Texas Nursing Student Association President, an office she’s held since June 2019. She also served on the Council of State Presidents Committee at NSNA’s Midyear Conference in Chicago, Illinois. At her local NSNA chapter, she served as Resolutions Chair in spring 2019, where she and co-author Rasheem Wynn argued in favor of reduced deferment time periods of homosexual blood donation. The resolution passed at both Annual TNSA and NSNA Conferences in Spring 2019. She's previously spoke about difficult situations and also accountability and responsibility in NSNA leadership. Rachel plans to give insight and communication about the journey of the current student nurse.

**Kristin K. Benton, DNP, RN,** is the Director of Nursing for the Texas Board of Nursing. Prior to becoming Board Staff, she taught for the Austin Community College Vocational Nursing Education program from 2000-2012 and served on the Texas Board of Nursing from 2008-2012. She served on the National Council of State Boards of Nursing NCLEX Item Review Subcommittee and currently serves on the Awards Committee. Dr. Benton received a Bachelor of Science in Psychology from the University of Florida, a Bachelor of Science in Nursing from Louisiana State University Health Sciences Center School of Nursing, a Master of Science in Nursing from the University of Texas Health Science Center in San Antonio and Doctor of Nursing Practice degree from Texas Tech University Health Sciences Center School of Nursing.
Lisa Campbell, DNP, RN, PHNA-BC is a Professor and Director of the Post-Master’s Doctor of Nursing Practice Program at Texas Tech University Health Sciences Center School of Nursing. She has been a registered professional nurse for 37 years. Her teaching focus for doctoral students is population health, epidemiology, and health policy. Through her teaching role, Dr. Campbell engages students in real-world population health and policy projects. Her research includes the impact of incivilities on faculty and staff and strategies to create a civil workplace culture, changes in public health nursing practice and the Affordable Care Act, and WIC peer counselor support and breastfeeding.

Dr. Campbell founded Population Health Consultants, LLC a company committed to improving population health. She consults with communities to evaluate local public health systems, facilitates community health needs assessments, community health improvement plans, and strategic planning for local and regional public health departments. Recently she served as the director of the Victoria County Public Health Department that served three counties. She led a diverse staff and implemented initiatives to advance public health in these rural communities.

Dr. Campbell is the immediate past chair of the American Public Health Associate Public Health Nursing Section, chairperson of the Council of Public Health Nursing Organizations, and a member of the Alliance of Nurses for Healthy Environments’ Board of Directors. She received her Doctor of Nursing Practice with a focus in public health nursing from the University of Tennessee College of Nursing, Memphis, her BSN and MSN from the University of Texas Health Science Center School of Nursing, Houston and post-Master’s as a Geriatric Nurse Practitioner.

Susan Hassmiller, RN, PhD, FAAN, senior adviser for nursing, joined the Robert Wood Johnson Foundation in 1997. In this role, she shapes and leads the Foundation’s nursing strategies in an effort to create a higher quality of care in the United States for people, families and communities. Drawn to the Foundation’s “organizational advocacy for the less fortunate and underserved,” Hassmiller is helping to assure that RWJF’s commitments in nursing have a broad and lasting national impact.

In partnership with AARP, Hassmiller directs the Foundation’s Future of Nursing: Campaign for Action, which seeks to ensure that everyone in America can live a healthier life, supported by a system in which nurses are essential partners in providing care and promoting health. This 50-state and District of Columbia effort strives to implement the recommendations of the Institute of Medicine’s report on the Future of Nursing: Leading Change, Advancing Health. Hassmiller served as the report’s study director. She is also serving as co-director of the Future of Nursing Scholars program, an initiative that
provides scholarships, mentoring and leadership development activities and postdoctoral research funding to build the leadership capacity of nurse educators and researchers.

Previously, Hassmiller served with the Health Resources and Services Administration, where she was the executive director of the U.S. Public Health Service Primary Care Policy Fellowship and worked on other national and international primary care initiatives. She also has worked in public health settings at the local and state level and taught community health nursing at the University of Nebraska and George Mason University in Virginia.

Hassmiller, who has been very involved with the Red Cross in many capacities, was a member of the National Board of Governors for the American Red Cross, serving as chair of the Disaster and Chapter Services Committee and national chair of the 9/11 Recovery Program. She is currently a member of the National Nursing Committee, and is serving as immediate past board chair for the Central New Jersey Red Cross. She has been involved in Red Cross disaster relief efforts in the United States and abroad, including tornadoes in the Midwest, Hurricane Andrew, September 11th, the 2004 Florida hurricanes and Katrina, and the tsunami in Indonesia.

Hassmiller is a member of the Institute of Medicine, now called the National Academy of Sciences, a fellow in the American Academy of Nursing, a member of the Joint Commission’s National Nurse Advisory Council, Hackensack Meridian Health System Board of Directors, and the CMS National Nurse Steering Committee.

Hassmiller received a PhD in nursing administration and health policy from George Mason University, master’s degrees in health education from Florida State University and community health nursing from the University of Nebraska Medical Center, and a bachelor’s degree in nursing from Florida State University. She is the recipient of numerous national awards in addition to receiving the distinguished alumna award for all the schools of nursing from which she graduated and three honorary doctoral degrees. Most notably, Hassmiller is the 2009 recipient of the Florence Nightingale Medal, the highest international honor given to a nurse by the International Committee of the Red Cross.
Janice I. Hooper, PhD, RN, FRE, CNE, FAAN, ANEF, began a nursing career as an ADN graduate from Maryville University in St. Louis, Missouri. She holds a BSN, MSN (Nursing of Children), and PhD from St. Louis University. She was a nursing educator in the St. Louis area for over 20 years. In 2002 she joined the Texas Board of Nursing Staff as an Education Consultant. She was inducted into the NCSBN Fellowship of the Institute of Regulatory Excellence in 2012, and served as Chair of the NCSBN NCLEX Examination Committee for 5 years, and chaired the NCSBN Education Outcomes and Metrics Committee for 2 years. She also serves as a Commissioner for NLN CNEA.

Pamela Lauer, MPH, is the program director for the Texas Center for Nursing Workforce Studies (TCNWS) in the Center for Health Statistics at the Department of State Health Services. She has been with the Center for Nursing Workforce Studies in various roles since February 2007.

During her time with the TCNWS she has led different projects on nursing education, nurse staffing, supply and demand of nurses, and workplace violence. She also represents the TCNWS as member of the research committee of the National Forum of State Nursing Workforce Centers where she has been involved in several national workforce data projects and activities. Pam has an undergraduate degree from the University of Texas at Austin and Master’s degree from the University of Texas Health Science Center.

Jane McCurley, DNP, MBA, RN, moved to Methodist Hospital and Methodist Children’s in October 2017 from her role at HCA Corporate where she served as Vice President and Assistant Chief Nurse Executive. Jane joined HCA as a Chief Nursing Officer in 2003. Prior to her corporate role she was at St. David’s North Austin Medical Center (SDNAMC). Her leadership as CNO was instrumental in advancing that organization to unprecedented levels of clinical success and national recognition. During Jane’s tenure, patient care advances contributed to the facility’s Neonatal Intensive Care Unit (NICU) earning the Beacon Award for Excellence in Critical Care Nursing (the first in Texas, and the first HCA NICU to receive the award). In 2016, the hospital’s Medical Surgical Nephrology Specialty Unit received the PRISM (Premier Recognition in the Specialty of Medical-Surgical Award), from the Academy of Medical-Surgical Nurses, another first for HCA.
Jane serves as the president-elect of the Texas Organization of Nurse Executives (TONE) and is the 2014 recipient of that organization’s Excellence in Nursing Leadership Award. She was co-lead for the first Central West Texas Team “Future of Nursing Campaign for Action”. Jane is board certified in Nursing Executive, Advanced by the American Nurse Credentialing Center (ANCC), Certified in Executive Nursing Practice by the American Organization of Nurse Executives, and is a Fellow of the American College of Healthcare Executives (FACHE). Jane became a Commissioner on Pathway to Excellence with the ANCC in 2018.

Emily Merrill, PhD, APRN, FNP, BC, CNE, FAANP, is Associate Dean, Professor, and Department Chair for APRN Programs at Texas Tech University Health Sciences Center (TTUHSC) School of Nursing, Lubbock, TX. She has almost 25 years of advanced nursing practice in primary care with additional expertise in working with Adult Protective Services. Her interests are APRN role development, development of innovative APRN educational programs, and supporting APRN faculty to develop innovations in APRN education and advanced practice.

She is a Fellow of the American Association of Nurse Practitioners and past president of the Texas Nurse Practitioners Foundation.

David E. Saucedo II, of El Paso, is president of the Saucedo Lock Company, a 4th generation family business founded in 1917. After graduating from the Mendoza College of Business at the University of Notre Dame, David returned home to El Paso. His work in the El Paso community is vast and most recently includes a runner-up finish for the Mayor of El Paso in a crowded field. In 2015, David was appointed by Governor Greg Abbott to the Texas State Board of Nursing - the largest licensing board in the state, he currently serves as vice-president of the board.
Nancy Spector, PhD, RN, FAAN, is the Director of Regulatory Innovations at the National Council of State Boards of Nursing (NCSBN). Before coming to NCSBN, Dr. Spector was a faculty member at Loyola University’s School of Nursing in Chicago, where she taught at the undergraduate and graduate levels. She has worked on a number of initiatives while at NCSBN, including the regulatory implications of social media, innovations and trends in nursing education, the future of nursing program approval, regulatory issues in distance learning programs, outcomes and metrics of nursing education programs, and she was instrumental in developing the innovative Regulatory Scholars Program and the Safe Student Reports study of nursing student errors and near misses. Dr. Spector was the PI on a NCSBN’s multisite transition to practice study, and she was a consultant on the National Simulation Study. Dr. Spector presents and publishes nationally and internationally on regulatory issues in nursing education.

Joan M. Stanley, PhD, CRNP, FAAN, FAANP, is Chief Academic Officer at the American Association of Colleges of Nursing. She serves as AACN’s representative to numerous nursing education initiatives, including the current re-envisioning of the AACN Essentials. Dr. Stanley has provided leadership for the development of the current and past BSN, Master’s and DNP Essentials. She led the development of major position statements on a variety of issues, including the Research-Focused Doctorate and the development of the DNP degree. She also served as AACN’s representative to the APRN LACE Network and the National Task Force for Quality NP Education from their inception. She held a faculty position, 1977-1982, in the Adult Primary Care NP Program at the University of Maryland and maintained an adult primary care practice from 1973-2018 at the University of Maryland Medical System.

Janet Sumner, PhD, APRN, CPNP, earned her Doctorate degree in Nursing at Texas Woman’s University, a Masters in Management Science at the University of Texas at Dallas, and a Masters in Nursing in the Pediatric Nurse Practitioner track at the University of Texas at Arlington. Dr. Sumner’s passion is nursing practice. Her curiosity and questions regarding regulatory and institutional requirements and how they impact individual practice led to her being chosen as the first Director of Operations for Advanced Practice at Parkland Health & Hospital System in 2012. Through collaboration with nursing and medicine, advanced
practice continues to increase its footprint, assuring the presence of support systems as APRNs and PAs are added, improving access for the patients.

Dr. Sumner works closely with medical leadership to identify opportunities for change, working with the institution’s Credentials and Privileging Committees, Medical Staff Bylaws Committee and provider peer assistance committee. She also works closely with nursing leadership in developing engagement of APRN staff with nursing initiatives such as Pathway to Excellence and the Magnet journey. She serves as the Administrative Liaison to nursing and advanced practice nursing peer review committees, sharing her knowledge of nursing practice through her work with these groups.

**Sarah Towery, MS, BSN, RN, NEA-BC**, is the Clinical Education Manager at Parkland Health & Hospital System in Dallas, TX. Sarah began her career at Parkland in July of 1999 as a Surgical Trauma ICU nurse resident. She entered the world of nursing education in December 2008 as a nurse residency coordinator for the Medical Surgical units and obtain her master’s degree in Nursing Education from Texas Woman’s University in August 2015. Her passion for the professional development of nurses, compassion for patients and eagerness to learn has challenged her to accept various professional and leadership roles within Parkland.

In her current role, Sarah oversees Nurse Residency and Nurse Fellowship programs that cross nine specialty practice settings. She also oversees Nursing Student Placements and academic relationships as well as continuing nursing education offerings. She was a volunteer on the Texas Nurses Association Continuing Nursing Education Committee for six years. She values the opportunity to contribute to the collaborative thinking project between the Texas BON, academia and healthcare nursing professionals and hopes to be of services in facilitating the successful transition of new graduate nurses into practice.

**Paula J. Webb, DNP, RN, NEA-BC, FAONL** is the Associate Professor at Texas Tech Health Sciences Center School of Nursing in Lubbock, Texas. Prior to her transition to academia, she served as CNO of Cook Children’s Medical Center in Fort Worth. Dr. Webb was recently honored for her contributions as a preeminent nursing leader through her induction as a Fellow for the American Organization for Nursing Leadership (AONL). Dr. Webb is the 2020 recipient of the Texas Organization for Nursing Leadership Excellence in Nursing Leadership Award. She is an active volunteer board member of professional and community organizations and has led numerous initiatives to improve nursing practice and healthcare in Texas. She also
serves as a Magnet Appraiser for the American Nurses Credentialing Center. She received her Associate Degree in Nursing from Cooke County Junior College, undergraduate and graduate nursing degrees at University of Texas at Arlington, and her Doctor of Nursing Practice degree from Rush University in Chicago.

Brandy Wells, DNP, APRN, NNP-BC has over 20 years of experience as a nurse, with the past 11 years as a Nurse Practitioner. She is currently the Assistant Director of Advanced Practice Providers in the Newborn ICU at Texas Children's Hospital. Mrs. Wells also has a passion to educate the next generation of nurses and has been an adjunct faculty clinical instructor for the University of Texas Arlington in the accelerated BSN program for the past eight years.

Patricia Yoder-Wise, RN, EdD, NEA-BC, ANEF, FAONL, FAAN, chairs the Board’s Task Force to Study Implications of Growth in Nursing Education Programs Meeting. She is Professor and Dean Emerita at Texas Tech University Health Sciences Center School of Nursing (Lubbock) and President of the National League for Nursing.

Lin Zhan, RN, PhD, FAAN, received a PhD degree from Boston College (1993), a Master of Science degree from Boston University (1986), and a Bachelor of Science degree from West China University of Medical Sciences (1980), and AACN Wharton Executive Fellow (2012).

Dr. Zhan is the Dean and tenured Professor at the Loewenberg College of Nursing, the University of Memphis, Tennessee, (2010-present). Previously, she was Dean and Professor, School of Nursing and Chair of Leadership Council of School of Health Sciences at Massachusetts College of Pharmacy & Health Sciences, Boston, MA (2008-2010); Director of PhD Program in Nursing and Health Promotion and a tenured Professor at University of Massachusetts Lowell (2003-2008) and a tenured Associate Professor at University of Massachusetts Boston (1993-2003).

Dr. Zhan has been a Fellow of American Academy of Nursing (FAAN) since 2001. She serves on the Academy’s Expert Panel on Aging (2001-) and Global Health (2015-). Dr. 
Zhan was elected to serve on Academy’s Fellow Selection Committee (2016-2018), and on the Diversity and Inclusion Committee (2018-2020).

Dr. Zhan’s program of research focuses on Quality of Life of older adults and ethnic minorities. Her scholarly work is evident by funded research projects, published over 100 articles, and six (6) edited books ranging from Asian American Voices to Accelerated Education in Nursing. Dr. Zhan has been sought to deliver keynotes and speeches related to health care, higher education leadership, minority health issues nationally and internationally. Dr. Zhan is an expert reviewer or an Editorial Board member for the Journal of Gerontological Nursing, Journal of Geriatric Nursing research, and Journal of Advance Nursing Science. Currently, funded by the Urban Child Institute ($1.17 million dollars), Dr. Zhan as the PI has led a group of faculty conducting research related to integration of Adverse Childhood Experiences (ACEs) across nursing curriculum and implementation of pediatric asthma management program across Shelby County Schools, with the goal to build a culture of health for urban children and families.

Dr. Zhan provides extensive professional services regionally, nationally, and internationally. Regionally, she chaired Tennessee Association of Nursing Deans/Directors (2014-2016); serves on the Le Bonheur National Leadership Council (2018-); and on the Advisory Committee of Assisi Foundation (2016-). Nationally, she served as AACN Board member at-large (2017-2019); AACN Board of Directors Treasurer (2019-2021), and chairs AACN Finance Committee. In addition, Dr. Zhan serves as the Board Liaison for AACN Essential Revisions Leadership Team, and the Board Liaison for AACN’s Diversity and Inclusion Committee. Internationally, Dr. Zhan has been an honorary professor for several universities in China and provided consultation for advance nursing education evidenced by established MSN and PhD programs in China and reforming clinical nursing education. In 2008-2009, Dr. Zhan along with a team served as a consultant for Partner Harvard Medical International to advance nursing education in Asia.

Dr. Zhan has received numerous regional, national, and international awards for her excellence in education, scholarship, and leadership.

Jolene Zych, PhD, APRN, WHNP-BC, is the APRN Consultant for the Texas Board of Nursing, and she has been in this position for over 20 years. She has given presentations on APRN licensure and practice to numerous groups throughout the state of Texas and at the national level. She has served as an expert resource to legislative staff members and to other state agencies and professional organizations. Jolene served on the National Council of State Boards of Nursing’s APRN committee from 2008 to 2012. Prior to her tenure with the Texas Board of Nursing, Jolene practiced as a women’s health nurse practitioner in various types of practice settings. Jolene has also served as adjunct faculty for a graduate nursing education program, teaching courses in research utilization and development of evidence-based practice projects.
Suggested Readings


Abstract: The American Organization of Nurse Leaders and the American Association of Colleges of Nursing have been working together since 2010 to address how academic-practice partnerships can most effectively advance the profession by preparing a well-educated workforce. This article describes the work to date and future strategic priorities.


Abstract

Rationale: Clinical practice is the primary focus of advanced practice nursing (APN) roles. However, with unprecedented needs for health care reform and quality improvement (QI), health care administrators are seeking new ways to utilize all dimensions of APN expertise, especially related to research and evidence-based practice. International studies reveal research as the most underdeveloped and underutilized aspect of these roles.

Aims: To improve patient care by strengthening the capacity of advanced practice nurses to integrate research and evidence-based practice activities into their day-to-day practice.

Methods: An academic-practice partnership was created among hospital-based advanced practice nurses, nurse administrators, and APN researchers to create an innovative approach to educate and mentor advanced practice nurses in conducting point-of-care research, QI, or evidence-based practice projects to improve patient, provider, and/or system outcomes. A practice-based research course was delivered to 2 cohorts of advanced practice nurses using a range of teaching strategies including 1-to-1 academic mentorship. All participants completed self-report surveys before and after course delivery.
Results: Through participation in this initiative, advanced practice nurses enhanced their knowledge, skills, and confidence in the design, implementation, and/or evaluation of research, QI, and evidence-based practice activities.

Conclusion: Evaluation of this initiative provides evidence of the acceptability and feasibility of academic-practice partnerships to educate and mentor point-of-care providers on how to lead, implement, and integrate research, QI and evidence-based activities into their practices.


Additional Resources


Abstract: The article reviews the Nurse Support Program II (NSP II) funded by the Maryland Health Services Cost Review Commission (HSCRC). The program aims to address the nursing and faculty shortage as the complex academic environment affects nurse faculty recruitment and retention. The financial requirements of obtaining advanced nursing degrees are also blamed for the recruitment and retention challenge. The program also includes a New Nurse Faculty Fellowship (NNFF) for nursing faculty.


Abstract

Background: The Northeast Region VA Nursing Alliance is an academic–practice partnership founded in 2007 between the Veteran’s Administration (VA) Boston/Bedford HealthCare Systems and six schools of nursing.

Method: The purpose of this retrospective review was to examine the outcomes of the Northeast Region VA Nursing Alliance in accordance with the mission, goals, and sustainability of the alliance.
Results: The review confirmed that the alliance has successfully accomplished the mission and goals and continues to be a leader in academic–practice partnerships.

Conclusions: Since inception, the academic–practice partnership has increased the number of clinical rotations and clinical faculty, educated nursing students on the care of Veterans, developed dedicated educational nursing units, increased Veteran-centered research, and provided a plethora of educational programs to increase knowledge related to Veteran health care issues.


This article describes the approach that the Robert Woods Johnson Foundation and the National Academy of Medicine are taking to develop a new report on the Future of Nursing 2020-2030 that will chart a course to improve the health and well-being of the nation’s nurses in the 21st century.


Abstract: This study used a qualitative descriptive design to examine the role of the expert staff nurse or clinical liaison nurse (CLN) participating in a community-based academic-practice partnership. Little is known about the influence of participation by expert nurses in community hospital settings. Focus groups were conducted with nine CLNs to explicate their experiences in a unit-based leadership practice model. Eight themes were identified: Reciprocal Learning Between Staff Nurses and Students; Reciprocal Learning Between Student and Patient; Working Around the System; Building Relationships; Valuing the CLN Role; Faculty Recognition of CLNs; Transforming Practice; and a variant theme, Recognition That Some Nurses Neither Value nor Enjoy Working With Students. The benefits of developing partnerships in community hospitals can be far reaching and may be of interest to educators and leaders in the profession. When a practice environment focused on evidence and was fueled by student enthusiasm reinvigorates staff nurses, their work world suddenly transforms.


Abstract
Aim: The aim of the study was to assess entry-level competency and practice readiness of newly graduated nurses.

Background: Literature on success of new graduates focuses primarily on National Council of State Boards of Nursing Licensure Examination (NCLEX-RN) pass rates, creating a false and incomplete picture of practice readiness.

Methods: Post hire and prestart Performance-Based Development System assessments were administered to more than 5,000 newly graduated nurses at a large midwestern academic medical center between July 2010 and July 2015.

Results: Aggregate baseline data indicate that only 23 percent of newly graduated nurses demonstrate entry-level competencies and practice readiness.

Conclusion: New data suggest that we are losing ground in the quest for entry-level competency. Graduates often are underprepared to operate in the complex field of professional practice where increased patient acuity and decreased length of stay, coupled with a lack of deep learning in our academic nursing programs, have exacerbated a crisis in competency.


Abstract: Schools of nursing located within academic health centers have embraced expanded opportunities to lead in this era of rapid change and considerable uncertainty in US health care. These schools bear a unique responsibility to work with their clinical nursing partners to advance the care of patients, improve the health of communities and populations, and help steward the nation’s health care resources. This article describes how the Emory University Nell Hodgson Woodruff School of Nursing has formed and sustained academic-practice partnerships in response to these imperatives. The structures and processes that have supported the partnerships are shared, as are the keys to success in a true partnership. The authors describe the work required to achieve mutually agreed-upon goals, along with the challenges that faculty and health care leaders have faced in their journey to system partnerships.


Abstract: There is a trend to adopt the Quality and Safety Education for Nurses (QSEN) competencies into nursing practice’s organizational activities. Incorporating the competencies has created unique challenges for the practice setting. The purpose of this article is to identify the different types of academic-practice partnerships that promote quality and safety, including a specific focus on how the QSEN competencies are being incorporated into practice settings.


Abstract: There is growing evidence to support partnerships between academic and practice institutions. In one of the Veterans Affairs Nursing Academic Partnerships (VANAP), nurses supervised undergraduate nursing students during the clinical practicum of acute care courses. To evaluate the partnership, faculty solicited feedback from nurses, clinical site leaders, and students. In this quality improvement project, feedback, in the form of written questionnaires and informal debriefing, was collected over four years at the end of sophomore and junior courses. Six site leaders, 71 students, and 34 nurses provided feedback. Common themes were: (1) all participants valued faculty presence during the clinical day, (2) students benefited from being paired with the same nurse throughout the course, (3) clinical teaching associates and site leaders suggested students be present for entire 12-hour shifts, and (4) clinical teaching associates desired more training to address student needs. Several changes were made using this feedback: piloting a 12-hour shift and providing nurses with in-services on strategies to coach nursing students. Follow-up feedback showed high levels of satisfaction with these changes. Collecting feedback from students and staff provides guidelines for changing educational practices. Implementing changes based on the feedback strengthens partnerships, supports student learning needs, and improves student experiences.


This article is about how Transcultural Nursing (TCN) Scholars “promote the advancement of a body of knowledge, initiate and disseminate research”. They state that when academia and practice partners develop a relationship, they can examine the relationship between culturally congruent care and organizational/patient outcomes. Combining resources from both areas leads to positive outcomes in both academic and practice institutions, which can promote teaching
and learning, and the clinical applications of transcultural nursing and healthcare globally.


Aims and objectives: To critically appraise available literature and summaries evidence pertaining to the patient safety knowledge and practices of new graduate registered nurses.

Background: Responsibility for patient safety should not be limited to the practice of the bedside nurses, rather the responsibility of all in the healthcare system. Previous research identified lapses in safety across the health care, more specifically with new practitioners. Understanding these gaps and what may be employed to counteract them is vital to ensuring patient safety.

Design: A focused review of research literature.

Methods: The review used key terms and Boolean operators across a 5-year time frame in CINAHL, Medline, psycINFO and Google Scholar for research articles pertaining to the area of enquiry. Eighty-four articles met the inclusion criteria, 39 discarded due to irrelevant material and 45 articles were included in the literature review.

Results: This review acknowledges that nursing has different stages of knowledge and practice capabilities. A theory-practice gap for new graduate registered nurses exists, and transition to practice is a key learning period setting new nurses on the path to becoming expert practitioners. Within the literature, there was little to no acknowledgement of patient safety knowledge of the newly registered nurse.

Conclusions: Issues raised in the 1970s remain a concern for today's new graduate registered nurses. Research has recognized several factors affecting transition from nursing student to new graduate registered nurse. These factors are leaving new practitioners open to potential errors and risking patient safety.

Relevance to clinical practice: Understanding the knowledge of a new graduate registered nurse upon entering clinical practice may assist in organizations providing appropriate clinical and theoretical support to these nurses during their transition.


Background: Many baccalaureate schools of nursing are using non-traditional placements for undergraduate community health clinical rotations. These placements occur at agencies not organizationally affiliated with the health care system and they typically do not employ registered nurses (RNs).

Objective and design: In this paper, we describe the qualitative findings of a mixed method study that explored these gaps as they relate to pre-registration nursing students' preparation for community health roles.

Results: While non-traditional community health placements offer unique opportunities for learning through carefully crafted service learning pedagogy, these placements also present challenges for student preparation for practice in community health roles. The theory-practice gap and the gap between the expected and actual performance of new graduates are accentuated through the use of non-traditional community clinical experiences. These gaps are not necessarily due to poor pedagogy, but rather due to the perceptions and values of the stakeholders involved: nursing students, community health nursing faculty, and community health nurses.

Conclusions: New ways must be developed between academe and community health practice areas to provide students with opportunities to develop competence for practice.


Background: Through the Veterans Affairs Nursing Academic Partnership (VANAP), baccalaureate nursing students and faculty participated in practice innovations in a Veterans Affairs Health Care System. Nationally, VANAP has attempted to bridge gaps between theory and practice and across care settings.

Approach: In a population health course, nursing students were placed in both inpatient and outpatient settings. Through activities such as post-conferences and population-based projects, students joined forces with Veterans Affairs staff on issues that affected veterans' health care.

Outcomes: Two student groups worked on amputation prevention from opposite ends of the spectrum. Their projects, with the continuation of these by faculty and staff, resulted in 47% decrease in vascular-related hospital readmissions.

Conclusions: Student placements in settings across the care continuum improved communication between the settings. The enhanced partnership between the 2 organizations addressed a relevant, meaningful patient care issue.
The Future of Nursing in Texas


**Abstract**

**Background:** Clinical learning environment is verified as a critical component of a nursing program, that provides students with unique learning opportunities in which classroom theory and skills are put to the test with real life situations.

**Material and Method:** A descriptive quantitative cross-sectional design was conducted in this study throughout a period of three consecutive months from 1st June, 2017 to the end of August 2017. Subjects were selected conveniently from the available students at the 5 main governmental hospitals of Gaza strip.

**Results:** The findings showed the greater part of students (56.3%) were enrolled in the senior level of the study. There was a significant agreement (Mean 3.5, t = 8.1) among student nurses about the role of availability of setting in reducing the theory-practice gap, that the process of orientation to the place of training could contribute to bridge the gap was captured the highest mean score (mean= 3.9, 78%). On the other hand, the study shows significant borderline agreement (3.4, 68%) about the availability of simulation labs at the colleges of nursing could contribute to bridge the gap, which might truly reflect the current lower availability of simulation in some nursing colleges of Gaza strip.

**Conclusion:** There is quite evident that gap’s phenomenon does exist and has its strengths as well as areas that can be improved by harmonizing the theoretical nursing approach with clinical practice approach and give opportunities for both clinical instructors and students to work within a more creative clinical environment.


**Abstract:** Public health clinical educators and practicing public health nurses (PHNs) are experiencing challenges in creating meaningful clinical learning experiences for nursing students due to an increase in nursing programs and greater workload responsibilities for both nursing faculty and PHNs. The Henry Street Consortium (HSC), a collaborative group of PHNs and nursing faculty, conducted a project to identify best practices for public health nursing student clinical learning experiences. Project leaders surveyed HSC members about preferences for teaching-learning strategies, facilitated development of resources and tools to guide learning, organized faculty/PHN pilot teams to test resources and tools with students, and evaluated the pilot team experiences through two focus groups. The analysis of the outcomes of the partnership engagement project led to the development of the Partnership Engagement Model (PEM), which may
be used by nursing faculty and their public health practice partners to guide building relationships and sustainable partnerships for educating nursing students.


Abstract In 2016 the American Association of Colleges of Nursing issued a report, Advancing Healthcare Transformation: A New Era for Academic Nursing that included recommendations for more fully integrating nursing education, research, and practice. The report calls for a paradigm shift in how nursing leaders in academia and practice work together and with other leaders in higher education and clinical practice. Only by doing so can we realize the full benefits of academic nursing in this new era in which integration and collaboration are essential to success. In this paper we: 1) examine how academic nursing can contribute to healthcare innovation across environments; 2) explore leadership skills for deans of nursing to advance the goals of academic nursing in collaboration with clinical nursing partners, other health professions and clinical service leaders, academic administrators, and community members; and, 3) consider how governance structures and policy initiatives can advance this work.


This article is about academic and practice partnerships to improve patient outcomes. The eight guiding principles to support effective relationships as recommended by the American Association of Colleges of Nursing (AACN) and the American Organization on Nurse Executives to create a positive academic-practice partnership task force include: 1) Sustainability, 2) respect, 3) shared knowledge, 4) helping nurses practice at the top of their licenses, 5) facilitating Academic-practice partnerships and patient outcomes, 6) organizational processes and structure, 7) enhancing practice environments to improve health outcomes, and 8) shared work on the future needs of the RN workforce.


OBJECTIVE: The aims of this article were to describe the implementation of an academic-practice partnership for healthcare system workforce development and provide preliminary outcomes of the associated pilot study. BACKGROUND: The demand for cross-continuum healthcare delivery models necessitates creation of workforce development structures for advanced practice nursing. METHODS: An
academic-practice partnership specified enrollment of 5 cohorts of BSN staff nurses in a 3-year DNP program. Qualitative methods were used to explore pilot data at midpoint of cohort 1 student progression to determine learning outcomes and DNP projects with potential for impact on organization goals. RESULTS: Partnership implementation experiences indicate that contractual agreements and an established evaluation plan are keys to academic practice partnership success. Pilot study findings suggest that curriculum core courses provide a foundation for designing DNP projects congruent with acute and primary care health system goals. Implementing an academic-practice partnership is a strategy for workforce development to increase retention of advanced practice nurses. CONCLUSION: Academic-practice partnerships can serve as a catalyst for a paradigm shift for changing models of care, thus enhancing workforce development succession planning for sustainable growth in healthcare systems.


Abstract:

Objective: The shortage of nurses is an overwhelming problem worldwide. Numerous studies indicate that fresh nursing graduates encounter many challenges in their first year after graduation. These difficulties affect their psychological health and influence their perseverance which results in a high resignation rate. Hong Kong is not an exceptional case; therefore, the aim of this study was to explore the challenges encountered by fresh nursing graduates during the transition period in order to provide insights to academics and clinical administrators in order to facilitate the transition and alleviate the negative impacts, thus increasing the retention rate.

Methods: This was a qualitative study and eight new nursing graduates (M = 4; F = 4) from the same local higher education institute were interviewed individually. Thematic coding was used to analyze the data.

Results: Finally, nine themes were identified including eight areas of challenges and one common attribute. Workload, lack of knowledge, communication, expectation, change of role, working atmosphere, support and a blame/complaint culture are the common areas of challenges that they encounter in the transitional period. Furthermore, this study also found that new nursing graduates possess a common attribute, i.e. positive personal attitude which seems able to enhance their perseverance in this period.

Conclusions: The identified themes are interrelated and all the stakeholders should join together and form a cycle of continuous improvement in order to improve the nursing program and clinical supports to the fresh nursing graduates.
Appendix F: World Café 101

What is a World Café?

A World Café is:

- A method for creating a living network of collaborative dialogue around questions that matter in the real-world of a specific community.
- Fosters creativity, innovation, and connection.
- The act of participating in a world café also serves as a metaphor for the networks we develop to create new knowledge by sharing diverse perspectives on questions that matter (Brown, 2002).

World Café: Guiding Principles

- Clarify the Context
- Create a Hospitable Environment
- Explore Questions that Matter
- Encourage Everyone’s Contribution
- Connect Diverse Perspectives
- Listen Together for Insights & Deeper Questions
- Harvest and Share Collective Discoveries (Brown, 2002)
World Café: How Does It Work?

Hosting A World Café

- Thoughtful set-up of environment
- Clear instructions re: etiquette and logistics (table changes, timing)
- Encourage participation by all
- May appoint “table stewards” to remain at each table to later assist with harvesting and synthesizing knowledge

Café Etiquette

- FOCUS on what matters
- CONTRIBUTE your thinking
- SPEAK your mind & heart
- LISTEN to understand
- LINK & CONNECT ideas
- LISTEN TOGETHER for insights, patterns, & deeper questions
PLAY, DOODLE, DRAW-writing on the tables is encouraged!
HAVE FUN! (Brown, 2002)

**Traditional Talking Stick**

The Talking Stick is a tool used in many Native American Traditions when a council is called. It allows all council members to present their Sacred Point of View. The Talking Stick is passed from person to person as they speak and only the person holding the stick is allowed to talk during that time period.

![Traditional Talking Stick Image]

**More Café Etiquette**

- Try to plan for no more than 6 participants per table
- You will participate in 5 different table discussions
- You will have a unique schedule of when to visit which table printed on your nametag
- Achieve a mix of perspectives
- 25 minutes per discussion circle
- ONLY HE/SHE WHO HOLDS THE TALKING STICK SPEAKS!
- Pass the talking stick on
- HAVE FUN!

**Resources**


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<th>Table Topic</th>
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Appendix H: Summit Results – Facilitator Reports

Each of the 12 topics had two facilitators – one at each of two discussions of the topics. Facilitators took notes during the discussions. Additionally, the facilitators and participants made notes on paper placed on the tables for that purpose. The notes were reviewed and edited. Some facilitators noted the academic or practice setting while others did not. “A” and “P” designations below represent Academic and Practice. The following information was compiled from the notes.

Topic: Academic Clinical Placement Questions

Table 1

What are the barriers experienced by schools of nursing in obtaining clinical placements for large groups of students?

- Competing programs for limited acute care clinical placements include: ADN, BSN, LVN, APRN, PA, Medical Residents, including both onsite and online requests from schools in and out of Texas, including online programs.
- Scheduling challenges arise for education if the clinical affiliation agreement is not consistently upheld, (e.g., space cancelled when students arrive on unit).
- Many schools still request 1 faculty:10 student placements. One option is to spread the groups across units with clinical teaching assistants.
- The biggest challenges in securing clinical rotations are with pediatrics, OB, psych. Vocational nursing programs have very limited offerings.
- If students show up on unit without prior approval, it is problematic for practice.
- Securing APRN clinical placements can be complex if the potential preceptors are not employees of the facility.
- Short notice on which programs will be on the units presents challenges for practice.
- Competing priorities for space and assigning multiple roles for nurses to work with new graduates, new RNs, preceptors, and interns on same unit create challenges for practice. Additionally, the need for post conference space, limitations of unit size and renovations affect the ability for practice to accommodate education program needs. Challenges for practice include balancing needs of new employees/residents with student placement.
- Preceptor training and preceptor fatigue can be challenging for practice.
Both education and practice agreed that the laborious paperwork required to obtain clinical placements is a challenge. Submitting and tracking requests of required documentation from practice numerous times every semester seems inefficient. What alternatives exist to clinical placements in acute care facilities and what barriers exists to implementing them? Move to a competency-based education model. APRN-led clinics can enhance the teaching environment. Education can prepare new healthcare providers to teach. The culture of nursing must embrace education and training. Practice recommends programs utilize all shifts for clinical learning experiences. Explore alternatives such as the Canadian model which has increased clinical experiences every semester. Increase the use of simulation up to 50% for schools not currently doing so. Faculty creativity is required to implement quality simulations and debriefings. Education, training and equipment are required. It takes well prepared faculty and lab staff to offer quality training in their area. Expand the use of long-term acute care facilities, maternal-child health clinics, school health, day care child centers/shelters for pediatric experiences. Expose students to underserved areas where we see the greatest need. Outpatient settings can be used for psychiatric clinical learning including substance use disorder clinics. However, if clinics are staffed by unlicensed personnel, this is limiting for nursing education.

Are there creative partnerships that can be formed to diminish the barriers to clinical placement?

- The Healthcare Workforce Alliance of Central Texas (HWACT) in Austin and the Dallas Fort Worth Hospital Council provide opportunities for education and practice to come together to work on collaborative challenges and solutions. This promotes professional obligation and increases trust.
- Include practice in education advisory councils and education in practice councils to open lines of communication and understanding, such as the required paperwork for APRNs, and the “whys” of processes and terminology.
- One innovative example of practice-education collaboration is the Academic Clinical Experience (ACE) offered to expand BSN student clinical capstone hours from 60 to 152 hours.
- Community settings are an untapped clinical resource that should be utilized.
• Partnerships need to be elevated to a higher standard. True dialogue must occur with direct stakeholder engagement. Both administration and frontline staff must be involved.
• Increase the use of dedicated education units (DEUs) to provide better clinical experiences for both nurses on units and students.
• Create a revenue stream for shareholders to have shared goals: academia, students, physicians, and practice.
• Practice recommends that programs evaluate curricula to allow students increased clinical time in their areas of interest. If a student is not interested in pediatrics or women’s health, increase other service lines. Use simulation and virtual reality to offset on unit time.
• Integrate service excellence throughout nursing programs which assists residencies in training new graduates and decreases unit staff anxiety if the facility is surveyed during student clinical times.

Takeaways:
• Dialogue verified that others have the same problems/challenges and opportunities to change.
• There is a need to share creative solutions - what works, what hasn’t worked and why.
• Increase student accountability for learning.
• An opportunity exists to standardize clinical onboarding requirements in all programs.
• Increase communication between academia and practice regarding expectations from both arenas.
• These were great conversations. One question could have taken the entire 25-minute discussion.

TOPIC: APRN Academic Clinical Placement

Tables 2 & 14

• CCNE standards
• Securing clinical placements is the responsibility of the program.
• Online students can present a challenge to securing clinical placements.
• Quality of clinical learning experiences is paramount.
• Enrollment trends can impact competition for clinical sites.
• Schools should only accept students whose clinical learning needs can be met (e.g., securing a preceptor).
• Preceptor expectations should be consistent with program expectations.
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- The Board of Nursing does not have authority to regulate APRN education programs.
- Are the number of APRN programs adequate?
- What qualifies a nurse to be a preceptor?
- Are there differences in student support in BSN programs compared to graduate programs?
- Preceptors need to be updated on where students are in the didactic portion of the program curriculum.
- Students may be unaware of what they want to do when they graduate.
- Out-of-state programs may or may not meet licensure requirements for TX and may compete with local programs for clinical placements.
- Paying preceptors is an "Elephant in room." Some believe there should be a policy prohibiting it.
- Employment trends should inform enrollment plans.
- Only allow local students enrolled in a TX school to complete clinicals in nearby hospitals.
- Utilize a clinical placement coordinator to find clinical placements.
- Use alumni as preceptors.
- Partnerships with organizations and universities can help to bridge the gap.
- Preceptors need at least 1 year of experience
- Reach out to national resources for help.
- Coordinate didactic with clinical experiences.
- Provide preceptors with library access.
- Preceptor orientation is necessary for a successful learning experience.
- Collaboration between hospital and academia is needed to agree on a process.
- What is the incentive for precepting? Preceptors need recognition.
- Is there a need for a preceptor coordination service?
- Improve communication among preceptors, faculty and students (including site visits).
- Consider the fellowship model for planning well-organized clinical rotations.
- Concern for quality of some out-of-state
- The focus of teaching is the common goal of safe patient care that meets or exceeds the current standard of care.
- Funding is needed.
- Some APRN students are paying for clinical sites or paying preceptors.
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- Ethical concerns related to preceptor payment
- Federal money may be an option to pay preceptors.

**Table 14**

What are the barriers experienced by schools of nursing in obtaining clinical placements for large groups of students?

- Competing programs for limited placement sites; nurse assignments; conference space, facility unit challenges; balancing new employees’ needs with students’ needs; placement; online students.
- Limited space for Peds, OB, Psych training
- Scheduling challenges at clinical sites; when students will be on units
- Challenges with APRN student placement
- Resistance from some students who do not want to rotate through every specialty, but want to focus on their specialty preference.
- Simulation quality; too much variation
- Laborious paperwork to obtain clinical sites/placements; duplication of work from semester to semester.
- Clinical placement ratios of 1 faculty: 10 students may need to be reviewed.
- Students showing up without prior scheduling is a challenge for practice.
- Preceptor fatigue from having students on the unit

What alternatives exist to clinical placements in acute care facilities and what barriers exist to implementing them?

- Explore use of other sites for clinical training: Long Term Acute Care (LTAC), Hospice, Schools, Clinics; underserved areas
- Increase use of simulation and debriefings
- Move to competency-based models; review/revise
- Assign faculty status to hospital preceptors; use as adjuncts to academic educators
- Utilize all shifts 24/7 for clinical rotations
- Create free-standing acute care settings to increase sites for communities in need and training. These sites can provide safe care at a lower cost (like college clinics or mobile units).
- Develop APRN driven clinics for teaching sites.
- Offer hospital preceptors CEUs or credit towards degree programs (clinical hours).
- Explore the Canadian model for clinical sites.
- APRN placement - use a regional approach so we do not have to get approval to go outside home areas.
• Use health fairs as a gateway to assess basic skills before going into hospital settings; increases sites.
• Assign students the maximum patient load (5-6 patients for Med-Surg) by the end of the rotation; helps them assimilate in the real world once licensed.
• Need improved communication strategies to let nurse leaders and preceptors know what students can/should do while in clinicals.
• Decrease the unit preceptor patient load while working with students.

Are there creative partnerships that can be formed to diminish the barriers to clinical placement?

• Partner with hospitals to create dedicated education units to improve experiences.
• Partner with other disciplines (pharmacy, physicians, etc.) to enhance simulation.
• CNOs/Nurse leaders and Academic leaders should partner and have regular collaborative meetings to assess what is working, what is not and generate solutions.
• HWACT Austin and Dallas Councils are great partners for collaboration.
• Include practice members on education advisory councils and vice versa.
• Partner with community agencies for clinical experience sites; untapped resources.
• Need administrative and front-line stakeholders to form meaningful partnerships.
• Connect nursing schools to hospitals (funding/partnerships/clinical sites).
• Collaborate more between healthcare organizations and academia versus being competitors.

Topic: APRN Scope of Practice

Tables 3 & 15

• High financial burden for APRNs
• Education strategies for teaching APRN scope of practice
• Telehealth- beneficial to collaborate with physicians
• Lack of full practice authority
• Paying for preceptors
• Employment challenges
• Employers may not understand the scope of practice of an APRN in a particular role and population focus.
• Scenarios can be used to teach scope (case studies).
• Transparency and collaboration between academia and practice
• Understanding APRN role and population foci
• Student needs academia to start scope of practice education at the beginning of the program.
• Institute policy surrounding scope/defined roles
• National task force for APRN-embedded with accreditation
• BON does not regulate APRN education programs.
• CCNE- accredits education programs
• Should out-of-state educated graduates be required to complete additional continuing education?
• Complex APRN application requirements
• Consider moving to train across the spectrum of care-similar to PA. Is APRN education too specialized?
• Emphasis on ethical standards of practice
• Requirements in place for entry into APRN program
• Consider the fellowship model for training APRNs
• Should there be a push for nurses to enter an APRN program with - less than 1 year experience?
• FNP may need additional formal education/training to care for acutely ill patients (inpatient/ER)
• Lack of standardization- varied clinical hours (minimum of 500).

**Topic: APRN Transition to Practice**

*Tables 4 & 16*

• Online programs-question of quality
• Define core competencies
• Standardize modules
• No local regulatory control over out of state schools
• Case conferences
• Better onboarding programs
• Mentorships (Virtual for rural areas)
• Build a standardized transition to practice model and share statewide
• Lack of individual (Educator, mentor) to transition new APRNs
• Start an APRN council
• Hire in cohorts (Train together)
• Schools have responsibility to prepare students consistently
• Students may have to find their own preceptors and pay a third party to do so.
• Few residency/fellowships are available for APRNs.
• Need for role clarify and acquisition during education program
• Where is the evidence for the number of clinical hours required?
• Educator shortage for APRN programs
• APRNs need to be precepted by APRNs for role development
Restricted practice = lower access to quality care
Who will pay for APRN residencies?
Will the community cover the cost if APRN practices in the community?

Healthy Work Environment

Table 5

- How do students and staff work synergistically to produce a healthy nursing work environment?
- Civility and strong positive culture
- Managing real-world expectations
- Address bullying or unacceptable behavior real time
- What are possible actions to improve the nursing work environment?
- Make serenity or meditation areas within organizations
- Create 8 hour shifts again
- Create innovative roles for “older” nurses
- Creative and innovative staffing models; quit doing it the same old way
- Plan deliberate touchpoints with students/instructors while on units- what’s working and what’s not
- Role-model civility
- Create welcoming environments
- How does nursing education prepare graduates to address these elements?
- Discuss and prepare students for the “real world”
- Teach debriefing skills
- Develop curriculum teaching civility and workplace violence prevention
- Add discussions about getting involved, unit practice councils, etc.
- Help students “find their voice” in a professional way
- How do we create more conversation together to improve the nursing work environment?
- Open the dialogue - put the elephant in the room
- Create consistent and frequent conferences, meetings between academia and practice
- Offer professional development to practice partners and vice versa
- Create a state-wide or national forum for best practice sharing
Table 17

- How do students and staff work synergistically to produce a healthy nursing work environment?
- Learn that it is ok to make mistakes; learn by putting the pieces together
- By learning from experience
- Generated attitudes- change culture on units
- Changing culture in practice - not assigning blame - systems approach
- Point of view between generations
- Patterns of recognition where breakdown occurs
- What are possible actions to improve the nursing work environment?
- Have adequate staffing on units
- Work as partners between academia and practice; eliminate redundancy
- Seek out “experts” on unit- not necessarily charge nurses
- Eliminate mandatory overtime
- Provide same group of patients, consistent assignments to staff and students
- How does nursing education prepare graduates to address these elements?
- Through the capstone experience - through the work of the student
- Identify issues
- Work in place as an RN where they that want the RN person as APRN; work units they want to move to
- Comfortable environment
- How do we create more conversation together to improve the nursing work environment?
- More collaboration
- Make sure hospital and academic partners know each other’s world
- Practice has limited knowledge of DECs - need to be educated
- Create Deans/Directors forums- develop strategies together

Takeaways:
- Emphasize self-care of students and staff
- Change attitudes from adversaries to partners
Topic: Customer Service Competencies

Table 6
How is customer service relevant to nursing practice?

Academia

- Students impact customer service (CS) care and numbers when in clinical spaces
- Modules to prepare students for communication strategies and customer service prior to clinicals (grant money)
- Soft skills
- Regulations in academia that don’t exist in practice
- Academia balances preparing students for NCLEX
- Students need to buy into the culture prior to coming into the nursing field
- Having more practicing nurses cross over to academia to talk with new nurses
- Incentivize nursing mentorship to encourage continuity
- Customer service is the hallmark of nursing – building relationships and rapport
- CS is important for individualized care and cultural relevant
- Healthy nurses = healthy patients
- Mentorship is vital
- Academia is focused on knowledge and content, not customer service
- Students report nurses treating patients without a customer service approach
- Empathy is vital
- Teaching empathy will foster CS
- Healthcare is a business
- It is a service industry
- CS is relevant because they have to pay attention to the individual person
- New buzz word for “the art of nursing”
- Language barrier can create a challenge for CS
- Generational gap for communication
- Learning to listen to the whole patient, paying attention to the whole patient
- It’s the face of nursing
- First impressions
- Customer service is how we build trust in the nursing profession
- Promotes better outcomes
Practice

- Customer service helps to mitigate litigation; builds relationships with families
- Organizational culture needs to be taught to students prior to clinicals
- Knowledge, skills and ability to have customer service
- Communication strategies
- Do nurses mistreat students and new graduates?
- Hesitancy in nurses to welcome students
- Vital for APRNs to build relationships
- Value-based care
- CMS rates hospitals based on HCAPS
- How to deal with difficult patients and situations
- CS is vital to break the monotony
- Focus on self-care to stay engaged
- Burn out or suicide rate among nurses and APRN
- Is it really customer service? It is a profession that affects their lives
- CS skills provide approachability
- Decrease in litigation
- Teaching resilience
- Being able to have conversations
- New graduate nurse may equate constructive feedback as conflict
- Expressing concern
- Elevating care
- Advocating for self and patient
- Basic communication – make it relevant and non-confrontational
- Second degree nurses tend to communicate better
- Increased life experiences
- Lead with quality and service
- Quality and service both - have to be done well
- Brand recognition from service experience
- Increasing revenue and increasing funding to further promote nursing programs
- Patients do pay for service
- Expectation to be taken care of as a customer
- Sometimes the expectations as a customer can be unrealistic
- Workplace violence and abuse of nurses can be a challenge in customer service
- How to protect nurses from burnout
- Environment determines personality of service
- Setting boundaries to protect nurses
What aspects of customer service do you expect from students entering practice?

**Academia**

- Learn how to communicate and problem solve
- Start on campus
- Understand the organizational culture
- How to ask open ended questions that are non-judgmental
- Build into the curriculum
- Simulations can be valuable to teach students, especially when there aren’t enough clinical spaces
- Funding is important to be able teach CS
- Academic partnerships to have a cohort of students
- Nurses cannot teach what we do not know or do not practice
- Professionalism, leadership, manners, respect
- Nurses need to know that this is a calling
- Having to teach professionalism
- Overcoming generational challenges in communication
- Oral and written customer service
- Engagement in professional organizations
- Culturally updated textbooks: For example, addressing transgender
- Patient experience may be a synonym for customer service
- Are we in the business of customer service or patient experience?
- Do simulations ever address customer service?
- Debriefing questions: How did you provide good customer service?
- Respect
- Teaching respectful conversation
- Give respect to get it back
- Expose to lots of different people and zip codes
- Learn how to respect the diversity of people
- Nursing is a calling, not a job for the money
- The calling requires that nurses maintain professionalism in all situations
- Civility
- Faculty can demonstrate good customer service and professionalism

**Practice**

- How to communicate in difficult situations
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- Conflict resolution
- Teach students to deal with stress
- Open to feedback, hearing and mentoring
- Nurses empowered to be a role model
- Don’t be focused only on patients and families; be a good customer to your manager, keep your word, meet deadlines that are set; be accountable
- Does the increase in simulation decrease opportunities to practice CS or problem-solving?
- Simulate difficult customer service situations
- Preceptors should role model customer service.
- Teach students to respond to violence (work place violence)
- Culturally competent care
- Nursing staff interacting with each other and being culturally competent with each other
- Listening to “customers”
- Being “present” vs. being efficient
- Seeking to understand other people and their perspectives on life
- Know the difference between learning and failing
- Transition to practice is learning to listen
- Culturally competent
- Learning to take unbiased care of an individual
- Teaching students to have conversations such as: How do you prefer to be referred to? What is your preferred name?
- Teaching nurses to have tough conversations that empower patients to be transparent/open
- Nurses struggle with time to provide good customer service
- Be kind
- Remembering that the situation is worse for the patient, be kind
- Everybody has a story
- Stop and listen to their story
- Look at the person, listen to where they are coming from
- Expectation of how patients are to be treated
- Do no harm; serve, take care of patients
- Protect nurses from workplace violence

What can be done to teach customer service?

Academia

- For every skill and simulation, failure to demonstrate AIDET is a critical fail  [AIDET= acknowledge, introduce, duration, explanation, thank you]
The Future of Nursing in Texas

- Debriefing
- Role model
- Set clear objectives for the student during clinical settings
- Generational gap in communication – not able to take criticism making it difficult to send them to the workplace
- Make it a competency or part of curriculum
- Teach generational issues – put the phone away, for example
- Standardized patients in simulations - Funding is necessary for this to happen
- Simulations can all be different
- Paying for preceptors?
- Set up preceptorships for students
- Role modeling from instructors, faculty, and hospital staff
- Learn what to do and what not to do
- Design learning experiences to teach customer service
- Some sort of CS question, belief in behavior, how does CS relate to nursing practice on applications?
- Mock conversations/interviews
- Simulations, but not all things can be simulated
- Role playing
- Don’t assume anything about students coming, teach customer service to all
- Demonstrate customer service
- Experience customer service in a different industry, outside of nursing, what does customer service look like somewhere else?

Practice

- Create modules to teach organizational culture
- Validate in the clinical environment - Staff, leaders, students
- Be clear on expectations for nursing students
- Be open to new experiences
- Culture competence - Understand how to interact with a person
- Emotional intelligence
- Understand the culture of an organization
- Demonstrate
- Build partnerships
- Nurses may have a lot to balance in practice settings, with orientees and student teaching.
- Help to prevent burn out among nurses
- Re-evaluate 12 hr shifts, maybe too long, creates increased stress
- Change the environment/incentives for preceptors
- Understand where the money goes, and how money is spent
- Value based care: HCAPS
Customer service is the right thing to do, but also affects payment to the organization
Sharing experiences with each other for learning purposes
What you see in patients is not who they are, but what they are going through.

Takeaways:

- Partnerships between practice and academia are important.
- Incorporate customer service throughout academic career.
- Communication with patients is a needed competency.
- Customer service is not a term that is compatible with nursing.
  - Nursing is a therapeutic/holistic relationship
- Mutual respect, not just coming from nurses
- Be sure that nursing students recognize the calling, and not just a job
- Nurses need to understand the incredible impact that they have on people’s lives.
- Potential to make a huge impact on people’s lives
- Patient experience needs to include the patient’s preferences.
- The customer service that a nurse provides becomes the face of nursing.

The main ideas talked about at this table revolved around:

- While health care is a business, customer service is a hallmark of nursing, building relationships with patients/families. There were many who took issue with the term “customer service,” stating that nursing is more of a therapeutic relationship than customer service. Nonetheless, nursing is a service industry. Reimbursements/Payments are based on surveys and HCAPS, so customer service is also just a practical aspect of the profession.
- Good customer service helps to mitigate litigation by creating relationships. It is a demonstration of professionalism. A nurse’s customer service becomes the face of nursing to that patient/family.
- Nursing students should be prepared for good customer service prior to entering clinical settings. Simulations could provide opportunities to practice customer service, providing role play opportunities to engage with difficult patients, confrontation, challenging situations.
- Good customer service should be modeled by everyone within the nursing profession, from the faculty, to mentors, to preceptors, to direct care nurses. Mentorship/Preceptorship should be ingrained in everyone within the nursing profession. Nursing programs
should consider creating mentorship programs as part of the nursing curriculum, where 3rd and 4th year nursing students are mentors to 1st or 2nd year nursing students. Teaching preceptorship while still in nursing school will produce nurses who are taught and prepared to be mentors as part of their nursing profession.

- Partnerships between academia and practice are imperative in order to teach organizational culture, emotional intelligence and mentorship. Incentivize and provide support for nursing mentors/preceptors to prevent burn out and continue to provide a welcoming atmosphere to foster good customer service.

Table 18

How is customer service relevant to nursing practice?

- Expectations are the same (or should be) as the staff
- It helps decrease patients and family anxiety

What aspects of customer service do you expect from students entering practice?

- Role modeling
- Empathy demonstration
- Uphold standards and accountability for customer service
- Demonstration of compassion and respect
- Live in a state of mindfulness
- Be present
- Have an understanding that nurses have patients as customers
- Respectful interactions; knocking first, thanking, don’t interrupt others, keep things neat and clean
- Be professional
- Talking in kind and calm voice
- Friendly tone of voice
- Patients are not the only customer; colleagues are too
- Build relationships
- Interprofessional
- Respectful and professional
- Students are a guest in the agency; play by the rules
- Do more than what is expected
- Cultural awareness: e.g., language challenges; get translator when necessary
- “Customer Servitude”
- Use good judgement along with personal values and ethics
- Non-judgmental
- Give the best of selves; leave personal issues at the door
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- Love what you do
- Respect, compassion, care
- Respect, knock when entering room, eye contact, share what you are going to do
- Listen attentively
- Culture of incivility not allowed
- Treating patients with compassion
- Showing up on time, dressed appropriately; follow rules
- Sensitivity to patients
- Be fiscally responsible re: supplies, etc.
- Attend to patient comfort needs

What can be done to teach customer service?

- Teach students AIDET as foundation
- Role playing, crucial conversations with new graduate or student
- Debriefing
- Discuss challenging situations- debrief; sharing stories
- Storytelling; really listen- awareness
- Basic scripting- make authentic
- Read customer
- Role modeling
- Incorporate skills into curriculum
- Allow to see “good” customer service and how others handle it
- Role playing, scripting that is sincere
- Role modeling in real time; simulation
- Teach by experiential teamwork sessions
- Scenarios of practice
- Every interaction has a human piece when caring for patients- make connection
- Need more remediation on how to do human interactions- compassionate care
- Teach the “why’s” and rationale of good customer service
- Teamwork teaching
- Case scenarios-role playing
- Clinical reflections and debriefing
- Videoing, labs and debriefing
- Teach to introduce self, AIDET
- Teach rationale

Takeaways:

- Expectations of customer service should be the same as staff
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- Listening is important, more mindfulness and focus
- Role modeling
- Need more conversation about what customer service is and why
- How to avoid distractions
- Developing relationship with sincerity
- Being a customer servant
- “Do no harm, but do good”
- Exceeding expectations
- Role playing scenarios in safe space
- Role modeling by staff
- Use debriefing as a learning tool

Topic: DECs

Table 7

Considering the 4 nursing roles in the DECs, what competencies should be taught to nursing students that will help them transition to practice?

- Information Technology (IT)- incorporating IT to enhance patient care (A/P)
- Connecting with patients (A/P)
- Teaching empathy; students feel isolated (A)
- Change views from task oriented to intuitive thinking (A)
- Teach patient-centered competencies- to understand how patients should be treated; patient safety advocate, member of healthcare team (A)
- Confidence building
- Need more critical care skill building (P)
- Quality and patient safety; clinical reasoning (A/P)
- Knowing your role with the healthcare team (A/P)
- Conflict resolution; Team STEPPS (P)
- Communication skills- they have other people on the team (A)
- Behavioral health (A/P)

What teaching strategies can be used to help students learn one of the 4 nursing roles?

- Use case studies and include a mental health component (A/P)
- Strategies to bridge from simulation to real patients (A/P)
- Change the way we teach DECs (A)
- Use a platform for discussion between academia and practice (A/P)
- Use nursing process (A)
Use simulation “out of the box” assignments to help students learn through uncomfortable scenarios (A)
Teach with practice partners- cannot educate in isolation (P)
Need consistency in educational strategies between academic programs (P)
Using simulation for patient safety teaching- it is a safe space (A)
Evolving case studies- allow students to make mistakes in simulation; role play in the classroom (A)
Simulations must mimic real scenarios (P)
Interprofessional role play (A/P)
Learn about community partnerships; behavior (A/P)
What should employers expect from graduates on one of the 4 roles?
Only have students enter through transition programs (P)
Safety practice and knowledge (P)
Get input on new graduates and give feedback to academic partners (P/A)
Use nurse residency programs to reinforce these skills (A/P)
Practice partners should expect to have to train new graduates (A)
Should have quality scorecards for each program shared with practice (P)
Should expect safety with some remediation- remember novice nurses are not specialists
Should have basic nursing knowledge
Need basic safety knowledge; know what a core measure is (P)

Takeaways:
Academia is willing to partner.
Bidirectional feedback between academia and practice is essential.
Communication and “soft skills” vital
New graduates are “novice” nurses
Need nursing program consistency
Teaching professionalism, patient centeredness, and empathy

Table 19
Considering the 4 nursing roles in the DECs, what competencies should be taught to nursing students that will help them transition to practice?
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Practice

- Delegation
- Patient safety – with stories from practice and in simulation
- Accurate documentation
- Being a patient safety advocate: remembering that the patient is the recipient of care
- For RNs, how to incorporate LVNs with team nursing returning in some facilities
- Scope of practice
- Having a voice (advocacy)
- Patient centered care – treat patient like one’s own parent
- Importance of certification (increases competency and quality of care)
- Awareness of how to prevent errors (clinical)
- Operating to full scope of practice
- Enculturate leadership abilities

Education

- Learn how to develop policy projects
- Attend Legislative Day
- Service excellence (customer service) (soft skills)
- Nurses taking care of self
- Emotional competence
- Professional identity
- Just culture
- Focus on patient-centered care
- How to be a member of the team
- The “business” aspect of nursing
- Carrying nursing concepts across care of different patients
- Clear distinctions among scopes of practice

What teaching strategies can be used to help students learn one of the 4 nursing roles?

Practice

- Stress that nursing is an art and science
- Encourage students to join a professional organization
- Use real life examples in teaching
- To teach delegation, use case studies with standardized patients and ask students to whom they would make assignments and delegate.
• Provide opportunities for students to shadow nurses in clinical setting prior to being assigned a patient assignment.
• Share information about student capabilities and program objectives with academic partners, especially capstone preceptors.
• Mobility students (LVN TO RN) students need to understand the differences in role and scope.
• Employers expect the same performance from nurses regardless of level of education. Is there anything education can do?
• Help students learn to manage more patients. Can this be done through simulation?
• Can delegation be taught through simulation?
• Teach cost factor for equipment and meds
• Simulations that include interruptions
• Policy writing, discussion boards; have students teach for a day

Education

• Focus on “health care team” rather than “medical team”
• Develop simulation scenarios on safety
• Introduce students to the organization in clinical
• Use ethics case studies
• Online simulation scenarios
• Remember that younger generations have skills with technology but also like face-to-face
• Apply education to practice in all 4 roles
• Carry out skills checks throughout program
• Teach students to develop their CV; discuss presenting yourself professionally
• Population health
• Help students apply the DECs in the practice area
• Journaling and reflecting
• Clinical experiences based on reality (more than one patient, etc.)
• Interprofessional – practicing scope among a team
• Delegation and supervision activities in clinical
• Using evidence-based-practice and evaluating its effects
• Case studies
• Simulation with chance to make errors safely

Question #3: What should employers expect from graduates on one of the 4 roles?
[Responses more or less expressed the desire that new nurses possess information suggested in teaching content in the first question.]
Topic: Healthcare Organization Placements

Table 8

What are the barriers organizations face when supporting the large volume of students needing placement?

- **P:** IT for EMR creates a huge burden getting students into the system to pass meds and make notes. Struggle with enough staff to support the student needs for EMR access.
- **P:** If we have a staffing shortage, it is challenging to also give a nurse a student. Peers seem to think a student is “help” when in reality it is an added responsibility. It is helpful to be very selective about who serves as a preceptor. Some nurses should not ever be preceptors.
- **A:** Faculty perspective – Staffing and communication issues in the clinical setting can impact a student’s experience. For example: limited staffing, notification of students coming, and the need for demonstration of customer service to students.
- **A:** Educator – we do not currently have barriers because they love having students. I take my own students. I put them with a nurse but I am there passing meds and assisting with skills. At another hospital, we have a lot of IT issues. We need to build relationships with hospitals.
- **P:** Nurse managers on the medical-surgical units are left out of the conversation. They need to be included. Perhaps we are communicating too high up the ladder and we need to collaborate with front line.
- **P:** Easy to get together with instructors, have them come ahead of time and orient. Explain the EMR.
- **A:** LVN faculty: many facilities do not want LVNs. Some hospitals go back and forth and will hire one RN with 3-4 LVNs under the RN. There is competition to get students into placement. We get bumped.
- **A:** APRNs are too busy to precept. Income is lost because they cannot see as many patients. Lack of interest. Online program barrier is that the students are struggling to find preceptors. Schools should help students find clinical placement. Students need assistance finding clinical sites.
- **A:** Difficult to get acute care placement. Some hospitals only want BSN students. Too many students with only so many units and patients for clinicals. Specialty areas are very limited and schools must seek permission if they go outside of their region for clinical sites.
A: We use a third-party group who works with all the schools and hospitals to keep a current database and negotiate for placement. No one wants to do nightshift. Faculty will not do nightshift either. We need new clinical placement software and are changing our system to function more efficiently. Our hospitals are pushing up to 50% simulation.

A: You cannot get bedside care, empathy, and compassion in simulation. You cannot really find the cultural challenges in simulation.

P: We had to cut back on students because we do not have enough preceptors to supervise.

A and P: It is the hardest part of my job as faculty to find placement. We need help convincing programs with how many sites and preceptors they really need.

A and P: Facility availability depending on the volume of students. Academia needs to look at a more creative way to get students into placement. Hospitals are willing to take students at all hours. Faculty need to be willing to support that.

P: We asked staff and managers what they could realistically handle. It is taxing and stressful on the staff but you still want to provide a positive experience. We came up with a number that we can handle.

A: As a house supervisor and instructor – we need to look at the level of student. If we have a level 100 student, this will take much more attention than a student at a 400 level. Is the instructor oriented to the unit? Does the instructor understand the turbulence on the unit?

P: Even just having extra people (bodies) can create crowding.

A: Experience with placement is pushback from staff because of what a burden it is to have students. The challenge is getting the buy-in from the staff to provide the right kind of environment for the students. We need a culture shift from front-line managers to want to provide an amazing experience for the students.

A: When we look at clinical sites…consider the objective and the level of the student.

A and P: If the hospital will not hire the student (LVN or ADN) they will not take students for clinical hours. There are very limited sites. You must get creative. Look beyond acute care. If there is a small rural town with availability, you can give the students a different perspective.
What can be done to facilitate a smooth process for students looking to gain access to preferred clinical sites?

- P: Easy to get together with instructors, have them come ahead of time and orient. Explain the EMR.
- A: Build relationships. Faculty do not want to look unprepared.
- A: Clinical database and coordination group. Third-party vendor assists with this.
- A: Representative from each school meets and negotiates clinical sites.
- A: APRN clinicals need to be addressed at a national level. Students cannot find placement.
- A: All the programs are not created equally.
- P: We have clinical managers that take care of clinical placement. You need to set and manage expectations of the students. Think about alternate placement sites like boys and girls club.
- A: Why can't all accredited institutions be required to post certification exam pass-rates?
- P: Elephant in the room – people do not understand the APRN education. Schools differ. PAs have a set requirement across the board. We have not set time limits with experience at the bedside as a prerequisite for admission.
- P: There is variability and misunderstanding of APRN programs. We need clear, consistent guidelines to make progress.
- A and P: Flexibility from the faculty to be willing to support student choice and availability. Look at different settings to make clinicals happen.

What are barriers experienced by students who wish to gain access to clinical sites?

- A: IT and EMR. No access to electronic system.
- A: student nervousness and anxiety. We give them objectives but they aren’t quite sure. Be approachable. Offering examples of patient and student experiences.
- P: Nurses working with students need something in writing to understand objectives. How can the staff contribute to learning?
- P: CNAs working with new grads are treating them as if they do not know anything. Hassle of working with students. Re-educating staff about working with students.
- A: Giving objectives to preceptors: nurse manager should have the objectives, faculty lets the nurses know what skills may be performed and what needs to be accompanied. With nursing assistants – students can learn so much from them. Be respectful.
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- P: Learn technical skills from nurses. Learn ADLs from techs.
- A and P: High number of sites with different EMRs and different access required. Clinical sites have started reducing access due to the high number of sites.

What can be done to facilitate a positive experience for students at their clinical site?

- P: Building relationships right off the bat. I want the relationship between nurses and managers, know your name, make it a positive relationship. Give them your life experience in nursing. How did you get where you are?
- P: Front line manager is the key. The front-line manager should be open, excited and welcoming to students. We need to embrace that and remember why we became nurses. Remember why we were excited to become a nurse. Make it personal (give a two-sentence bio) to make it a personal relationship.
- A: When the students are with the nurses in clinical, we want the nurses to make eye contact so the students feel appreciated and acknowledged.
- A: Paperwork for clinicals is done the night before. They may experience nurses who do not want to be the preceptor, but the student is ready for the patient because the patient has been researched. This empowers the student because the student is familiar with the patient.
- A: What is the student’s responsibility? How prepared and assertive are the students?
- A: Facilitate a positive experience but it is hard to change this on a personal level. Some nurses do not want a student. We do need to change the culture, but some people are not preceptors.
- A: We have had to hire several FTEs to facilitate student placement.
- A and P: welcoming, parking, lockers
- A and P: CNO to meet and greet students and nursing managers should be doing the same. Lead by example. Make them feel valued. Help staff remember to welcome students and help them. Make them feel special and recognized. Treat them how you would want to be treated. It helps to have a coordinator who can match students with preceptors for the duration of their study. It would help if preceptors and hospitals were given incentives (CNE hours, tuition) through grants to provide clinical access for students.
• A and P: We need more awareness about available grants/funding sources to help with incentives to offset the burden of preceptorships.

Takeaways:

• Communication and relationships are vital from the top level of administration down to front line nurse manager to establish relationships with student, faculty, nurse.
• Students should share their objectives with their preceptors.
• Students and nurses need to build relationships.
• Preceptorship vs. instructors – what is better - having a preceptor who works for the hospital or a faculty member who works for the college? Probably best to have both and also this depends on the student. Preceptors need to be experienced nurses comfortable with a student.
• Preceptors need additional preparation on how to be a preceptor. Some nurses do not know how to precept but have a strong desire.
• It is a job (an FTE) to place students in clinical sites. There are lengthy orientations per site. EMR is a big part of orientation and they are unique to each site.
• Finding clinical placement needs to be an organized, methodical process with sharing and respect by all schools in the area.
• There is a strong benefit to coordinating with competing schools for clinical sites.
• Students need a more welcoming arena.
• Is there an incentive for a staff nurse to precept a student? This needs to start at the top. Practice partners need to buy in to this. Can a precepting nurse have one fewer patient? Some organizations pay preceptors (coaches) to have students for one year. Those students are invested. Can they get a tuition credit? Can they get a shift differential?
• Regarding clinicals: someone trained you. Pay it forward.
• You cannot make a person want to teach. You cannot make a nurse want to be a preceptor. Find the nurses who want to precept.
• Lack of knowledge about APRN programs and lack of consistent messaging is an issue.
• We cannot do it the way we have always done it.
• We must have frequent meetings between hospital nurse administrators, faculty and students.
Table 20
What are the barriers organizations face when supporting the large volume of students needing placement?

- **PRACTICE** – The system in place can sometimes limit placements. San Antonio has EdServe that manages clinical placements. Allows to document and give access to medscan, EMR.

- **ACADEMIC** – Need to have strong academic relationships for placements. Bottleneck is contracts – have 900 contracts. A template may be beneficial.

- **BOTH** – Processing lots of students for clinicals and give them access to items.

- **Large volume of students needing placement?**

- **BOTH** – With the development of additional graduate programs, hospitals may not be able to accommodate program’s needs. Taking students at all times of day. Risk - preceptor burnout – doing new hires & nursing students. Need to figure out balance. Infrastructure is not there in some communities. Preceptors should know program objectives when precepting. Opportunity for improvement.

- **BOTH** – Large metro areas are difficult to accommodate placements. Medical schools compete for slots. Some are having pay per hour for preceptors.

- **BOTH** – Preceptor Crisis. Whole lot of schools competing for same preceptor. Lots of schools paying for preceptors. Medicine and Nursing structured differently related to payment.

- **ACADEMIC** – Faculty & Clinical placement shortage. Legislature did not pass loan payment bill. Clinicals need to think of creative alternative sites.

- **ACADEMIC** – Clinical shortages – doing nights – 12 hour shifts – started doing. Have trouble finding faculty to teach at night. Keep same faculty with student whole time.

- **PRACTICE** – have 2000 students per year at site. Trying to get schools to coordinate clinical times. Have giant excel spreadsheet to see who is where. Night shifts are wide open.

- **ACADEMIC** – Barrier is their service area – do not have a lot of clinical facilities. Dean says they cannot go to other areas. LVN program.

- **PRACTICE** – Have lots of schools and all asking for spots. Also have other students – medical & PA and hard to balance it all out. Have a limited number of preceptors and many more students and can’t get to them all. Preceptor fatigue yet everyone needs them.
- **SCHOOLS** – Schools may want to accept more students than they can comfortably accept.
- **SCHOOLS** – El Paso has 4 universities competing for 7 hospitals. Divide out by school by days. Challenging to schedule clinicals. One nurse can have up to 5 students following them. Precepting too many students and they are tired. Burnout. Lack of facility organization.
- **PRACTICE** – Preceptor fatigue. Nurses do not get money to precept. No incentive for this.
- **ACADEMIC** – Lack of preceptors – especially Capstone. Have a selective list of preceptors who like to do it.
- **ACADEMIC** – Lack of clinical placements – moving away from LVN – ADN/BSN students trump them.
- **ACADEMIC** – Should we do clinicals in other ways than face to face – consider other ways to meet educational outcomes and may not be face to face. Should schools increase the use of simulation? Sometimes not the best to do.
- **CLINICAL** – Need to have evidence of immunizations, training – burdensome to track.

**What can be done to facilitate a smooth process for students looking to gain access to preferred clinical sites?**

- **BOTH** – Have CCPS [a centralized placement service] to help with placements. Corporate paperwork requests come late when students are in clinicals.
- **ACADEMIC** – Works with hospitals in multiple cities due to multiple campuses. Different cultures. DEUs are good across disciplines and we want to do more.
- **PRACTICE** – Prefer students from sites where they have strong partnerships. Need to have faculty who can go with them. Have DEUs and will be expanding them. They are ideal place for students to learn. Staff, students, and schools love DEUs.
- **ACADEMIC** – What is a preferred site? Experience lots of different settings. Some may not be the best choice for them.
- **ACADEMIC** – Communication. Need to have well rounded background. Rural areas – get to experience more variety – get to do more.
- **ACADEMIC** – Expose LVN students to where they can practice.
- **ACADEMIC** – You are on supply side – but there are too many barriers for this. Students don’t have choice. Too many students and not enough placements
- **PRACTICE** – Idea – with undergraduate program partnering with hospitals – limit clinicals to one hospital to ensure smooth
transition to employment for two years after that. Only exposed to one hospital.

- **ACADEMIC** - All hospitals require different immunizations, etc. and all require different forms. Need standardize process for students to check off on for placements.
- **ACADEMIC** – provide mock scenarios with multiple disciplines. Collaborative process to work together
- **ACADEMIC** – As early as last semester – give students choices for their capstone projects. Try to match person and their choice to preceptor. Only allow max of 2 preceptors to precept students.
- **CLINICAL** – Good to match student to preceptor.
- **ACADEMIC** – Give something back to the clinical site from university. Provide opportunities for socializing outside of the hospital.
- **ACADEMIC** – Offer services that faculty and students can do for the hospital. Help each other.
- **ACADEMIC** – Need formal preceptor program for school and hospital. Provide orientation for preceptor and preceptee.

**What are barriers experienced by students who wish to gain access to clinical sites?**

- **BOTH** – Affiliation agreements may take a long time to get. And have to be updated.
- **ACADEMIC** – Don’t want to drive distances – use time to listen to audio course.
- **PRACTICE** – Volume of students impacts which skills can be taught in clinical settings.
- **ACADEMIC** – Orientation to facilities are demanding. EHR/documentation limitations. Charting is not always a priority.
- **ACADEMIC** – Time it takes to get contract done. Have 2 full time faculty to get agreements. May take 3 to 6 months to affiliation agreement. Then the next barrier is the orientation.
- **PRACTICE** – Have a student clinical coordinator who helps orient students.
- **HOSPITALS** – Clinical coordinators say they don’t have room for this school even if they are local – have to go across the state to get clinicals. Come from out of city and they will not probably work with that hospital.
- **SCHOOLS** – Students have very little choice on where they go – they will go where the school tells them. Forms for students to complete are cumbersome – 12 forms for one hospital. Have to have faculty to complete same forms and orientation too difficult. Students see difficulty of doing this.
• ACADEMIC – Work to create a supportive environment for new nurses. Reimagine the relationship between faculty and student – have a partnership agreement. When they go to practice and encounter incivility – they understand what is happening. Teach students to be civil to each other. Studying this more. Assume best intentions when someone has reacted.

What can be done to facilitate a positive experience for students at their clinical site?

• BOTH – Keep same preceptors. Follow for 4 shifts.
• PRACTICE – Live mission, values. Want to have positive environment. Live out culture. Leadership follows this.
• ACADEMIC – Research in bullying – happens in other disciplines too.
• BOTH – Better communication between schools & hospitals. Set up for success. Share the clinical objectives. Orient staff to what they need to do.
• BOTH – MSN/Leadership students went to CNO and asked for better access for students. Offer skills for research, manuscript. Helps school have input into the facility. Even with undergraduates do a study.
• BOTH – Have all students do StrengthsFinder. Helps faculty to teach students. Communication. Standardization – all on same page.
• BOTH – move faculty around and then they have to get to know the nurses, staff – have to do so that the students can have good experience and trusted by hospital staff.
• BOTH – Some hospitals limit student’s access to tools so do not truly get idea of workflow in clinicals. Makes it difficult to transition. Faculty must learn the systems/tools.
• Elephant – Preceptor Burnout. Consider incentivizing preceptors. One university has given perks for preceptors. Some hospitals are seeing this as conflict of interest.
• BOTH – Know the objectives for clinicals. Schools need to talk to preceptors about objectives.
• CLINICAL – Have debriefing, understand better how to react and figure out what is going on.
• ACADEMIC – Come in with positive outlook instead of negative. How can I do it right way – ask that.
• ACADEMIC – We need to tell and educate the hospitals too when student asks questions.
• ACADEMIC – Have a tool – student information sheet to bring to clinical everyday – has what they can do and cannot do. Purpose is the conversation. What can you do and not what you can’t do
• Letting student know expectation and in turn have positive outcome.
• ACADEMIC - Emotional Intelligence – Coping skills. Better understand patient.

Other Comments
• Consider funding faculty positions for DEUs.
• Need to have clinical placements.
• Come up with better system to do clinical placements and not have clinical partners limit placements.
• Prioritize BSN programs.
• BOTH – Hopeful that the new essentials (AACN) would help and make it easier to accommodate competencies.
• Team building – Multidiscipline.
• Other health care disciplines are facing similar challenges between academia & clinical partners.
• Communication is key factor.
• Clinical Agreement processing is too cumbersome. Sometimes a year or more to get completed.
• This topic would be good to take to students and ask them.

One action-oriented idea
• Strong relationships with academia and practice.
• DEUs have been very successful. Require a lot of partnering. Resources on both sides.
• Come up with a better system for clinical placements and not have clinical partners limit placements. Prioritize BSN programs.
• Importance of relationship between academia and practice.
• What can they do to help each other? See what clinical can do for you – both ways – clinical and practice.
• Collaboration is Key - Healthcare org and schools work closer together to have a collaborative program to integrate students into employment at their organization.
• Identify the benefits the schools provide to clinical partners.
### Topic: Opportunities to Practice Clinical Judgement

**Table 9**

What can education programs teach/do to help students develop clinical judgement?

- Stay on the same unit for one semester (A/P)
- Reduce simulations (A/P)
- Educating staff on student objectives for the semester (A)
- Define clinical judgment. What does that look like? (P)
- Teach resiliency and the value of learning from mistakes (P)
- Make sure students have a frame of reference; what should happen (A)
- Bring patients into the classroom to tell their stories (A)
- Teach in a way that students can apply principles/methods to manage one illness/episode to another (A)
- Stop “death by PowerPoint”-focus on teaching judgement (A/P)
- Use smaller nurse to patient ratios at clinicals (A)
- Use simulations(A)
- Reduce no value-added assignments(A)

How can clinical partners assist nursing education programs to develop clinical judgement skills in nursing students?

- Communication. How does the clinical setting see clinical judgement? (P)
- Enlist clinical partners to provide actual scenarios for students to discuss with outcomes. (P)
- Take more of a mentorship role (P)
- Help students understand the NCLEX questions are not the end all/be all to practice (P)
- Use case studies(A/E)
- Reduce amount of student paperwork in the clinical area to allow more time with unit nurses (A)
- Recognize the challenges students have with placement/preceptors (A)
- Incentivize preceptors to get more qualified participants (A/P)
- Work with clinical partners to develop/demonstrate nurse driven care (A)
- Provide real life interdisciplinary scenarios(P)
- Decrease time student is observing patient care and more time providing direct patient care(A)
- “Elephant”- students not allowed to document in EMR (A)
- Make sure preceptors “want” to precept (A)
• Give precepting incentive (P)
• Have clinical partner give recommendations for preceptor expectations (P)

What would a student demonstrate to faculty, or a new grad to their employer, that would indicate they have good clinical judgement?

• Use scenarios in classroom to demonstrate the role and behavior of nurse using clinical judgement (P)
• Clinical partners assist with reviewing case studies (P)
• Make sure students have clear objectives for judgement- knows what to demonstrate (A)
• Able to provide self-care (A/P)
• Ability to accept accountability for the patient (P)
• Ability to recognize triggers to escalate care (A)
• Incorporate the measurable essential competencies developed by ANCC in learning
• “Elephant”- not every hospital has the funding to offer an extended fellowship that provides more opportunity to develop clinical judgement (P)
• Encourage students/new nurses to ask questions, recognize need to ask questions, and quickly escalate changes in patient status. (A/P)

Table 21

What can education programs teach/do to help students develop clinical judgement?

• More collaboration between faculty and facility; same preceptor, trusting relationship, give students more autonomy to utilize clinical judgement (P)
• Programs should match expertise of faculty with clinical site, negotiate relationship better (P)
• Collaborative relationships with industry partner, meet once a month to discuss both perspectives, panel discussions (A)
• Educate preceptors to draw out questions and to teach clinical thinking. Need same preceptor to invest in student (P)
• Some clinical facilities are unfamiliar with what the DEC’s are. Academia could provide preceptor training for facilities to encourage some expectations of graduates- be on the same page, improve communication (A)
• Connection in communication; Preceptors need to provide specific feedback to faculty related to students’ abilities for it to be meaningful. (A/P)
• Provide rubrics based on DEC’s to clinical sites. (A)
• Identify gaps in student performance. (P)
• Need scenarios based on learning; more practice with when to call physician (P)
• Use evolving case studies that build on scenes; decision trees, SBAR, etc. (A/P)
• Develop questionnaire on issues that occurred while teaching (A/P)
• Need more case studies and simulations to allow students to practice concepts learned in readings/lectures (P)
• Narrative documentation helps students think through case, journaling, reflective questions (A)
• Need to learn to listen, lost art of listening, “get to the point”, take care of patients that way (P).
• Evolving case studies to improve judgment (A)
• Forgetting how we learn (pedagogy); some students demonstrate more mature behavior in the clinical setting than others. (A)
• Engaged teaching, encouraging different thinking (A)
• Students need to learn to focus on patients, not self (A)

How can clinical partners assist nursing education programs to develop clinical judgement skills in nursing students?

• Decide what entry level to different units is (A)
• Need dialogue, hospitals do things differently, community hospitals vs. academic. Need to understand the culture of each facility; collaboration on a regular basis (P)
• Work with clinical partners on the importance of Transition to Practice programs (A)
• Disconnect in expectations, “thinking like a nurse” and the focus on completing skills/tasks are incongruent (A)
• Encourage conversation between academia and practice to understand importance of NCLEX scores, and other elements, to academia. (P)
• Have zero tolerance for incivility between nurses and students. (A)
• Use simulation and case studies. (A/P)
• Good collaboration with academic partner; academia and practice involved in curriculum development; regular interface and dialogue (A/P)
• Survey students and facility to find out concerns (A)
• Large facilities have too many students that want clinical spots. Entry level employment requirements should be considered as a basis for clinical placement. (P)

• Seek out more non-traditional or acute care settings, not everyone wants to be in acute care; behavioral health, rehab, LTAC’s do not allow students to access the medical records or Pyxis anymore; be more open to students (A)

• Need to reduce stigma of behavioral health (A)

• Grant to teach well exams for transgender patients- funding issues to teach those skills (A)

• Buy videos for standardized patient teaching to non-verbal patients; partner with simulation to teach those skills (P)

• Hard to get facilities to take NP students (A)

• Show up at program advisory committee meetings to share list of needs (A)

What would a student demonstrate to faculty, or a new grad to their employer, that would indicate they have good clinical judgement?

• Students engage in use of soft skills- need ability to view providers as a team (A)

• Encouraging new graduates to ask questions and be ok with the fact that you don’t know everything, coach on communication (P)

• Teach the “Concerned, Uncomfortable, Safety” (CUS) communication method to ask questions (A)

• Do not hire for skills, hire for culture, mission, vision, values; expect a baseline of skills; we will train. Cannot train people with bad attitudes. (P)

**Topic: Precepting**

**Tables 10 & 22**

**Challenges of Precepting**

• Preceptors experiencing burnout, overworked therefore creating lack of available preceptors

• Lack of training/preparation for preceptors

• Forced precepting, preceptors not always vetted or desiring to precept which can impact the student experience negatively

• Patient load not lessened/modified for preceptors

• Students are paying for preceptors sometimes through commercial providers due to lack of preceptors.

• Is there a balance between the supply and demand for various APRN roles?
• If students are paying for preceptors, is this known? Is this being monitored? Is this ethical?
• Students reporting a general negative/pessimistic culture/atmosphere. Students feeling unwelcomed or unwanted when they arrive to their precepting site.
• Students reporting to precepting site sometimes may not have a preceptor assigned to them, thus losing time.
• Are new nurses being taught resilience?

Possible Solutions for Precepting Challenges

• Modify preceptor’s schedule to have more time to precept and lessen burn out
• Have online training or modules for preceptors prior to precepting. Preceptors are provided clear goals student and objectives prior to precepting.
• Have nurse managers/leaders nominate or assign preceptors which can help minimize nurses who do not want to precept.
• Creating student liaison positions within institutions so that if a student reports to clinical site and is told there is no preceptor available or if other issues arise the nursing instructor and student liaison can assist and advocate on behalf of the student creating a better experience and outcome for the student.
• Applying for grants or state funds that would compensate and recruit more nursing preceptors to replace the need for paid APRN preceptorships. As a profession, we must precept our own students.
• Have more community based/global health curriculum built into nursing programs as a way to foster service and resilience among nursing students and future nurses.

Topic: Social Determinants of Health

Tables 11 & 23

• Consider telehealth
• Care to a care group or a community in addition to individual patient care
• Collaborate with community (Grocery store, police)
• Suitcase clinics (Homeless areas)
• Think lower level of Maslow to care for patients, Ask the questions to assess needs.
• Child care needed
• Lack of transportation (No gas money)
Cost of care (food/housing first)
Housing (Homeless)
Finances of families
Lack of knowledge about SDOH at all levels
Cultural awareness
How do we share what we learn? Elephant!
Outreach to partners
How do we fix poverty? Elephant!
Nutrition matters
Substance use effects

Topic: Student Access to EHRs
Tables 12 & 24

- Some practice sites are implementing Epic student profile for login. Are other EHRs providing student access?
- Overcrowding is a concern at clinical sites, nurses do not have time to provide patient history/data if the student does not have access themselves.
- Partnership with clinical sites is key. Go into clinical site to advocate for student access.
- How do we ensure competency? Individual student navigation occurs at the clinical site. The nurses have to teach students how to use EHR. Students need the data for clinical competence.
- Epic is view only. No student documentation. Consider separate nursing student notes and documentation that will/will not be part of the medical record.
- Nurses have to document medications for the students since they do not have access. Students need to be able to scan and document medications on their own name vs under someone else.
- Heavy regulation. CMS provides a lot of funding. We are getting a lot of red flags and have to advocate for the need for increased access to train the next generation of workforce. Liability is a significant barrier for administration and the legal counsel.
- Orientation to EHR is significant. Waste of time to learn on site for students and nurses.
- Well-developed facility-based orientations prior to beginning clinical hours at a site provides students with the opportunity to learn the EHR and facility.
- Ask hospitals and programs for their policies and procedures for EHR student access/ and documentation. Need uniformity of policies between clinical sites and educational institutions,
uniformity in orientation among sites within the same organization (a single student orientation prior to beginning clinical hours at a large hospital network).

- Look at the environment and address how we can fix this issue.
- Student access to EHR – Students are frustrated because they cannot complete assigned patient documentation.
- We are using Simchart, to bring EHR into the classroom
- We do not use a EHR method for sim.
- Bringing Epic into the clinical setting allowed students to have access in a simple readymade function for creating student profiles
- NP programs, adapted strategies for NPs to work around not having access.
- Different documentation systems at different facilities make it difficult to ensure equal orientation for all students.
- We are looking to use an educational institution based EHR for students to document as if they were interacting within a real EHR record. Faculty have access when students do not. Facilities are concerned with students altering the medical record/chart.
- NP – It is an issue of cost. A primary practice setting uses different systems. Sites have only purchased access for a limited number of users and the facility is not willing to pay more to accommodate students.
- Clinical settings are reluctant to share information, they feel if they give students access, they will not maintain confidentiality. How can we be expected to train students well without access?
- Lack of trust for students exist. What if the student does something wrong with the info? What is the liability for the clinical partner? Clinical partners must be able to trust those on the academic side to supervise the students.
- We do teach students on HIPAA, and ethics, Social media use.
- It is imperative for students to be trained in EHR at the clinical site. Disconnect exists in that clinical partners say students are not ready to practice safely and at the same time limit EHR access. Facilities must invest in in-house student EHR training, to ensure safe patient care by students and to enable the education of the next generation.
- We should not focus on investing in alternate strategies but rather fix the barriers. Safe and effective care necessitates access to real patient records.
- Students cannot practice safely as students if they do not have access to the EHR.
- NP workarounds create ethical issues. The organization is against EHR access for students but the preceptor does so they enable workarounds.
- We must train how we practice. If I do it, I document it.
- We teach them to document incorrectly because they are students. Workarounds violate ethics and create nurses that are unprepared to document in the real world.
- We have worked with clinical sites to get access for students. Pharmacy has refused student access to Pyxis. We do have access to the computer system. How can you expect our students to learn without access?
- EHR access is not a part of the conversation to why a clinical site is a good site. We need them. A lack of EHR access should not eliminate a clinical site.
- Trust must be established – between facility sites and educational settings. Education does provide supervision and structured policies. We need enhanced communication between practice and education to ensure a uniform objective for training students.
- The utilization of EHR systems at clinical sites that have built in features to expedite student access is convenient.
- Current solutions in practice – faculty are given access and allow students to document in their account under their supervision. Students that will have student profiles within an EHR attend an orientation prior to clinical to cover facility policies and the system.
- A disconnect between educational policies and clinical partner policies is a barrier. Overcrowding of students at clinical sites is a barrier as nurses are expected to give students access/teach them and they do not have time for all of the students assigned to them.
- Clinical partners and programs should meet before (maybe during and after) an academic semester to discuss policy updates, expectations, etc. The goal being to create uniform policies between educational institutions and facilities regarding EHR access and usage.
- Some clinical sites are receptive of allowing student access and enable access readily. Faculty are contacting clinical sites to discuss access; you must ask for it.
- Privacy, security, accuracy, and ethics concerns are inherent in access to medical records. Increasing the number of people with access heightens those concerns.
- NP students are visiting practice locations that are small, limited resources compared to a hospital organization. These smaller sites only purchase a limited number of licenses for EHR access and are not willing to use one on a student.
Clinical partners expect graduates to be ready for practice yet at the same time prevent access to EHR which is essential to their training. Clinical partners and faculty must connect to address this disconnect. One solution being used in practice is for a facility to purchase an EHR system designed for student education/simulation to be used in the classroom/skills lab. Examples are EHR tutor and simlab. Simulated EHR access is not a direct substitute for working with a patient’s EHR in a clinical setting.

Simulation EHR. Sometimes students’ chart in the medical record, sometimes they do not. It is a luxury for students to chart in an EHR system.

Different EHR is a restriction for competency. Hospital and academia meeting before and after semester to discuss changes in policy and EHR use.

How do students come to know their patients? How can they be expected to know the patient’s medical history?

Students learn about their patients the day of their clinical. They get report from the nurse.

There are so many different EHR records. It is a burden on the hospital side to create all the student profiles. Differing policies at clinical sites delay access.

Lack of charting stations for staff and students. Interoperability is an issue. Competency is impaired by all the different EHRs being utilized in the community.

There is not enough time to orient on EHR if we have to focus on Clinical judgement.

In-house EHR training and use. Simulated EHR. How can we incorporate EHR into the classroom?

EHR records are expensive. Sim center at EHR location has an EHR. Smaller programs may not have the IT support or funds to implement an in house EHR. CMS needs to provide some funding for education.

Fund the entire health program not just nursing. Teach all programs with the same EHR. To offload cost for nursing program.

I see limited access as a liability as it results in uninformed and unsafe care.

Clinical facilities restrict students from fulfilling all the functions of nursing care which includes documentation.

Students are accessing EHR in simulations and the classroom setting.
• The focus of education is teaching medical judgment. EHR systems are so varied the expectation is that they will either learn the concept at clinical sites or on the job. It is not considered an essential educational component.
• Smaller programs could seek uniform in house EHR system use across all health professions programs so the cost is not solely borne by a nursing program. Clinical partners must enact polices. Clarify clinical issues for organizational leaders beyond nursing.
• Some students do not have access at all. They pay as part of their book package for an in-house Elsevier EHR system. We must do this or they will not have access. It is a policy in the clinical sites.
• We must let students experience EHR in the practice setting to learn how to practice.
• Grad program – part of onboarding to large institutions includes EHR onboarding. Some of the primary care settings provide limited access and opportunity for student profiles.
• Our lack of access is not new. It has been this way for years.
• Safety is a concern because students are not being trained adequately in the use of the facility specific EHR.
• Students are expected to orient themselves and obtain their own login from the facility. Preceptors are having to give students greater access than what they have because the student access does not always allow them access to everything they need.
• Facilities are concerned about what students will document. They are concerned about their liability. Do not want students to document and have access to all information.
• Students have to be proficient in EHR and if the facilities do not do it we must buy it.
• Construction of templates – guidance for note writing. We should provide documentation templates for students for example history/observation–, end of shift assessment, etc. Management defines what is allowed and is not allowed. What guidance is provided is not specific enough
• Can we alleviate facility concerns by providing student charting that is not a component of the medical record but is recorded in the EHR? Epic allows students to.
• Access has to occur for adequate student experience.
• Preceptors – My clinical site does not allow my students to do what the educational institution may.
• It is not safe for students to work with patients without access.
• Security wise – workarounds – do not allow for accurate documentation of actions in EHR in that we do not know if the
documenter actually collected the data and performed the assessment or skill.

- Students are accessing EHR in simulations and the classroom setting.
- Barriers. Trust, liability, policy. Preceptors are unaware of what students are allowed to do per their educational program.
- Alleviate facility concerns by providing student profiles that address their concerns such as enabling charting that is not a component of the medical record but is recorded in the EHR. Provide preceptor orientation packets detailing program policies regarding EHR so they are aware of what students can/cannot do.
- Some units are easier to access.
- Non-acute units are less familiar with students and their documenting ability
- Small hospitals do not have manpower to orient students to EHR
- Lack of computer space for students
- IT manpower is an issue (Takes extended amount of time to get student approved to document in EHR)
- Too many EHR systems for students to learn
- Large amount of paperwork for students to gain access to EHR
- Access varies depending on the unit the student is on
- Paper charting, instead of computer charting, increases confidentiality concerns and makes it difficult to check student notes for accuracy.
- Financial implication for wrong charting
- Students MUST document in EHR
- Faculty not oriented to EHR either and cannot help students
- HIPAA violations with students having access to charts
- Knowing what to chart is more important than having access
- New grads do not know narrative charting with use of new EHR charting
- Cost of giving students access (Some charge/per provider)
- APRN students cannot chart - requires preceptor to do it (Increases their workload)
- Provide clinical orientation where EHR access can be granted
- Use EHR tutor at school to assist with documenting when no access at the hospital
- Dummy system in EHR for students to chart
- Document during simulation
- Relationship between school and hospital to plan for EHR Access
- Keep student at same facility to ease EHR access changes.
- Hospital orientation includes EHR access
The Future of Nursing in Texas

- Have students complete handwritten notes as test to gain EHR access
- Grad education (NPs have student access- Note remains pended and approved then posted)

Takeaways:

- The utilization of EHR systems at clinical sites that have built in features to expedite student access is convenient.
- Current solutions in practice – faculty are given access and allow students to document in their account under their supervision. Students that will have student profiles within an EHR attend an orientation prior to clinical to cover facility policies and the system.
- A disconnect between educational policies and clinical partner policies is a barrier (educational programs say they can do it and clinical sites say that they cannot). Overcrowding of students at clinical sites is a barrier as nurses are expected to give students access/ teach them and they do not have time for all of the students assigned to them.
- Clinical partners and programs should meet before (maybe during and after) an academic semester to discuss policy updates, expectations, etc. The goal is being able to create uniform policies between educational institutions and facilities regarding EHR access and usage.
- Some clinical sites are receptive of allowing student access and enable access readily. Faculty are contacting clinical sites to discuss access, you must ask for it.
- Privacy, security, accuracy, and ethics concerns are inherent in access to medical records. Increasing the number of people with access heightens those concerns.
- NP students are visiting practice locations that are small, limited resources compared to a hospital organization. These smaller sites only purchase a limited number of licenses for EHR access and are not willing to use one on a student.
- Clinical partners expect graduates to be ready for practice yet at the same time prevent access to EHR which is essential to their training. Clinical partners and faculty must connect to address this disconnect. One solution being used in practice is for a facility to purchase a EHR system designed for student education/simulation to be used in the classroom/skills lab. Examples are EHR tutor and simlab. The problem with this solution is that in doing this we enable the current problem to exist going forward. Simulated EHR access is not a direct substitute for working with a patient’s EHR in a clinical setting.
The Future of Nursing in Texas
Appendix I: Post-Summit Evaluation

At the conclusion of the Summit, participants were asked to complete an evaluation. The following material identifies questions participants were asked to address and representative examples of responses to each of the questions.

**Question:** Please list two ways you will integrate any of the ideas discussed during the World Café discussions at this Summit into your practice.

**Representative Examples of Responses**

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Work toward disseminating ideas generated. 2- Plan to continue the dialogue between education and practice.</td>
</tr>
<tr>
<td>Consider the challenges practice partners have regarding knowing what APRN students need to do in the clinical setting. Patience with students</td>
</tr>
<tr>
<td>Utilize upstream concepts for better client health. Policy activism.</td>
</tr>
<tr>
<td>Loved the talking stick idea and the elephant in the room.</td>
</tr>
<tr>
<td>Enhancing the partnerships with our local universities.</td>
</tr>
<tr>
<td>We are a small practice setting with 2 APRNs and minimal staff so minimal changes discussed are applicable to our practice but we will eagerly await to see the results and possible changes that participation that the conference makes to the future of nursing.</td>
</tr>
<tr>
<td>I will discuss possibilities to improve transition to practice with my programs and colleagues on both the practice and academic side. I will continue to look at ways to implement the identified needs for improvement.</td>
</tr>
<tr>
<td>1. Add social determinants of health to faculty development programs and as a session at TAVNE conference. 2. Update/revise DECs in the fall and spread the word about DECs to all nursing schools and practice sights. Support the involvement of more practice participants when revising DECs. 3. Increase academic-partnerships (clinical nursing educators with clinical placement representatives, Advisory Councils) in our community.</td>
</tr>
<tr>
<td>I will use the ideas generated during the discussions to better inform curriculum in the SON. 1) Earlier discussion in the nursing program of social determinants of health as a concept. 2) Evaluation of clinical placements to use some of the ideas generated.</td>
</tr>
<tr>
<td>still processing</td>
</tr>
<tr>
<td>Apply to preceptorship in our program of APRNs. Share the ideas/pearls learned in this summit with the rest of our nursing faculty.</td>
</tr>
<tr>
<td>1. I will take our discussion back to my school where I am in semester three of the DNP program. 2. I will become a preceptor for NP students when I am back in the clinical setting.</td>
</tr>
<tr>
<td>Talking stick Join Nurses together</td>
</tr>
<tr>
<td>Will share ideas with faculty colleagues</td>
</tr>
<tr>
<td>1) I am going to use some of the questions from the round table discussion with my students to receive feedback from them. 2) I will try and change the mindset of students presenting to clinical-to be more confident.</td>
</tr>
</tbody>
</table>
Improved partnership with academic colleagues, discussion of opportunities for new strategic partnerships within TX.

1. I will encourage faculty and/or preceptors to utilize open communication when discussing student learning objectives. 2. I will encourage graduating ADNs to continue their education while working to gain first-hand experience.

1. Continue to explore creative solutions with academia and practice, such as dedicated education units (DEUs). 2. Share results with Workforce Solutions for potential integration into community Healthcare Workforce Alliance of Central Texas (HWACT) committee.

We are considering changes to include the Social Determinants of Health into our community clinical rotations. We are considering the start of a mentor program between RN and LVN students.

Discussion with my faculty and follow up with contacts made

1. Will work with Community Partners to improve EMR Access 2. Will work with Community Partners to develop a curriculum and incentives to improve the quality of our preceptors.

Discuss with our directors how to make the experience for students better. Modify residency to bolster information relative to delegation and working on teams.

I will do further research on the academic partnerships with mentors and students.

Not actively in a clinical setting at this time - key points though were better communication between clinical and academic partners. Most experienced nurses are not necessarily the best preceptors for students.

1. Work with member hospitals to strengthen their collaboration with the schools of nursing in their communities 2. As an advocacy organization continue to support nurse-friendly legislation such as APRN scope of practice

1. The problems with finding preceptor/clinical sights are unfortunate. I will make myself available to precept in the future when the opportunity arises. 2. I will practice nursing while remaining mindful about social determinants of health so that I can deliver the highest quality care possible.

Work to establish academic partnerships and enhanced relationship with academia. Work to maintain positive culture for student clinical experiences and support preceptors through recognition and ongoing education

Ways to improve communication with preceptors and university.

Already planning new interventions based on my conversation with colleagues. Student culture and transition to practice.

1) Will disseminate this creative concept so that other states may want to use it. 2) Some great ideas for alternative clinical experiences were provided that I plan to disseminate to other boards of nursing and educators.

1. Develop a Quality Report Card for our school 2. Develop strong relationships with practice partners, especially in setting outside of acute care

the talking stick and the elephant and adding a world cafe setting

Collaborate more effectively with partners and modify ways of achieving clinical objectives

1. I will incorporate the innovative strategies suggested to improve ways to implement alternatives to clinical at facilities. 2. I will share what I have learned with other practitioners in academia.

Takeaway from student presentation: change the culture. Review revised AACN Essentials when published

Transition to practice changes; Decreased acceptance of students from outside TX

I will use this format in future conferences I plan
Loved the summit. I really felt listened to. I felt the conversation has been started. I will bring this back to my region leaders to get ideas as well. Also discuss better ways to work with preceptors/APRNs and ideas about partnerships with designated schools to hospitals.

Develop a clear policy/procedure for pre-clinical course planning meetings for faculty. Attempt consistency in clinical placements for students to help decrease the time spent in facility orientation.

Focus on integration of social determinants of health (SDOH) into health policy and future legislation

Educate on SDOH and care models to support

Investigate answers to questions raised regarding preceptor-orientee arrangement. Work with my state professional association on ways to help address some issues pertaining to APRN practice.

Incorporation into student learning experience with creative new ideas gained from discussions by using students to directly discuss clinical learning environment. Ensure faculty are held accountable in terms of communication with facility on a regular structured basis

I will advocate for World Cafe discussions in my home state

I have already come back and discussed including nurses from the practice area in our curriculum evaluation/development. I have also begun the discussion of evaluating the number of FNP students we admit based on the demand AND looking at the need for a Psychiatric Mental Health Nurse Practitioner (PMHNP) certification program.

1. Increase meaningful dialogue with clinical partners. 2. Clarify terminology used in education that may be different in practice, even though the meaning is the same.

Ideas for updating the DECs, Encourage resolution of clinical placements

Use the acute care setting to have conversations with students with what is happening in the community when the patient is discharged. Partner with facilities to co-create a Clinical Nursing Faculty Academy and seek a grant for innovative projects, pilot from TBON.

in my profession and in my teaching
Share info with other stakeholders. Stay engaged with process.

Discuss preceptor challenges with lead academia leaders Network with other healthcare professionals to openly discuss ways to improve Social determinants of health

Discuss with co-workers ways to reduce the gap in communication with clinical agencies. Also discuss other creative ways to enhance clinical learning (simulations) when clinical placement is difficult to find.

Work closely with local educational associates and provide a more interactive team on our end to guide nursing students in building relationships with patients. We will provide more complex assessment opportunities to provide a richer educational experience.

More discussions with hospital partners, considerations about clinical placements

Presentations, communication

Clinical placement ideas and teaching DECs.

1. Create more opportunities to incorporate social needs teaching in BSN education 2. Consider an effort to use an EHR tutor in facilities for clinical instead of having students use the hospital EHRs.

Plan to share data with other directors at currently facility. Will come up with process to change culture of nursing students on the units.

Look at ways academics and practice can work together to ease transition into practice for new graduates.
1. Work cohesively and meet regularly with our industry partners and consider the role of nurses in each level in addressing the healthcare continuum especially in communities and emphasizing the social determinants of health and identify a system level approach that can foster synergistic effect and not a fragmented approach. 2. Develop competencies for all nurses to work in community-based settings and explore projects that promote and build a culture of health and equal access to healthcare.

As faculty I will pursue looking for community partners in education. I will work to improve the transition of FNP students to clinical sites. Looking at DEUs to learn more about these. Looking at improving clinical expectations between students and facilities.

Difficult to narrow down to 2! 1. Appreciate the better understanding of the challenges to clinical partnerships between academia and clinical settings. I came away with several ways to improve on the clinical side. Also, a great reminder that the attitude toward precepting starts at the top.... I can influence that! 2. Multiple opportunities noted to enhance clinical judgement skills. Identify preceptors that want to precept. The use of Dedicated Education Units
Question: Is there anything else you would like to say that you did not get a chance to?

Representative Examples of Responses

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, except this was perhaps the best meeting that I have ever attended. It was thought provoking and engaged everyone in looking at solutions in a new way. It was energizing!</td>
</tr>
<tr>
<td>Outstanding conference. Many new innovative approaches to address gaps between academia and practice. Look forward to publication of monologue or white paper.</td>
</tr>
<tr>
<td>During day one the TNP representative spoke about clinical placements and the difficulty all are experiencing. CCNE does not state that schools of nursing must find preceptors for all students. It is a partnership between students and schools for placement. Not all students want to go to the placements provided. I understand that the NPs are overwhelmed by demand but perhaps they prioritize to Texas Schools first then look at out of state programs. I am looking forward to hearing more ideas generated at the World Cafe for placement of APRN students.</td>
</tr>
<tr>
<td>Transition to practice - we need enhancement in the feedback practice provides education regarding their students and a true belief that we are being heard when issues are identified with their students. too many graduates too quickly - can't get them jobs and can't support providers who are not ready to support their own learning there must be a better way for matching preceptors and students.</td>
</tr>
<tr>
<td>Concern over FNP online-learning across the country</td>
</tr>
<tr>
<td>Thank you for a wonderful experience. It was VERY nice to see, learn and discuss with colleagues from the other side of Nursing. For the first time in my 32 years of professional nursing, I believed that my ideas seriously were given thought by colleagues from Academia as well as top Hospital System Administrators. Obviously, I am from the practice setting.</td>
</tr>
<tr>
<td>It would have benefited if all of the scopes were brought into the discussion. It mainly focused on APRN. VN, RN most importantly.</td>
</tr>
<tr>
<td>Good opportunity to start open communications. The table discussions were good. Each question encouraged more questions. My recommendation is to allow more time per question to explore deeper dive into challenges and solutions. I found this was a time for the participants to share their frustrations and vent which was important. Thank you for pulling this together. Hope we can keep the momentum going.</td>
</tr>
<tr>
<td>The last part of the conference, the harvesting, was way too slow, repetition, and a waste of time. It would have been better to take a break while each person was able to point out the 1 thing that was the best from the group. Or they need to harvest and send out a results email. It was a great conference until the debriefing.</td>
</tr>
<tr>
<td>The Summit was amazing. I am not sure how often you are planning this, but I think it would be a great idea to have it every other year (do it during the non-legislative year).</td>
</tr>
<tr>
<td>This was a great opportunity and would like to see it occur again in the future.</td>
</tr>
<tr>
<td>Excellent planning</td>
</tr>
<tr>
<td>The Summit was excellent and I look forward to a timely turn around on the Summit results and next steps.</td>
</tr>
<tr>
<td>I think we could have had richer discussions at the table with fewer questions that were more generative.</td>
</tr>
<tr>
<td>While I loved the world cafe, I did not hear any new suggestions on how to close the gap between academia and practice</td>
</tr>
<tr>
<td>Soft skills should be added to the DECs when they are revised.</td>
</tr>
</tbody>
</table>
I believe this was a great opportunity to come together and discuss the gaps between practice and academia.

Overall, great perspectives- I really liked the variation.

Can't wait for the summary report. Many good ideas to incorporate.

I thoroughly enjoyed the meeting and networking.

I appreciate being included. The mix of participants was great. The presentations with a consumer and the Student Nursing Association (SNA) president were very valuable. The world café format worked well. I definitely benefited from the many ideas I heard from multiple perspectives.

I’m wondering if there is a way to use technology to summarize the table conversations. Even if it was a word cloud. After a while when the facilitators were sharing, we started hearing the same concepts over and over. I appreciated that some recognized this and shortened their “shares.” I would appreciate someone timing them to limit their sharing too if that's what it takes. So maybe a timer that's not the two leaders?

Found the information to be eye opening and thoroughly enjoyed the opportunity to attend.

As a community member that lives in Rio Grande Valley Region and as a nurse educator, let us not forget our community members that live in "colonias." Colonias are common along Texas-Mexican border regions that live in impoverished neighborhoods that have inadequate access to basic needs let alone in healthcare. I also received an e-mail from our chapter on my way home to McAllen yesterday around 11:17PM, the Philippine Nurses Association of South Texas Rio Grande Valley chapter (the only ethnic minority nursing organization in Rio Grande Valley recognized by National Coalition of Ethnic Minority Nurse Associations (NCEMNA) for 15 years) and the South Central Region, Philippine Nurses of America and we recommend the following: 1. Leveraging on Technology - Advancing Simulation Lab not only in Schools of Nursing and Universities but most of all in Hospitals (big and small) 2. Increasing School of Nursing admission capacity by increasing Nursing faculty 3. Promote Nursing Excellence in all levels 4. Promote Diversity and Inclusion in all levels 5. Enhancement of Nursing Students Clinical experience 6. Strong partnerships of Hospitals (practice) and Academia 7. Promote research in clinical practice, academia, and both together. 8. Advancing Population Health Through Health Promotion and Disease Prevention 9. Promote and advance Nursing and Healthcare Agenda with congressmen and senators.
Question: Thank you for attending the Summit and providing constructive feedback. Please feel free to provide any additional comments.

Representative Examples of Responses

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<tr>
<td>Thank you for the excellent Summit and the opportunity to participate.</td>
</tr>
<tr>
<td>Plan additional World Cafe’ conferences every 5 years, so various stakeholders can meet and discuss new approaches to gaps between academia and practice. Appreciated the nursing student speaker who presented valuable insights.</td>
</tr>
<tr>
<td>Thank you to all the organizations who were involved and all the individuals who took the time to attend. It was quite a commitment to get the level of participation needed to generate the type of discussion needed.</td>
</tr>
<tr>
<td>Thank-you for the attention to details to ensure all stakeholders were “at the table” and we had an avenue to voice ideas.</td>
</tr>
<tr>
<td>I look forward to another Summit and would like to be invited to future meetings.</td>
</tr>
<tr>
<td>The Summit was great! Thank you for speaking to this topic. I do believe there is a gap between Academia and Practice setting. Working towards bridging this gap is necessary.</td>
</tr>
<tr>
<td>The facility was great for the world café. The speakers, especially Pam Lauer and the NCSBN lady were very well prepared and knowledgeable.</td>
</tr>
<tr>
<td>This was a very thoughtful and well-organized Summit. Thank you to all who worked to make it such a success.</td>
</tr>
<tr>
<td>Amazed at the rich experience and education in the room and the collaboration. The World Café was the perfect method</td>
</tr>
<tr>
<td>The handouts could have been better-electronically. If you could separate the actual lectures that would be great for the future.</td>
</tr>
<tr>
<td>This was a phenomenal event and I feel privileged to have been part of it.</td>
</tr>
<tr>
<td>Thank you, it was a privilege to be invited to attend.</td>
</tr>
<tr>
<td>Great Summit.</td>
</tr>
<tr>
<td>How are we going to have follow up on this? A lot of energy went in to making this Summit possible. A lot of ideas are shared. The elephant in the room: is this going on deaf ears?</td>
</tr>
<tr>
<td>I think there was a lot of down time in between sessions which could have been condensed into 1 day. The World Cafe questions overlapped on several topics and should have been better integrated into similar themes</td>
</tr>
<tr>
<td>I enjoyed the 2 days. I look forward to see the outcomes of this project and hope to be invited back</td>
</tr>
<tr>
<td>Thank you allowing me to have a great experience.</td>
</tr>
<tr>
<td>The opportunity to interact across the spectrum of nursing had tremendous value in my opinion.</td>
</tr>
</tbody>
</table>
Explore the Transition to Practice (TTP) model from NCSBN and introduce it with our clinical partners. Develop TTP Program for APRNs. Include students, individuals, families, and communities' voice into design of educational - clinical operations and the community health system. Research is needed to identify system-level collaborative approach in nursing practice for eliminating disparities in healthcare and address the social needs of our community. It seems nurses are expected to solve all the problems in healthcare, let us come up with initiatives about the importance of nurse's well-being and health and wellness so we can foster a greater impact to the community we are committed.

Thank you for this wonderful opportunity to hear our voices and being so brave to bring out the "elephant" in the room in every topic that was discussed. KUDOS to everyone!

Very informative having industry and academia at the same table to discuss needs. Looking forward to the report.

The "World Cafe" activity was interesting and a creative way to implement a more participatory and active experience in a conference. I loved the ability to network with a wide variety of fellow nurse professionals.
The Future of Nursing in Texas: Stakeholders Moving Towards Alignment