Transforming Clinical Education

As calls for transformation in nursing education proliferate, faculty members across the country are seeking innovative ways to better prepare students for practice within emerging health care systems. Yet despite the widespread interest in transformation in the abstract, many faculties continue to grapple with how to create and sustain such transformations in their day-to-day practice and their particular contexts. In a recent survey of faculty teaching clinical in prelicensure RN programs, many faculty described devising innovative strategies to address one or more of the substantive challenges they faced, yet none of the reported strategies were deemed “very effective” by respondents (Ironside & McNelis, 2010). In addition, it was often the case that an innovative strategy used in one area resulted in new challenges emerging in another area. One teacher recently likened this approach to transformation to playing “whack-a-mole”—a continuous and exhausting process with very limited effectiveness.

In part, the difficulty faculty face in transforming clinical education is exacerbated when they focus on adopting innovative strategies rather than first giving serious consideration to the underlying pedagogies from which the selection of strategies is derived. In other words, the strategies we choose reflect how we see and think about nursing practice; our views of what counts as nursing knowledge, skills and abilities; the relationships among students, teachers, clients, and clinicians; the clinical sites we select and how and when we use them; and the ethical stance we embody. Changing strategies without attending to the pedagogical underpinnings won’t lead to substantive and lasting transformation but merely to new ways to do the same thing. Rather, transforming clinical education requires a substantive change in how we, as teachers, think about clinical education. It will require us to reexamine our pedagogies!

In many schools of nursing, clinical education experiences begin with a group of students providing direct care to a single client in a nonacute setting. During these experiences, students spend a great deal of time practicing “basic” nursing skills (e.g., personal care, transferring, feeding, intake and output, vital signs) because these skills are thought to be “fundamental” to learning nursing practice—in fact, these courses are often called “fundamentals” courses. But for something to be fundamental means it is of central importance and necessary for progression within the field. When the current model of clinical education was devised more than 80 years ago (Tanner, 2006), these skills may well have reflected the fundamental aspects of practice. But is the same true in today’s complex, uncertain, technology-rich, evolving health care system? What are the fundamental skills necessary for nursing practice now and in the health care system of the future? Exploring these questions with faculty and clinical colleagues may provide us with new possibilities for enacting transformation in clinical education.

It is true that providing basic, direct care is important and should be part of clinical education. However, the significant issue that must be addressed is when and how this is taught and learned and how much repetition is needed for students to demonstrate they have learned it. Has our goal of preparing students to provide safe, quality care relied for too long on inherited approaches that now inadvertently undermine that goal?

For example, faculty responding to the survey of clinical education in prelicensure education described working valiantly to give students experience passing medications, often to the detriment of their own interactions with students and to the exclusion of other clinical experiences (Ironside & McNelis, 2010). Underlying this persistent attention to administering medications is the assumption that making safe medication processes habitual will prevent future errors—the more practice students have, the more proficient they will be and the more confident faculty can be of students’ safety in practice.

Yet the current literature shows that medication errors occur due to the highly interactive effects of individual, client, and system factors such as fatigue, interruptions and distractions, lack of knowledge, workplace climate, authority gradients, technological supports, workload, and stress (Agyemang & While, 2010; Brady, Malone, & Fleming, 2009; Chang & Mark, 2009; Jones & Treiber, 2010). Similarly, nurses’ reliance on memory and habitual practice presents a safety risk (Cronenwett et al, 2007). Chang and Mark (2009) suggested that although knowledge and experience are important aspects of safety, repetition may actually lead to decreased attentiveness and a failure to recognize new problems or risks. If we are to transform clinical education, we must challenge the inherited view of clinical education that focuses on isolated clinical skills (such as adminis-
tering medications) that students repeatedly perform or check-off in the clinical setting and ask ourselves new questions, such as: How many times must a student perform a skill to demonstrate they know how to and can reliably perform it and the requisite safety checks in practice settings? How do we teach students to effectively handle interruptions, distractions, fatigue, stress, and authority gradients common to practice settings? How do students learn to intercept errors or to identify and address safety risks in a specific clinical context?

Examining the pedagogies underlying our approach to clinical education also challenges us to give serious consideration to the nature of the practice for which we are preparing students. The recent Institute of Medicine Report on the Future of Nursing (2010) states that nurses spend only 20% of their time providing direct patient care and that nurses must become “health coaches, care coordinators, informaticians, primary care providers, and health team leaders in a greater variety of settings” (p. 9). In addition, it states that nursing programs should provide the “tools needed to evaluate and improve standards of care and the quality and safety of care” (p. 10).

Do our clinical courses reflect this shift, or are these aspects we address only if and when we have time (most likely during the final weeks of the program)? Would students be better prepared for the emerging health care system if fundamentals courses focused on working with clients and clinicians to examine real or potential safety risks and the outcomes of care and variation that occur in their assigned setting (Cooke, Ironside, & Ogrinc, in press) rather than spending all their time providing total patient care to one patient? What if students explored nurse sensitive indicators, the status of these indicators, and the quality improvement efforts occurring in a particular setting rather than focusing primarily on checking-off particular skills? Would students see their practice in a new light if clinical curricula began with experiences that focused on learning to find, evaluate, and use information, to explore how effectively (or not) certain health conditions are managed across particular settings, and to participate in interdisciplinary improvement initiatives? Would students see these important aspects of their practice differently if these were the fundamental skills of nursing that inform (rather than follow) learning to provide direct care?

Changing how we think about fundamentals similarly opens new possibilities for thinking about the settings in which students learn these skills. Given that an increasing number of nurses work outside acute care, with the number expected to grow in the emerging health system (Institute of Medicine, 2010), clinical experiences that span care settings over time are more likely to help students to appreciate the client’s experience of the health care system, the complexities of managing chronic illness, the gaps that occur during transitions across service areas, the importance of handoffs and documentation, and the importance of interdisciplinary collaboration. How might we configure clinical experiences that aren’t bound to a particular setting and point in a client’s illness trajectory?

This is a time of great opportunity for faculties because national attention is being focused on nursing education in an unprecedented way. Perhaps the most important question we can ask ourselves is: How willing are we to transform our clinical courses to prepare new nurses with the knowledge, skills, and attitudes they will need in the emerging health care system? This work will be challenging. It will require us to critically examine the pedagogies we use and to be courageous enough to create new kinds of clinical experiences. Indeed, throughout the Institute of Medicine report (2010), the need for nurses to have the adaptive capacity to respond to changes in the health care system is stressed. Perhaps we can best foster this capacity in our students by “walking the talk” and designing clinical courses that readily adapt to and reflect the changing context in which nursing practice occurs.

References


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The authors have no financial or proprietary interest in the materials presented herein.

doi:10.3928/01484834-20110216-01