2019 NCSBN APRN Roundtable Development of a Competency-based Common Clinical Assessment Tool for Nurse Anesthesia Education Video Transcript

Event
2019 NCSBN APRN Roundtable

More info: https://www.ncsbn.org/13301.htm

Presenter
Laura Bonanno, DNP, PhD, CRNA, Associate Professor, Louisiana State University

- [Laura] I'm not sure if having the talk after lunch is the best spot but hopefully I'll be able to keep you engaged and have your attention to talk about how we at the Council on Accreditation developed a competency-based common clinical assessment tool for nurse anesthesia education.

So just to disclose to you that I unfortunately have no financial relationships with any commercial interest related to the content of this presentation. So I'll introduce you to our tool. It is a common clinical assessment tool. It was developed in hopes that it could be used by the nurse anesthesia programs across the country to track the progression of student registered nurse anesthetist and recognizing the difference between assessment of clinical performance versus didactic or theoretical classwork.

A variety of organizations provide research input into competency requirements for nurse anesthesia students and the Council on Accreditation requires that student registered nurse anesthetists demonstrate competence in a variety of clinical indicators. So these clinical indicators include patient safety, perianesthesia care, critical thinking, communication, leadership, and professional role.

And it's based on these regulations and recommendations that we felt the need at the Council on Accreditation to develop a common clinical assessment tool that could incorporate current evidence and standards. These are just some of the agencies that we looked at in developing our tool: the American Association of Colleges of Nursing, the National Board of Certification and Recertification of Nurse Anesthetists, QSEN, IPEC, and the AANA.

The significance of standardized clinical performance assessment in nurse anesthesia programs benefits many. It benefits individuals. And when we're talking about individuals, we're referring to the students themselves, the program faculty or administration, and clinical preceptors or clinical educators. It also has benefits to the institution being the nurse anesthesia program, the university system, and the accrediting body.

And here, we're talking about the Council on Accreditation. And then also, the potential for benefits to patients and healthcare systems. So based on these regulations and recommendations, we developed the goals of what our evaluation would look like. And first of all, we knew it was necessary to define the clinical outcomes that were necessary for anesthesia practice, also to validate behaviors that demonstrate successful achievement of these clinical outcomes, to provide feedback to students and program faculty that's effective feedback and objective feedback.

And then early identification of students who may be not meeting program expectations or expectations for clinical performance so that we could identify these early and then, hopefully, intervene to put the student back on the right track. And then to improve quality and safety by being able to evaluate competence. So when we looked at the current clinical, educational, and research literature, we kind of found eight major principles for clinical assessment tools that emerged.

And this was not just based on nurse anesthesia education, it was nursing medicine, allied health. And so here you can see the challenges: the lack of clarity in the existing tools, lack of holistic integration, lack of validity, timeliness, reliability, constructiveness, objectivity, and generalizability.

All of these led to a decreased effectiveness in evaluation. And we'll talk about each one. Here is a list of the ones that we kind of focused on here in developing our tool: objectivity, reliability, timeliness, validity, holistic integration, and clarity.

So when you talk about objectivity, this refers to the ability of the evaluator to remain impartial. The clinical assessment of students is unlikely to be completely objective. We know that there's just inherent subjectivity and the potential for bias depending on who's doing the evaluation.

So the tools were not standardized. And that led, again, to more possibility of the introduction of bias. And then other factors, in addition to that, were socialization between the faculty and the students. Probably the biggest one is the reluctance of clinical educators to give feedback that they would consider negative.

That seems to be very, very difficult across the board and they fear that it may lead to litigation, that they may be associated with a student failing a course, those kinds of things. So we recognize that there was, in nurse anesthesia education, the need for a standardized tool to limit that introduction of subjectivity. Reliability refers to the extent a result can be reproduced.

And a significant problem with clinical performance assessment in nurse anesthesia education is the uncertain reliability measurement over time and across different raters. Different raters, and by raters, I'm talking about the clinical educators doing the evaluation, focus on different aspects of clinical performance and have different expectations about acceptable levels of performance.

And we see that. I'm sure that if you're not a nurse anesthetist, you see that in your respective specialty area as well. I mean you'll have the same student doing the same thing and the different clinical educators look at it differently and evaluate it differently. You have the clinical educators who thinks everybody is a great job and they all get the highest rating and then you have those that can…the student can just never seem to meet those expectations.

And then in addition, clinical practicum experiences are balanced but they're not standardized. So all the students start off at the same base, so to speak, but as they're progressing, it's not always at the same level. It's depending on where they are assigned clinically, what hospital, what cases they are able to do at that particular hospital. So they're not all exactly at the same level all the time.

Students and preceptors agree that achieving consistency in assessment throughout the program is difficult, and that results in these ineffective assessment of clinical performance. The main thing, I think, takeaway here is that we are relying on the clinical evaluation by clinical educators. And so if that feedback is not accurate and objective, then the program or the faculty may make decisions based on that feedback that could really have a career-altering effect on the student.

I mean they could have to go on remediation, they could ultimately, you know, something even worse, being dismissed or removed from the program based on these evaluations. So in nurse anesthesia education, we knew that we needed a tool that could be both rater and context-independent. And timeliness in evaluation refers to the amount of time it takes to complete the evaluation and to provide feedback to the learner.

When there's a time lag between observation and rating a performance, the possibility of introduction of error is clearly there. So if you are working with a student or the clinical educator says, "Oh, yeah, leave that evaluation for me. I'll get to it.

Put it in my box," and maybe it's a couple of days later, we know that they're relying on memory and they're not able to actually document that performance. And then the effectiveness is also reduced when there's a time lag between rating and feedback to the student. So I need to fill out the evaluation and discuss it with the student versus telling the student, "Oh, you did a great job."

And then two days later, they get the evaluation in writing and maybe those things don't match up. So the timeliness of giving the feedback also allows the student to correct any deficiencies in their clinical performance and to work on those. And students and preceptors identified that current tools were too complex, too lengthy, and too time- consuming to complete. So our hope was that we could reduce both and end up with more reliable evaluations that were completed timely.

Validity in assessment tools is the degree to which an instrument measures what it is intended to measure. And this has been an ongoing problem across health profession educational programs for a while to search for a valid method to assess clinical performance. Current clinical assessment documents were limited.

There was a lack of clarity. There was no clear common definition of competency that was used and there was also variation in expectations for individual proficiencies. Defining competence seemed to be problematic as well as determining which behaviors were required as performance indicators in clinical practice and trying to measure those behaviors objectively.

So there was, again, the need to develop a common standardized tool where you align the purpose of assessment with the curricular outcomes and also the ability to focus on observation of actual clinical performance.

Holistic integration refers to the discipline process of actively, skillfully, conceptually, applying, analyzing, synthesizing, and/or evaluating information gathered from or by observation, experience, reflection, reasoning. It seems really complicated but what we've found is in some of the tools, the focus was on observing a task or evaluating a specific task.

And so we needed a tool that fostered critical thinking. So I kind of look at it as, you know, that was what was definitely missing in the evaluation tools that we looked at across programs and the students then were more focused on the task than on putting the big picture together. It wasn't just the need for, "I have this big vascular case and so I need a central line, and I'm going to be focused on placing that central line."

There's so much more that goes into that. There's so much more that we wanted to capture and measure, was the ability to anticipate the need, to have everything that you needed to put the central line in in the room, ultrasound, gloves, gown, all of those things together the CBP line set up ahead of time. All of those things that really are critical thinking and more than just task-focused.

And then clarity, the current tools were unclear. They were broad. They lacked focus. They included academic jargon that maybe the students or the clinical educators didn't quite understand. So it was clear to us that the tool needed to have clear expectations for the students.

The clinical educators needed to clearly understand what was expected of the students. We needed to get rid of the academic jargon and use terms that could be understood by both. And then the importance of putting those outcome measures and behaviors in simple terms and using a simple scale that could be evaluated by the educators. So here's what we did.

Following a January 2015 Council on Accreditation meeting, the special interest group called the Common Clinical Assessment Tool Special Interest Group was formed and members were appointed to that taskforce or special interest group. And the charge was to investigate the feasibility of developing a common clinical assessment tool for use by nurse anesthesia educational programs, to provide reliability lacking in the myriad of forms, evaluation forms, that were currently being used by programs, to assure alignment of evaluation of student clinical performance with Council on Accreditation and nursing standards, to develop a timeline that included the key activities, a cost estimate to develop the tool, and to implement the tool, and then to identify characteristics and key content areas that needed to be included in the tool.

Initially, the group was chaired by Dr. Sass Elisha. He was a COA educator member and I was on the task force along with a couple of practitioner members, Amanda Brown and Brett Clay. We had Kathy Cook, who was a former council member, Demetrius Porche, who was a Dean of the School of Nursing and former COA member.

I think he was a COA member at the time. And then we have Dr. Frank Gerbasi, who is the executive director…It's Chief Executive Officer. Excuse me, we've changed our names recently, the COA and two staff people, Molyka Leonard and Susan Monsen. Juan Gonzalez came on the council, I guess, a little over a year ago and he has now been charged with being the champion of implementation of the tool.

So in 2015, there was a survey that was sent to nurse anesthesia programs to look at the current state of their clinical evaluation of students. And we asked the programs to identify the strengths of the current evaluation tools that they're using, the weaknesses of those tools, challenges that they encounter with obtaining valid and reliable clinical evaluations from preceptors, whether or not they use different versions of the clinical evaluation tool based on the level of the student or based on a particular specialty rotation, whether or not the clinical evaluation tool was supported by technology platforms, so whether or not those evaluations could be completed online or were they only on paper, and then finally, were they interested?

Were the programs interested in having a common clinical assessment tool? From the results of this survey, we found that a single evaluation tool that has core competencies based on COA standards and allows a program to insert other questions based on their individual program requirements was desirable. We also found that the tool should be concise, be available electronically, and via paper.

So we needed to have both. And again, have a section where the preceptors could include comments. We also found that there were some programs that were happy with their current evaluation tool. They didn't want to change and we felt like that was important to allow them that ability too. So it's not mandated. Its optional for the programs to decide whether or not they want to use it.

And that the cost of using the tool should not be prohibitive to programs. Other sources of information that we used to inform the development of the tool, we held focus sessions that included program administrators, program faculty, students, clinical educators, to get their input as to what they wanted the tool to look like.

We used the AANA member profile questions. We looked at the content outline from the National Certification Exam by the National Board for Certification and Recertification for Nurse Anesthetists. We looked at the Graduate QSEN Competencies, the IPEC Core Competencies and we really liked the definitions that we found in this particular article by Englander at all that was entitled "Toward a Common Taxonomy of Competency Domains for Health Professions and Competencies for Physicians," but it was easily adaptable in our situation.

And then we completed crosswalks to ensure that we had consistency with COA standards and AACN essentials and competencies. So we looked at the COA standards for accreditation of nurse anesthesia programs, the practice doctorate standards, because we won't be admitting students into masters programs after 2022.

And we also looked at the AACN essentials of doctoral education for advanced nursing practice and the AACN common APRN doctoral competencies. At the time, I believe that tool was in draft form but we did make sure that we were aligned with that, and now, I think it's since then available. We got approval from the Institutional Review Board at Louisiana State University.

So they approved the content and the methodology of the COA's Delphi study that we were proposing because we wanted to be able to publish our findings. So for the Delphi study, our participants included program administrators and the requirements were that they had a doctoral degree and a minimum of one year of experience.

We included program faculty. Again, doctoral degree was required and they had to have a minimum of one year of experience as a program faculty member. We included CRNA clinical educators. We preferred a doctoral degree but recognized that that's not the standard and so a masters degree was required and a minimum of one year of experience as a clinical educator.

And then we included nurse anesthesia students as well. They had to have completed one year of clinical education and be in good standing at their program. So what we did was…this was very much a working group. We met together, we took the feedback from all of those different events, the focus groups, the surveys.

We took all of that together and we signed into groups and developed what we thought would be the domains, the descriptors, the competencies for each domain, and the progression indicators. We did some homework beforehand but we met face-to-face. We all came to our headquarters here in Chicago and met for I guess about, right at two days.

But we as a group felt it was really important to get everyone in the same room, limit the distractions, and really work. And so when we came out of that first meeting, we had a draft in place and were able to begin and ready to send that out for comments. After we went through the first round of our Delphi study, which we'll go into in detail, we did change some terminology.

We had initially used the term "unsafe" and found that that was not something that was felt favorably by some of our faculty and the students. And so we made a change and we're very happy that we did. So we did three rounds of the Delphi study and after…and in each round, it was evaluated.

The tool was evaluated by the participants and then we revised the instrument based on that feedback. So again, we were assigned to workgroups by domain. And so after each round of the Delphi study, or during the Delphi study, I guess I should say, the participants were asked to rate the relevancy of each domain, each domain descriptor, each competency, and each progression indicator.

And then they were also asked to give their comments. And so we looked at each of those each time. We had a statistician that we actually hired to work on this with us because the statistical analysis was quite complex. And so we were able to, when we got the feedback, separate it out by who was giving that feedback.

So we could kind of see where there were similarity and differences. So in terms of structure, there were three essential components to each of the scoring rubrics. And the scoring…it's really one big tool but there are four domains and in each domain, it includes the domain itself and then a domain descriptor. It includes the competency and then the competencies is described.

And then it has ratings of performance across the top. So you can see those levels where we have safety concern. That's where we initially had it as unsafe. But an area of safety concern all the way to proficient with proficient being entry into practice, what we're expecting of our graduates. And in the safety concern, so for this example here, the competency is, "To provide safe and vigilant patient care throughout the perianesthesia period."

And then the two descriptors, "Timely response to alarms, audible indicators, anesthesia and/ or surgical events and limiting the distractions." So if it was a safety concern, the student fails to demonstrate safe practices throughout perianesthesia period. We felt like that was critical. We had a lot of discussion about it, but, you know, for example to fail, I mean, previously, the tools might have just had novice to proficient.

So if a student turned the alarms off or was on their cell phone or something during a case not paying attention to the monitors, how do we capture that? And so that's kind of where the safety concern we felt was really, really important. Because depending on the specific domain or the specific competency, they're still nursing, they're still professionals, they still should know what's expected in certain situations.

And then in the proficient category, you'll see that as we move along, it kind of…this is where you'll see some of those doctoral competencies coming into play. If it's decided on by the particular program and they wanted to have like a scoring ability for each of those different levels, that could be worked in as well.

So I know it's difficult to read, but we did provide the slides to you so that you could go in and see. But here, the first domain is patient safety in perianesthesia care. You can see the descriptor is "Administers and manages comprehensive, safe, and patient-centered anesthesia care across the lifespan for a variety of procedures." So the first one we just went over here, competency number one.

But if you go down to competency number four, the competency is, "Delivers culturally competent perianesthesia care." So in some of our specific competencies, you'll notice that we blocked out novice and advanced beginner because we felt like you either do or you don't. It wasn't necessary to try to have the clinical educator rate that along the way.

It was clear-cut. You should be able to develop culturally competent care. It's inherent in nursing profession, not just advanced practice. So you can see there's…I mean some of these competencies along the way are kind of specific to nurse anesthesia education, but we wanted you to be able to see how we came up with each of those.

And then for the progression indicator... So here's the second part of domain one, patient safety in perianesthesia-centered care. If you kind of look, you have the safety concern, "Fails to perform induction safely," so to speak. And then you can see at the novice, we're saying it's with continual direction. With advanced beginner, it's with minimal direction.

With competence, it's independently. And then in proficient, when you're moving into entry into practice, it's "Manages complex induction events. Troubleshoots and resolves concerns, and suggests alternative plans." So you can see the progression there clearly. And this is just the last competency under patient safety and perianesthesia care that relates to regional anesthesia techniques.

So here's our second domain, knowledge and critical thinking. And the domain descriptor "Comprehends, applies, synthesizes, and evaluates new and existing knowledge and experience to guide clinical anesthesia decision-making. So the first competency there, I'll just use as an example. "Uses knowledge, experience, and science-based principles to formulate an anesthetic plan."

The safety concern would be, "They fail to use knowledge, experience and science-based principles to formulate an anesthetic plan." So they didn't have a plan. Versus if you move all the way and you progress all the way to proficient or entry into practice, "They use knowledge, experience, and science-based principles to formulate an individualized anesthetic plan independently, and they use in a professional collaboration,"so bringing in those doctoral competencies.

Again, this is still some of the additional competencies for knowledge and critical thinking. Again, kind of as you move down, we're looking at more anesthesia-specific. And then the third one, professional communication and collaboration. The domain descriptor, "Engages an effective communication with patients, their families, significant others, and other healthcare professionals to deliver safe, patient-centered anesthesia care."

So the first competency here, "Utilizes communication skills with patients, their families, and significant others and other healthcare professionals." And then the descriptors, "Accepts instruction and constructive feedback.Uses effective, empathetic, respectful verbal and nonverbal communication.Educates and advocates for patients and their families.Teaches others.Maintains patient confidentiality and informs the public of the role and practice of the CRNA."

So we tried to include some examples so that when the clinical educators are going to evaluate or they have a specific concern and they're not really sure how to score that, it's clear here. It's spelled out for them. Now, the descriptors are not all exhaustive, clearly cannot include everything here that we're going to want them to evaluate, but it gives them some guidance.

And again, they also have the opportunity to put their comments in as well. So the safety concern here is, "Fails to utilize effective communication skills with patients, their family, significant others, or other healthcare professionals." And then again, here's one of those examples where we felt like you're already a nurse, you're already a professional. You should be able to do these things and know how to communicate in a professional manner.

So you either do it or you don't, so to speak. Here's, again, this is just still on professional communication and collaboration, looking at some other different competencies is we included in here, maintaining a comprehensive, accurate, and legible healthcare record, so documentation, transfer of care.

So transfer is a responsibility for the patient care that assures continuity and patient safety. And again, we included examples here: reports to the RN, gives the medical history, gives pertinent information related to the anesthetic and post-operative management. And then the fourth one here, "Provides leadership that facilitates intra-professional and inter-professional communication," and we included examples there as well.

Domain four, the professional role. "Practices in a responsible and an accountable manner that complies with professional, legal, ethical, and regulatory standards with an awareness and responsiveness to the larger healthcare system." So you can see the competency here adheres to AANA and ANA code of ethics and again, walking out novice and advanced beginner because you either comply or you don't.

And then if you move into the proficiency category or entry into practice, we added in, not only do you adhere to those standards, but you also use inter-professional collaboration to uphold the code of ethics. So you're looking at the bigger picture, not just your own personal performance. And then we included also in here, "Adheres to AANA standards for nurse anesthesia practice."

Again, either you do or you don't. And for the proficient category or entry into practice that you use inter-professional collaboration to uphold those standards. Some others within the professional role is, "Interacts with professional integrity." We felt like that was critical to have integrity in there in some way. And then here is, "Demonstrates truthfulness, honesty, and consistency."

"Functions with professional, legal regulatory standards. Adheres to institutional policies," is another competency, that they're responsible and accountable for their practice and that they provide cost-effective anesthesia care. So for our next steps, the tool is complete and it was approved by the full council and it's gone out for comments.

So we're finished with that piece of it. Right now, we have…programs can register to use the tool. That's in progress right now. We sent this out to all programs. They had to register whether or not they were going to…they wanted to be included in using the tool because we wanted to make sure that we didn't just roll this tool out and not provide any instruction or ability on how to use it, not only for the programs but also for the clinical educators.

So that is underway and as soon as we complete that and have all of the programs who are going to be using the tool, we'll begin educating those programs on how to effectively use it. We are in the process of writing up the findings for publication. We hope to publish this in the AANA Journal and possibly other advance practiced nursing education journals as well so that we can get this out and other specialty areas may want to look at adopting something similar.

We are planning to copyright the tool. We have collaborated with the two platforms that currently are used by most programs are Typhon and Medatrax. So we have collaborated with them from the beginning on how can this be incorporated electronically. They have both said it's not going to be an issue for us and so we're working with them to get the tools available online.

And then I mentioned the orientation and training webinars will be available for the programs. And then we're going to obviously continue ongoing evaluation and then if revisions are found to be necessary, we'll work to do those as well. And that's all I have related to the tool and I open the floor up to any questions you may have about the tool.

- [Joan] Hi, I'm Joan Stanley from the American Association of Colleges of Nursing and I just want to applaud all the work that you have done. I mean this is fantastic.

You know, we facilitated the discussion to start beginning some of this work around common APR and doctoral-level competencies. So I just wanted to let everybody know, in addition to saying how great I thought this was, and we can learn a lot, that we do intend, and we have been talking about it, bringing that Invitational group back together. All the organizations that participated in that project, in that initiative, many of you are here.

So we do intend to bring the group back together and we will be reaching out to those, you particularly, but those other organizations that have moved forward because we need to assess where we are with assessment after having competencies. I would also like to add though that we're revising all of our essential documents and we are using the same framework and trying to replicate and build on what we did with the APR and common competencies.

So this is very helpful and we will be…everybody will learn tremendously from what you've done.

- Thank you. Thank you very much. - [Maureen] I was going to add to Joan's comment. I see a lot of harmonization in this work and the work that was done with the DNP competencies. Are you getting, in this initial phase, pushback from any quarters?

Are there some who are not accepting the idea? I mean I know it's voluntary. So in that sense, it doesn't really put pressure so much on the programs. But are you getting any kind of sort of kickback with it or pushback?

- No. The only thing that we've heard is, I guess, you know, I mentioned earlier in the presentation that they wanted the tool to be concise. And that's hard and we struggled with that. And I think probably if you look at it on a paper, you're going to say, "This is not concise."

But I think, and what we felt as a group, and this was addressed, you know, as we went out with the three rounds of the Delphi study, that having the progression indicators and having those examples, the descriptors, is going to be so useful. So I think once the learning curve is done, the clinical educators, the program, the students, are going to get used to that and I think it's not going to seem near as long.

I mean I can just speak for myself. The tool that my program currently uses at LSU, this is going to make a tremendous difference because we have such trouble getting the feedback from the clinical educators. We'll get a call, "Oh, they're not where they're supposed to be." Help us understand what that means. You know, or, "I didn't want to write it down but the student, you know, did this, this, and this."

We need the documentation and we need it to be effective documentation that can be used, not just to the detriment of the student, but to help the student improve as well. - [Male] Thanks for the presentation. Good job. Any word yet on the cost associated with this tool? You mentioned cost and I imagine once a fee is established, it will be a fee that the nurse anesthesia program, if they elect to use this tool, would pay the COA.

Is that correct?

- Oh my gosh. I don't think we've established that frankly. I'm going to ask Dr. Gerbasi to help us out here. - [Frank] Hi, Frank Gerbasi.

Actually, the cost is exactly zero. Zero. Yeah, I mean that was part of the rollout. We really felt it wasn't something the council looked at as a money-making proposition. We wanted to help programs really be more consistent in the way we're conducting evaluations and getting feedback and we feel like this instrument is really going to be helpful in that area.

So we've had a lot of really positive feedback. I know the one point in that evaluation, and Laura had mentioned it, is a comments section and that's really important as anyone knows that have done evaluations. Those comments say a lot more than anything else, usually. So we wanted to really keep that in there as well. But we have about 30 programs that have signed up to use it initially.

We're going to do the training and after the training, we'll have them use it and then do an evaluation of that and make any revisions that we need to make.

- And I will add that if…we wanted to make it so that if you did… if the clinical educator did score the student as a safety concern, so to speak, that will require a comment so that we can…it needs to be collaborated with a specific observable behavior that indicated the safety concern.

- [Charity] I'm charity Cooper. I'm a nurse midwife. I serve on the Board of Nursing in Illinois and I've done about a jillion of these forms over the years as clinical faculty. My question would be how often do you see the clinical faculty doing this? Would this be a daily evaluation that's done?

So this is after every clinical session.

- Yeah, I think it could be used by daily evaluation but some programs have said that they're going to use it for their other, you know, for their…we have to do evaluations pretty much twice a semester, all programs do of the students. So it could be used in both situations.

- It looks awesome.

- Thank you. - [Louse] Hi, I'm Louise Hershkowitz. I'm a CRNA. I'm also the president of the Virginia Board of Nursing. In my clinical life, I was also a clinical educator and I think one of the most important components of this is the education of the clinical educators and utilization of the tool.

The various programs have all had their own tools, none of which have necessarily been anywhere near as effective with this, but I think the consistency and the ability...and this audience, probably, isn't aware of the number of clinical educators there are out there, and many of them struggle with, "How do I even look at filling out an evaluation?"

They don't have the background, per se, for it. So that whole component of this in terms of educating clinical faculty I think is really going to be very important in using it and I thank you for your work.

- Yeah. I agree. I mean I think that's why it's important to put those expectations, the behaviors directly on the tool so that the clinical educators can use those as a reference. But I agree with Louise. I mean in nurse anesthesia education or nurse anesthesia clinical education, they're not paired up with one particular preceptor as they may be in other specialties.

So they may go to one clinical site for a month and work with a different clinical preceptor every day. And then the other issue is there may be clinical sites that have more than one anesthesia program there. So the clinical educators are using one tool for this program, one tool for this program. Again, there's no standardization in how they're completed. So hopefully, this will be helpful to the clinical educators as well and we will have a way to educate them on the tool itself.

The problem we face is getting the clinical educators to actually…we've had…in my particular program, we've held preceptor workshops, we've invited them to come so that we can explain to them what's expected of the students and the attendance sometimes is not where we would hope that it would be. I'm sure you've experienced that as well. So it's an ongoing issue.

- [Jelda] Hi, my name is Jelda Ramirez. I'm from Houston. And we do emergency nurse practitioner work and we've created what I call practice standards beyond competency which are competencies for the emergency nurse practitioner. We've done very similar work than what you have done based on domain. But what we've identified is that because our preceptors are not the same very often, we have created an actual physical book that the actual student carries with them and has a daily evaluation that is based on which specific domains they're doing in which semester of their emergency program they're in.

Beyond that, we've developed a similar instrument that's robust like yours with multiple components of the milestones or evaluation levels. That's given to them via a Qualtrics link where the actual preceptor receives the email with the link and then it's private and then it gets sent directly back to the faculty and that's done twice a semester.

Since we are a specialty beyond the population, we get to be a little bit more creative and what my university is doing it is that they're using us kind of as the prototype because we are unique and in the specialty to see if they can move forward similar to what you're doing.

You all are unique in that you have all of your organizations and certifications within one realm. With those of us that have different populations and different specialties and different competencies, that sometimes makes it a little bit more difficult for us. But what you've done is a great cornerstone for us. So thank you.

- Thank you. Any other question?

- Thank you so much.

- Okay. Thank you very much.