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The Future of Nursing: Innovative Education and Leadership

Over the years, Governance Institute research on hospital and health system board composition has shown that nurses make up a very small fraction of board leadership, and many organizations do not have nurse representation on their boards at all. With the increasing industry focus on patient experience and value-based care, we believe the nurse perspective is critical in order to improve in these areas. Despite this, we have yet to see an uptick in the number of nurses on boards.

We recently spoke with Anne Bavier, Dean and Professor, College of Nursing and Health Innovation, University of Texas at Arlington,[1] to discuss the future of nursing education and the importance of nurse leadership throughout all levels of healthcare provider organizations, including the board.

This is the second in a series of articles focusing on the importance of nurses on boards and in healthcare leadership positions, focusing on case examples of organizations that emphasize nurse leadership. These articles are being published in partnership with the Nurses on Boards Coalition. The University of Texas at Arlington is a Founding Healthcare Leadership Organization Strategic Partner of the Nurses on Boards Coalition.

1 Ms. Bavier retired on August 31, 2018.

Organization Profile

Four years ago, the UTA College of Nursing, with undergraduate and graduate degrees in nursing, was merged together with the Department of Kinesiology, which offers undergraduate degrees in movement sciences and a Ph.D. in kinesiology, to form a new College of Nursing and Health Innovation. Public Health was recently added as a new program.

The college has an enrollment of about 25,000 students (making up about 30 percent of overall university enrollment, the largest component), most of whom are in nursing programs, offered both online and on campus.

While there is no academic medical center as part of the university, the college builds relationships with other academic health centers in the state, the most significant of which is the University of Texas Southwestern, about 20 minutes away. This partnership has allowed the building of a robust research program in bone and muscle physiology and collaborative sciences, which includes work on cancer, ALS, peripheral perfusion studies in hypertensives and different subpopulations, chronic kidney failure, and working with elderly women in heart failure in conjunction with the heart failure clinics at UT Southwestern.

In addition, the college has a Smart Hospital, which is a national model for simulation instruction with more than 60 patient simulators and 40 standardized patients (specially trained actors) that serve as simulated patients. It is an inclusive educational and research entity with a 13,000 square foot Smart Hospital location and a 13,000 square foot Smart Lab location, both located on The University of Texas at Arlington campus.

What is new in the way that nurses are being educated right now, and especially educating nurses to be leaders?

Anne Bavier: The emerging and cutting-edge ingredient in nursing education today is related to the fact that there is a critical national nursing shortage. And as the "baby boomers" now are retiring in larger and larger numbers, the crisis is even heavier. With the movement of healthcare to more of a primary care focus, the demand is not only for baccalaureate-prepared nurses in primary care, but also advance practice nurses to take care of the kind of recurring chronic conditions that occur and are seen in a primary care practice.

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And these are all done in ways that the advance practice nurses, then, can refer into specialty or advance providers in the fields of medicine. We are doing a lot of online education with very sophisticated and developed modules and teaching. We have very high standards of blueprinting courses towards competencies in the profession. And we do it in such a way that all online students are provided with the main course materials, and they are put in a section of about 25 students with a Master's or Doctorate prepared coach who works with the group to get through the materials and assignments and to answer questions.

Simulation is now very well done in computerized mannequins and with patient actors. We are developing a much more rigorous approach using virtual simulation because it is difficult for every nursing school to obtain adequate clinical sites for placement of students. Virtual simulations can get students into different kinds of experience and different thinking patterns in those contexts to prepare them for the actual patient care environment.

This is where I think the future is for nursing education. Nurses are usually working when they go to school, particularly those who have one degree and are going after the next one; they're employed. So, we have a lot of students all over the nation because we can deliver what they need in the online platform. And we have methodologies that are well-developed for them to work in their hometowns and get qualified supervision that is equal to what they would have if they lived here in Arlington.

We see care moving towards a model of being provided by a team that includes physicians, nurses, care coordinators, nurse practitioners, etc. How are you integrating the teamwork perspective in the education program? And in particular, where does the aspect of how physicians and nurses work together come in?

AB: We have an osteopathic medical school in the area, as well as a new allopathic M.D. program coming in a month. We do some regular simulation activities with them and other disciplines, as well as case management and debriefing with interdisciplinary faculty. And the faculty is coming together to discuss what is important, and to be able to role model a respect and understanding of the other disciplines so that the students have an experience where, for instance, they may lean very heavily on a pharmacy student because they're all trying to figure out what kind of medication to give somebody. Or, they're working on a scenario that requires advanced knowledge from a social work/community resources point of view.

By giving them some of these experiences early on in their training, we're forming their thinking. We're forming them as professionals who relate to the other disciplines with what I call situational leadership. If a member of the team has the best knowledge base to meet the needs of the patient or the family, then that person takes over for a while. If you're a hospital and you need a hospitalist versus a general primary care provider, then the hospitalist takes over. So, we're trying to invoke these discussions and conversations across faculty and across student groups so that as the horizon changes and the mix of players change, there is a deep understanding of what it means to have respect for a colleague; they know how to tap into their knowledge and allow the leadership to happen in terms of what's best for the patient.

We know that the physician perspective at the board level is very important, especially for the board's oversight of quality and patient experience. One of the things we're trying to better articulate is the importance of the nurse voice in the board and what the key differences are between the nurse and physician perspective. What, in your experience, are the key differences between those two perspectives and why is it important to also have that nurse perspective in the boardroom?

AB: I have participated on quality committees and boards of several academic medical centers, and what I've learned is that, when you do a root-cause analysis of any kind of situation, it is rare that one kind of discipline was at fault. Generally, it's a communication issue or misunderstanding that crosses disciplines. All of the perspectives need to be heard and voiced. For example, when we say the rate of an infection is down, it may not be because of what a physician did. If it's a catheter line, infection rates are reduced because of stringent nursing protocols that protect the points where the catheter goes into the body from exposure to germs.

The board needs to hear about how complicated it is from a nursing perspective to do these things. If you're a busy nurse in an acute-care setting—or complex care setting of any kind—you have multiple

demands on you. And so, I tell my colleagues and lay people on the committee and board about the burdens the nurse would be facing as they do these things.

When we look at a case, we ask how our communication could have been better, who should have been involved in the communication, and whether our standard procedure communication was inadequate for this situation or if somebody veered off the path and why. In regards to the safety of a patient, particularly in the acute-care setting, the one provider there 24/7 is the nurse. The nurses are there when vital signs change. They see a change in sleep pattern, or a family member in the hall who shared some family dynamics that weren't helping the patient. Nurses are the eyes and ears, so they need assessment and intervention skills.

I explain these kinds of details to boards. I've found my physician colleagues to be wonderfully engaged in this also because their mission is quality care, and yet they know and we all know you can't do everything for every person. It really is a team environment. Knowing the perspectives of the team members in a situation really then helps all members of the team to grow.

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There are wonderful studies now, for instance, on operating room error. If you keep the same nursing staff in the operating room with the same physician team every day, they have fewer errors because they are used to communicating and working together. This is the kind of information and level of perspective we need to share with boards.

What is the value of the nursing perspective both on the board and at a senior leadership level when it comes to some other areas of focus right now in the industry such as population health, consumerism, and patient experience? What can the nurse bring to the table?

AB: Nurses have engrained in them that patient education and family education are part of their job. Beyond a checklist, nurses must ensure that people can understand and complete their care instructions. When you get to the board level of keeping the consumer happy, what does the nurse say when she or he goes on rounds, what are they asking the patients? Rather than starting off with height and weight, but instead, how are you feeling and what do you really need for us to do for you today? What will make a difference to you? That initial engagement with the nurse sets the tone and the stage for the patients as consumers, so they can feel like the team is there to help them achieve their own goals.

What advice do you have for boards looking to increase nurse representation?

AB: As you reach out to nursing for a voice in the boardroom, it is important to help the entire board membership realize that a lot of the contribution to care is guided and directed by nurses. Regardless of which team members make decisions, the implementation is often and typically under the supervision of the nurse. It's going to fall to nursing to be sure that it gets done well and the patient understands it.

So, having a nurse on the board to look at things as they come up, whether they're policies, or changing strategies, or moving or opening new clinics, this allows the board members to think about the context from which the patient is getting the most interaction.