HCEA Newsletter

Volume 4, Issue 1 Summer 2002

Message from the President

Aloha HCEA Members

Summer is here and this means that we are already half way finished with 2002. Summer also means that regular school is out and a lot of us will be traveling with our kids. What does this mean to HCEA? It means that we have only six more months left or about 180 days to be exact to accomplish our 2002 Goals. It is a very short time when you consider the items we still need to accomplish. Yes, we still need your help to make HCEA Goals come to a reality.

So, once more, I am asking you to refer to the last HCEA Newsletter and call one of the leaders and offer your expertise and help. Your HCEA Board and Officers truly need your support.

On the other note, I am very excited to inform you that the HCEA 2002 Health Education Institute Committee led by Charlyn Snow, has been working very hard and the program prepared so far includes exciting, diverse, and excellent topics in every area of health and patient education. It does not matter whether you are a seasoned health educator or a novice; they have something for you. This is a conference that you will not want to miss. Mark your calendar and save October 3 - 5, 2002 to attend “The Declaration of Education” in Philadelphia. Just keep in mind that if your organization will not cover for your expenses to attend the conference, but you are willing to pay on your own, you can use your expenses as continuing education tax deduction when filing your 2002 tax return. You are in education and you need to keep up with the latest trends in health care education in order to be a resource and to deliver the best quality education to your patients or staff. I hope to see you in the number one tourist spot in the nation — Philadelphia!

The same rule applies to your HCEA membership fee. So, I am urging you to renew your HCEA membership if you have not yet done so. In fact, try to get a new member and this is one way that you could show your support to HCEA. As I have said in the past, HCEA is only as good as to the commitment and dedication of its officers and members.

Speaking of dedication and commitment, I would like for all of us to take a moment in our private time to say a prayer for our friend, colleague and HCEA founding President, Jean Raines who passed away earlier this month. It was with her leadership, dedication and commitment that HCEA was born. We surely will miss Jean! So in her honor, let us unite and work together and continue to enhance the association she has started — HCEA!

God Bless Us All,
Nancy Walch, RN, MPH, CDE, CHES
President, HCEA 2002

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From the Editor

Welcome to the HealthCare Education Association Newsletter. Hard to believe that half of the year is past, already. This newsletter serves to keep you informed of current issues within the organization, to provide information about current and emerging trends, and to give you opportunities to be involved in your professional organization. We are still trying to name the newsletter! Only one entry from last time, so get those creative thoughts going and submit a nomination for a name.

• Let's name the newsletter! Send your entries to me at regina.phelps@centrahealth.com and I will enter your nomination. The board will select a name and announce it in the next newsletter. The winner will receive a Free Copy of the *JCAHO & HCEA Education Manual*

• Have a burning issue or a question about patient, staff or community education you would like to see discussed or written about in the newsletter? Email regina.phelps@centrahealth.com and we will try to find someone to write about it!

• Want to write? Try your wings as an author in the HCEA Newsletter. Again, email regina.phelps@centrahealth.com with your idea for an article and we can decide when and how! I will be glad to assist first time writers with your submissions, so-go for it!

You can become involved in the association!
Let us know how we can serve you and you can gain expertise from THE organization for health care educators.

Regina Phelps, RN, MN

HCEA Newsletter

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Tips for New Trainers

By Judy Hoff

A career defining moment occurred many years ago when I was a new grad. I was told to go to a meeting at 10 AM. I dutifully appeared at my first "Inservice". As Gloria shared her wisdom on a new way of charting, I thought she had the greatest job in the world. At that very moment, I put my sights on being an Inservice nurse. Now we are known as educators, learning officers, staff developers, knowledge managers and so on. The basics are still the same, WE LOVE HELPING PEOPLE ACHIEVE THEIR GREATEST POTENTIAL!!!

Since my great epiphany, I have been in and out of so many education potholes. I hope some of these tips will keep you out of trouble. Here are some of the things that I think about every time I prepare a presentation.

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Shift Manager Education Series via Cohort Learning

Cheryl Burnette RN, MEd

As an Education Specialist for a large non-profit health care organization in Central Virginia, I am often called upon to design and deliver educational programs in a variety of venues to clinical and non-clinical staff. A new position would be developed and my colleagues and I were to educate a group of clinical nurses in a new Shift Manager role via a series of planned courses. The objective was not just to have them take our "series", but to develop this group into a cohort. We wanted them to experience not just the courses, but the group interaction and collegiality that may not have occurred had they taken these classes on an individual basis. I have long appreciated that education and learning involved in a structured group over time can enhance and increase learning through the higher levels of Bloom's taxonomy, (Bloom 1956). No pun intended, but it was very exciting and stimulating to see this group "bloom!"

Initially, Nursing Leadership and the Department of Education partnered to develop the job description and the content of courses for the series. Interested clinical nurses applied for the position and were selected by their Unit Manager. The position required nurses have at least three years of experience and current practice at a Clinical Nurse II level or above. The job relationships included supervision of RN's, LPN's, CNA's, Nurse Externs/Techs and Health Unit Coordinators on their units. They would report directly to their Unit Manager.

After the final selection, the Department of Education began with a kick-off at a local country club with our Vice President of Nursing as the keynote speaker. Division Directors also presented topics such as finance, recruitment and retention, leadership responsibilities and developing manager competencies. The next grouping of courses occurred within 6 weeks. These courses included Communication, Conflict and, Delegation in which the participants evaluated communication and conflict techniques and worked on problem solving skills within their group. Other courses offered included Leadership 101, Honoring Boundaries, Keeping the Good Ones, Customer Service for Managers, Success in the Shift Manager Role and a closing celebration for their efforts.

During the course work, participants were expected to keep journals, and communicate, not only with their Unit Managers and staff, but within their cohort. They now have a group email list so they can access each other to communicate questions, challenges, frustrations and successes. Other courses are planned for the fall with a focus on research and evidence based practice. The cohort is also responsible for deciding other classes that may benefit them.

The collegiality of this group already is amazing to witness. The nurses in this cohort wanted the position of Shift Manager and seem motivated to learn as much as they possibly can. The cohesiveness and support they give each other not only increases productivity in the managerial competencies they are expected to perform, but also improves job satisfaction and retention. In conclusion, evaluation of the Shift Manager Series using a cohort approach can be professionally rewarding, not only for the participants and educators involved, but also for the institution and customers.

Cheryl Burnette, RN, MEd is an Education Specialist at Centra Health in Lynchburg, Virginia.

Tips for New Trainers

Continued from page 3

1. Use your preferred style, it works best. There are many different presentation styles. Some people develop detailed scripts, some simple outlines. Personally, if I had to read from a script, my audience would turn into fossils before my eyes. Whatever your style, make a careful plan. The worst thing you can do is wing it. God didn't give us wings so don't use a strategy that you aren't built for.

2. Know your stuff cold. Stay in your area of expertise. In my younger years, I accepted teaching opportunities where I was moderately familiar with the topic. It was education suicide. I had no experience to draw from. If you need to teach in areas where it isn't like "falling off a log" do a pilot. Use your colleagues or friends to work out some of the bumps before you go live.

3. Always use good learning principles. The basics are often what are most forgotten. Remember the basics. Tell them what you are going to tell them, tell them and tell them what you told them.
Take the time to assess the need, design behavioral objectives, etc.

4. Always make sure you are dealing with a training or education problem and not a management problem. In my early days, I fell into this trap (still am tempted). Beware when someone says something like, "You need to do prepare a time management class for Emily, she can never get to work on time!" Be a detective and get to the root of the problem.

5. Never keep people overtime. Time is a critical resource. Don't steal it from people. Construct a good agenda and stick to it.

6. Focus on the audience and not yourself. This external focus makes a better presentation. This connection can help to get rid of the jitters. Nervousness is a "me" focus.

7. Great icebreakers get you off to a great start. I believe that they must be used with a purpose. They should tie into the topic.

8. Never put all learners in the same bucket. Learners learn differently. Add an auditory, a visual and a kinesthetic appeal to reach all learners.

9. Use your ears more than your mouth. The more you talk the less they learn. Get your learners involved. Involvement creates interest and helps them integrate the information. Case studies and exercises work great.

10. Keep evaluations in perspective. Isn't it amazing that you can have 49 excellent evaluations and one mediocre and we focus on the one?

11. Have fun, and be creative. Often, our most memorable learning was also fun.

12. Never, never ever use an overhead or PowerPoint slide with type font. The purpose of a slide is to highlight your story. A heading, three bullet points (with a hefty font) and a graphic are always best.
Use audiovisuals well.

13. Never go it alone. When getting ready for a presentation, I ask all of my education friends for suggestions. It is amazing how many people want you to be successful and are ready to help.

14. Appreciate the opportunity. Teaching people is a great honor. Seize and cherish each moment.
Teaching is a great privilege.

Judy Hoff has spent thirty years in staff development. She started HDD in 1995. She develops online curriculums for healthcare. Feel free to call her with comments. 952-292-2994, toll free 866-323-4169.

JOINT COMMISSION GUIDE TO STAFF EDUCATION

Staff education is perhaps the most important tool to help ensure delivery of safe, efficient, and appropriate care. Errors, near misses, and quality deficiencies can be virtually eliminated with top-notch staff education at your organization. This book provides you with **advice from experts** in the field and **examples from organizations** breaking new ground in health care staff education.

This book is a collaboration between JCAHO and the Health Care Education Association (HCEA), and begins with a collection of contributed essays from staff education experts on today's key topics in health care. A sampling of topics includes:

- recruiting and retaining employees
- competency assessment
- orientation for new staff
- mentoring, preceptorship, and coaching
- technological advances in learning mediums
- ensuring administrative support
- budgeting
- using consultants vs. in-house resources
- linking staff development to business strategy
- documentation.

The remainder of the book presents examples of cutting-edge and exemplary staff education practices in the following areas:

- advance directives
- age- and population-specific competency
- confidentiality and privacy
- disaster preparedness
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- identifying signs of abuse and neglect
- infection control
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Wipe Out Learning Barriers!

By Fran London, MS, RN

I think the concept of learning barriers has outlived its usefulness.

How we look at a problem determines what solutions are possible. How we ask a question limits the answers we could get. In a common teaching framework we decide, before we teach, what the learner needs to know. Our standardized careplans suggest that everyone with that diagnosis should get a specific handout, written in English. Then, as an aside in our assessment, we ask, “Does this patient have any learning barriers? What are they?” This produces a list of things that get in the way of teaching that person. Oh, he speaks Spanish. Or oh, his hearing is impaired. Or oh, he’s too emotional now to pay attention.

Once we identify a learning barrier, we have to treat the learner as a special case. We have to take extra time to modify our teaching approach—-extra time we don’t have. If the learner doesn’t speak English, we have to call in an interpreter. If the learner can’t read, we need to find a video.

Then, when that patient is still unable to perform health-promoting self-care, we say, “We did our best, but he had a learning barrier.” The concept of learning barriers relieves us of guilt.

This is nice, but we’ve got the process backwards.

The basic premise is not true. The patient doesn’t have a barrier to learning. Adult learning principles tell us adults learn when they feel the need. That patient, unless comatose or cognitively impaired, could and would learn if he or she found it necessary. Crisis theory tells us that when old problem-solving methods fail, the person is suddenly open to learning new skills.

Here’s an analogy: A beginning cook needs a recipe. An experienced cook looks at ingredients and creates a meal. (Even if the experienced cook uses a recipe, she or he often adapts it with a personal touch.) Focusing on learning barriers promotes a cookbook approach to teaching. But teaching, like cooking, can be far more fluid. The teaching process is interactive and dynamic. Like the cook who can see what’s in the kitchen and create a meal, I propose we recognize that we already know how to teach. All we need is the ability to assess our learner’s needs and abilities, the information that we are going to share (content), and the tools to best communicate that information (such as conversation and handouts). In that order. If we don’t have content we can look it up. If we don’t have tools, we can create them as we go. But first, and most importantly, we need to figure out what this learner needs to learn.

We should simply and directly individualize teaching to meet the needs of each learner. What does this learner want to know? What does this learner need to know? Instead of asking, “Does this patient have any learning barriers?” ask, “How can we best share this information with this particular patient?”

If we must have a barrier to blame for failed teaching, let’s make it a teaching barrier. “I need better teaching skills to help this patient understand.” Identifying teaching barriers would put the responsibility on us, the educators.

Why should I bother to quibble over semantics? Because when our teaching fails, it becomes clear these two views lead us to different responses. If our teaching fails and we think the problem is a learning barrier, the logical solution would be to give up. After all, it’s not our problem. The learner has a barrier. On the other hand, if our teaching fails and we think the problem is our inability to individualize teaching appropriately, the logical solution would be to try another approach. This encourages us to continue to seek solutions, improve our skills, and gives us more control. And, ultimately, the patient is more likely to learn.

Patient education skills range from novice to expert. A newly licensed health care provider may teach at the most basic level; the teaching of an experienced professional can be quite sophisticated. The concept of learning barriers makes us aware that there are reasons our teaching sometimes doesn’t work. Now, with this higher awareness, let’s take teaching to the next level. Let’s see the whole learner. Let’s focus our attention to discover the learner’s needs and abilities. Let’s collaboratively work with that learner to optimize self-care. Let’s really do patient-centered care. In this context, learning barriers vaporize. They were just figments of our imaginations.

Try it and let me know what you think.

Fran London, MS, RN is the Health Education Specialist at Phoenix Children’s Hospital, and the author of No Time to Teach? A Nurse’s Guide to Patient and Family Education *published by Lippincott Williams and Wilkins in 1999. You may contact her at flondon@phoenixchildrens.com*

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