In-Real-Time Learning

We are either moving forward or backward. I haven’t decided yet. Today’s care is much more advanced than a few decades ago, and yet, it is always the basics that really count.

When I entered the field of continuing education (CE) in nursing, our focus was on day-long sessions with multiple objectives, which were delivered mostly by lecture. Most of the education in health care facilities (then simply hospitals) related to orientation and mandatory events such as skills checks. We didn’t develop people—we simply focused on checklists.

Then CE exploded, and we offered short courses, such as 1-hour offerings on a topic. We began to focus on competencies and included some rudimentary ways of facilitating that development. Then we moved to such innovation as bringing CE to the learner via a mobile cart, audio or video recordings, and then the Internet. More recently, simulation has been included when skill development was important.

Eventually we got to “just-in-time” learning (JIT). The JIT often was short video clips showing a procedure or a short Word document with the facts related to the latest information. We used this information when we encountered new situations—ones we didn’t normally encounter wherever we worked.

Then the novel coronavirus changed that education. Now we are learning “in-real-time” (IRT). IRT learning means we actually know very little, and we start with a set of facts in the morning and come away at the end of the day with another set. Many of us are likely operating on some old information about something, but with COVID-19, it is because of how rapidly the knowledge changes. It simply is not possible to stay totally current and perform our usual work. Add to that the changes that are happening through policy mechanisms.

To further complicate the policy perspective, variances are found across states and within states. No wonder we cannot keep up with what we need to know to be current in our care. Mayors, governors, and the President all issue policy statements, some of which are inconsistent with the others and sometimes inconsistent with policy directives from groups such as the Centers for Disease Control and Prevention. It is no wonder many in the health professions are intellectually frustrated. Right now we can say very little about using best practices except for those related to personal protective equipment, physical proximity to others, and hand hygiene.

Despite all of the turmoil, nurses, among other groups, piece together their knowledge as if they were making a quilt or completing a puzzle. We have to have all of the pieces for a coherent whole, and we all feel at a loss because we don’t have the big picture of what the final product is supposed to look like. I am amazed how well we are doing with the IRT approach, and I hope we never have to do it again!

Thank you to all who are helping to keep abreast of what we all need to know! Educators may not be seen as mission critical in some delivery sites, but we are mission critical for the next phase when we want to be sure we know what has transpired and what is needed to move forward. We also know that many educators are trying to help transition what normally is intensive care unit practice to nonintensive units. Helping nurses who don’t normally manage respirators is but one example. We are all adapting (learning IRT) to be relevant to the cause.

Here is my hope: Florence Nightingale revolutionized care when she went to the Crimean War. Today’s nurses will revolutionize health care because we are fighting this current viral war. As the public messages say, “We are all in this together!”

Everyone, be safe!

Patricia S. Yoder-Wise, RN, EdD, NEA-BC, ANEF, FAONL, FAAN
Editor-in-Chief
psywrn@aol.com

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