

Kathleen B. Gaberson
Marilyn H. Oermann

Clinical Teaching
Strategies in

NURSING

Clinical Teaching Strategies in Nursing

THIRD EDITION

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 **SPRINGER PUBLISHING COMPANY**
NEW YORK

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Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Margaret Zuccarini

Project Manager: Laura Stewart

Cover Design: Steve Pisano

Composition: Apex CoVantage, LLC

E-book ISBN: 978-0-8261-0582-0

09 10 11 12/ 5 4 3 2 1

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Library of Congress Cataloging-in-Publication Data

Gaberson, Kathleen B.

Clinical teaching strategies in nursing / Kathleen B. Gaberson, Marilyn H. Oermann. — 3rd ed.

p. ; cm.

Includes bibliographical references and index.

ISBN 978-0-8261-0581-3

1. Nursing—Study and teaching. I. Oermann, Marilyn H. II. Title.

[DNLM: 1. Education, Nursing. 2. Teaching—methods. WY 18 G112c 2010]

RT73.G26 2010

610.73071—dc22

2010000405

Printed in the United States of America by Bang Printing.

*In loving memory of
Matthew Quay Ammon, a.k.a. Obi Wan Kanobi.*

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Preface

Teaching in clinical settings presents nurse educators with challenges that are different from those encountered in the classroom. In nursing education, the classroom and clinical environments are linked because students must apply in clinical practice what they have learned in the classroom, online, and through other experiences. However, clinical settings require different approaches to teaching. The clinical environment is complex and rapidly changing, with a variety of new settings and roles in which nurses must be prepared to practice.

The third edition of *Clinical Teaching Strategies in Nursing* examines concepts of clinical teaching and provides a comprehensive framework for planning, guiding, and evaluating learning activities for undergraduate and graduate nursing students and health care providers in clinical settings. It is a comprehensive source of information for full- and part-time faculty members whose responsibilities largely center on clinical teaching. Although the focus of the book is clinical teaching in nursing education, the content is applicable to teaching students in other health care fields.

The book describes clinical teaching strategies that are effective and practical in a rapidly changing health care environment. It presents a range of teaching strategies useful for courses in which the teacher is on-site with students, in courses using preceptors and similar models, in simulation laboratories, and in distance education environments. The book also examines innovative uses of virtual reality and nontraditional sites for clinical teaching.

A new feature of the third edition is an exhibit in each chapter that highlights sections of the Clinical Nurse Educator (CNE^{CM}) Examination Detailed Test Blueprint that relate to the chapter content; the entire test blueprint is reprinted as an appendix with permission of the National League for Nursing. An instructor's manual with learning activities for each chapter, suggestions for teaching this content, and PowerPoint

presentations for each chapter are available to faculty members who adopt this textbook. To obtain an electronic copy, contact Springer Publishing Company (textbook@springerpub.com).

The book is organized into four sections. The first section, “Foundations of Clinical Teaching,” comprises five chapters that provide a background for clinical teaching and guide the teacher’s planning for clinical learning activities. Chapter 1 discusses various elements of the context for clinical teaching and presents a philosophy of clinical teaching that provides a framework for planning, guiding, and evaluating clinical learning activities. Chapter 2 discusses the intended and unintended results of clinical teaching; it emphasizes the importance of cognitive, psychomotor, and affective outcomes that guide clinical teaching and evaluation. In chapter 3, strategies for preparing faculty, staff, and students for clinical learning are discussed. This chapter includes suggestions for selecting clinical teaching settings and for orienting faculty and students to clinical agencies. Student use of personal digital assistants in preparation for clinical learning activities is a new addition to this chapter. Chapter 4 discusses the process of clinical teaching, including identifying learning outcomes, assessing learning needs, planning learning activities, guiding students, and evaluating performance. Various clinical teaching models are described. This chapter also addresses important qualities of clinical teachers as identified in research on clinical teaching effectiveness and the stressful nature of clinical teaching and learning. Chapter 5 addresses ethical and legal issues inherent in clinical teaching, including the use of a service setting for learning activities, the effects of academic dishonesty in clinical learning, and the appropriate accommodations for students with disabilities.

The second section of the book focuses on effective clinical teaching strategies. One important responsibility of clinical teachers is the selection of appropriate learning assignments. Chapter 6 discusses a variety of clinical learning assignments in addition to traditional patient care activities and suggests criteria for selecting appropriate assignments. Chapter 7 focuses on self-directed learning activities to achieve desired cognitive and affective learning outcomes. It reviews various approaches to meeting the individual needs of learners through the use of multimedia and computer-assisted instruction as well as more traditional print resources. In chapter 8, the use of clinical simulation to complement actual clinical learning activities is discussed, including suggestions for designing simulation scenarios and running them effectively. Chapter 9 is a new addition to the book; its focus is on the use of

virtual reality and game-based learning in clinical education. The chapter includes theoretical bases for the use of these technologies and the value of virtual reality and game-based learning in helping students to develop understanding and skills related to culture and diversity that they can transfer to future clinical practice. Chapter 10 discusses the use of case method, case study, and grand rounds as clinical teaching methods to guide the development of problem-solving and clinical judgment skills. In chapter 11, the role of discussions in clinical learning and clinical conferences is explored. Effective ways to plan and conduct clinical conferences, questioning to encourage exchange of ideas and higher-level thinking, and the roles of the teacher and learners in discussions and conferences are presented.

The third section includes chapters that discuss appropriate clinical teaching techniques for special circumstances and settings. Chapter 12 describes one graduate nursing program's approach to clinical teaching in a distance learning program. The suggested strategies are applicable to a wide variety of graduate and undergraduate nursing education programs. Chapter 13 describes effective strategies for using preceptors in clinical teaching. The selection, preparation, and evaluation of preceptors are discussed, and the advantages and disadvantages of using preceptors are explored. This chapter also discusses the use of learning contracts as a strategy for planning and implementing preceptorships. Chapter 14 presents effective ways to use diverse settings for clinical learning activities. A number of examples of such settings are given, such as community-based, international, and underused traditional patient care sites.

The final section contains two chapters that focus on clinical evaluation and grading. Chapter 15 focuses on written assignments of various types, including short written assignments for critical thinking, journals, concept maps, and portfolios, among others. Suggestions are made for selecting and evaluating a variety of assignments related to important clinical outcomes. Chapter 16 is a succinct summary of three chapters in Oermann and Gaberson's *Evaluation and Testing in Nursing Education*, third edition (Springer, 2009). For a more extensive discussion of that topic, readers are referred to this companion book.

Our thinking about and practice of clinical teaching has been shaped over many years by a number of teachers, mentors, and colleagues as well as through our own clinical teaching experience. It is impossible to acknowledge the specific contributions of each, but we hope that by the publication of this book, they will know how much they have influenced

us as teachers. We also acknowledge Margaret Zuccarini, our editor at Springer, for her patience, encouragement, and creative approach to this edition.

Kathleen B. Gaberson
Marilyn H. Oermann

Foundations of Clinical Teaching

SECTION I

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1

Contextual Factors Affecting Clinical Teaching

A major determinant of the effectiveness of clinical teaching is the context in which it occurs. Clinical teaching is performed by a faculty within a curriculum that is planned and offered in response to professional, societal, and educational expectations and demands, using available human, intellectual, physical, and financial resources—the context of the curriculum. Because the context is different for each nursing education program, each curriculum is somewhat unique (Iwasiw, Goldenberg, & Andrusyszyn, 2009, p. xi). Therefore, the practice of clinical teaching differs somewhat from program to program. It is not possible to recommend a set of clinical teaching strategies that will be equally effective in every nursing education program. Rather, the faculty must make decisions about clinical teaching that are congruent with the planned curriculum and relevant to its context (Iwasiw et al., pp. 8–9).

THE CURRICULUM PHILOSOPHY

In the sense that it is used most frequently in education, a philosophy is a system of enduring shared beliefs and values held by members of an academic or practice discipline. Philosophy as a comprehensive scientific discipline focuses on more than beliefs, but beliefs determine the

direction of science and thus form a basis for examining knowledge in any science.

Philosophical statements serve as a guide for examining issues and determining the priorities of a discipline (Haynes, Boese, & Butcher, 2004, p. 77; Iwasiw et al., 2009, p. 172). Although a philosophy does not prescribe specific actions, it gives meaning and direction to practice, and it provides a basis for decision making and for determining whether one's behavior is consistent with one's beliefs. Without a philosophy to guide choices, a person is overly vulnerable to tradition, custom, and fad (Fitzpatrick, 2005; Tanner & Tanner, 2006).

A curriculum philosophy includes statements of belief about the goals of education, the nature of teaching and learning, and the roles of learners and teachers (Iwasiw et al., 2009, p. 172). It provides a framework for making curricular and instructional choices and decisions from among options. The values and beliefs included in a curriculum philosophy provide structure and coherence for a curriculum, but statements of philosophy are meaningless if they are contradicted by actual educational practice (Dillard, Sitkberg, & Laidig, 2005; Tanner & Tanner, 2006). In nursing education, a curriculum philosophy directs the curriculum development process by providing a basis for selecting, sequencing, and using content and learning activities. Moreover, the curriculum philosophy of the nursing education program should be congruent with that of the academic institution of which it is a part (Iwasiw et al., 2009, pp. 172–173).

Although traditional views of curriculum development hold that a philosophy is essential as the foundation for building a curriculum, some nursing education leaders have suggested that a set of assumptions or one or more theories could be used instead (Bevis, 2000; Iwasiw et al., 2009, p. 174). When used as a curriculum foundation, learning theories such as behaviorism, cognitive theories, and interpretive pedagogies reflect a faculty's beliefs about learning, teaching, student characteristics, and the educational environment. Nursing theories such as Rogers's Unitary Person Model, Newman's Model of Health, and Watson's Theory of Human Caring may also serve as both theoretical and philosophical contexts for a curriculum (Iwasiw et al., pp. 173–174).

Contemporary nursing curriculum philosophies often are a blend of philosophy, nursing theory, and learning theory. Among others, these blended philosophical approaches include:

- Apprenticeship or cognitive apprenticeship
- Collaborative inquiry

- Constructivism
- Critical social theory
- Feminism
- Humanism
- Interpretive inquiry
- Phenomenology
- Pragmatism (Iwasiw et al., 2009, pp. 175–178)

This book provides a framework for planning, guiding, and evaluating the clinical learning activities of nursing students and health care providers based on the authors' philosophical approach to clinical teaching. That philosophical context for clinical teaching will be discussed in the remainder of this chapter.

A PHILOSOPHICAL CONTEXT FOR CLINICAL TEACHING

Every clinical teacher has a philosophical approach to clinical teaching, whether or not the teacher realizes it. That philosophical context determines the teacher's understanding of his or her role, approaches to clinical teaching, selection of teaching and learning activities, use of evaluation processes, and relationships with learners and others in the clinical environment. These beliefs serve as a guide to action, and they profoundly affect how clinical teachers practice, how students learn, and how learning outcomes are evaluated. Reflecting on the philosophical basis for one's clinical teaching may evoke anxiety about exposing oneself and one's practice to scrutiny, but this self-reflection is a meaningful basis for continued professional development as a nurse educator (O'Mara, Carpio, Mallette, Down, & Brown, 2000).

Readers may not agree with every element of the philosophical context discussed here, but they should be able to see congruence between what the authors believe about clinical teaching and the recommendations they make to guide effective clinical teaching. Readers are encouraged to articulate their own philosophies of nursing education in general and clinical teaching in particular to guide their clinical teaching practice.

A Lexicon of Clinical Teaching

Language has power to shape thinking, and the choice and use of words can affect the way a teacher thinks about and performs the role of clinical

teacher. The following terms are defined so that the authors and readers will share a common frame of reference for the essential concepts in this philosophical approach to clinical teaching.

Clinical. This word is an adjective, derived from the noun *clinic*. *Clinical* means involving direct observation of the patient. Like any adjective, the word *clinical* must modify a noun. Nursing faculty members often are heard to say, “My students are in clinical today” or “I am not in clinical this week.” Examples of correct use include “clinical practice,” “clinical instruction,” and “clinical evaluation.”

Clinical teaching or *clinical instruction.* The central activity of the teacher in the clinical setting is clinical instruction or clinical teaching. The teacher does not supervise students. Supervision implies administrative functions such as overseeing, directing, and managing the work of others. Supervision is a function that is more appropriate for professional practice situations, not the learning environment.

The appropriate role of the teacher in the clinical setting is competent guidance. The teacher guides, supports, stimulates, and facilitates learning. The teacher facilitates learning by designing appropriate activities in appropriate settings and allows the student to experience that learning.

Clinical experience. Learning is an active, personal process. The student is the one who experiences the learning. Teachers cannot provide the experience; they can provide only the opportunity for the experience. The teacher’s role is to plan and provide appropriate activities that will facilitate learning. However, each student will experience an activity in a different way. For example, a teacher can provide a guided observation of a surgical procedure for a group of students. Although all students may be present in the operating room at the same time and all are observing the same procedure, each student will experience something slightly different. One of the reasons teachers require students to do written assignments or to participate in clinical conferences is to allow the teacher a glimpse of what students have derived from the learning activities.

ELEMENTS OF A PHILOSOPHICAL CONTEXT FOR CLINICAL TEACHING

The philosophical context of clinical teaching that provides the framework for this book includes beliefs about the nature of professional

practice, the importance of clinical teaching, the role of the student as a learner, the need for learning time before evaluation, the climate for learning, the essential versus enrichment curricula, the espoused curriculum versus curriculum-in-use, and the importance of quality over quantity of clinical activities. Each of these elements serves as a guide to action for clinical teachers in nursing.

Clinical Education Should Reflect the Nature of Professional Practice

Nursing is a professional discipline. A professional is an individual who possesses expert knowledge and skill in a specific domain, acquired through formal education in institutions of higher learning and through experience, and who uses that knowledge and skill on behalf of society by serving specified clients. Professional disciplines are differentiated from academic disciplines by their practice component.

Clinical practice requires critical thinking and problem-solving abilities, specialized psychomotor and technological skills, and a professional value system. Practice in clinical settings exposes students to realities of professional practice that cannot be conveyed by a textbook or a simulation (Oermann & Gaberson, 2009). Schön (1987) represented professional practice as high, hard ground overlooking a swamp. On the high ground, practice problems can be solved by applying research-based theory and technique. The swampy lowland contains problems that are messy and confusing, that cannot easily be solved by technical skill. Nurses and nursing students must learn to solve both types of problems, but the problems that lie in the swampy lowlands tend to be those of greatest importance to society. Most professional practice situations are characterized by complexity, instability, uncertainty, uniqueness, and the presence of value conflicts. These are the problems that resist solution by the knowledge and skills of traditional expertise (Schön, 1983).

Because professional practice occurs within the context of society, it must respond to social and scientific demands and expectations. Therefore, the knowledge base and skill repertoire of a professional nurse cannot be static. Professional education must go beyond current knowledge and skills to prepare for practice in the future. Thus, clinical teaching must include skills such as identifying knowledge gaps, finding and utilizing new information, and initiating or managing change. Additionally, because health care professionals usually practice in interdisciplinary

settings, nursing students must learn teamwork and collaboration skills (Oermann & Gaberson, 2009; Speziale & Jacobson, 2005).

Thus, if clinical learning activities are to prepare nursing students for professional practice, they should reflect the realities of that practice. Clinical education should allow students to encounter real practice problems in the swampy lowland. Rather than focus exclusively on teacher-defined, well-structured problems for which answers are easily found in theory and research, clinical educators should expose students to ill-structured problems for which there are insufficient or conflicting data or multiple solutions (Oermann & Gaberson, 2009).

Clinical Teaching Is More Important Than Classroom Teaching

Because nursing is a professional practice discipline, what nurses and nursing students do in clinical practice is more important than what they can demonstrate in a classroom. Clinical learning activities provide real-life experiences and opportunities for transfer of knowledge to practical situations (Oermann & Gaberson, 2009). Some learners who perform well in the classroom cannot apply their knowledge successfully in the clinical area.

If clinical instruction is so important, why doesn't all nursing education take place in the clinical area? Clinical teaching is the most expensive element of any nursing curriculum. Lower student-to-teacher ratios in clinical settings usually require a larger number of clinical teachers than classroom teachers. Students and teachers spend numerous hours in the clinical laboratory; those contact hours typically exceed the number of credit hours for which students pay tuition. Even if the tuition structure compensates for that intensive use of resources, clinical instruction remains an expensive enterprise. Therefore, classroom instruction is used to prepare students for their clinical activities. Students learn prerequisite knowledge in the classroom and through independent learning activities that they later apply and test, first in the simulation laboratory and then in clinical practice.

The Nursing Student in the Clinical Setting Is a Learner, Not a Nurse

In preparation for professional practice, the clinical setting is the place where the student comes in contact with the patient or consumer for the purpose of testing theories and learning skills. In nursing education,

clinical learning activities historically have been confused with caring for patients. In a classic study on the use of the clinical laboratory in nursing education, Infante (1985) observed that the typical activities of nursing students center on patient care. Learning is assumed to take place while caring. However, the central focus in clinical education should be on learning, not doing, as the student role. Thus, the role of the student in nursing education should be primarily that of learner, not nurse. For this reason, the term *nursing student* rather than *student nurse* is preferred, because in the former term, the noun *student* describes the role better.

Sufficient Learning Time Should Be Provided Before Performance Is Evaluated

If students enter the clinical area to learn, then it follows that students need to engage in activities that promote learning and to practice the skills that they are learning before their performance is evaluated to determine a grade. Many nursing students perceive that the main role of the clinical teacher is to evaluate, and many nursing faculty members perceive that they spend more time on evaluation activities than on teaching activities. Nursing faculty members seem to expect students to perform skills competently the first time they attempt them, and they often keep detailed records of students' failures and shortcomings, which are later consulted when determining grades.

However, skill acquisition is a complex process that involves making mistakes and learning how to correct and then prevent those mistakes. Because the clinical setting is a place where students can test theory as they apply it to practice, some of those tests will be more successful than others. Faculty members should expect students to make mistakes and not hold perfection as the standard. Therefore, faculty members should allow plentiful learning time with ample opportunity for feedback before evaluating student performance summatively.

Clinical Teaching Is Supported by a Climate of Mutual Trust and Respect

Another element of this philosophy of clinical teaching is the importance of creating and maintaining a climate of mutual trust and respect that supports learning and student growth. Faculty members must respect students as learners and trust their motivation and commitment to the profession they seek to enter. Students must respect the faculty's

commitment to both nursing education and society and trust that faculty members will treat them with fairness and, to the extent that it is possible, not allow students to make mistakes that would harm patients.

The responsibilities for maintaining this climate are mutual, but teachers have the ultimate responsibility to establish these expectations in the nursing program. In most cases, students enter a nursing education program with 12 or more years of school experiences in which teachers may have been viewed as enemies, out to get students, and eager to see students fail. Nurse educators need to state clearly, early, and often that they see nursing education as a shared enterprise, that they sincerely desire student success, and that they will be partners with students in achieving success. Before expecting students to trust them, teachers need to demonstrate their respect for students; faculty must first trust students and invite students to enter into a trusting relationship with the faculty. This takes time and energy, and sometimes faculty members will be disappointed when trust is betrayed. But in the long run, clinical teaching is more effective when it takes place in a climate of mutual trust and respect, so it is worth the time and effort.

Clinical Teaching and Learning Should Focus on Essential Knowledge, Skills, and Attitudes

Most nurse educators believe that each nursing education program has a single curriculum. In fact, every nursing curriculum can be separated into knowledge, skills, and attitudes that are deemed to be essential to safe, competent practice and those that would be nice to have but are not critical. In other words, there is an essential curriculum and an enrichment curriculum. No nursing education program has the luxury of unlimited time for clinical teaching. Therefore, teaching and learning time is used to maximum advantage by focusing most of the time and effort on the most common practice problems that graduates and staff members are likely to face.

As health care and nursing knowledge grow, nursing curricula tend to change additively. That is, new content and skills are added to nursing curricula frequently, but faculty members are reluctant to delete anything. Neither students nor teachers are well served by this approach. Teachers may feel like they are drowning in content and unable to fit everything in; students resort to memorization and superficial, temporary learning, unable to discriminate between critical information and less important material. “Since it is impossible for faculty to teach everything that future nurses will encounter, nurse educators must be skillful

in deciding what information is essential and how to teach it” (Speziale & Jacobson, 2005, p. 233).

Every nurse educator should be able to take a list of 10 clinical objectives and reduce it to 5 essential objectives by focusing on what is needed to produce safe, competent practitioners. To shorten the length of an orientation program for new staff members, the nurse educators in a hospital staff development department would first identify the knowledge, skills, and attitudes that were most essential for new employees in that environment to learn. If faculty members of a nursing education program wanted to design an accelerated program, they would have to decide what content to retain and what could be omitted without affecting the ability of their graduates to pass the licensure or certification examination and practice safely.

Making decisions like these is difficult, but what often is more difficult is getting a group of nurse educators to agree on the distinction between essential and enrichment content. Not surprisingly, these decisions often are made according to the clinical specialty backgrounds of the faculty; the specialties that are represented by the largest number of faculty members usually are deemed to hold the most essential content. These beliefs may explain why a group of nursing faculty members who teach medical-surgical nursing would suggest that a behavioral health clinical practice session should be cancelled so that all students may hear a guest speaker’s presentation on arterial blood gases or why many nursing faculty members advise students to practice for a year or two after graduation in a medical-surgical setting before transferring to the clinical setting that students initially express an interest in, such as behavioral health, community health, or perioperative settings.

This is not to suggest that the curriculum should consist solely of essential content. The enrichment curriculum is used to enhance learning, individualize activities, and motivate students. Students who meet essential clinical objectives quickly can select additional learning activities from the enrichment curriculum to satisfy needs for more depth and greater variety. Learners need to spend most of their time in the essential curriculum, but all students should have opportunities to participate in the enrichment curriculum as well.

The Espoused Curriculum May Not Be the Curriculum-in-Use

In a landmark guide to the reform of professional education, Argyris and Schön (1974) proposed that human behavior is guided by operational

theories of action that operate at two levels. The first level, espoused theory (the “paper curriculum”), is what individuals say that they believe and do. Espoused theory is used to explain and justify action. The other level, theory-in-use (the “practice curriculum”), guides what individuals actually do in spontaneous behavior with others. Individuals usually are unable to describe their theories-in-use, but, when they reflect on their behavior, they often discover that it is incongruent with the espoused theory of action. Incongruity between espoused theory and theory-in-use can result in ineffective individual practice as well as discord within a faculty group.

Similarly, a nursing curriculum operates on two levels. The espoused curriculum is the one that is described in the self-study for accreditation or state approval and in course syllabi and clinical evaluation tools. This is the curriculum that is the subject of endless debate at faculty meetings. But the curriculum-in-use is what actually happens. A faculty can agree to include or exclude certain learning activities, goals, or evaluation methods in the curriculum, but when clinical teachers are in their own clinical settings, often they do what seems right to them at the time, in the context of changing circumstances and resources. In fact, one of the competencies included on the National League for Nursing (NLN) Certified Nurse Educator (CNE) Examination Detailed Test Blueprint is “Respond effectively to unexpected events that affect clinical . . . instruction” (NLN, 2005, p. 2). In other words, every teacher must interpret the espoused curriculum in view of circumstances and resources in the specific clinical setting and the individual needs of students and patients at the time. In reality, a faculty cannot prescribe to the last detail what teachers will teach (and when and how) and what learners will learn (and when and how) in clinical settings. Consequently, every student experiences the curriculum differently; hence the distinction between learning *activity* and learning *experience*.

When the notion of individualizing the curriculum is taken to extremes, an individual faculty member can become an “academic cowboy” (Saunders, 1999), ignoring the curriculum framework developed through consensus of the faculty in favor of his or her own “creative ideas and unconventional approaches to learning” (p. 30). Because a curriculum philosophy is designed to provide clear direction to the faculty for making decisions about teaching and learning, the integrity of the program of study may be compromised if the practice of an individual clinical teacher diverges widely from the collective values, beliefs, and ideals of the faculty. Academic freedom is universally valued

in the educational community, but it is not a license to disregard the educational philosophy adopted by the faculty as a curriculum framework (Saunders, 1999). Thus, the exploration of incongruities between espoused curriculum and curriculum-in-use should engage the faculty as a whole on an ongoing basis while allowing enough freedom for individual faculty members to operationalize the curriculum in their own clinical teaching settings.

Quality Is More Important Than Quantity

Infante (1985) wrote, “The amount of time that students should spend in the clinical laboratory has been the subject of much debate among nurse educators” (p. 43). Infante proposed that when teachers schedule a certain amount of time (4 or 8 hours) for clinical learning activities, it will be insufficient for some students and unnecessarily long for others to acquire a particular skill. The length of time spent in clinical activities is no guarantee of the amount or quality of learning that results. Both the activity and the amount of time need to be individualized.

Most nursing faculty members worry far too much about how many hours students spend in the clinical setting and too little about the quality of the learning that is taking place. A 2-hour activity that results in critical skill learning is far more valuable than an 8-hour activity that merely promotes repetition of skills and habit learning. Nurse educators often worry that there is not enough time to teach everything that should be taught, but, as noted in the previous section, a rapidly increasing knowledge base assures that there will never be enough time. There is no better reason to identify the critical outcomes of clinical teaching and focus most of the available teaching time on guiding student learning to achieve those outcomes.

USING A PHILOSOPHY OF CLINICAL TEACHING TO IMPROVE CLINICAL EDUCATION

In the following chapters, the philosophical context for clinical teaching articulated here will be applied to discussions of the role of the clinical teacher and the process of clinical teaching. Differences in philosophical approach can profoundly affect how individuals enact the role of clinical teacher. Every decision about teaching strategy, setting, outcome, and role behavior is grounded in the teacher’s philosophical perspective.

The core values inherent in an educator's philosophy of clinical teaching can serve as the basis for useful discussions with colleagues and testing of new teaching strategies. Reflection on one's philosophy of clinical teaching may uncover the source of incongruities between an individual's espoused theory of clinical teaching and the theory-in-use. When the outcomes of such reflection are shared with other clinical teachers, they provide a basis for the continual improvement of clinical teaching.

Nurse educators are encouraged to continue to develop their philosophies of clinical teaching by reflecting on how they view the goals of clinical education and how they carry out teaching activities to meet those goals. A philosophical approach to clinical education thus will serve as a guide to more effective practice and a means of ongoing professional development (Petress, 2003).

SUMMARY

The context in which clinical teaching occurs is a major determinant of its effectiveness. The context of the curriculum comprises internal and external influences, expectations, and demands that ground the curriculum and make it unique. The internal contextual factors include the faculty's shared beliefs about the goals of education, the nature of teaching and learning, and the roles of learners and teachers—the philosophical context of the curriculum.

A philosophical context for clinical teaching influences one's understanding of the role of the clinical teacher and the process of teaching in clinical settings. This philosophy includes fundamental beliefs about the value of clinical education, roles and relationships of teachers and learners, and how to achieve desired outcomes. This philosophical approach to clinical teaching is operationalized in the remaining chapters of this book.

Terms related to clinical teaching were defined to serve as a common frame of reference. The adjective *clinical* means involving direct observation of the patient; its proper use is to modify nouns such as *laboratory*, *instruction*, *practice*, or *evaluation*. The teacher's central activity is *clinical instruction* or *clinical teaching* rather than supervision, which implies administrative activities such as overseeing, directing, and managing the work of others. Because learning is an active, personal process, the student is the one who experiences the learning. Therefore, teachers cannot provide *clinical experience*, but they can offer opportunities

and activities that will facilitate learning. Each student will experience a learning activity in a different way.

The philosophical context of clinical teaching advocated in this book contains the following beliefs. Clinical education should reflect the nature of professional practice. Practice in clinical settings exposes students to realities of professional practice that cannot be conveyed by a textbook or a simulation. Most professional practice situations are complex, unstable, and unique. Therefore, clinical learning activities should expose students to problems that cannot be solved easily with existing knowledge and technical skills.

Another element of the philosophy of clinical teaching concerns the importance of clinical teaching. Because nursing is a professional practice discipline, the clinical practice of nurses and nursing students is more important than what they can demonstrate in a classroom. Clinical education provides opportunities for real-life experiences and transfer of knowledge to practical situations.

In the clinical setting, nursing students come in contact with patients for the purpose of applying knowledge, testing theories, and learning skills. Although typical activities of nursing students center on patient care, learning does not necessarily take place during caregiving. The central activity of the student in clinical education should be learning, not doing.

Sufficient learning time should be provided before performance is evaluated. Students need to engage in learning activities and practice skills before their performance is evaluated summatively. Skill acquisition is a complex process that involves making errors and learning how to correct and then prevent them. Teachers should allow plentiful learning time with ample opportunity for feedback before evaluating performance.

Another element of this philosophy of clinical teaching is the importance of a climate of mutual trust and respect that supports learning and student growth. Teachers and learners share the responsibility for maintaining this climate, but teachers ultimately are accountable for establishing expectations that faculty and students will be partners in achieving success.

Clinical teaching and learning should focus on essential knowledge, skills, and attitudes. Because every nursing education program has limited time for clinical teaching, this time is used to maximum advantage by focusing on the most common practice problems that learners are likely to face. Educators need to identify the knowledge, skills, and attitudes that are most essential for students to learn. Learners need to spend most of their time in this *essential curriculum*.

In clinical settings, the espoused curriculum may not be the curriculum-in-use. Although most faculty members would argue that there is one curriculum for a nursing education program, in reality, the espoused curriculum is interpreted somewhat differently by each clinical teacher. Consequently, every student experiences this curriculum-in-use differently. A faculty cannot prescribe every detail of what teachers will teach and what learners will learn in clinical settings. Instead, it is usually more effective to specify broader outcomes and allow teachers and learners to meet them in a variety of ways. Individual faculty members are cautioned not to take individualizing the curriculum as a license to ignore the shared philosophy that guides curriculum development and implementation.

Finally, the distinction between quality and quantity of clinical learning is important. The quality of a learner's experience is more important than the amount of time spent in clinical activities. Both the activity and the amount of time should be individualized.

Exhibit 1.1

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A. Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 4. desired learner outcomes
- B. Use teaching strategies based on
 - 1. educational theory
- J. Create a positive learning environment that fosters a free exchange of ideas

2. Facilitate Learner Development and Socialization

- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse

4. Participate in Curriculum Design and Evaluation of Program Outcomes

- B. Actively participate in the design of the curriculum to reflect
 - 1. institutional philosophy and mission
 - 2. current nursing and health care trends
 - 3. community and societal needs
 - 4. educational principles, theory, and research

(continued)

F. Update courses to reflect the philosophical and theoretical framework of the curriculum

Note. This exhibit and CNE Core Competency exhibits in subsequent chapters identify selected competencies that relate to content in each chapter. The lettering and numbering of competencies correspond to the structure of the Certified Nurse Educator (CNE^{CM}) Examination Detailed Test Blueprint.

REFERENCES

- Argyris, C., & Schön, D. A. (1974). *Theory in practice: Increasing professional effectiveness*. San Francisco: Jossey-Bass.
- Bevis, E. O. (2000). Illuminating the issues. In E. O. Bevis & J. Watson (Eds.), *Toward a caring curriculum: A new pedagogy for nursing* (pp. 13–35). Boston: Jones & Bartlett.
- Dillard, N., Sitkberg, L., & Laidig, J. (2005). Curriculum development: An overview. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 89–102). St. Louis, MO: Elsevier Saunders.
- Fitzpatrick, J. J. (2005). Can we “escape fire” in nursing education? [Editorial]. *Nursing Education Perspectives*, 26, 205.
- Haynes, L., Boese, T., & Butcher, H. (2004). *Nursing in contemporary society: Issues, trends, and transition to practice*. Upper Saddle River, NJ: Pearson Prentice Hall.
- Infante, M. S. (1985). *The clinical laboratory in nursing education* (2nd ed.). New York: Wiley.
- Iwasiw, C. L., Goldenberg, D., & Andrusyszyn, M. (2009). *Curriculum development in nursing education* (2nd ed.). Sudbury, MA: Jones and Bartlett.
- National League for Nursing. (2005). *Certified Nurse Educator (CNE) Examination Detailed Test Blueprint*. Retrieved August 8, 2009, from <http://www.nln.org/facultycertification/information/detailedblueprint.pdf>
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- O’Mara, L., Carpio, B., Mallette, C., Down, W., & Brown, B. (2000). Developing a teaching portfolio in nursing education: A reflection. *Nurse Educator*, 25, 125–130.
- Petress, K. (2003). An educational philosophy guides the pedagogical process. *College Student Journal*, 37, 129–134.
- Saunders, R. B. (1999). Are you an academic cowboy? *Nursing Forum*, 34, 29–34.
- Schön, D. A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.
- Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.
- Speziale, H. J. S., & Jacobson, L. (2005). Trends in nurse education programs 1998–2008. *Nursing Education Perspectives*, 26, 230–235.
- Tanner, D., & Tanner, L. (2006). *Curriculum development: Theory into practice* (4th ed.). Englewood Cliffs, NJ: Prentice Hall.

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2

Outcomes of Clinical Teaching

To justify the enormous expenditure of resources on clinical education in nursing, teachers must have clear, realistic expectations of the desired outcomes of clinical learning. What knowledge, skills, and values can be learned only in clinical practice and not in the classroom or through independent learning activities?

Nurse educators traditionally have focused on the *process* of clinical teaching. Many hours of discussion in faculty meetings have been devoted to how and where clinical learning takes place, which clinical activities should be required, and how many hours should be spent in the clinical area. However, current accreditation criteria for higher education in general and nursing in particular focus on evidence that the nursing education program is producing important intended outcomes of learning. Therefore, the effectiveness of clinical teaching should be judged on the extent to which it produces such outcomes.

This chapter discusses broad outcomes of nursing education programs that can be achieved through clinical teaching and learning. These outcomes may be operationally defined and stated as competencies and specific objectives in order to be useful in guiding teaching and evaluation. Competencies and specific objectives for clinical teaching are discussed in chapter 4.

INTENDED OUTCOMES

Since the 1980s, accrediting bodies in higher education have placed greater emphasis on measuring the performance of students and graduates, holding faculty and institutions accountable for the outcomes of their educational programs (Dillard, Sitkberg, & Laidig, 2005). Outcomes are the products of educational efforts—the behaviors, characteristics, qualities, or attributes that learners display at the end of an educational program. Teachers are responsible for specifying outcomes of nursing education programs that are congruent with the current and future needs of society. Changes in health care delivery systems, demographic trends, technological advances, and developments in higher education influence the competencies needed for professional nursing practice (Boland, 2005). A nursing faculty must take these influences into account when designing a context-relevant curriculum (Iwasiw, Goldenberg, & Andrusyszyn, 2009).

In the curriculum development process, after the faculty agrees on the philosophical context for the nursing education program, it formulates curriculum outcome statements (Iwasiw et al., 2009). The desired outcomes for clinical teaching contribute to the achievement of the overall curriculum outcomes and therefore should be congruent with them.

In nursing education, a number of different terms are used to refer to professional abilities that learners are expected to demonstrate at program completion. *Outcomes* can be used to indicate the actual abilities demonstrated by program graduates or the intended or expected results of the education program. The latter connotation is more accurately referred to as *outcome statements*. Other terms used to denote such outcomes are *terminal objectives* (usually associated with a behaviorist philosophical approach), *goals* (more broadly stated), and *ends-in-view* (open-ended descriptions of learning). Expectations of performance at the end of a curriculum level or course are often termed *competencies* (Iwasiw et al., 2009, pp. 182–183). In this book, we use the term *outcomes* to refer to the intended or expected results of clinical teaching.

The curriculum reform movement of the 1980s focused on the importance of outcomes rather than process in improving the quality of teaching and learning in nursing education. This approach suggests that an orderly curriculum design does not take into account each learner's individual needs, abilities, and learning style and that learners can reach the same goal by means of different paths. Development of an outcome-driven

curriculum begins with specifying the desired ends and then selecting content and teaching strategies that will bring about those ends (Boland, 2005; Diekelmann, Ironside, & Gunn, 2005).

Thus, planning for clinical teaching should begin with identifying learning outcomes that are necessary for safe, competent nursing practice. These outcome statements are derived from the philosophical approach chosen to guide curriculum development and are related to the three domains of learning: cognitive (knowledge and intellectual skills), psychomotor (skills and technological abilities), and affective (professional attitude, values, and beliefs) (Oermann & Gaberson, 2009, pp. 16–25). They also include outcomes that incorporate more than one of these domains.

Cognitive Domain Outcomes

Clinical learning activities enable students to transfer knowledge learned in the classroom and through independent learning activities to real-life situations. In clinical practice, theory is translated into practice. By observing and participating in clinical activities, students extend the knowledge that they acquired in the classroom and in self-directed learning. To use resources effectively and efficiently, clinical learning activities should focus on the development of knowledge that cannot be obtained in the classroom or other settings.

As discussed in chapter 1, new content is added to nursing curricula frequently, reflecting the growth of new knowledge in nursing and health care. If the faculty is not willing to delete content that is no longer current or essential, the potential exists for creating a congested, content-saturated curriculum in which both students and teachers lose focus on the essential knowledge outcomes (Giddens & Brady, 2007; Ironside, 2004). Nurse educators thus need to develop evidence-based teaching skills that will help them to critically evaluate the evidence for content additions and deletions and decide what knowledge is essential for students to acquire (Speziale & Jacobson, 2005). For nursing education programs that prepare candidates for licensure or certification, consulting the licensure or certification examination test plans will help the faculty to focus attention on essential program content (Boswell & Cannon, 2005). The National Council of State Boards of Nursing (NCSBN) test plans for the National Council Licensing Examinations (NCLEX™) (NCSBN, 2009) and the American Association of Colleges of Nursing (AACN) publications *The Essentials of Baccalaureate Education for*

Professional Nursing Practice (AACN, 2008) and *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 2009) are helpful resources for selecting and organizing essential content in baccalaureate and graduate programs in nursing.

Knowing how to practice nursing involves high-level cognitive abilities such as problem solving, critical thinking, decision making, and clinical reasoning. Traditional pedagogies that emphasize memorizing content and applying it in clinical practice are not sufficient for teaching the high-level thinking abilities necessary to ensure high-quality nursing care and patient safety in the complex environments of the contemporary health care system. Newer approaches such as narrative pedagogy promote the teaching of thinking instead of content and its application in clinical practice. In a hermeneutic approach to discovering how nursing faculty members use new pedagogies to teach thinking, Ironside (2005) found that shifting emphasis away from the teacher's covering content to engaging students in understanding the evolving context for nursing practice promotes development of thinking from multiple perspectives. Students who experienced the new pedagogies encountered thinking as an experience, not as learning a process or skill. Thus, when faculty members intend to teach high-level thinking, they should use approaches that engage students as participants in questioning, interpreting, and thinking about significant issues from multiple perspectives (Ironside).

Problem Solving

Clinical learning activities provide rich sources of realistic practice problems to be solved. Some problems are related to patients and their health needs; some arise from the clinical environment. As discussed in chapter 1, most clinical problems tend to be complex, unique, and ambiguous. The ability to solve clinical problems thus is an important outcome of clinical teaching and learning, and the nursing process itself is a problem-solving approach. Most nurses and nursing students have some experience in problem solving, but complex problems of clinical practice often require new methods of reasoning and problem-solving strategies. Nursing students may not be functioning on a cognitive level that permits them to problem solve effectively. To achieve this important outcome, clinical activities should expose the learner to realistic clinical problems of increasing complexity.

Many nurse educators and nursing students believe that problem solving is synonymous with critical thinking. However, the ability to solve

clinical problems, while necessary, is insufficient for professional nursing practice, because it focuses on the solution or outcome instead of a more complete understanding of a situation in context.

Critical Thinking

Critical thinking is an important outcome of nursing education. Early emphasis on developing critical thinking skills was stimulated by previous National League for Nursing Accreditation Commission (NLNAC) criteria for accreditation of prelicensure nursing education programs, but it is no longer an accreditation standard (NLNAC, 2008a, 2008b, 2008c). Likewise, critical thinking is not a specified outcome for prelicensure programs accredited by the Commission on Collegiate Nursing Education (2008). Because critical thinking and clinical reasoning are integral to the ability to practice professional nursing, most employers of new nursing graduates expect them to demonstrate this competency. One recent study of trends in professional nursing education programs revealed that critical thinking was expected to receive less emphasis in the future. This finding suggested that either nurse educators have incorporated critical thinking into curricula so well that they see no need for continued emphasis, that past emphasis on critical thinking had been driven by external forces, or that nurse educators perceive the need to *develop* rather than *teach* critical thinking skills (Speziale & Jacobson, 2005).

Many definitions of critical thinking exist, and the faculty must agree on a definition that is appropriate for a given program to provide direction for teaching and assessing this outcome as well as communicating the construct effectively to students. Critical thinking is a process used to determine a course of action involving collecting appropriate data, analyzing the validity and utility of the information, evaluating multiple lines of reasoning, and coming to valid conclusions. It is purposeful, outcome-directed, and evidence-based (Alfaro-LeFevre, 2004).

Although most educators would classify critical thinking as a cognitive domain outcome, some definitions of critical thinking characterize it as a composite of attitudes, knowledge, and skills. It involves the ability to seek and analyze truth systematically and with an open mind as well as attitudinal dimensions of self-confidence, maturity, and inquisitiveness. Critical thinking requires habits of the mind such as reflective thinking, clinical reasoning, and clinical judgment (Alfaro-LeFevre, 2004). Clinical learning activities help learners to develop discipline-specific critical

thinking skills as they observe, participate in, and evaluate nursing care in an increasingly complex and uncertain health care environment.

Decision Making

Professional nursing practice requires nurses to make decisions about patient care involving problems, possible solutions, and the best approach to use in a particular situation. Other decisions involve managing the clinical environment, care delivery, and other activities (Oermann & Gaberson, 2009). The decision-making process involves gathering, analyzing, weighing, and valuing information in order to choose the best course of action from among a number of alternatives. Selecting the best alternative in terms of its relative benefits and consequences is a rational decision. However, nurses rarely know all possible alternatives, benefits, and risks; thus, clinical decision making usually involves some degree of uncertainty. Decisions also are influenced by an individual's values and biases and by cultural norms, which affect the way the individual perceives and analyzes the situation. In nursing, decision making is mutual and participatory with patients and staff members so that the decisions are more likely to be accepted. Clinical education should involve learners in many realistic decision-making opportunities to produce this outcome.

Psychomotor Domain Outcomes

Skills are another important outcome of clinical learning. Nurses must possess adequate psychomotor, communication, and organizational skills to practice effectively in an increasingly complex health care environment. Skills often have cognitive and attitudinal dimensions, but the skill outcomes that must be produced by clinical teaching typically focus on the performance component.

Psychomotor Skills

Psychomotor skills are integral to nursing practice, and any deficiency in these skills among new graduates often leads to criticism of nursing education programs. Psychomotor skills enable nurses to perform effectively in action situations that require neuromuscular coordination. These skills are purposeful, complex, movement-oriented activities that involve an overt physical response. The term *skill* refers to the ability to carry out physical movements efficiently and effectively, with speed

and accuracy. Therefore, psychomotor skill is more than the capability to perform; it includes the ability to perform proficiently, smoothly, and consistently, under varying conditions and within appropriate time limits. Psychomotor skill learning requires practice with feedback in order to refine the performance until the desired outcome is achieved. Thus, clinical learning activities should include plentiful opportunities for practice of psychomotor skills with knowledge of results to facilitate the skill-learning process.

However, psychomotor skill development involves more than technical proficiency. While performing technical skills, nursing students and staff members must also perform caring behaviors, critical thinking, clinical reasoning, problem solving, and decision making. However, the ability to integrate all of these competencies at once usually is not achieved until the technical skill component is so well developed that it no longer requires the nurse's or nursing student's conscious attention for successful performance. It is only at this point that the learner sees the whole picture and is able to focus on the patient as well as the technical skill performance (O'Connor, 2006).

Interpersonal Skills

Interpersonal skills are used throughout the nursing process to assess patient and family needs, plan and implement care, evaluate the outcomes of care, and record and disseminate information. These skills include communication abilities, therapeutic use of self, and using the teaching process. Interpersonal skills involve knowledge of human behavior and social systems, but there also is a motor component largely comprising verbal behavior such as speaking and writing and nonverbal behavior such as facial expression, body posture and movement, and touch. To encourage development of these outcomes, clinical learning activities should provide opportunities for students to form therapeutic relationships with patients; to develop collaborative relationships with health professionals; to document patient information, plans of care, care given, and evaluation results; and to teach patients, family members, and staff members individually and in groups.

Organizational Skills

Nurses need organization and time management skills to practice competently in a complex environment. In clinical practice, students learn

how to set priorities, manage conflicting expectations, and sequence their work to perform efficiently. One organizational skill that has become an important job expectation for professional nurses is delegation. In most health care settings, patient care is provided by a mix of licensed and unlicensed assistive personnel, and professional nurses must know how to delegate various aspects of patient care to others (Derickson & Caputi, 2004). Nurses need to know both the theory and skill of delegation—what to delegate, to whom, and under what circumstances—and to understand the legal aspects of empowering another person to carry out delegated tasks (Derickson & Caputi). However, students will not learn these skills unless they are given opportunities to practice them with faculty guidance (O'Connor, 2006, p. 13). They need to learn to communicate clearly to the delegate what is to be done and why, when and how it should be done, and expectations for response or report back to the delegator (O'Connor, p. 5). As discussed in chapter 6, if clinical learning assignments focus exclusively on total patient care activities, students will not gain enough experience in carrying out this delegation responsibility to perform it competently as graduates (Derickson & Caputi, 2004).

Depending on the level of the learner (graduate or undergraduate student, staff nurse), clinical activities also provide opportunities for learners to develop leadership and management skills. These skills include the ability to manage the care of a group of patients, to evaluate the performance of self and others, to allocate and coordinate resources, and to manage one's own career development (Derickson & Caputi, 2004; O'Connor, 2006, pp. 13–14; Yoder-Wise, 2003).

Affective Domain Outcomes

Clinical learning also produces important affective outcomes—beliefs, values, attitudes, and dispositions that are essential elements of professional nursing practice (Oermann & Gaberson, 2009). Affective outcomes represent the humanistic and ethical dimensions of nursing. Professional nurses are expected to hold and act on certain values with regard to patient care, such as respect for the patient's uniqueness, supporting patient autonomy and right to choose, and the confidentiality of patient information (Gardner & Suplee, 2010, p. 146). The values of professional nursing are expressed in the American Nurses Association *Code of Ethics for Nurses* (2005), and the nursing faculty should introduce the Code early in any nursing education program and reinforce

its values by planning clinical learning activities that help students to develop them.

Additionally, professional nurses must be able to use the processes of moral reasoning, values clarification, and values inquiry. In an era of rapid knowledge and technology growth, nursing education programs also must produce graduates who are lifelong learners, committed to their own continued professional development.

Professional socialization is the process through which nurses and nursing students develop a sense of self as members of the profession, internalizing the norms and values of nursing in their own behavior. Professional socialization occurs at every level of nursing education: in initial preparation for nursing, when entering into the work setting as a new graduate, when returning to school for an advanced degree, and when changing roles within nursing.

Students are socialized into the role of professional nurse in the clinical setting, where accountability is demanded and the consequences of choices and actions are readily apparent. The clinical setting provides opportunities for students to develop, practice, and test these affective outcomes. Clinical education should expose students to strong role models, including nursing faculty members and practicing nurses who demonstrate a commitment to professional values, and it should provide value development opportunities that serve to socialize students to the profession.

Cultural Competence

Although the previous discussion attempted to classify outcomes according to cognitive, psychomotor, or affective domain, some intended outcomes of clinical learning are not easily categorized. One example is cultural competence, an outcome that includes elements of all three domains. Several related terms have been used to refer to different variations of this outcome. Kleiman, Frederickson, and Lundy (2004) defined these terms as follows:

- Cultural awareness: the recognition that people live within some cultural context, both inherited and experiential, that is particular to their group
- Cultural sensitivity: the belief that attention to the cultural contexts within patients' lives influences patient care and promotes beneficial patient outcomes

- **Cultural competence:** knowledge about an individual patient's cultural affiliations and the skill necessary to integrate them into the patient's care

The population of the United States is becoming increasingly multicultural. If current population trends continue, by the year 2050, the percentage of Americans of European descent will fall from the 69% reported in the 2004 census to 50%. The population of Americans of Asian and Hispanic descent is expected to triple, and African Americans are projected to double in number. To respond competently to these demographic changes, nursing students must be prepared to deal with diversity in all of its forms (Hines-Martin & Pack, 2009). "Quality health care and cultural competency are correlated. In other words, providing the best nursing care is part of being culturally competent, and vice versa" (Johnson, 2005, p. 53).

The development of this outcome begins with awareness of cultural diversity and specific knowledge about cultural values, beliefs, rules, and traditions of the nurse's own culture as well as the patient's and progresses to appreciating the similarities and differences between the nurse's and patients' cultures. The culturally competent nurse is able to communicate with patients in ways that meet their needs and is knowledgeable about various cultures with regard to their health beliefs and behaviors (Hines-Martin & Pack, 2009). Three approaches can be used to deliver culturally competent care:

- *Cultural preservation:* supporting the use of scientifically valid cultural health practices, such as acupuncture for managing pain for an Asian American patient
- *Cultural accommodation:* supporting the use of cultural health practices that are known to be safe, such as placing a coin on the umbilicus of a newborn Hispanic infant
- *Cultural repatterning:* working with patients to help them change cultural health practices that are harmful, such as avoiding the use of herbs that interact adversely with anesthesia or prescribed medication (Huber, 2009)

Promoting culturally competent care is a priority in nursing and in nursing education. Therefore, clinical teachers should plan learning activities that will challenge learners to explore cultural differences and to develop culturally appropriate responses to patient needs.

UNINTENDED OUTCOMES

Although nurse educators usually have the intended outcomes in mind when they design clinical learning activities, those activities may produce positive or negative unintended outcomes as well. Positive unintended outcomes include career choices that students and new graduate nurses make when they have clinical experiences in various settings. Exposure to a wide variety of clinical specialties stimulates learners to evaluate their own desires and competence to practice in those areas and allows them to make realistic career choices. For example, nursing students who do not have clinical learning activities in an operating room are unlikely to choose perioperative nursing as a specialty. However, if students participate in clinical activities in the operating room, some will realize that they are well suited to practice nursing in this area, while others will decide that perioperative nursing is not for them. In either case, students will have a realistic basis for their career choices.

Clinical learning activities can produce negative unintended outcomes as well. Nurse educators often worry that students will learn bad practice habits from observing other nurses in the clinical environment. Often, students are taught to perform skills, document care, or organize their work according to the instructor's preferences or school or agency policy. However, students may observe staff members in the clinical setting who adapt skills, documentation, and organization of work to fit the unique needs of patients or the environment. Students often imitate the behaviors they observe, including taking shortcuts and using work-arounds while performing skills, including omitting steps that the teacher may believe are important to produce safe, effective outcomes. The power of role models to influence students' behavior and attitudes should not be underestimated. However, the clinical teacher should be careful not to label the teacher's way as good and all other ways as bad. Instead, the teacher should encourage learners to discuss the differences in practice habits that they have observed, evaluate them in terms of theory or principle, and identify more positive role models (Gardner & Suplee, 2010, pp. 9–10).

Another negative unintended outcome of clinical learning may be academic dishonesty. Academic dishonesty is intentional participation in deceptive practices such as lying, cheating, or false representation regarding one's academic work. Clinical teachers often try to instill the traditional health care cultural value that good nurses do not make errors. Even though the Institute of Medicine's report on health care

errors (Kohn, Corrigan, & Donaldson, 2000) has caused growing concern about patient safety and the need to prevent errors, a standard of perfection is unrealistic for any practitioner, let alone nursing students and new staff members whose mistakes are an inherent part of learning new knowledge and skills. A teacher's emphasis on perfection in clinical practice may produce the unintended result of student dishonesty to avoid punishment for making mistakes. Punishment for mistakes, in the form of low grades or negative performance evaluations, is not effective in preventing future errors. The unintended result of punishment for mistakes may be that learners conceal errors or lack of knowledge or skill; bluffing their way through tasks or failure to report errors can have dangerous consequences for patients in clinical settings and also creates lost opportunities for learners to learn to correct and then prevent their mistakes (Kohn et al., 2000; O'Connor, 2006, pp. 277–278). If the instructor has established a learning climate of mutual trust and respect, acknowledges the possibility of errors, and assures students of respectful treatment when they admit their inadequacies, students will be less likely to behave dishonestly (O'Connor, p. 278). Nursing faculty members also must be exemplary role models of academic and professional integrity for students (Tippit et al., 2009).

SUMMARY

Outcomes of clinical teaching include abilities in cognitive, psychomotor, and affective domains that are acquired through clinical teaching and learning. Current nursing education program accreditation criteria focus on evidence that meaningful outcomes of learning have been produced. The effectiveness of clinical teaching can be judged on the extent to which it produces intended learning outcomes.

Clinical learning activities should focus on the development of *knowledge* that cannot be acquired in the classroom or other learning settings. In clinical practice, knowledge is applied to practice. In addition to understanding specific information, knowledge outcomes include cognitive skill in problem solving, critical thinking, decision making, and clinical reasoning. *Problem solving* ability is an important outcome of clinical teaching. Problems related to patients or the health care environment typically are unique, complex, and ambiguous and often require new methods of reasoning and problem-solving strategies. *Critical thinking* is a process used to determine a course of action after

collecting appropriate data, analyzing the validity and utility of the information, evaluating multiple lines of reasoning, and coming to valid conclusions. Critical thinking is facilitated by attitudinal dimensions of self-confidence, maturity, and inquisitiveness. Clinical learning activities help learners to develop discipline-specific critical thinking and clinical reasoning skills as they observe, participate in, and evaluate nursing care. *Decision making* involves gathering, analyzing, weighing, and valuing information in order to choose the best course of action from among a number of alternatives. Because nurses rarely know all possible alternatives, benefits, and risks, clinical decision making usually involves some degree of uncertainty. Clinical education should involve learners in realistic situations that require them to make decisions about patients, staff members, and the clinical environment in order to produce this outcome.

Psychomotor skills are another important outcome of clinical learning. Many skills have cognitive and attitudinal dimensions, but clinical teaching typically focuses on the performance component. Psychomotor skill includes the ability to perform proficiently, smoothly, and consistently under varying conditions and within appropriate time limits. *Interpersonal skills* are used to assess client needs, plan and implement patient care, evaluate the outcomes of care, and record and disseminate information. These skills include communication, therapeutic use of self, and teaching patients and others. Interpersonal skills involve knowledge of human behavior and social systems, but there also is a motor component largely comprising verbal and nonverbal behavior. Nurses need *organizational skills* in order to set priorities, manage conflicting expectations, and sequence their work to perform efficiently. Clinical learning activities provide opportunities for learners to develop leadership and management skills.

Clinical learning also produces important affective outcomes that represent the humanistic and ethical dimensions of nursing. Professional nurses are expected to hold and act on certain values with regard to patient care and to use the processes of moral reasoning, values clarification, and values inquiry. These values are developed and internalized through the process of professional socialization. In an era of rapid knowledge and technology growth, nursing education programs also must produce graduates who are lifelong learners, committed to their own continued professional development.

One example of an outcome that encompasses all three domains is cultural competence. Cultural competence is the ability to provide care that fits the cultural beliefs and practices of patients. This outcome

includes understanding and appreciating the similarities and differences between the nurse's and patients' cultures.

Clinical learning activities also produce positive and negative unintended outcomes. Exposure to a wide variety of clinical specialties stimulates learners to evaluate their own desires and competence to practice in those areas and allows them to make realistic career choices. However, observing various role models in the clinical environment may result in students' learning bad practice habits. The unintended result of a teacher's unrealistic emphasis on perfection in clinical practice may be academically dishonest behavior such as concealing lack of knowledge or skill or failing to report errors, both with potentially dangerous consequences.

Exhibit 2.1

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A. Implement a variety of teaching strategies appropriate to
 - 4. desired learner outcomes
- G. Model reflective thinking practices
- H. Model critical thinking
- I. Create opportunities for learners to develop their own critical thinking skills
- J. Create a positive learning environment that fosters a free exchange of ideas
- K. Show enthusiasm for teaching, learning, and the nursing profession that inspires and motivates students
- L. Demonstrate personal attributes that facilitate learning (e.g., caring, confidence, patience, integrity, respect, and flexibility)
- Q. Act as a role model in practice settings

2. Facilitate Learner Development and Socialization

- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- H. Encourage professional development of learners

REFERENCES

- Alfaro-LeFevre, R. (2004). *Critical thinking and critical judgment: A practical approach* (3rd ed.). St. Louis, MO: Elsevier Saunders.
- American Association of Colleges of Nursing. (2008). *Essentials of baccalaureate education for professional nursing practice*. Retrieved September 20, 2009, from <http://www.aacn.nche.edu/education/pdf/BaccEssentials08.pdf>
- American Association of Colleges of Nursing. (2009). *Essentials of master's education for advanced practice nursing [Draft]*. Washington, DC: Author.
- American Nurses Association. (2005). *Code of ethics for nurses with interpretive statements*. Retrieved September 21, 2009, from http://nursingworld.org/ethics/code/protected_nwcoe813.htm
- Boland, D. L. (2005). Developing curriculum: Frameworks, outcomes, and competencies. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 167–186). St. Louis, MO: Elsevier Saunders.
- Boswell, C., & Cannon, S. (2005). Too much material, too little time: I'm drowning as a novice faculty member. *Nursing Education Perspectives*, 26, 208.
- Commission on Collegiate Nursing Education. (2008). *Standards for accreditation of baccalaureate and graduate degree nursing programs*. Retrieved September 21, 2009, from <http://www.aacn.nche.edu/Accreditation/pdf/standards.pdf>
- Derickson, L. M., & Caputi, L. (2004). *Teaching the critical thinking skills of delegating and prioritizing*. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (pp. 681–695). Glen Ellyn, IL: College of DuPage Press.
- Diekelmann, N. L., Ironside, P. M., & Gunn, J. (2005). Recalling the curriculum revolution: Innovation with research. *Nursing Education Perspectives*, 26, 70–77.
- Dillard, N., Sitkberg, L., & Laidig, J. (2005). Curriculum development: An overview. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 89–102). St. Louis, MO: Elsevier Saunders.
- Gardner, M. R., & Suplee, P. D. (2010). *Handbook of clinical teaching*. Sudbury, MA: Jones and Bartlett.
- Giddens, J. F., & Brady, D. P. (2007). Rescuing nursing education from content saturation: The case for a concept-based curriculum. *Journal of Nursing Education*, 46, 65–69.
- Hines-Martin, V. P., & Pack, A. H. (2009). INDE project: Developing a cultural curriculum within social and environmental contexts. In S. D. Bosher & M. D. Pharris (Eds.), *Transforming nursing education: The culturally inclusive environment*. New York: Springer Publishing.
- Huber, L. M. (2009). Making community health care culturally correct. *American Nurse Today*, 4(5), 13–15.
- Ironside, P. M. (2004). "Covering content" and teaching thinking: Deconstructing the additive curriculum. *Journal of Nursing Education*, 43, 5–12.
- Ironside, P. M. (2005). Teaching thinking and reaching the limits of memorization: Enacting new pedagogies. *Journal of Nursing Education*, 44, 441–449.
- Iwasiw, C. L., Goldenberg, D., & Andrusyszyn, M. (2009). *Curriculum development in nursing education* (2nd ed.). Sudbury, MA: Jones and Bartlett.
- Johnson, L. D. (2005, Winter). The role of cultural competency in eliminating health disparities. *Minority Nurse*, 52–55.

- Kleiman, S., Frederickson, K., & Lundy, T. (2004). Using an eclectic model to educate students about cultural influences on the nurse-patient relationship. *Nursing Education Perspectives*, 25, 249–253.
- Kohn, L., Corrigan, J., & Donaldson, M. (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press, Institute of Medicine.
- National Council of State Boards of Nursing. (2009). *Test plan for the National Council Licensure Examination for Registered Nurses*. Retrieved September 20, 2009, from <https://www.ncsbn.org/1287.htm>
- National League for Nursing Accrediting Commission. (2008a). *NLNAC 2008 standards and criteria: Associate degree programs in nursing*. Retrieved September 20, 2009, from http://www.nlnac.org/manuals/SC2008_ASSOCIATE.htm
- National League for Nursing Accrediting Commission. (2008b). *NLNAC 2008 standards and criteria: Baccalaureate degree programs in nursing*. Retrieved September 20, 2009, from http://www.nlnac.org/manuals/SC2008_BACCALAUREATE.htm
- National League for Nursing Accrediting Commission. (2008c). *NLNAC 2008 standards and criteria: Diploma programs in nursing*. Retrieved September 20, 2009, from http://www.nlnac.org/manuals/SC2008_DIPLOMA.htm
- O'Connor, A. B. (2006). *Clinical instruction and evaluation: A teaching resource* (2nd ed.). Sudbury, MA: Jones and Bartlett.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- Speziale, H.J.S., & Jacobson, L. (2005). Trends in nurse education programs 1998–2008. *Nursing Education Perspectives*, 26, 230–235.
- Tippit, M. P., Ard, N., Kline, J. R., Tilghman, B. C., Chamberlain, B., & Meagher, P. G. (2009). Creating environments that foster academic integrity. *Nursing Education Perspectives*, 30, 239–244.
- Yoder-Wise, P. S. (2003). *Leading and managing in nursing* (3rd ed.). St. Louis, MO: Mosby.

3

Preparing for Clinical Learning Activities

Nurse educators should consider a number of factors in preparing for clinical learning activities. Equipping students to enter the clinical setting must be balanced with preparing staff members for the presence of learners in a service setting and by respect for the needs of patients. This chapter describes the roles and responsibilities of faculty members, staff members, and others involved in clinical teaching and suggests methods of preparing students and staff members for clinical learning activities. Strategies for selecting clinical learning activities will be discussed in chapter 6.

UNDERSTANDING THE CONTEXT FOR CLINICAL LEARNING ACTIVITIES

To begin preparations for clinical teaching and learning, nurse educators should reflect on the context in which these activities take place. Teachers and learners use an established health care or community setting for a learning environment, thus becoming guests within that setting. What are the implications for clinical teaching and learning effectiveness under these conditions?

Over the last century, basic preparation for professional nursing has moved from service-based training and apprenticeship to academic educational programs in institutions of higher learning. As a result of this service-education separation, the clinical teacher and students who enter a clinical setting for learning activities often are regarded as guests of the health care agency or community site. They participate in the activities of the established system and attempt to follow the norms of its culture, but they are not a constant presence (Case & Oermann, 2004; O'Connor, 2006).

The clinical teacher and students in an academic nursing education program comprise a temporary system within the permanent culture of the clinical setting. Similarly, a staff development instructor and orientees may represent a temporary system. A temporary system is a set of individuals who work together on a complex task over a limited period of time. Although clinical teachers are professional colleagues to nursing staff members and are viewed as nurses by patients, their primary role is that of educator. Even if they are employed by the agency as a staff member on a casual or part-time basis in addition to their academic positions, faculty members enact a different role in that agency when they are guiding the clinical learning activities of students, and role confusion often is inevitable (O'Connor, 2006).

Being a good guest involves knowing and adhering to the established routines, policies, and practices of the clinical setting. Clinical teachers negotiate with staff members for access to learning opportunities and resources while simultaneously protecting students from criticism and preventing errors. Often, students point out discrepancies between nursing staff practice and the standards or procedures that the students were taught. The teacher needs to explain such differences in terms of choice of approach to solving a clinical problem, when appropriate, rather than offering a value judgment. When possible, the clinical teacher should point out staff members who are positive role models of clinical excellence and professionalism (O'Connor, 2006, p. 28).

At times, a clinical teacher's desire for positive relationships with staff members, reluctance to delay or slow patient care, and concern for patient and student safety result in minimizing students' risk taking in an effort to prevent errors. For example, teachers may select assignments for students that allow them to demonstrate previously developed competencies rather than choose learning activities that will challenge students to deepen their understanding and develop higher skill levels. If the teacher expects that a student will not be able to complete patient

care activities in a timely manner, the instructor may forego a rich opportunity for the student to learn to prioritize, organize, and complete a complex set of tasks for the patient and to work collaboratively with other health care team members to do so efficiently. Excessive gatekeeping actions of this kind do not allow students to test hypotheses about clinical nursing care and learn to take appropriate, calculated risks.

Although clinical teachers and nursing students are guests in the health care environment, they also are a vital resource to a health care agency. Nursing students represent potential future employees of that organization, and most health care administrators and managers view the presence of nursing students in the facility as a recruitment opportunity (Case & Oermann, 2004). Positive clinical learning experiences may encourage nursing students to consider future employment in that agency, and nursing staff members who nurture the development of students can have a powerful influence on such a choice.

In a sense, the role of the clinical teacher is that of culture broker or boundary spanner, in which the teacher interprets the norms of the clinical culture to the students and the norms of the academic culture to the staff members (O'Connor, 2006, p. 33). The focus of the health care agency is on delivery of quality patient care resulting in measurable positive outcomes; the focus of the educational institution is on meeting the learning needs of students and producing desired learning outcomes (Hunsberger et al., 2000). The clinical and management staffs of the health care agency are responsible for providing quality care to patients, as specified in standards of the Joint Commission for Accreditation of Healthcare Organizations.

Many staff members, however, are unaware of or misinterpret these standards; they expect nursing students to participate fully in all unit activities, assume responsibility for patient care, take the same kinds of patient assignments, and complete the same patient care tasks as do staff members. They may recall their own clinical education as being more rigorous than the contemporary clinical activities that they witness (Case & Oermann, 2004); communicating those perceptions to nursing students can produce self-doubt, discouragement, and dissatisfaction among the novices. The teacher as culture broker must allow students to experience the real world of clinical nursing and, at the same time, communicate to staff members that trends and current issues in nursing education mean that “it’s not your mother’s nursing school.” Keeping clinical agency staff members, managers, and administrators informed about the nature of contemporary nursing education and keeping students

updated on current challenges and priorities in the health care environment will help to integrate students more effectively into the real world of clinical nursing.

SELECTING CLINICAL SETTINGS

Clinical teachers may have sole responsibility for selecting the settings in which clinical learning activities occur, or their input may be sought by those who make these decisions. In either case, selection of clinical sites should be based on important criteria such as compatibility of school and agency philosophy, availability of opportunities to meet learning objectives, geographical location, agency licensure or accreditation, availability of positive role models, and physical resources (Gardner & Supplee, 2010, p. 18; O'Connor, 2006, pp. 26–27). In some areas, selection of appropriate clinical settings may be difficult because of competition among several nursing programs, and nursing programs typically must contract with a variety of agencies to provide adequate learning opportunities for students. Using a large number of clinical sites increases the time and energy required for teachers to develop relationships with staff, to obtain necessary information about agencies, and to develop and maintain competence to practice in diverse settings.

Selection Criteria

Nurse educators should conduct a careful assessment of potential clinical sites before selecting those that will be used. Faculty members who also are employed in clinical agencies may provide some of the necessary information, and teachers who have instructed students in an agency can provide ongoing input into its continued suitability as a practice site. Assessment of potential clinical agencies should address the following criteria (Case & Oermann, 2004, O'Connor, 2006):

- *Opportunity to achieve learning outcomes.* Are sufficient opportunities available to allow learners to achieve learning objectives? For example, if planning, implementing, and evaluating preoperative teaching is an important course objective, the average preoperative patient census must be sufficient to permit learners to practice these skills. If the objectives require learners to practice direct patient care, does the agency allow this, or will

learners only be permitted to observe? Will learners from other educational programs be present in the clinical environment at the same time? If so, how much competition for the same learning opportunities is anticipated?

- *Level of the learner.* If the learners are undergraduate students at the beginning level of the curriculum, the agency must provide ample opportunity to practice basic skills. Graduate students need learning activities that will allow them to develop advanced practice skills. Does the clinical agency permit graduate students to practice independently or under the guidance of a preceptor, without an on-site instructor? Are undergraduate students in a capstone course permitted to participate in clinical learning activities under the guidance of an appropriate staff member as preceptor, without the physical presence of a faculty member?
- *Degree of control by faculty.* Does the agency staff recognize the authority of the clinical teacher to plan appropriate learning activities for students, or do agency policies limit or prescribe the kinds and timing of student activities? Do agency personnel view learners as additions to the staff and expect them to provide service to patients, or do they acknowledge the role of students as learners?
- *Availability of role models for students.* As discussed in chapter 2, students often imitate the behaviors they observe in nursing staff members. Are the agency staff members positive role models for students and new staff nurses? If learners are graduate students who are learning advanced practice roles, are strong, positive role models available to serve as preceptors and mentors? Is staffing adequate to permit staff members to interact with students and participate in their learning?
- *Geographical location.* Although geographical location of the clinical agency usually is not the most important selection criterion, it can be a crucial factor when a large number of clinical agencies must be used. Travel time between the campus and clinical settings for faculty and students must be considered, especially if learning activities are scheduled in both settings on the same day. Is travel to the agency via public transportation possible and safe, especially if faculty and students must travel in the evening or at night? Are public transportation schedules convenient; do they allow students and faculty to arrive at the agency in time for the scheduled start of activities, and do they permit a return trip to

campus or home without excessive wait times? Does the value of available learning opportunities at the agency outweigh the disadvantages of travel time and cost?

- *Physical facilities.* Are physical facilities such as conference space, locker room or other space to store personal belongings, cafeteria or other dining facility, library and other reference materials, and parking available for use by clinical teachers and students?
- *Staff relationships with teachers and learners.* Do staff members respond positively to the presence of students and welcome appropriate questions from them? Will the staff members cooperate with teachers in selecting appropriate learning activities and participate in orientation activities for faculty and students?
- *Orientation needs.* Some clinical agencies require faculty members to attend scheduled orientation sessions before they take students into the clinical setting. The time required for such orientation must be considered when selecting clinical agencies. If faculty members also are employed in the agency as casual or per diem staff, this orientation requirement may be waived. Can any parts of the orientation be completed without being present in the agency, such as online or via self-study? Is the clinical teacher who is new to a clinical setting permitted to work in the staff nurse role for several days prior to bringing students to the agency, to become familiar with the unit routines and to begin to form collaborative relationships with staff members?
- *Opportunity for interdisciplinary activities.* Are there opportunities for learners to practice as members of an interdisciplinary health care team? Will learners have contact with other health care practitioners such as physical therapists, pharmacists, nutritionists, respiratory therapists, social workers, infection control personnel, and physicians?
- *Agency requirements.* Unless the educational program and the clinical facility are parts of the same organization, a legal contract or agreement usually must be negotiated to permit students and faculty to use the agency as a clinical teaching site. Such contracts or agreements typically specify requirements such as school and individual liability insurance; competence in cardiopulmonary resuscitation; professional licensure for faculty, graduate students, and RN-to-BSN students; immunization and other health requirements; dress code; use of name tags or identification badges; requirements for student drug testing; and requirements

for criminal background checks for students and clinical teachers. Sufficient time must be allowed before the anticipated start of clinical activities to negotiate the contract and for faculty and students to meet the requirements. Faculty members usually must have current unencumbered professional nursing licenses for each state in which they instruct in the clinical area, unless the clinical agencies are located in states that have adopted the Nurse Licensure Compact (National Council of State Boards of Nursing, n.d.) and the faculty member also is licensed in one of those states.

- *Agency licensure and accreditation.* Accreditation requirements for educational programs may specify that clinical learning activities take place in accredited health care organizations. If the agency must be licensed to provide certain health services, it is appropriate to verify current licensure before selecting that agency as a clinical site.
- *Costs.* In addition to travel expenses, there may be other costs associated with use of an agency for clinical learning activities. Any fees charged to schools for use of the agency or other anticipated expense to the educational program and to individual clinical teachers and students should be assessed.

PREPARATION OF FACULTY MEMBERS

When selection of the clinical site or sites is complete, the nurse educator must prepare for the teaching and learning activities that will take place there. Areas of preparation that must be addressed include clinical competence, familiarity with the clinical environment, and orientation to the agency or setting.

Clinical Competence

Clinical competence has been documented as an essential characteristic of effective clinical teachers. Clinical competence includes theoretical knowledge and expert clinical skills and judgment in the practice area in which teaching occurs (Oermann & Gaberson, 2009).

Standards for accreditation and state approval of nursing education programs may require nurse faculty members to have advanced clinical preparation in graduate nursing programs in the clinical specialty

area in which they are assigned to teach. In addition, faculty members should have sufficient clinical experience in the specialty area in which they teach. This is particularly important for faculty members who will provide direct, on-site guidance of students in the clinical area; the combination of academic preparation and professional work experience supports the teacher's credibility and confidence. Students often identify the ability to demonstrate nursing care in the clinical setting as an essential skill of an effective clinical instructor (Case & Oermann, 2004; Gardner & Supplee, 2010; Kelly, 2007; Lee, Cholowski, & Williams, 2002; Tang, Chou, & Chiang, 2005).

Clinical teachers should maintain current clinical knowledge through participation in continuing education and practice experience. Nurse educators who have a concurrent faculty practice or joint appointment in a clinical agency, or who work part-time in a clinical role in addition to their academic assignment, are able to maintain their clinical competence by this means, especially if they practice in the same specialty area and clinical agency in which they teach.

Familiarity With the Clinical Environment

If the clinical teacher is entering a new clinical area, he or she may ask to work with the staff for a few days prior to returning to the site with students. This enables the teacher to practice using equipment that may be unfamiliar and to become familiar with the agency environment, policies, and procedures. If this is not possible, the teacher should at least observe activities or shadow a nursing staff member in the clinical area to discern the characteristics of the patient population, the usual schedule and pace of activities, the types of learning opportunities available to develop desired outcomes, the diversity of health care professionals in the agency, and the presence of other learners (Case & Oermann, 2004; O'Connor, 2006, pp. 31–33).

As previously mentioned, a clinical agency may require faculty members whose students use the facility to attend an orientation program. Orientation sessions vary in length from several hours to a day or more and typically include introductions to administrators, managers, and staff development instructors; clarification of policies such as whether students may administer intravenous medications; review of documentation procedures; and safety procedures. Faculty members may be asked to demonstrate competent operation of equipment such as infusion pumps that their students will be using or to submit evidence

that they have met the same competency standards that are required of nursing staff members.

PREPARATION OF CLINICAL AGENCY STAFF

Preparation of the clinical agency staff usually begins with the nursing education program's initial contact with the agency when negotiating an agreement or contract between the program and the agency. Establishing an effective working relationship with the nursing staff is an important responsibility of the clinical teacher. Ideally, nursing staff members would be eager to work with the faculty member to help students meet their learning goals. Indeed, in academic health centers and other teaching institutions, participation in education of learners from many health care disciplines is a normal job expectation. In reality, however, some staff members enjoy working with students more than others. Because teachers usually cannot choose which staff members will be involved with students, it is important for the teacher to communicate the following information to all staff members.

Clarification of Roles

Staff members often expect the instructor to be responsible for the care of patients whom students are assigned to work with. Many clinical teachers remark that if they have 10 students and each student is assigned 2 patients, the instructor is responsible for 30 individuals. These role expectations are both unrealistic and unfair to all involved parties.

Although the clinical teacher is ultimately responsible for student learning, students have much to gain from close working relationships with staff members. Staff members can serve as useful role models of nursing practice in the real world; students can observe how staff members must adapt their practice to fit the demands of a complex, ever-changing clinical environment. At the same time, staff members often are stimulated and motivated by students' questions and the current information that they can share. The presence of students in the clinical environment often reinforces staff members' competence and expertise, and many nurses enjoy sharing their knowledge and skill with novices. Clinical teachers therefore should encourage staff members to participate in the instruction of learners within guidelines that teachers and

staff members develop jointly. Students should be encouraged to use selected staff members as resources for their learning, especially when they have questions that relate to specific patients for whom the staff members are responsible.

An important point of role clarification is that the responsibility for patient care remains with staff members of the clinical agency, as mentioned earlier. If a student is assigned learning activities related to care of a specific patient, a staff member, often called the primary nurse, is assigned the overall responsibility for that patient's care. Students are accountable for their own actions, but the primary nurse and student should collaborate to ensure that patient needs are met. Staff members may give reports about patient status and needs to students who are assigned to work with those patients; students should be encouraged to ask questions of staff members about specific patient care requirements; to share ideas about patient care; and to report changes in patient condition, problems, tasks that they will not be able to complete, and the need for assistance with tasks (Case & Oermann, 2004; O'Connor, 2006, p. 29).

Role expectation guidelines such as these should be discussed with staff members and managers. When mutual understanding is achieved, the guidelines may be written and posted or distributed to relevant personnel and students.

Level of Learners

Staff members can have reasonable expectations of learner performance if they are informed of the students' levels of education and experience. Beginning students and novice staff members will need more guidance; staff members working with these learners should expect frequent questions and requests for assistance. More experienced learners may need less assistance with tasks but more guidance on problem solving and clinical decision making. Sharing this information with staff members allows them to plan their time accordingly and to anticipate student needs.

It is especially important for faculty members to tell agency personnel what specific tasks or activities learners are permitted and not permitted to do. This decision may be guided by educational program or agency policy, the curriculum sequence, or by the specific focus of the learning activities on any given day. For example, during one scheduled clinical session, an instructor may want students to practice therapeutic use of self through interviewing and active listening, without relying on physical care tasks. The instructor should share this information with the staff and ask them to avoid involving students in physical care on that day.

Learning Outcomes

The overall purpose and desired outcomes of the clinical learning activities should be communicated to staff members. As demonstrated in the previous example, knowledge of the specific objectives for a clinical session permits staff members to collaborate with the teacher in facilitating learning. If students have the specific learning objective of administering intramuscular injections, staff members can be asked to notify the teacher if any patient needs an injection that day so that the student can take advantage of that learning opportunity.

Knowledge of the learning objectives allows staff members to suggest appropriate learning activities even if the teacher is unable to anticipate the need. For example, an elderly patient who is confused may be admitted to the nursing unit; the staff nurse who is aware that students are focusing on nursing interventions to achieve patient safety might suggest that a student be assigned to work with this patient.

Need for Positive Role Modeling

The need for staff members to be positive role models for learners is a sensitive but important issue. As discussed in chapter 2, teachers often worry that students will learn bad practice habits from experienced nurses who may take shortcuts when giving care. When discussing this issue with staff members, instructors should avoid implying that the only right way to perform skills is the teacher's way. Instead, the teacher might ask staff members to point out when they are omitting steps from procedures and to discuss with learners the rationale for those actions. In this way, staff nurses can model how to think like a nurse, a valuable learning opportunity for nursing students (Ironside, 1999).

Asking staff nurses to be aware of the behaviors that they model for students and seeking their collaboration in fostering students' professional role development is an important aspect of preparing agency staff to work with learners. To accomplish this goal, instructors need to establish mutually respectful, trusting relationships with staff members and to sustain dialogue about role modeling over a period of time.

The Role of Staff Members in Evaluation

Agency staff members have important roles in evaluating learner performance. The clinical performance of learners must be evaluated formatively and summatively. Formative evaluation takes the form of feedback

to the student during the learning process; its purpose is to provide information to be used by the learner to improve performance. Summative evaluation occurs at the end of the learning process; its outcome is a judgment about the worth or value of the learning outcomes (Oermann & Gaberson, 2009). Summative evaluations usually result in academic grades or personnel decisions such as promotions or merit pay increases.

Teachers should explain carefully their expectations about the desired involvement of staff members in evaluating student performance. Agency personnel have an important role in formative evaluation by communicating with teachers and learners about student performance. Because staff members often are in close contact with students during clinical activities, their observations of student performance are valuable, but the teacher should keep in mind that staff members may have different expectations for student performance than the instructor does (Case & Oermann, 2004). Staff members should be encouraged to report to the teacher any concerns that they may have about student performance as well as observations of exemplary performance; clinical instructors should accept this input and then validate the report by their own observations (O'Connor, 2006, p. 238). Staff members also should feel free to praise students or point out any errors they may have made or make suggestions for improving performance. Immediate, descriptive feedback is necessary for learners to improve their performance, and often staff members are better able than teachers to provide this information to students.

However, it is the teacher's responsibility to make summative evaluation decisions. Staff members should know that they are an important source of data on student performance and that their input is valued but that ultimately it is the clinical teacher who certifies competence or assigns a grade.

PREPARING THE LEARNERS

Students need cognitive, psychomotor, and affective preparation for clinical learning activities. It is the clinical teacher's responsibility to assist students with such preparation as well as to assess its adequacy before students enter the clinical area.

Cognitive Preparation

General prerequisite knowledge for clinical learning includes information about the learning outcomes, the clinical agency, and the roles of

teacher, student, and staff member. Additionally, in some nursing education programs, students are able and expected to prepare ahead of time for each clinical learning session. This preparation may include one or more of the following tasks: gathering information from patient records; interviewing patients and family members; assessing patient needs; performing physical assessment; reviewing relevant pathophysiology, nursing, nutrition, and pharmacology textbooks; and completing written assignments such as a patient assessment, plan of care, cognitive map, or instructor-designed preparation sheet. In some programs, students complete these types of learning activities during and following their clinical learning activities.

Teachers should ensure that the expected cognitive preparations for clinical learning do not carry more importance than the clinical learning activities themselves. That is, learning should be expected to occur during the clinical learning activities as well as during preclinical preparation. If students receive their learning assignments in advance of the scheduled clinical activity, they can reasonably be expected to review relevant textbook information and to anticipate potential patient problems and needs. If circumstances permit a planning visit to the clinical agency, the student may meet and interview the patient and review the patient's health record. However, requiring extensive written assignments to be completed before the actual clinical activity implies that learning takes place only before the student enters the clinical area. Students cannot be expected to formulate a realistic plan of care before assessing the patient's physical, psychosocial, and cultural needs; this assessment may begin before the actual clinical activity, but it usually comprises a major part of the student's activity in the clinical setting. Thus, preclinical planning should focus on preparations for the learning that will take place in clinical practice. For example, the teacher may require students to formulate a tentative nursing diagnosis from available patient information, formulate a plan for collecting additional data to support or refute this diagnosis, and plan tentative nursing interventions based on the diagnosis. A more extensive written assignment submitted after the clinical activity may require students to evaluate the appropriateness of the diagnosis and the effectiveness of the nursing interventions.

Additionally, because students often copy information from textbooks (or, regrettably, from other students) to complete such requirements, written assignments submitted before the clinical learning activity may not show evidence of clinical reasoning and problem solving, let alone comprehension and retention of the information. For example, some teachers require students to complete drug cards for each medication

prescribed for a patient. Students often copy published pharmacologic information without attempting to retain this information and to think critically about why the medication was prescribed or how a particular patient might respond to it. A better approach is to ask students to reflect on the pharmacologic actions of prescribed drugs and to be prepared to discuss relevant nursing care implications, either individually with the instructor or in a group conference. If it is not possible for students to determine in advance which drugs are being used to treat patients whose care they will be participating in, the clinical instructor may ask students to study particular drug classifications and their prototype drugs and to be prepared to seek and use appropriate information resources when the student obtains the drug list. For example, if students are studying nursing care of patients who are at risk of cerebral vascular accident, they should be familiar with several classifications of antihypertensive drugs and understand the common desired, side, and adverse effects. Students then can formulate a tentative plan of care for these patients and then modify and individualize the plan when they are able to assess specific patients.

Nursing students should learn to use a variety of reference materials both to prepare for clinical practice and as resources during clinical learning activities. Handheld devices such as personal digital assistants (PDAs) are a new resource that can be used for these purposes. There is a growing body of information about PDA use by nursing students at various levels (Glasgow & Cornelius, 2005), but research-based evidence for its effectiveness is still limited (George & Davidson, 2005). In one survey of nursing education programs, 68% required students to purchase their own handheld devices (Smith & Pattrillo, 2006). Among nursing students who use electronic books (e-books) and similar resources on PDAs, pharmacology books show the heaviest usage (Williams & Dittmer, 2009). Altmann and Brady (2005) found that a drug guide was the electronic resource most commonly used by nursing students.

A quasi-experimental study of student preference for and use of e-books in one BSN program found that students used PDAs both for preclinical preparation and during clinical learning activities (Williams & Dittmer, 2009). The drug e-book was identified as the most helpful resource, followed by the pathophysiology and laboratory test e-books. Preference for e-book use as a resource over print resources grew among students in the experimental groups during the study, except for students in their first clinical nursing course, suggesting that beginning students need more guided learning activities with new technology

tools. Students perceived that use of e-books on PDAs decreased the amount of time needed for preclinical preparation. Based on these results, Williams and Dittmer (2009) proposed that clinical teachers may need to view students' preclinical preparation differently: Should nursing students be allowed or even encouraged to search for information as needed throughout a clinical learning activity instead of completing a written preparation assignment?

We recommend that students be expected to complete some cognitive preparation before clinical practice, but extensive, detailed written preparation assignments are unrealistic and often shift focus away from learning *during* clinical activities. Encouraging students' identification and use of appropriate, available information resources during clinical practice facilitates development of clinical reasoning and problem-solving abilities and increases students' self-confidence (Williams & Dittmer, 2009).

Psychomotor Preparation

Skill learning is an important outcome of clinical teaching. However, the length and number of clinical learning sessions often are limited in nursing education or new staff orientation programs. When learning complex skills, it is more efficient for students to practice the parts first in an environment such as a simulation center or skills laboratory, free from the demands of the actual practice setting. In such a setting, students can investigate and discover alternative ways of performing skills, and they can make errors and learn to correct them without fear of harming patients. Thus, students should have ample skill practice time before they enter the clinical area so that they are not expected to perform a skill for the first time in a fast-paced, demanding environment. It is the clinical teacher's responsibility to assure that students have developed the desired level of skill before entering the clinical setting. Chapter 8 presents a comprehensive discussion of the use of clinical simulation.

Affective Preparation

Affective preparation of students includes strategies for managing their anxiety and for fostering confidence and positive attitudes about learning. Most students have some anxiety about clinical learning activities. Mild or moderate anxiety often serves to motivate students to learn, but excessive anxiety hinders concentration and interferes with information

processing and learning (O'Connor, 2006). The role of the teacher in reducing the stress of clinical practice is discussed in more detail in chapter 4. However, in preparation for clinical learning activities, teachers may employ strategies to identify students' fears and reduce their anxiety to a manageable level. A preclinical conference session might assess learners' specific concerns and assure students of the teacher's confidence in them, desire for their success, and availability for consultation and guidance during the clinical activities.

For example, during a preclinical conference on the first day of clinical practice in a course, the instructor may state that it is common for students to feel anxious before a clinical activity but that anxiety usually decreases during the experience. The teacher may encourage students to identify and name the specific source and nature of their anxieties; once these are identified, the teacher can help students to use a problem-solving approach to identify helpful responses. For instance, if students express concern that something may happen that they will not know how to handle, the teacher may help students to list all the potential adverse events and then brainstorm possible responses to them (O'Connor, 2006, pp. 266–267). Throughout such a discussion, teachers should reassure students of their availability to answer questions and assist them with clinical reasoning and problem solving during the clinical learning activities.

Orientation to the Clinical Agency

Like clinical teachers, students also need a thorough orientation to the clinical agency in which learning activities will take place. This orientation may take place before or on the first day of clinical activities. Staff members often assist the teacher in orienting students to the agency and helping them to feel welcome and comfortable in the new environment.

Orientation should include:

- The geographical location of the agency
- The physical setup of the specific unit where students will be placed
- Names, titles, and roles of personnel
- Location of areas such as rest rooms, dining facilities, conference room, locker rooms, public telephones, and library
- Information about transportation and parking
- Agency and unit policies

- Daily schedules and routines
- Patient information documentation systems

In addition, students need to have a telephone number at the clinical setting where they can be contacted in case of family emergency, know what procedures to follow in case of illness or other reason for absence on a clinical day, understand the uniform or dress requirements, and know what equipment to bring (e.g., stethoscope) and what to leave at home (e.g., personal valuables).

Not all of this information needs to be presented on site; some creative clinical teachers have developed audiovisual media that provide a virtual tour of the facility. If the agency uses computer software to document patient information, the instructor may be able to acquire a copy of the software application and make it available in the school's computer facility. Learners can be expected to review such media before coming to the clinical site.

The First Day

Students almost always perceive the first day of clinical learning activities in a new setting as stressful; this is especially true of learners in their initial clinical nursing course. Students' first exposure to the clinical environment can either promote their independence as learners or foster dependence on the instructor due to fear. Clinical teachers should plan specific activities for the first day that will allow learners to become familiar with and comfortable in the clinical environment and at the same time alleviate their anxiety. These activities may include tours, conferences, games, and special assignments.

Even if learners have attended an agency orientation, it is helpful to take them on a tour of the specific areas they will use for learning activities, pointing out locations such as rest rooms, drinking fountains, fire alarms and extinguishers, and elevators, stairwells, and emergency exits. The instructor should introduce learners to staff members by name and title. If students need agency-specific identification badges, parking permits, or passwords for use of the computer system, the teacher may make the necessary arrangements ahead of time or accompany students to the appropriate locations where these items can be acquired. If an empty patient room is available, the instructor may demonstrate the use of equipment such as bed controls, call bell, oxygen delivery systems, and lighting controls (O'Connor, 2006, p. 73).

Exhibit 3.1

A SCAVENGER HUNT STRATEGY

Anywhere General Hospital
Unit 2C

Work in pairs to search for the location of the items or areas listed below. Check them off as you find them.

- Locker room
- Restrooms
- Oxygen shut-off valves
- Fire alarms
- Fire extinguishers
- Emergency exits
- Assignment board
- Patient health records
- Patient teaching materials
- Nurse manager's office
- Medication dispensing carts
- Linen carts
- Kitchen
- Utility room
- Biohazardous waste containers
- Waterless hand sanitizer dispensers
- Reference materials
- Conference room

Special assignments may include review and discussion of patient records, practice of computer documentation, and a treasure hunt or scavenger hunt to help learners locate typical items needed for patient care. Exhibit 3.1 is an example of a scavenger hunt activity used in orienting students to a medical-surgical unit of a hospital. Learners may be asked to observe patient care for a specified period of time, interview a patient or family member, or complete a short written assignment focused on documenting an observation.

These activities may be followed by a short group conference during which students are encouraged to discuss their impressions, experiences, and feelings. The teacher should review the roles of student, teacher, and staff members and should emphasize lines of communication. For example, students need to know who to ask for help and under what circumstances—that is, when to ask questions of staff members

and when to seek assistance from the teacher. Handouts summarizing these expectations and requirements are useful because students can review them later when their anxiety is lower. If a dining facility is available in the clinical setting, this conference may take place in that location to allow students to relax with refreshments away from patient care areas. The conference may conclude by making plans for the next day of clinical practice, including selecting assignments and discussing how learners should prepare for their learning activities. Selection of clinical assignments is discussed in detail in chapter 6.

SUMMARY

This chapter described the roles and responsibilities of faculty, staff members, and others involved in clinical teaching and suggested strategies for preparing students and staff members for clinical learning.

The teacher and learners comprise a temporary system within the permanent culture of the clinical setting. Negative consequences of this relationship can be avoided by establishing and maintaining regular communication between the instructor and staff members. Clinical teachers function as culture brokers and border spanners to help integrate students more fully into the real world of nursing practice.

Settings for clinical learning should be selected carefully, based on important criteria such as compatibility of school and agency philosophy, licensure and accreditation, availability of opportunities to meet learning objectives, geographical location, availability of positive role models, and physical resources. Selection of appropriate clinical settings may be complicated by competition among several nursing programs for a limited number of agencies. Specific criteria for assessing the suitability of potential clinical settings were discussed.

When clinical sites have been selected, educators must prepare for teaching and learning activities. Areas of preparation include clinical competence, familiarity with the clinical environment, and orientation to the agency. Clinical competence has been documented as an essential characteristic of effective clinical teachers and includes knowledge and expert skill and judgment in the clinical practice area in which teaching occurs. Teachers may maintain clinical competence through faculty practice, joint appointment in clinical agencies, part-time clinical employment, and continuing nursing education activities. The teacher may become familiar with a new clinical setting by working with or

observing the staff for a few days prior to returning to the site with students. The clinical agency may require faculty members to attend an orientation program that includes introductions to agency staff, clarification of policies concerning student activities, and review of skills and procedures.

Preparation of the clinical agency staff usually begins with the teacher's initial contact with the agency. Roles of teacher, students, and staff members should be clarified so that staff members have guidelines for their participation in the instruction of learners. An important point of role clarification is that, although students are accountable for their own actions, the responsibility for patient care remains with staff members of the clinical agency. Staff members also need to be aware of specific learning objectives, the level of the learner, the need for positive role modeling, and expectations concerning their role in evaluating student performance. Although staff members' feedback is valuable in formative evaluation, the teacher always is responsible for summative evaluation of learner performance.

Students need cognitive, psychomotor, and affective preparation for clinical learning activities. Cognitive preparation includes information about the learning objectives, the clinical agency, and the roles of teacher, student, and staff member. Students may be expected to prepare for each clinical learning session through reading, interviewing patients, and completing written assignments. However, requirements for extensive written assignments to be completed before the actual clinical activity may imply that learning takes place only before the student enters the clinical area.

The instructor has a responsibility to assess that students have the desired level of skill development before entering the clinical setting. When learning complex skills, it is more efficient for students to practice the parts first in a simulated setting such as a skills laboratory, free from the demands of the actual practice setting. Students should have ample skill practice time before they enter the clinical area so that they are not expected to perform a skill for the first time in a fast-paced, demanding environment.

Affective preparation of students includes strategies for managing their anxiety and for fostering confidence and positive attitudes about learning. Most students have some anxiety about clinical learning activities. Mild or moderate anxiety often serves to motivate students to learn, but excessive anxiety hinders concentration and interferes with learning. In preparation for clinical learning activities, teachers may

employ strategies such as a structured preclinical conference to identify students' fears and reduce their anxiety to a manageable level.

Students also need a thorough orientation to the clinical agency in which learning activities will take place. This orientation should include information about the location and physical setup of the agency, relevant agency personnel, agency policies, daily schedules and routines, and procedures for responding to emergencies and for documenting patient information.

Students almost always perceive the first day of clinical learning activities in a new setting as stressful. Clinical teachers should plan specific activities for the first day that will allow learners to become familiar with and comfortable in the clinical environment and at the same time alleviate their anxiety. These activities include tours, conferences, games, and special assignments.

Exhibit 3.2

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- D.** Use information technologies to support the teaching-learning process
- I.** Create opportunities for learners to develop their own critical thinking skills
- J.** Create a positive learning environment that fosters a free exchange of ideas
- L.** Demonstrate personal attributes that facilitate learning (e.g., caring, confidence, patience, integrity, respect, and flexibility)
- N.** Develop collegial working relationships with clinical agency personnel to promote positive learning environments
- P.** Demonstrates ability to teach clinical skills
- Q.** Act as a role model in practice settings

2. Facilitate Learner Development and Socialization

- D.** Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E.** Foster the development of learners in these areas
 - 1.** cognitive
 - 2.** psychomotor
 - 3.** affective

(continued)

4. Participate in Curriculum Design and Evaluation of Program Outcomes

- C. Demonstrate knowledge of curriculum development including
 - 1. identifying program outcomes
- H. Maintain community and clinical partnerships that support the educational goals
- I. Create community and clinical partnerships that support the educational goals

5. Pursue Continuous Quality Improvement in the Academic Nurse Educator Role

- A. Engage in activities that promote one's socialization to the role
- E. Participate in professional development opportunities that increase one's effectiveness in the role

6. Engage in Scholarship, Service, and Leadership

- A. Function as a Change Agent and Leader
 - 8. Promote innovative practices in educational environments
- C. Function Effectively within the Institutional Environment and Academic Community
 - 4. Integrate the values of respect, collegiality, professionalism, and caring to build an organizational climate that fosters the development of learners and colleagues

REFERENCES

- Altmann, T. K., & Brady, D. (2005). PDAs bring information competence to the point-of-care. *International Journal of Nursing Education Scholarship*, 2(1), Article 10. Retrieved September 28, 2009, from www.bepress.com/ijnes/vol2/iss1/art10/
- Case, B., & Oermann, M. H. (2004). Teaching in a clinical setting. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (pp. 126–177). Glen Ellyn, IL: College of DuPage Press.
- Gardner, M. R., & Suplee, P. D. (2010). *Handbook of clinical teaching*. Sudbury, MA: Jones and Bartlett.
- George, L., & Davidson, L. (2005). PDA use in nursing education: Prepared for today, poised for tomorrow. *Online Journal of Nursing Informatics*, 9(2). Retrieved September 28, 2009, from http://ojni.org/9_2/george.htm
- Glasgow, M. E., & Cornelius, F. (2005). Benefits and costs of integrating technology into undergraduate nursing programs. *Nursing Leadership Forum*, 9, 175–179.
- Hunsberger, M., Baumann, A., Lappan, J., Carter, N., Bowman, A., et al. (2000). The synergism of expertise in clinical teaching: An integrative model for nursing education. *Journal of Nursing Education*, 39, 278–282.

- Ironside, P. M. (1999). Thinking in nursing education: A student's experience learning to think. *Nursing and Health Care Perspectives*, *20*, 238–242.
- Kelly, C. (2007). Students' perceptions of effective clinical teaching. *Nursing Education Today*, *27*, 885–887.
- Lee, W. S., Cholowski, K., & Williams, A. K. (2002). Nursing students' and clinical educators' perceptions of characteristics of effective clinical educators in an Australian university school of nursing. *Journal of Advanced Nursing*, *39*, 412–420.
- National Council of State Boards of Nursing. (n.d.). *Nurse licensure compact*. Retrieved September 28, 2009, from <https://www.ncsbn.org/nlc.htm>
- O'Connor, A. B. (2006). *Clinical instruction and evaluation: A teaching resource* (2nd ed.). Sudbury, MA: Jones and Bartlett.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer.
- Smith, C. M., & Patrillo, R. E. (2006). PDAs in the nursing curriculum: Providing data for internal funding. *Nurse Educator*, *31*, 101–102.
- Tang, F., Chou, S., & Chiang, H. (2005). Student perceptions of effective and ineffective clinical instructors. *Journal of Nursing Education*, *44*, 187–192.
- Williams, M. G., & Dittmer, A. (2009). Textbooks on tap: Using electronic books housed in handheld devices in nursing clinical courses. *Nursing Education Perspectives*, *10*, 220–225.

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4

Process of Clinical Teaching

Clinical teaching is a complex interaction between students and teachers. Influencing the clinical teaching process are characteristics of the teacher and learner; the clinical environment and nature of practice within that environment; patients, families, and others for whom students are caring; agency personnel and other health care providers; and the inherent nature of clinical practice with its uncertainties.

The process of clinical teaching is described in this chapter, but the reader should be aware that this process is not prescriptive. Instead, it provides a framework for the teacher to use in planning clinical activities appropriate for the learning outcomes and students, guiding students in the practice setting, and evaluating clinical performance. A framework assists faculty members to create an environment and opportunities for students to learn; the outcomes of those experiences, however, may vary considerably among students because of the many factors that influence the learning process. This chapter also describes characteristics of effective clinical teachers and models of clinical teaching, such as traditional, in which one teacher guides the learning of a small group of students; preceptor; and partnership.

TEACHING AND LEARNING

Teaching is a complex process intended to facilitate learning. While the goal of teaching is to lead students in discovering knowledge for themselves, the teacher encourages this discovery through deliberate teaching actions that lead in that direction. Self-discovery does not imply a lack of structure; instead, the teacher provides structure and learning activities for self-discovery by the student.

Clinical teaching is a series of deliberate actions on the part of the teacher to guide students in their learning. It involves a sharing and mutual experience on the part of both teacher and student and is carried out in an environment of support and trust. Teaching is not telling, it is not dispensing information, and it is not merely demonstrating skills. Instead, teaching is *involving* the student as an active participant in this learning. The teacher is a resource person with information to share for the purpose of facilitating learning and acquisition of new knowledge and skills.

Learning is a process through which people change as a result of their experiences. Some people view learning as an overt and measurable change in behavior resulting from an experience; however, this view negates a change in perception and insight as learning. In the clinical setting, new insights, ideas, and perspectives may be as critical to the student's learning and development as overt and measurable behaviors. Learning, therefore, may be a change in observable behavior or performance, or it may reflect a new perception and insight not manifested by an overt change in behavior.

The teaching-learning process is a complex interaction of these processes. The teacher is a facilitator of learning, and the student is an active participant. The need for students to be actively involved in their learning is critical in the teaching-learning process, particularly in the clinical setting. When students are actively involved in their learning and perceive a positive teacher-student relationship, they can be honest about their learning needs and how faculty can help them in developing their clinical competencies.

Active learning also fosters critical thinking because students can explore alternative perspectives and different decisions that could be made in a clinical situation (Oermann, 2004b). They can think about and discuss with others how concepts and theories are used to solve clinical problems. By being actively involved in their learning, students can

reflect on their clinical experience and put their thoughts into words, which leads to new knowledge and deeper learning (Murphy, 2005).

Although teaching and learning are interrelated processes, each may occur without the other. Significant learning may result from the student's clinical activities without any teacher involvement. Similarly, the teacher's carefully planned assignments and activities for students may not lead to any new learning or development of competencies. The goal of clinical instruction is to create the *environment and activities for learning*, recognizing that each student will gain different insights and outcomes from them.

PROCESS OF CLINICAL TEACHING: FIVE COMPONENTS

The process of clinical teaching includes five steps:

1. Identifying the outcomes for learning
2. Assessing learning needs
3. Planning clinical learning activities
4. Guiding students
5. Evaluating clinical learning and performance

The process of clinical teaching is not linear; instead, each component influences others. For example, clinical evaluation provides data on further learning needs of students that in turn suggest new learning activities. Similarly, as the teacher works with students, observations of performance may alter the assessment and suggest different learning activities.

Identifying Outcomes for Learning

The first step in clinical teaching is to identify the goals and outcomes of clinical practice as discussed in chapter 2. These intended learning goals and outcomes suggest areas for assessment, provide guidelines for teaching, and are the basis for evaluating learning. Faculties identify these outcomes in different ways. In some nursing programs, the outcomes of learning are stated as objectives to be achieved by students in the clinical course. In other programs, they are expressed in the form of clinical competencies to be demonstrated at the end of the course or for specific clinical activities. Clinical competencies often address 10 areas

of learning. These areas are listed in Exhibit 4.1 with examples of competencies in each area.

In some clinical courses, students need to demonstrate learning and performance in all of these areas as well as others specific to the clinical specialty or setting. Other courses may focus on only a few of these areas of learning. Clinical competencies may be stated broadly, similar to most of the examples in Exhibit 4.1, or they can be more specific, such as, “administer intravenous injection of medications.” In any clinical course, the competencies should be achievable by students, considering their prior knowledge, skills, and experiences; clinical learning opportunities available in the setting; and time allotted for clinical practice.

The clinical competencies should be communicated clearly to students, in written form, and understood by them. Similarly, the teacher has an important responsibility in *discussing* these outcomes and related clinical activities with agency personnel, not *telling* them. Agency personnel need input into decisions about the clinical activities and their match with the goals, philosophy, and care delivery system of the clinical setting. With this input, the teacher may need to alter intended clinical activities and plan simulations and other types of learning opportunities for students.

Students also should have input into the clinical competencies; there may be some already achieved by students and others to be added to meet their individual learning needs and goals. There should be some flexibility in the clinical course as long as students demonstrate the competencies and achieve the essential knowledge and skills for progressing through the nursing program.

It is important for all clinical teachers—full- and part-time, adjunct, and preceptors—to understand the clinical competencies of the course and prior courses that students have completed. The course leader is responsible for ensuring that all educators in a course, no matter what their role, use the outcomes and competencies to guide their selection of patients and other learning activities for students and to assess performance.

Assessing Learning Needs

Teaching begins at the level of the learner. The teacher’s goal, therefore, is to assess the student’s present level of knowledge and skill and other characteristics that may influence achieving the outcomes of the clinical practicum. The first area of assessment involves collecting data on whether the student has the prerequisite knowledge and skills for the

EXAMPLES OF CLINICAL COMPETENCIES

1. Concepts, theories, and other knowledge for clinical practice
Analyzes the pathophysiological basis for the development of clinical manifestations in common patient conditions.
Applies multicultural concepts of care to the community as client.
2. Use of research and other evidence in clinical practice
Uses evidence on pain management interventions in planning care for patients.
Evaluates research studies for applicability to long-term care of patients with dementia and their caregivers.
3. Assessment, diagnosis, plan, interventions, and evaluation of outcomes
Collects data that are developmentally and age appropriate for healthy and ill children.
Considers multiple nursing interventions for care of patients with complex health problems.
4. Psychomotor and technological skills, other types of interventions, and informatics competencies
Demonstrates skill in conducting a physical examination.
Uses informatics tools to retrieve and critically analyze information.
5. Values related to care of patients, families, and communities and other dimensions of health care
Recognizes personal values that might conflict with professional nursing values.
Accepts cultural, ethnic, and other differences of patients and communities.
6. Communication skills, ability to develop interpersonal relationships, and skill in collaboration with others
Collaborates with other health providers in interdisciplinary care of children with disabilities.
Communicates effectively with patients, families, staff, and others in the health care setting.
7. Development of knowledge, skills, and values essential for continuously improving the quality and safety of health care
Identifies quality problems in a clinical setting using relevant measures and potential solutions.
Participates in analyzing own and system errors and designing unit-based improvements.
8. Management of care, leadership abilities, and role behaviors
Manages care effectively for a small group of patients.
Demonstrates the role and behaviors of a nurse as leader.
9. Accountability and responsibility of the learner
Accepts responsibility for own actions and decisions.
Values own role in preventing errors.
10. Self-development and continued learning
Identifies own learning needs in clinical practice.
Seeks learning opportunities to develop clinical competencies.

clinical situation at hand and for completing the learning activities. For instance, if the learning activities focus on interventions for health promotion, students first need some understanding of health and behaviors for promoting health. Changing a sterile dressing requires an understanding of principles of asepsis. The teacher's role in assessment of the learner is important so that students engage in learning activities that build on their present knowledge and skills. When students lack the prerequisites, then the instruction can remedy these and more efficiently move students forward in their learning.

Not every student will enter the clinical course with the same prerequisite knowledge and skills, depending on past learning and clinical experiences. The teacher, therefore, should not expect the same entry competencies for all students. Assessment reveals the point at which the instruction should begin and does not imply poor performance for students, only that some learners may need different types of learning activities for the objectives. Assessment also may indicate that some students have already attained certain clinical competencies and can progress to new areas of learning.

The second area of assessment relates to individual characteristics of students that may influence their learning and clinical performance. Students and nurses today represent a diverse group of learners with varied cultural backgrounds, learning styles, ages, and other characteristics. Students bring with them a wealth of life and other experiences. In nursing programs, particularly second-degree programs, there is a wide range of ages of students, reflecting different generations and ways of thinking. Students in a nursing program may be baby boomers born between 1943 and 1960; generation X (gen X) students, born from 1961 to 1981; and the millennial/Net generation, born between 1982 and 2002 (Henry, 2006; Oblinger, 2003). There are different learning styles and expectations across these generations. Students who are gen Xers and millennials prefer experiential activities and being involved in decisions about their learning activities. Those students, in contrast to older students and most nursing faculty members, are part of the information age and grew up with the World Wide Web, communicating with others electronically, and multitasking (Billings, Skiba, & Connors, 2005; Pardue & Morgan, 2008). Generational differences may affect how students approach their education. Twenge (2009) recommended that faculty members provide specific instructions and frequent feedback to these students, emphasize the relevance of the information being learned, deliver the instruction in short segments, and use multimedia and an interactive format.

In addition, many students combine their nursing education with other role responsibilities, such as family and work. Information about these characteristics, among others, gives the teacher a better understanding of the students and their responses to different learning situations. Faculty members need to accept individual differences among students and use this knowledge in planning the learning activities.

Planning Clinical Learning Activities

Following assessment of learner needs and characteristics, the teacher plans and then delivers the instruction. In planning the learning activities, the main considerations are the competencies to be developed in the clinical practicum, or outcomes to be met in the clinical component of the course, and individual learner needs. Other factors that influence decisions on clinical activities include the evidence on the effectiveness of the clinical teaching method and learning activities being considered, characteristics of the clinical setting, and teacher availability to guide learners.

Clinical Competencies/Outcomes of Clinical Course

Clinical learning activities are selected to facilitate students' developing the essential competencies for clinical practice in that course or to meet the outcomes of the clinical practicum, depending on how these are stated by faculty members in the clinical course. The learning activities may include patient care assignment, but care of patients is not the only learning activity in which students engage in the practice setting. The specific competencies to be developed or outcomes to be achieved in that course should guide selection of learning activities. If the competencies focus on communication skills, then the learning activities may involve interviews with patients and families, papers analyzing those interactions, role play, and simulated patient-nurse interactions rather than providing direct care.

Learner Needs

While the clinical outcomes provide the framework for planning the learning activities, the other main consideration is the needs of the student. The activities should build on the student's present knowledge and skills and take into consideration other learner characteristics. Each student does not have to complete the same learning activities; the teacher

is responsible for individualizing the clinical activities so that they best meet each student's needs while promoting achievement of the course outcomes.

Learning activities also build on one another. Planning includes organizing the activities to provide for the progressive development of knowledge and skills for each learner.

Evidence on Effectiveness of Clinical Teaching Method and Learner Activities

Decisions about the teaching methods to use and types of activities in which students will participate in the clinical setting should be based on evidence about what works best for promoting student learning. Nurse educators should review the literature to identify evidence to support the teaching methods they are planning and to get ideas about other strategies and activities for students that might be as or more effective. The evidence also will guide how a teaching method is implemented—for example, how to debrief after a simulation and the level of questions to ask to promote higher-level thinking. Evidence-based clinical nursing education involves four phases: (1) asking questions about best practices in teaching students in the clinical setting, (2) searching for research and other evidence to answer those questions, (3) evaluating the quality of the evidence and whether it is ready to be used in clinical teaching, and (4) deciding whether the findings are applicable to one's own clinical course, students, and setting (Oermann, 2007, 2009).

Characteristics of the Clinical Setting

The size of the agency, the patient population, the educational level and preparation of nurses and their availability and interest in working with students, other types of health care providers in the setting, and other characteristics of the clinical environment should be considered in planning the learning activities. These characteristics are considered in choosing an agency for use in a course, as discussed in chapter 3, and they also guide the faculty in planning learning activities.

Teacher Availability

The teacher's availability to work with students in the clinical setting is an important consideration in planning the learning activities. Being

available to students to guide their learning when needed is a characteristic of an effective clinical teacher. The number and level of students in a clinical group, for instance, may influence the type of learning activities planned for a course. Beginning students and nurses new to a clinical practice area may require more time and guidance from the teacher than experienced students and nurses. This principle also is important in distance education and other courses using preceptors; the preceptor must be available to guide students' learning in clinical practice.

Guiding Learners in Clinical Practice

The next step in the process of clinical teaching is guiding learners to acquire the essential knowledge, technological and other skills, and values for practice. Guiding is a facilitative and supportive process that leads the student toward achievement of the outcomes. It is a process of coaching students in their learning. Guiding is not supervision; supervision is a process of overseeing. Effective clinical teaching requires that the teacher guide students in their learning, not oversee their work.

This is the instructional phase in the clinical teaching process—the actual teaching of students in the clinical setting either on site or at a distance. For distance education courses, the instructional phase may be carried out by preceptors, advanced practice nurses in the clinical setting, and other providers depending on the course outcomes. With some learning activities, the teacher has a direct instructional role—for instance, demonstrating an intervention to students and questioning them to expand their understanding of a clinical situation. Other teaching activities, though, may be indirect, such as giving feedback on papers and preparing preceptors for their role, among others.

Murphy (2004) emphasized that clinical instruction is not only about the content being learned but also involves guiding students in learning how to learn and think about patient care. She found that focused reflection in clinical practice and articulation of thoughts in journals and postclinical conferences facilitated the development of students' clinical reasoning. Through this process, students become aware of their learning and thinking, recognizing their learning needs and developing skills needed for lifelong learning.

Clinical education provides the avenue for acquiring the knowledge and behaviors for practice in a particular role, whether it is a beginning professional nurse or new role such as advanced practice nurse. This process requires learning about the role as the initial step and observing

and working with nurses in that role as the second step. In clinical instruction, the teacher guides the student in learning about the role and role behaviors of the nurse, and models important values and attributes of the professional in that role. If there is a caring relationship between the teacher and students with honest and open communication, then students can more easily internalize the behaviors and values they are learning about into their own practice (Hentz, 2005). Socialization comes from an integration of clinical and other experiences, not only from the guidance of the teacher. The experiences of students with preceptors, other nurses, and other health care providers contribute to this socialization process.

Skill in Observing Performance

In the process of guiding learners, the teacher needs to be skilled in: (a) observing clinical performance, arriving at sound judgments about that performance, and planning additional learning activities if needed and (b) questioning students to promote critical thinking and higher-level learning. Observing students as they carry out their clinical activities allows the teacher to identify continued areas of learning and when assistance is needed from the teacher. This information, in turn, suggests new learning activities for clinical practice.

Observations of students may be influenced by the teacher's values and biases, which may affect *what they see* as they observe a student's performance and their *impressions* of the quality of that performance. All educators should know their own values and biases that might influence their observations of student performance in clinical practice and judgments about student performance of the competencies. Guidelines for observing students are summarized in Exhibit 4.2.

Skill in Questioning Students

The second skill needed by the teacher to effectively guide clinical learning activities is an ability to ask thought-provoking questions without students feeling that they are being interrogated. Open-ended questions about students' thinking and the rationale they used for arriving at clinical judgments foster development of critical thinking skills, an important outcome of clinical practice (Hoffman, 2008; Hsu, 2007; Oermann, 2008; Oermann, Truesdell, & Ziolkowski, 2000; Profetto-McGrath, Smith, Day, & Yonge, 2004; Sedlak & Doheny, 2004).

Exhibit 4.2

GUIDELINES FOR OBSERVING STUDENTS IN CLINICAL PRACTICE

- Examine own values and biases that may influence observations of students in clinical practice and judgments about clinical performance.
- Do not rely on first impressions for these might change significantly with further observations of the student (Nitko & Brookhart, 2007).
- Make a series of observations before drawing conclusions about clinical performance.
- Share with students on a continual basis observations made of clinical performance and judgments about whether students are meeting the clinical competencies.
- Focus observations on the outcomes of the clinical course or competencies to be achieved.
- When the observations reveal other aspects of performance that need further development, share these with students and use the information as a way of providing feedback on performance.
- Discuss observations with students, obtain their perceptions of performance, and be willing to modify judgments when a different perspective is offered (Oermann & Gaberson, 2009).

Faculty members, however, tend to ask questions that focus on recall of facts rather than ones that foster critical thinking (Profetto-McGrath et al., 2004). When questioning students in clinical practice, the teacher should assess understanding of relevant concepts and theories and how they apply to patient care. Other questions can ask students about different decisions possible in a clinical situation, consequences of each decision, the decision they would make, and their rationale; different problems, possible interventions, and their evidence base; and assumptions underlying their thinking (Oermann et al., 2000). Questions should encourage learners to think beyond the obvious.

The way in which questions are asked also is significant. The purpose of questioning is to encourage students to consider other perspectives and possibilities, not to drill them and create added stress. In the beginning of a clinical course, and particularly in the beginning of the nursing program, the teacher should discuss the purpose of questioning and its relationship to developing critical thinking skills. The teacher can demonstrate the type of questions that will be asked in the course and how those questions encourage critical thinking.

Because questioning is for instructional purposes, students need to be comfortable that their responses will not influence their clinical

grades. Instead, the questions asked and answers given are an essential part of the teaching process, to promote learning and development of critical thinking skills, not for grading purposes. Only with this framework will students be comfortable in responding to higher-level questions and evaluating alternative perspectives, using the teacher as a resource. Collegial discussions promote reflection on practice competence and lead to developing clinical judgment (Weber, 2005).

Evaluating Clinical Learning and Performance

The remaining component of the clinical teaching process is evaluation. Clinical evaluation serves two purposes: formative and summative. Through formative evaluation, the teacher monitors student progress toward meeting the outcomes of the clinical course and demonstrating competency in clinical practice. Formative evaluation provides information about further learning needs of students and where additional clinical instruction is needed. Clinical evaluation that is formative is not intended for grading purposes; instead, it is designed to diagnose learning needs as a basis for further instruction.

Summative evaluation, in contrast, takes place at the end of the learning process to ascertain whether the course outcomes have been achieved and competencies developed (Oermann & Gaberson, 2009). Summative evaluation provides the basis for determining grades in clinical practice or certifying competency. It occurs at the completion of a course, an educational program, orientation, and other types of programs. This type of clinical evaluation determines what *has been* learned rather than what *can be* learned.

There are many clinical evaluation strategies that can be used in nursing courses. These are discussed and examples are provided in chapter 16.

QUALITIES OF EFFECTIVE CLINICAL TEACHERS

Clinical teaching requires an educator who is knowledgeable about the clinical practice area, is clinically competent, knows how to teach, relates effectively to students, and is enthusiastic about clinical teaching. The teacher also serves as a role model for students or selects clinicians who will model important professional behaviors.

There has been much research in nursing education on characteristics and qualities of an effective clinical teacher. Every clinical teacher should be aware of behaviors that promote learning in the practice setting and ones that impede student learning.

Knowledge

Teachers in nursing, as in any field, need to have expertise in the subject they are teaching. In clinical teaching, this means that educators are knowledgeable about the types of patient problems in the clinical setting, how to manage them, new technologies in patient care, and related research (Beitz & Wieland, 2005; Gignac-Caille & Oermann, 2001; Tang, Chou, & Chiang, 2005). Teachers must be up-to-date in the area of clinical practice in which they are working with students. This is particularly true in the traditional model of clinical teaching in which the teacher is responsible for planning and guiding student learning in practice.

In a study by Tang and colleagues (2005), having “sufficient professional knowledge” was one of the three highest ranked clinical teacher behaviors. In another study, Wolf and associates (2004) analyzed student evaluations of faculty performance. Strengths of the teacher included characteristics such as being knowledgeable, creating a positive learning environment, being professional and supportive of students, and displaying scholarly attributes.

Clinical Competence

Teachers cannot guide student learning in clinical practice without being competent themselves. Clinical competence is an important characteristic of effective clinical teaching in nursing (Gignac-Caille & Oermann, 2001; Tang et al., 2005). In a study by Gignac-Caille and Oermann (2001), 292 students in various levels of their associate degree nursing programs identified “demonstrates clinical skills and judgment” as the most important characteristic of effective clinical instructors. The best teachers are experts in their clinical specialty, have maintained their clinical skills, can demonstrate nursing care in a real situation, and can guide students in developing essential clinical competencies.

This quality of teaching may be problematic for faculty members who teach predominantly in the classroom or change practice settings frequently and do not keep current in their clinical specialty. In some

nursing education programs, clinical faculty members are required to maintain a clinical practice certification, which encourages continued competency. For programs without such a requirement, it is up to the teacher to maintain clinical expertise and skills.

Skill in Clinical Teaching

Skill in clinical teaching includes the ability of the teacher to assess learning needs, plan instruction that meets those needs and fosters achievement of the outcomes of the clinical course, guide students in developing their clinical competencies, and evaluate learning fairly. These teaching skills are described more specifically in Exhibit 4.3.

The clinical teacher needs to know *how to teach*. While this seems obvious, in some settings, clinical teachers, preceptors, and others working with students are not prepared educationally for their roles. They have limited knowledge about how to guide students' learning in the clinical setting and assess their performance. Being an expert clinician is not enough. In a study by Wetherbee, Nordrum, and Giles (2008) with physical therapy clinical educators, there was a positive correlation between the number of years of clinical teaching experience and scores on the Nursing Clinical Teacher Effectiveness Inventory. With experience, educators can refine their skills in clinical teaching and develop their expertise, using self-reflection and feedback from students.

In a study by Berg and Lindseth (2004), the instructional skills of the teacher were ranked second highest when students ($n = 171$) were asked to describe characteristics of an effective teacher in nursing. When those same students were asked about ineffective teachers, lack of teaching skill was ranked highest.

Skills in evaluating clinical performance both formatively, for feedback, and summatively, at the end of a period of time in the clinical course, are critical for effective teaching. Research has shown that effective teachers are fair in their evaluations of students, correct student errors without belittling students and diminishing their self-confidence, and give prompt feedback that promotes further learning and development.

Interpersonal Relationships With Students

The ability of the clinical teacher to interact with students, both on a one-to-one basis and as a clinical group, is another important teacher behavior. Qualities of an effective teacher in this area are showing confidence

Exhibit 4.3

CLINICAL TEACHING SKILLS

- Assesses learning needs of students, recognizing and accepting individual differences
- Plans assignments that help in transfer of learning to clinical practice, meet learning needs, and promote acquisition of knowledge and development of competencies
- Communicates clearly to students outcomes of learning and expectations of students in clinical practice
- Considers student goals and needs in planning the clinical activities
- Structures clinical assignments and activities in clinical practice so they build on one another
- Explains clearly concepts and theories applicable to patient care
- Demonstrates effectively clinical skills, procedures, and use of technology
- Provides opportunities for practice of clinical skills, procedures, and technology and recognizes differences among students in the amount of practice needed
- Is well prepared for clinical teaching
- Develops clinical teaching strategies that encourage students to problem solve, arrive at clinical decisions, and think critically in a clinical situation
- Asks higher-level questions that assist students in thinking through complex clinical situations and cases requiring critical thinking
- Encourages students through teaching and assessment to think independently and beyond accepted practices and to try out new interventions
- Varies clinical teaching strategies and learning activities to stimulate student interest and meet individual needs of students
- Guides learning and students' use of resources for learning
- Is available to students in clinical practice when they need assistance
- Serves as a role model for students
- Provides specific, timely, and useful feedback on student progress
- Shares observations of clinical performance with students
- Encourages students to evaluate their own performance
- Corrects mistakes without belittling students
- Exhibits fairness in evaluation

in students, respecting students, being honest and direct, supporting students and demonstrating caring behaviors, being approachable, and encouraging students to ask questions and seek guidance when needed. In Gignac-Caille and Oermann's (2001) study of effective clinical teaching, the 10 most important characteristics identified by faculty members were composed of behaviors from the subscales of interpersonal

relationships and teaching skills. Considering the demands on students as they learn to care for patients, students need to view the teacher as someone who supports them in their learning. Manias and Aitken (2005) emphasized the important role of the clinical teacher in providing this support to nursing students.

Personal Characteristics of the Clinical Teacher

Personal attributes of the teacher also influence teaching effectiveness. These attributes include enthusiasm, a sense of humor, willingness to admit limitations and mistakes honestly, patience, and flexibility when working with students in the clinical setting, among others (Berg & Lindseth, 2004; Gignac-Caille & Oermann, 2001; Tang et al., 2005). Students often describe effective teachers as ones who are friendly and provide an opportunity for them to share feelings and concerns about patients. Three other personal qualities important in teaching in any setting are integrity, perseverance, and courage (Glassick, Huber, & Maeroff, 1997). While these characteristics were originally used to describe the teacher as a scholar, they are just as important in carrying out the clinical teaching role. Integrity implies truthfulness with students and fairness in dealing with them in the process of learning and in clinical evaluation. The teacher develops an atmosphere of trust for students to engage in open discussions, examine alternatives, and discuss conflicting opinions with the faculty member. Fairness “involves the presentation of one’s own interpretations and conclusions in ways that keep open an examination of alternatives” (Glassick et al., 1997, p. 64).

In clinical teaching, faculty members need to persevere in their efforts to improve their teaching competencies. They should be willing to reflect on their teaching and evaluation practices and consider better ways of designing clinical activities and guiding students in their learning. Good teachers, like good scholars, strive to perfect their teaching skills over time and avoid stagnation in their teaching approaches.

STRESSES OF STUDENTS IN CLINICAL PRACTICE

Clinical practice is inherently stressful. In the clinical setting, students face uncertainties and unique situations that they may not have encountered in their prior learning. For some students, clinical practice is

stressful because they are unsure about approaches and interventions to use. Students fear making a mistake that would harm the patient (Oermann & Lukomski, 2001). Interacting with the teacher, other health care providers, the patient, and family members also may contribute to the stress that students experience in clinical practice.

Other stresses, from the students' perspective, relate to the changing nature of patient conditions, a lack of knowledge and skill to provide care to patients, unfamiliarity in the clinical setting, working with difficult patients, developing technological skills, and being observed and evaluated by the teacher (Gorostidi et al., 2007; Moscaritolo, 2009; Oermann & Lukomski, 2001; Sheu, Lin, & Hwang, 2002).

In many of these studies, the clinical teacher and behaviors of the teacher created the most stress for students. This finding reinforces the need for the faculty to develop supportive and trusting relationships with students in the clinical setting and be aware of the stressful nature of clinical learning activities. A climate that supports the process of learning in clinical practice is dependent on a caring relationship between teacher and student rather than an adversarial one. Cook (2005) found that when teachers convey inviting messages, such as showing respect for students, expressing pleasure with the clinical group, and being friendly, among others, students reported less anxiety. When students experience stress, they need clinical teachers who are sensitive to their concerns, demonstrate empathy, and provide clear guidance (Gibbons, Dempster, & Moutray, 2008).

Learning in clinical practice occurs in public under the watchful eye of the teacher, the patient, and others in the setting. By keeping the nature of clinical learning in mind and using supportive behaviors when interacting with students, the teacher can reduce some of the stress that students naturally feel in clinical practice.

STRESSFUL NATURE OF CLINICAL TEACHING

Clinical teaching can be stressful for the teacher. First, it is time consuming. A three-credit theory or online course usually requires 3 hours per week of instruction, 1 clock hour for each credit hour, not including preparation time. However, a three-credit clinical course may require 6 to 9 hours of clinical teaching a week, 2 to 3 clinical practice hours per credit hour, and even more in some nursing education programs.

This time commitment for clinical teaching may create stress for faculty members who also are involved in research, scholarship, professional service, and clinical practice. In many nursing education programs, faculty members are responsible for writing grant proposals, conducting research, writing for publication, serving on committees, providing community service, and maintaining a clinical practice. These multiple roles are demanding for clinical educators.

In addition to demands associated with the multiple roles of a nursing faculty member, other aspects of clinical teaching may be stressful. These include:

- Coping with the many expectations associated with clinical teaching
- Feeling exhausted at the end of a clinical teaching experience with students
- Job demands that interfere with activities of personal importance
- Too heavy a workload
- Pressure to maintain clinical competence or a clinical practice without time to do so
- Feeling unable to satisfy the demands of students, clinical agency personnel, patients, and others
- Teaching inadequately prepared students (Oermann, 1998)

Novice faculty members and teachers new to a nursing education program should find a mentor in the school who can support them as they learn the educator role in that setting. Mentoring is a strategy to avoid burnout and promote the well-being of nursing faculty (Dunham-Taylor, Lynn, Moore, McDaniel, & Walker, 2008; Shirey, 2006). Mentors can be good sources of guidance on how to balance clinical teaching with other faculty roles. Faculty members on the tenure track may need release time from clinical teaching responsibilities to work on research and scholarship; changes in workload should be negotiated early in one's career to allow adequate time for scholarly activities.

MODELS OF CLINICAL TEACHING

There are different models of clinical teaching: traditional, in which the teacher is directly responsible for guiding students in the clinical setting; preceptor; and clinical teaching partnership. In the preceptor and

partnership models, preceptors and others in the clinical setting provide the clinical instruction, with the faculty member responsible for overall planning, coordinating the experience, grading clinical practice, and assuming other course-related responsibilities.

Traditional Model

In the traditional model of clinical teaching, the educator provides the instruction and evaluation for a small group of nursing students and is on site during the clinical experience. A benefit of this model is the opportunity to assist students in using the concepts and theories learned in class, through online instruction, in readings, and through other learning activities in patient care. The teacher can select clinical activities that best meet the students' needs and are consistent with course goals and objectives. Because the clinical teacher is involved to varying degrees with the nursing curriculum overall, the clinical activities may be more carefully selected to reflect the concepts and theories that students are learning in the course than when preceptors or partners provide the instruction. In addition, the faculty member may be more committed to implementing the philosophy of the nursing program than preceptors or clinicians hired only for clinical teaching, often on a short-term basis.

Disadvantages, though, are the large number of students for whom faculty members may be responsible; not being accessible to students when needed because of demands of other students in the group; teaching procedures, clinical skills, and use of technologies for which the faculty member may lack expertise; the time commitment of providing on-site clinical instruction for faculty members with multiple other roles; and high costs for the nursing program. Faculty members who are part-time or adjunct may not be sufficiently familiar with the philosophy and goals of the program, overall curriculum, clinical competencies developed prior to and following the course in which they are teaching, and other program characteristics, which may affect their planning of clinical activities for students and their expectations of students in the course. It is critical for the full-time faculty to prepare and orient part-time and adjunct faculty members involved in clinical teaching so they are not only aware of their role and responsibilities but also understand how their course relates to the overall nursing curriculum.

In the traditional model, the clinical learning experiences are dependent on patients in the setting at the time when students are present. As

patients' conditions change, students may lack the requisite knowledge and skills to care for them. Nielsen (2009) identified another disadvantage in that students in acute care settings may prepare for particular assignments, but when they arrive on the unit, the patient is discharged. In courses in which students provide total patient care, they have limited time for contact with other patients in the setting. Nielsen proposed a concept-based approach in which students focus their learning on concepts—for example, oxygenation—and clinical practice provides experiences in those concepts across different patients.

Another disadvantage of the traditional model of clinical teaching is that the educator and students may not be part of the health care system in which students have clinical practice. They are outsiders to the clinical setting and may not understand the system of care in that setting and its culture. As such, faculty members must work closely with the managers and clinical nursing staff to ensure an effective clinical experience for students. It is up to the faculty member to develop a working relationship with the staff, which is essential to create an environment for learning and take advantage of experiences available in the setting. In the traditional model of clinical teaching, faculty members who are not also practicing in the clinical setting often invest extensive time in developing and maintaining these relationships.

The relationships that nursing faculty members develop in the clinical setting are not only with nursing staff but also involve other health care providers. With overlapping roles and responsibilities of health care providers and emphasis on interprofessional care, nursing students need clinical learning activities in which they examine their own role in relationship to other providers and collaborate with other health professionals. This learning can occur with simulations. Simulations that involve nursing, medical, pharmacy, and other students provide a way for students to learn to collaborate and gain an understanding of different perspectives to patient care. Baker and colleagues (2008) found that interprofessional education with simulation was an effective strategy to teach students about collaborative models of care delivery.

Preceptor Model

In the preceptor model of clinical teaching, an expert nurse in the clinical setting works with the student on a one-to-one basis in the clinical setting. Preceptors are staff nurses and other nurses employed by the

clinical agency who, in addition to their ongoing patient care responsibilities, provide on-site clinical instruction for the assigned students. In addition to one-to-one teaching, the preceptor guides and supports the learner and serves as a role model. In a preceptor-based nursing course, students can transition into independent practice, become socialized into their professional role, and develop their clinical competencies (Blum, 2009; Kim, 2007; Smedley & Penney, 2009). In addition to improving clinical skills, a preceptorship fosters development of perceived competence among nursing students and their self-confidence (Kim, 2007; King, Singh, & Harris, 2009).

In the preceptor model of clinical instruction, the faculty member from the nursing program serves as the course coordinator, liaison between the nursing education program and clinical setting, and resource person for the preceptor. The faculty member, however, is typically not on site during the clinical practicum. The preceptor model involves sharing clinical teaching responsibilities between nursing program faculty members and expert clinicians from the practice setting. Guidelines for setting up a preceptorship are described in chapter 13.

One strength of the preceptor model is the consistent one-to-one relationship of the student and preceptor, providing an opportunity for the student to work closely with a role model. This close relationship promotes professional socialization and enables students to gain an understanding of how to function in the role for which they are being prepared. Other advantages of preceptorships are that students are able to work closely with a clinical expert in the field, develop self-confidence, improve their critical thinking and decision-making skills, and learn new clinical skills under the guidance of the preceptor.

Potential disadvantages of the preceptor model are lack of integration of theory, research, and practice; lack of flexibility in reassigning students to other preceptors if needed; and time and other demands made on the preceptors. Although preceptors should be prepared educationally for this role, some preceptors may lack clinical teaching skills. The preceptor model is commonly used at upper levels of the prelicensure curriculum, often in the final clinical course; for graduate nursing students; and in distance education courses. However, preceptors also can be used with beginning nursing students, providing an opportunity for them to develop their clinical knowledge and skills guided by an expert in the role and gain a realistic view of clinical practice. In distance education courses, when students do not live locally, clinical settings can

be established close to the students' homes with preceptors providing the clinical instruction.

Partnership Model

There are varied types of partnerships in nursing education. Some of these are the result of nursing program faculties and administrators searching for ways to increase student enrollment and cope with budgetary constraints, a nursing faculty shortage, and not enough clinical sites, combined with health care agencies experiencing a nursing shortage (American Association of Colleges of Nursing, 2002; Frank, 2008; Oermann, 2004a). In partnerships, nursing education programs collaborate with clinical agencies and the community to respond to these issues as well as work together to meet the health care needs of the community (Campbell & Filer, 2008; Campbell & Jeffers, 2008; Francis-Baldesari & Williamson, 2008; Pharez, Walls, Roussel, & Broome, 2008; Stolder, Rosemeyer, & Zorn, 2008).

Partnerships vary widely. In some programs, the partnership model is a collaborative relationship between a clinical agency and nursing program that involves sharing an advanced practice nurse (APN) and academic faculty member. The APN teaches students in the clinical setting, with the faculty member serving as course coordinator, and the faculty member in turn contributes to the clinical agency—for example, by conducting research and serving as a consultant. Expertise and services are shared between the partners. In this type of partnership, the APN may work with a graduate nursing student on an individualized basis or may teach a group of prelicensure students, as in the traditional clinical teaching model. At both the undergraduate and graduate levels, the faculty member works closely with the APN to ensure the selection of relevant clinical activities for students.

Another example of a partnership for clinical teaching is the clinical partner model in which a faculty member teaches two groups of students, as in the traditional model, but is partnered with two clinical adjunct instructors from the clinical setting. Each of the adjunct instructors is assigned to one of these clinical groups (Campbell & Dudley, 2005). This model provides a way to double the capacity of the nursing faculty and gives the students an opportunity to be mentored and taught by expert clinicians practicing in that setting.

Other partnerships are community based, linking education, practice, and research (Pharez et al., 2008; Plowfield, Wheeler, & Raymond, 2005).

Through partnerships patients may get care they otherwise would not receive, students gain learning experience, and nursing faculty members also get practical experience (Yeh, Rong, Chen, Chang, & Chung, 2009).

Selecting a Clinical Teaching Model

There is no one model that meets the needs of every nursing education program, clinical course, or group of students. The teacher should select a model considering these factors:

- Educational philosophy of the nursing program
- Philosophy of the faculty about clinical teaching
- Goals and intended outcomes of the clinical course and activities
- Level of nursing student
- Type of clinical setting
- Availability of preceptors, expert nurses, and other people in the practice setting to provide clinical instruction
- Willingness of clinical agency personnel and partners to participate in teaching students and other educational activities

SUMMARY

The process of clinical teaching begins with identification of the goals and outcomes for clinical learning and proceeds through assessing the learner, planning clinical learning activities, guiding students, and evaluating clinical learning and performance. The goals and outcomes suggest areas for assessment, provide guidelines for teaching, and are the basis for evaluating learning. They may be expressed in the form of clinical objectives, outcomes, or competencies and may be established for an entire course or for specific clinical activities. The outcomes of clinical practice should be communicated clearly to students, in written form, and understood by them. Similarly, the teacher has an important responsibility in discussing these outcomes and related clinical activities with agency personnel.

Teaching begins at the level of the learner. The teacher's goal, therefore, is to assess the student's present level of knowledge and skill and other characteristics that may influence developing the clinical competencies. This assessment is important so that students engage in learning activities that build on their present knowledge and skills. When

students lack the prerequisites, then the instruction can remedy these deficiencies and more efficiently move students forward in their learning. The second area of assessment relates to individual characteristics of students that may influence their learning and clinical performance, such as age, learning style, and cultural background.

Following assessment of learner needs and characteristics, the teacher plans and then delivers the instruction. In planning the learning activities, the main considerations are the objectives and individual learner needs. The next step in the process of clinical teaching is that of guiding learners to acquire essential knowledge, skills, and values for practice. In this process of guiding learners, the teacher needs to be skilled in: (a) observing clinical performance, arriving at sound judgments about that performance, and planning additional learning activities if needed and (b) questioning learners to encourage critical thinking but without interrogating them.

The last component of the clinical teaching process is evaluation. Clinical evaluation can be formative or summative. Through formative evaluation, the teacher monitors student progress in meeting the clinical outcomes and demonstrating competency in clinical practice. Summative evaluation, in contrast, takes place at the end of the learning period to ascertain whether the outcomes have been achieved and competencies developed. It occurs at the completion of a course, an educational program, orientation, and other types of programs. This type of clinical evaluation determines what *has been* learned rather than what *can be* learned.

Teaching in the clinical setting requires a faculty member who is knowledgeable, is clinically competent, knows how to teach, relates effectively to students, and is enthusiastic about clinical teaching. The research in nursing education over the years has substantiated that these qualities are important in clinical teaching.

Clinical practice is stressful for students. Students have identified dimensions of clinical learning that often produce anxiety, such as fear of making a mistake that would harm the patient; interacting with the patient, the teacher, and other health care providers; the changing nature of patient conditions; a lack of knowledge and skill to practice giving care to patients; and working with difficult patients, among others. In some research studies, students have reported that the teacher is a source of added stress for them. These findings highlight the need for faculty members to develop supportive and trusting relationships with students in the clinical setting and to be aware of the stressful nature of

this learning experience. A climate that supports the process of learning in clinical practice is dependent on a caring relationship between teacher and student rather than an adversarial one.

The teacher chooses a model for clinical teaching: traditional, preceptor, or partnership. In the traditional model of clinical teaching, the instruction and evaluation of a group of students are carried out by a faculty member. In the preceptor model of clinical teaching, an expert nurse in the clinical setting works with the student on a one-to-one basis. The preceptor also guides and supports the learner and serves as a role model. The faculty member is typically not on site during the clinical experience but has important responsibilities for the course such as serving as course coordinator, providing the classroom instruction, serving as a liaison between the nursing education program and clinical setting, and being a resource person for the preceptor.

Partnerships also were described in this chapter. The partnership model varies with the academic institution but generally is a collaborative relationship between the nursing education program and a clinical agency or with the community. Partnerships emphasize collaboration among partners to meet the needs of the partners and community as a whole.

Exhibit 4.4

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A.** Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- B.** Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education
- C.** Modify teaching strategies and learning experiences based on consideration of
 - 2. past clinical experiences
 - 3. past educational and life experiences

(continued)

- F. Communicate effectively orally and in writing with an ability to convey ideas in a variety of contexts
- H. Model critical thinking
- I. Create opportunities for learners to develop their own critical thinking skills
- J. Create a positive learning environment that fosters a free exchange of ideas
- K. Show enthusiasm for teaching, learning, and the nursing profession that inspires and motivates students
- L. Demonstrate personal attributes that facilitate learning (e.g., caring, confidence, patience, integrity, respect, and flexibility)
- M. Respond effectively to unexpected events that affect clinical and/or classroom instruction
- N. Develop collegial working relationships with clinical agency personnel to promote positive learning environments
- O. Use knowledge of evidence-based practice to instruct learners
- P. Demonstrates ability to teach clinical skills
- Q. Act as a role model in practice settings

2. Facilitate Learner Development and Socialization

- A. Identify individual learning styles and unique learning needs of learners
- C. Advise learners in ways that help them meet their professional goals
- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- F. Adapt teaching styles and interpersonal interactions to facilitate learner behaviors
- H. Encourage professional development of learners

5. Pursue Continuous Quality Improvement in the Academic Nurse Educator Role

- A. Engage in activities that promote one's socialization to the role
- D. Participate in professional development opportunities that increase one's effectiveness in the role
- F. Select professional development activities to continue to grow and evolve in the role
- G. Balance the teaching, scholarship, and service demands inherent in the role of the educator and as influenced by the requirements of the institutional setting

6. Engage in Scholarship, Service, and Leadership

- A. Function as a Change Agent and Leader
 - 8. Promote innovative practices in educational environments

(continued)

- B. Engage in Scholarship of Teaching
 1. Exhibit a spirit of inquiry about teaching and learning, student development, and evaluation methods
 2. Use evidence-based resources to improve and support teaching
 3. Develop an area of expertise in the academic nurse educator role
- C. Function Effectively within the Institutional Environment and Academic Community
 2. Network, collaborate, and partner with other disciplines to enhance nursing's influence within the academic community
 4. Integrate the values of respect, collegiality, professionalism, and caring to build an organizational climate that fosters the development of learners and colleagues

REFERENCES

- American Association of Colleges of Nursing. (2002, October). Using strategic partnerships to expand nursing education programs. *AACN Issue Bulletin*. Retrieved July 2, 2009, from <http://www.aacn.nche.edu/Publications/issues/Oct02.htm>
- Baker, C., Pulling, C., McGraw, R., Dagnone, J., Hopkins-Rosseel, D., & Medves, J. (2008). Simulation in interprofessional education for patient-centered collaborative care. *Journal of Advanced Nursing*, *64*, 372–379.
- Beitz, J. M., & Wieland, D. (2005). Analyzing the teaching effectiveness of clinical nursing faculty of full- and part-time generic BSN, LPN-BSN, and RN-BSN nursing students. *Journal of Professional Nursing*, *21*, 32–45.
- Berg, C. L., & Lindseth, G. (2004). Research brief. Students' perspectives of effective and ineffective nursing instructors. *Journal of Nursing Education*, *43*, 565–568.
- Billings, D., Skiba, D., & Connors, H. (2005). Best practices in Web-based courses: Generational differences across undergraduate and graduate nursing students. *Journal of Professional Nursing*, *21*, 126–133.
- Blum, C. (2009). Development of a clinical preceptor model. *Nurse Educator*, *34*, 29–33.
- Campbell, S. E., & Dudley, K. (2005). Clinical partner model: Benefits for education and service. *Nurse Educator*, *30*, 271–274.
- Campbell, S., & Filer, D. (2008). How can we continue to provide quality clinical education for increasing numbers of students with decreasing numbers of faculty? *Annual Review of Nursing Education*, *6*, 45–63.
- Campbell, S., & Jeffers, B. (2008). The sister model: A framework for academic and service partnerships in nursing home settings. *Journal of Gerontological Nursing*, *34*(9), 18–24.
- Cook, L. J. (2005). Inviting teaching behaviors of clinical faculty and nursing students' anxiety. *Journal of Nursing Education*, *44*, 156–161.
- Dunham-Taylor, J., Lynn, C., Moore, P., McDaniel, S., & Walker, J. (2008). What goes around comes around: Improving faculty retention through more effective mentoring. *Journal of Professional Nursing*, *24*, 337–346.

- Francis-Baldesari, C., & Williamson, D. (2008). Integration of nursing education, practice, and research through community partnerships: A case study. *Advances in Nursing Science, 31*(4), E1–E10. doi: 10.1097/01.ANS.0000341416.11586.3a
- Frank, B. (2008). Enhancing nursing education through effective academic-service partnerships. *Annual Review of Nursing Education, 6*, 25–43.
- Gibbons, C., Dempster, M., & Moutray, M. (2008). Stress and eustress in nursing students. *Journal of Advanced Nursing, 61*, 282–290.
- Gignac-Caille, A. M., & Oermann, M. H. (2001). Student and faculty perceptions of effective clinical instructors in ADN programs. *Journal of Nursing Education, 40*, 347–353.
- Glassick, C. E., Huber, M. T., & Maeroff, G. I. (1997). *Scholarship assessed*. San Francisco: Jossey-Bass.
- Gorostidi, X., Egilegor, X., Erice, M., Iturriotz, M., Garate, I., Lasa, M., et al. (2007). Stress sources in nursing practice: Evolution during nursing training. *Nurse Education Today, 27*, 777–787.
- Henry, P. (2006). Making groups work in the classroom. *Nurse Educator, 31*, 26–30.
- Hentz, P. B. (2005). Education and socialization to the professional nursing role. In K. Masters (Ed.), *Role development in professional nursing practice* (pp. 99–109). Sudbury, MA: Jones and Bartlett.
- Hoffman, J. (2008). Teaching strategies to facilitate nursing students' critical thinking. *Annual Review of Nursing Education, 6*, 225–236.
- Hsu, L-L. (2007). Conducting clinical post-conference in clinical teaching: A qualitative study. *Journal of Clinical Nursing, 16*, 1525–1533.
- Kim, K. (2007). Clinical competence among senior nursing students after their preceptorship experiences. *Journal of Professional Nursing, 23*, 369–375.
- King, M., Singh, M., & Harris, L. (2009). A critical care bridging program to prepare fourth-year baccalaureate students for specialty practice. *Dynamics, 20*(1), 12–17.
- Manias, E., & Aitken, R. (2005). Clinical teachers in specialty practice settings: Perceptions of their role within postgraduate nursing programs. *Learning in Health and Social Care, 4*, 67–77.
- Moscaritolo, L. (2009). Interventional strategies to decrease nursing student anxiety in the clinical learning environment. *Journal of Nursing Education, 48*, 17–23.
- Murphy, J. I. (2004). Using focused reflection and articulation to promote clinical reasoning: An evidence-based teaching strategy. *Nursing Education Perspectives, 25*, 226–231.
- Murphy, J. I. (2005). How to learn, not what to learn: Three strategies that foster lifelong learning in clinical settings. In M. H. Oermann & K. T. Heinrich (Eds.), *Annual review of nursing education* (Vol. 3, pp. 37–55). New York: Springer Publishing.
- Nielsen, A. (2009). Educational innovations. Concept-based learning activities using the clinical judgment model as a foundation for clinical learning. *Journal of Nursing Education, 48*, 350–354.
- Nitko, A. J., & Brookhart, S. M. (2007). *Educational assessment of students* (5th ed.). Upper Saddle River, NJ: Pearson Education.
- Oblinger, D. (2003). Boomers, gen Xers, millennials: Understanding the new students. *EDUCAUSE Review, 38*, 37–47.
- Oermann, M. H. (1998). Work-related stresses of clinical nursing faculty. *Journal of Nursing Education, 37*, 302–304.

- Oermann, M. H. (2004a). Reflections on undergraduate nursing education: A look to the future. *International Journal of Nursing Education Scholarship*, 1(1), article 5. doi: 10.2202/1548-923X.1011
- Oermann, M. H. (2004b). Using active learning in lecture: Best of “both worlds.” *International Journal of Nursing Education Scholarship*, 1(1), article 1. doi: 10.2202/1548-923X.1001
- Oermann, M. H. (2007). Approaches to gathering evidence for educational practices in nursing. *Journal of Continuing Education in Nursing*, 38, 250–257.
- Oermann, M. H. (2008). Ideas for postclinical conferences. *Teaching and Learning in Nursing*, 3, 90–93.
- Oermann, M. H. (2009). Evidence-based programs and teaching/evaluation methods: Needed to achieve excellence in nursing education. In M. Adams & T. Valiga (Eds.), *Achieving excellence in nursing education* (pp. 63–76). New York: National League for Nursing.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- Oermann, M. H., & Lukomski, A. P. (2001). Experiences of students in pediatric nursing clinical courses. *Journal of the Society of Pediatric Nurses*, 9, 65–72.
- Oermann, M. H., Truesdell, S., & Ziolkowski, L. (2000). Strategy to assess, develop, and evaluate critical thinking. *Journal of Continuing Education in Nursing*, 31, 155–160.
- Pardue, K., & Morgan, P. (2008). Millennials considered: A new generation, new approaches, and implications for nursing education. *Nursing Education Perspectives*, 29, 74–79.
- Pharez, M., Walls, N., Roussel, L., & Broome, B. (2008). Combining creativity and community partnership in mental health clinical experiences. *Nursing Education Perspectives*, 29, 100–104.
- Plowfield, L. A., Wheeler, E. C., & Raymond, J. E. (2005). Time, tact, talent, and trust: Essential ingredients of effective academic-community partnerships. *Nursing Education Perspectives*, 26, 217–220.
- Profetto-McGrath, J., Smith, K. B., Day, R. A., & Yonge, O. (2004). The questioning skills of tutors and students in a context based baccalaureate nursing program. *Nurse Education Today*, 24, 363–372.
- Sedlak, C. A., & Doheny, M. O. (2004). Critical thinking: What’s new and how to foster thinking among nursing students. In M. H. Oermann & K. Heinrich (Eds.), *Annual review of nursing education* (Vol. 2, pp. 185–204). New York: Springer Publishing.
- Sheu, S., Lin, H., & Hwang, S. (2002). Perceived stress and physio-psycho-social status of nursing students during their initial period of clinical practice: The effect of coping behaviors. *International Journal of Nursing Studies*, 39, 165–175.
- Shirey, M. (2006). Faculty issues. Stress and burnout in nursing faculty. *Nurse Educator*, 31, 95–97.
- Smedley, A., & Penney, D. (2009). A partnership approach to the preparation of preceptors. *Nursing Education Perspectives*, 30, 31–36.
- Stolder, M. E., Rosemeyer, A. K., & Zorn, C. R. (2008). In the shelter of each other: Respite care for students as a partnership model. *Nursing Education Perspectives*, 29, 295–299.
- Tang, F., Chou, S., & Chiang, H. (2005). Students’ perceptions of effective and ineffective clinical instructors. *Journal of Nursing Education*, 44, 187–192.

- Twenge, J. (2009). Generational changes and their impact in the classroom: Teaching Generation Me. *Medical Education*, *43*, 398–405.
- Weber, S. (2005). Promoting critical thinking in students. *Journal of the American Academy of Nurse Practitioners*, *17*, 205–206.
- Wetherbee, E., Nordrum, J., & Giles, S. (2008). Effective teaching behaviors of APTA-credentialed versus noncredentialed clinical instructors. *Journal of Physical Therapy Education*, *22*, 65–74.
- Wolf, Z. R., Bender, P. J., Beitz, J. M., Wieland, D. M., & Vito, K. O. (2004). Strengths and weaknesses of faculty teaching performance reported by undergraduate and graduate nursing students: A descriptive study. *Journal of Professional Nursing*, *20*, 118–128.
- Yeh, M., Rong, J., Chen, M., Chang, S., & Chung, U. (2009). Development of a new prototype for an educational partnership in nursing. *Journal of Nursing Education*, *48*, 5–10.

5

Ethical and Legal Issues in Clinical Teaching

Clinical teaching and learning take place in a social context. Teachers, students, staff members, and patients have roles, rights, and responsibilities that sometimes are in conflict. These conflicts create legal and ethical dilemmas for clinical teachers. This chapter discusses some ethical and legal issues related to clinical teaching and offers suggestions for preventing, minimizing, and managing these difficult situations.

ETHICAL ISSUES

Ethics are standards of conduct based on beliefs about what is good and bad, obligations related to good and bad acts, and principles underlying decisions to conform to these standards (O'Connor, 2006). Ethical standards make it possible for nurses, patients, teachers, and students to understand and respect each other. Contemporary bioethical standards are related to respect for human dignity, autonomy, and freedom; beneficence; justice; veracity; privacy; and fidelity (Husted & Husted, 2007; O'Connor, 2006; Oermann & Gaberson, 2009; Williams, 2002). These standards are important considerations for all parties involved in clinical teaching and learning.

Learners in a Service Setting

If the word *clinical* means “involving direct observation of the patient,” clinical activities must take place where patients are. Traditionally, learners encounter patients in health care service settings, such as acute care, extended care, and rehabilitation facilities. With the current focus on primary prevention, however, patients increasingly receive health care in the home, community, and school environments (Stokes & Kost, 2004). Whatever the setting, patients are there to receive health care, staff members have the responsibility to provide care, and students are present to learn (Williams, 2002). Are these purposes always compatible?

Although it has been more than three decades since Corcoran (1977) raised ethical questions about the use of service settings for learning activities, those concerns still are valid. In the clinical setting, nursing students or new staff members are learners who are somewhat less skilled than experienced practitioners. Although their activities are observed and guided by clinical teachers, learners are not expected to provide cost-effective, efficient patient care services. On the other hand, patients expect quality service when they seek health care; providing learning opportunities for students usually is not their priority. The ethical standard of *beneficence* refers to the duty to help, to produce beneficial outcomes, or at least to do no harm (Husted & Husted, 2007). Is this standard violated when the learners’ chief purpose for being in the clinical environment is to learn, not to give care?

Patients who encounter learners in clinical settings may feel exploited or fear invasion of their privacy; they may receive care that takes more time and creates more discomfort than if provided by expert practitioners. The presence of learners in a clinical setting also requires more time and energy of staff members, who usually are expected to give and receive reports from students, answer their questions, and demonstrate or help with patient care. These activities may divert staff members’ attention from their primary responsibility for patient care, interfere with their efficient performance, and affect their satisfaction with their work (Corcoran, 1977).

Because achieving the desired outcomes of clinical teaching requires learning activities in real service settings, teachers must consider the rights and needs of learners, patients, and staff members when planning clinical learning activities. The clinical teacher is responsible for making the learning objectives clear to all involved persons and for ensuring that learning activities do not prevent achievement of service goals. Patients

should receive adequate information about the presence of learners in the settings where they are receiving care before giving their informed consent to participate in clinical learning activities. The teacher should ensure the learners' preparation and readiness for clinical learning as well as his or her own presence and competence as an instructor, as discussed in chapter 3.

Student-Faculty Relationships

Respect for Persons

As discussed in chapter 1, an effective and beneficial relationship between clinical teacher and student is built on a base of mutual trust and respect. Although both parties are responsible for maintaining this relationship, the clinical teacher must initiate it by demonstrating trust and respect for students. A trusting, respectful relationship with students demonstrates the teacher's commitment to ethical values of respect for human dignity and autonomy (O'Connor, 2006, pp. 299–300).

In a classic study of nursing students' perceptions of unethical teaching behaviors (Theis, 1988), 50% of the incidents described by students occurred in clinical settings, compared with 39% in the classroom. Of the clinical incidents, 58% were classified as violations of respect for persons. Examples of such behavior included questioning and criticizing students in public areas, talking about a patient in the patient's presence, and allowing students to observe a catheterization without asking the patient's permission. As these examples illustrate, a clinical teacher's failure to model respect for patients also can be considered an unethical teaching behavior. Theis pointed out that, in some instances, the teacher's behavior may have been misinterpreted by students. For example, while the student believed that the instructor failed to seek the patient's consent to the presence of observers, the instructor may have done so when the student was not present. However, if the teacher had obtained consent, pointing this out to the student would have prevented the misunderstanding as well as reinforced the ethical value of respect for persons (Theis, 1988).

A more recent case study (Lewenson, Truglio-Londrigan, & Singleton, 2005) identified similar issues related to an incident of ethical violation in a classroom setting. Although the initial focus was on the student's breach of conduct, the faculty recognized issues related to their own ethical conduct and how they modeled that behavior to students. The

importance of teaching and practicing ethical conduct in academic settings was emphasized.

Fairness and Justice

The ethical standard of justice refers to fair treatment—judging each person’s behavior by the same standards. Clinical teachers must evaluate each student’s performance by the same standard. Students may perceive a clinical teacher’s behavior as unfair when the teacher appears to favor some students by praising, supporting, and offering better learning opportunities to them more than others (Theis, 1988). Developing social relationships with some students could be perceived as favoritism by other students (Gardner & Suplee, 2010, p. 190). The teacher’s relationships with students can be friendly and warm but should be collegial without being personal and social (O’Connor, 2006, p. 300).

For these reasons, nurse educators should be prudent about their use of social networking sites such as Facebook and Twitter. Faculty members have used Twitter to communicate with students, build relationships with them, and enhance their learning. For example, clinical teachers may use Twitter like instant messaging to inform students about a change in plans (such as cancellation of clinical learning activities or a change of location) and to communicate with preceptors who may not have easy access to their e-mail during work hours (Skiba, 2008). But these uses of social networking sites should be separate from the teacher’s personal use of these technologies. Befriending students on their Facebook pages and following them on Twitter implies an egalitarian relationship that does not acknowledge the power advantage that faculty members hold (O’Connor, 2006, p. 300; Oermann & Gaberson, 2009, p. 338). Inviting students to sign up as friends or followers to a Facebook or Twitter account that the teacher uses for social interaction with peers invites their discovery of information that the teacher might prefer to be private.

Keeping these disadvantages in mind, teachers can use these networking sites to facilitate clinical learning. A clinical teacher might establish a Twitter account and lock it, then invite students to follow. Using this account as a filter for information, the faculty member can teach followers mini-lessons and update them on relevant topics. For example, the teacher may maximize teachable moments that occur outside of the clinical learning environment (Kryder, 2009; Skiba, 2008), such as sharing a new idea from a conference, alerting students to the publication of

a relevant article in a current issue of a professional nursing journal, or suggesting that students view a particular television show that relates to content they are studying. The clinical teacher might send a weekly tweet to students with a question or brainteaser related to the competencies they are attempting to master. Because some students may have to pay for individual text messages, based on their wireless account type, it is best to inform students well in advance that you will be using this technology and invite those who have concerns to talk to you privately (Skiba, 2008).

Students' Privacy Rights

When students have a succession of clinical instructors, it is common for the instructors to communicate information about student performance. Learning about the students' levels of performance in their previous clinical assignment helps the next instructor to anticipate their needs and to plan appropriate learning activities for them. Although students usually benefit when teachers share such information about their learning needs, personal information that students reveal in confidence should not be shared with other teachers. The U.S. Family Educational Rights and Privacy Act of 1974, as amended, restricts disclosure of students' academic information to individuals who have a legitimate need to know; written permission from students is necessary to discuss their performance with anyone else. Evaluative statements about student performance should not be shared with other faculty members, but information about a student's need for a particular learning activity or more practice with a specific skill is necessary for a teacher to provide the appropriate guidance (Gardner & Suplee, 2010, p. 191).

Additionally, when sharing information about students, teachers should focus on factual statements about performance without adding personal judgments. Characterizing or labeling students is rarely helpful to the next instructor, and such behavior violates ethical standards of privacy as well as respect for persons.

Because clinical teachers in nursing education programs are professional nurses, they sometimes experience conflict regarding their knowledge of students' health problems. As nurses, they might tend to respond in a therapeutic way if a student revealed personal information about a health concern, but as teachers, their primary obligation is to a teacher-student relationship. Absent any existing institutional policy or compelling evidence that the personal information should be disclosed

to protect the safety of the student or other person, educators should follow the principle of what action would best promote student learning (Morgan, 2001).

Clinical teachers who are aware of a student's health problem also should avoid making special exceptions for this student that would not be available to other students. Students who need special accommodations because of a health problem should request them from the institution's office of disability services. If accommodations are granted, the clinical teacher should discuss with the student how they will be made available (Gardner & Suplee, 2010, p. 192). See the discussion on students with disabilities later in this chapter.

Competent Teaching

Applying the ethical standard of beneficence to teaching, students have a right to expect that their clinical teachers are competent, responsible, and knowledgeable. As discussed in chapter 4, clinical competence, including expert knowledge and clinical skill, is an essential characteristic of effective clinical teachers. In addition, clinical teachers must be competent in facilitating students' learning activities, including planning appropriate assignments and giving specific, timely feedback on individual student performance. Examples of unethical behavior related to clinical teacher competence include not being available for guidance in the clinical setting and not planning sufficiently for a clinical learning activity that maximizes student learning (O'Connor, 2006, pp. 302–303).

Academic Dishonesty

Although cheating and other forms of dishonest behavior are believed to be common in the classroom environment, academic dishonesty can occur in clinical settings as well. Academic dishonesty is defined as intentional participation in deceptive practices regarding the academic work of self or others. Dishonest acts include lying, cheating, plagiarizing, altering or forging records, falsely representing oneself, and knowingly assisting another person to commit a dishonest act (O'Connor, 2006, pp. 301–302; Tippett et al., 2009).

Examples of academic dishonesty in the clinical setting include:

- **Cheating:** A student copies portions of a classmate's case study analysis and presents the assignment as her own work. Similarly,

a student who asks for a staff member's assistance to calculate a medication dose but tells the instructor that he did the work alone also is cheating.

- *Lying*: A student tells the instructor that she attempted a home visit to a patient but the patient was not at home. In fact, the student overslept and missed the scheduled time of the visit.
- *Plagiarism*: While preparing materials for a patient teaching project, a student paraphrases portions of a published teaching pamphlet without citing the source.
- *Altering a document*: A staff nurse orientee appends information to the documentation of nursing care for a patient on the previous day without noting it as a late addition.
- *False representation*: As a family nurse practitioner student begins a physical examination, the patient addresses the student as "Doctor." The student continues with the examination and does not tell the patient that he is a nurse.
- *Assisting another in a dishonest act*: Student A asks Student B to cover for her while she leaves the clinical agency to run a personal errand. The teacher asks Student B if he has seen Student A; Student B says that he thinks she has accompanied a patient to the physical therapy department.

Although some of the previous examples may appear to be harmless or minor infractions, dishonest acts should be taken seriously because they can have harmful effects on patients, learners, faculty-student relationships, and the educational program. Clinical dishonesty can jeopardize patient safety if learners fail to report errors or do not receive adequate guidance because their competence is assumed (Bavier, 2009). Mutual trust and respect form the basis for effective teacher-learner relationships, and academic dishonesty can damage a teacher's trust in students. Dishonest acts that are ignored by teachers contribute to an environment that supports academic dishonesty, conveying the impression to students that this behavior is acceptable or at least excusable (Tippett et al., 2009). Additionally, honest students resent teachers who fail to deal effectively with cheating.

According to several recent research reports, dishonesty as a student is related to later unethical acts as a practicing nurse (Harper, 2006; Kenny, 2007; Kiehl, 2006; Langone, 2007). For this reason, many nurse faculty members are conscientious about holding students accountable to standards of integrity and imposing severe consequences as permitted

by policy. However, student appeals of such nursing faculty decisions often are overturned or modified by grade appeal panels comprising faculty members from nonclinical disciplines who may not understand the serious implications for patient safety (Bavier, 2009).

Clinical academic dishonesty usually results from one or more of the following factors:

- *Competition, desire for good grades, and heavy workload.* Competition for good grades in clinical nursing courses may result from student misunderstanding of the evaluation framework. If students believe that a limited number of good grades are available, they may compete fiercely with their classmates, sometimes leading to deceptive acts in an attempt to earn the highest grades. Additionally, many nursing students have additional pressures related to employment and family responsibilities; they may feel overloaded and unable to meet all of the demands of a rigorous nursing education program without resorting to cheating. “Higher education is increasingly a high stakes environment where a student’s retention in or progression through a program, [retention of a] scholarship or loan, parental approval, or other significant factor is dependent on academic success” (Tippitt et al., 2009, p. 239).
- *Emphasis on perfection.* As discussed in chapter 2, clinical teachers often communicate the expectation that good nurses do not make mistakes. Although nurse educators attempt to prepare practitioners who will perform carefully and skillfully, a standard of perfection is unrealistic. Students naturally make mistakes in the process of learning new knowledge and skills, and punishment for mistakes, in the form of low grades or a negative performance evaluation, will not prevent these errors. In fact, it is the fear of punishment that often motivates students to conceal errors, and errors that are not reported are often harmful to patient safety (Kohn, Corrigan, & Donaldson, 2000).
- *Poor role modeling.* The influence of role models on behavior is strong. Nursing students and novice staff nurses who observe dishonest behavior of teachers and experienced staff members may emulate these examples, especially when the dishonest acts have gone unnoticed, unreported, or unpunished (Tippitt et al., 2009).

Clinical teachers can use a variety of approaches to discourage academic dishonesty. They should be exemplary role models of honest

behavior for learners to emulate (Tippitt et al., 2009). They should acknowledge that mistakes occur in the learning process and create a learning climate that allows students to make mistakes in a safe environment with guidance and feedback for problem solving. However, students need reassurance that, if humanly possible, teachers will not allow them to make errors that would harm patients. Finally, each nursing education program should develop a policy that defines academic dishonesty and specifies appropriate penalties for violations. This policy should be communicated to all students, reviewed with them at regular intervals, and applied consistently and fairly to every violation (Tippitt et al.).

When enforcing the academic integrity policy, it is important to apply ethical standards to protect the dignity and privacy of students. A public accusation of dishonesty that is found later to be ungrounded can damage a student's reputation. The teacher should speak with the student privately and calmly, describe the student's behavior and the teacher's interpretation of it, and provide the student with an opportunity to respond to the charge. It is essential to keep an open mind until all available evidence is evaluated, because the student may be able to supply a reasonable explanation for the behavior that the teacher interpreted as cheating (O'Connor, 2006, p. 300).

LEGAL ISSUES

It is beyond the scope of this book to discuss and interpret all federal, state, and local laws that have implications for clinical teaching and evaluation, and the authors are not qualified to give legal advice to clinical teachers regarding their practice. It is recommended that clinical teachers refer questions about the legal implications of policies and procedures to the legal counsel for the institution in which they are employed; concerns about a teacher's legal rights in a specific situation are best referred to the individual's attorney. However, this section discusses common legal issues that often arise in the practice of clinical teaching.

Students With Disabilities

Two federal laws have implications for the education of learners with disabilities. The Rehabilitation Act of 1973, Section 504, prohibits public postsecondary institutions that receive federal funding from denying access or participation to individuals with disabilities. The Americans with

Disabilities Act of 1990 guarantees persons with disabilities equal access to educational opportunities if they are otherwise qualified for admission (Frank & Halstead, 2005; O'Connor, 2006, p. 309). A qualified individual with a disability is one who has a physical or mental impairment that substantially limits one or more of that individual's major life activities, and that the individual has a record of or is regarded as having such impairment (Brent, 2004b). In nursing education programs, qualified individuals with disabilities are those who meet the essential eligibility requirements for participation, with or without modifications (Southern Regional Education Board [SREB], 2004).

A common goal of nursing education programs is to produce graduates who can function safely and competently in the roles for which they were prepared. For this reason, it is appropriate for those who make admission decisions to determine whether applicants could reasonably be expected to develop the necessary competence. The first step in this decision process is to define the core performance standards necessary for participation in the program. Because nursing is a practice discipline, core performance standards include cognitive, sensory, affective, and psychomotor competencies. The SREB recommended that such lists of core performance standards be shared with all applicants to nursing education programs to allow them to make initial judgments about their qualifications (SREB, 2004).

Persons with disabilities who are admitted to nursing education programs are responsible for informing the institution of the disability and requesting reasonable accommodations (Brent, 2004b). Each nursing education program must determine on an individual basis whether the necessary modifications reasonably can be made. Reasonable accommodations for participating in clinical learning activities might include:

- Allowing additional time for a student with a qualified learning disability to complete an assignment
- Allowing additional time to complete the program
- Scheduling clinical learning activities in facilities that are readily accessible to and usable by individuals who use wheelchairs or crutches
- Providing the use of an amplified stethoscope for a student with a hearing impairment

Reasonable accommodations do not include lowering academic standards or eliminating essential technical performance requirements. However, nurse educators need to distinguish essential from

traditional functions by discussing such philosophical issues as whether individuals who will never practice bedside nursing in the conventional manner should be admitted to nursing education programs (Frank & Halstead, 2005).

Disabilities may be visible (e.g., limited mobility, visual or hearing deficit, physical or functional loss of a limb) or invisible (e.g., learning disability, behavioral health problem, chronic illness). As previously discussed, clinical teachers should not attempt to determine whether accommodation is indicated, nor should they decide on the specific type of accommodation necessary. The disabilities services officer of the educational institution determines whether the student is a qualified individual with a disability, and if so, whether the disability requires accommodations. This officer then issues a formal, written description of the required clinical accommodations, usually to the student, who decides whom to share it with. Accommodation statements should not be shared with others without the student's written permission (Gardner & Suplee, 2010, pp. 48–49). The purpose of accommodation is to provide the student with a disability the means to compensate for it so that full participation in the clinical learning activity is possible. Many nursing faculty members voice concerns about the capacity of students with physical disabilities to perform physical tasks associated with nursing practice. A clinical teacher of a student with a physical disability should carefully analyze a planned learning activity to identify the essential elements necessary to produce desired outcomes, keeping in mind that much of the professional nurse's work is intellectual. Is it more important for a nursing student to demonstrate the ability to reposition a patient or to demonstrate the ability to assess the patient's skin integrity and pulmonary and circulatory function, recognize the need for repositioning, delegate the task to a licensed or unlicensed staff member and supervise that person as necessary, and evaluate the patient outcomes? Students with disabilities are the best sources of information about their disabilities and the limitations that they present, adaptations they have learned to compensate for them, and what accommodations have worked in the past. After appropriate accommodations are provided, however, students with disabilities must be evaluated according to the same criteria as other students (O'Connor, 2006, p. 310).

Due Process

Another legal issue related to clinical teaching is that of student rights to due process. In educational settings, due process requires that students

be informed of the standards by which their performance will be judged, that they will receive timely feedback about their performance, and that they will have an opportunity to correct behavior that does not meet standards. In other words, learners have the right to be informed of their academic deficiencies, how those deficiencies will affect their academic progress, and what they need to do to correct the problem (Brent, 2004a; Johnson & Halstead, 2005). Students who experience academic failure or dismissal from a nursing education program often appeal these decisions on the basis of denial of due process.

The 14th Amendment of the United States Constitution specifies that the state cannot deprive a person of life, liberty, or property without due process of law. With regard to the rights of students to due process, however, this constitutional protection extends only to those enrolled in public institutions. Students at private institutions may base a claim against the school on discrimination or contract law. For example, if a private school publishes a code of student rights and procedures for student grievances in its student handbook, those documents may be regarded as part of a contract between the school and the student. In paying and accepting tuition, the student and the school jointly agree to abide by this code of rights and set of procedures. A student may sue on the basis of breach of contract if the school does not follow the stated due process procedures (Brent, 2004a; Johnson & Halstead, 2005).

Courts hold different standards for due process based on whether it applies to academic or disciplinary decisions. Academic decisions include assigning a failing grade in a course, delaying progress, and dismissal from a program because of failure to maintain acceptable academic standing. The courts traditionally have been reluctant to intervene in academic decisions, believing that the faculty is competent to judge student performance according to academic criteria or objectives (Brent, 2004a). Thus, academic due process is viewed by the courts as substantive due process, and the following procedures are generally sufficient:

- Students are informed in advance about the academic standards that will be used to judge their performance and about the process for appealing such decisions.
- Students are notified about the potential for academic failure well before grading decisions are made. Ideally, notification occurs orally and in writing, and the teacher and student work together to determine a plan for overcoming the deficiencies.

- Student performance is evaluated using the stated standards or criteria, and grades are assigned according to the stated policy.
- If a student believes that a grade or other academic decision is unfair, the stated appeal or grievance process is followed. Usually, the first level of appeal is to the teacher or group of faculty members who assigned the grade. If the conflict is not resolved at that level, the student usually has the right of appeal to the administrator to whom the teacher reports. The next level of appeal usually is to a student standing committee or appeal panel of nursing faculty members. Finally, the student should have the right to appeal the decision to the highest-level administrator in the nursing program and then to the appropriate academic administrators at the parent institution.

Of course, if students exhaust every level of appeal and still are not satisfied with the outcome, they have the right to seek relief in the court system. It is important to note that the courts will allow such a lawsuit to go forward only if there is evidence that the student has first exhausted all internal school remedies. However, if the educational program faculty and administrators have followed substantive due process procedures as described above, it is unlikely that the academic decision will be reversed. If the student appeals to a court of law, the burden of proof that academic due process was denied rests with the student. With regard to due process for academic decisions, the key to resolving conflict and minimizing faculty liability is in maintaining communication with students whose performance is not meeting standards (Brent, 2004a; Johnson & Halstead, 2005).

Disciplinary decisions such as dismissal on the basis of misconduct or dishonesty require a higher level of due process called procedural due process. Procedural due process guarantees the right to a hearing before dismissal. Disciplinary due process includes the following components:

- The student is provided with adequate written notice including specific details concerning the misconduct. For example, a notice may inform the student that she failed to attend a required clinical activity; that neither the faculty member nor nursing unit secretary was informed of the anticipated absence, in violation of school policy on professional conduct; and that, because this incident represented the third violation of professional conduct

standards, the student would be dismissed from the program according to the sanctions provided in the policy.

- The student is provided the opportunity for a fair, impartial hearing on the charges. The student has the right to speak on his own behalf, to present witnesses and evidence, and to question the other participants in the case (usually teachers and administrators). Using the example above, the student might present evidence that she did attempt to call the faculty member to report her absence; this evidence could include the date and time of the call, the name of the person with whom she spoke, and a copy of a telephone bill verifying the date, time, and number called. Although the student and the faculty member are entitled to the advice of legal counsel, neither attorney may question or cross-examine witnesses.

If the decision of the hearing panel is to uphold the dismissal, the student has the right to seek remedy from the court system if he believes that due process was not followed. However, in disciplinary cases, the burden of proof that due process was denied rests with the student.

Negligence, Liability, and Unsafe Clinical Practice

When determining whether a given action meets the criteria for professional negligence, the overall standard of care is what an ordinary, reasonable, and prudent person would have done in the same context. The standard of care for a nursing student is not what another nursing student would have done; students are held to the same standards of care as registered nurses (Brent, 2004b). The concept of personal liability also applies to cases of professional negligence. Each person is responsible for her own behavior, including negligent acts. Students are liable for their own actions as long as they are performing according to the usual standard of care for their education and experience, and they seek guidance when they are uncertain what to do. Therefore, it is not true that students practice under the faculty member's license (Brent, 2004b; O'Connor, 2006, p. 304).

Teachers are not liable for negligent acts performed by their students as long as the teacher has (1) selected appropriate learning activities based on objectives; (2) determined that students have prerequisite knowledge, skills, and attitudes necessary to complete their assignments; and (3) provide competent guidance. However, teachers are liable for their negligent

actions if they make assignments that require more knowledge and skill than the learner has developed or if they fail to guide student activities appropriately (O'Connor, 2006, pp. 304, 306). Even if the clinical teacher was not negligent in making assignments or guiding student learning, he is likely to be named as a defendant in any lawsuit arising from a nursing student's alleged negligence or malpractice. For this reason, clinical teachers should carry sufficient individual professional liability insurance to cover the costs of defending themselves, even if their employers provide insurance coverage for faculty members (O'Connor, 2006, p. 306).

If a student demonstrates clinical performance that potentially is unsafe, the student and the teacher who made the assignment may be liable for any subsequent injury to the patient. However, because time for learning must precede time for evaluation, is it fair for the teacher to assign a failing grade in clinical practice before the end of the course when to do so would prevent the student's access to learning opportunities for which she has paid tuition? In this case, denying access to clinical learning activities because of unsafe practice or inadequate clinical reasoning should not be considered an academic grading decision. Instead, it is an appropriate response to protecting the rights of patients to safe, competent care—a disciplinary decision (Gardner & Suplee, 2010, p. 197).

The teacher's failure to take such protective action potentially places the teacher and the educational program at risk for liability. Instead of denying the student access to all learning opportunities, removal from the clinical setting should be followed by a substitute assignment that would help the student to remove the deficiency in knowledge, skill, or attitude. For example, the student might be given a library assignment to acquire the information necessary to guide safe patient care, or an extra skills laboratory session could be arranged to allow more practice of psychomotor skills. A set of standards on safe clinical practice and a school policy that enforces the standards are helpful guides to faculty decision making and action while protecting student and faculty rights. Exhibit 5.1 is an example of safe clinical practice standards, and Exhibit 5.2 is an example of a policy that enforces these standards.

Documentation and Record Keeping

Teachers should keep records of their evaluations of student clinical performance. These records may include anecdotal notes, summaries of faculty-student conferences, progress reports, and summative clinical evaluations. These records are helpful in documenting that students

Exhibit 5.1

STANDARDS OF SAFE CLINICAL PRACTICEXXXXXX UNIVERSITY
SCHOOL OF NURSING
BSN PROGRAM
STANDARDS OF SAFE CLINICAL PRACTICE

In clinical practice, students are expected to demonstrate responsibility and accountability as professional nurses with the goal of health promotion and prevention of harm to self and others. The School of Nursing faculty believes that this goal will be attained if each student's clinical practice adheres to the Standards of Safe Clinical Practice. Safe clinical performance always includes, but is not limited to, the following behaviors:

1. Practice within boundaries of the nursing student role and the scope of practice of the registered professional nurse.
2. Comply with instructional policies and procedures for implementing nursing care.
3. Prepare for clinical learning assignments according to course requirements and as determined for the specific clinical setting.
4. Demonstrate the application of previously learned skills and principles in providing nursing care.
5. Promptly report significant client information in a clear, accurate, and complete oral or written manner to the appropriate person or persons.

Acknowledgment

I have read the XXXXXX University School of Nursing Standards of Safe Clinical Practice and I agree to adhere to them. I understand that these standards are expectations for my clinical practice and will be incorporated into the evaluation of my clinical performance in all clinical courses. Failure to meet these standards may result in my removal from the clinical area, which may result in clinical failure.

Signature and Date

received feedback about their performance, areas of teacher concern, and information about student progress toward correcting deficiencies (Case & Oermann, 2004).

An anecdotal note is a narrative description of the observed behavior of the student in relation to a specific learning objective. The note also may include the teacher's interpretation of the behavior, recorded separately from the description. Limiting the description and optional

Exhibit 5.2

POLICY ON SAFE CLINICAL PRACTICE

XXXXXX UNIVERSITY
SCHOOL OF NURSING
BSN PROGRAM
SAFE CLINICAL PRACTICE POLICY

POLICY

During enrollment in the XXXXXX University School of Nursing BSN Program, all students, in all clinical activities, are expected to adhere to the Standards of Safe Clinical Practice. Failure to abide by these standards will result in disciplinary action, which may include dismissal from the nursing program.

PROCEDURES

1. Students will receive a copy of the Standards of Safe Clinical Practice, and they will be reviewed during the Annual Nursing Assembly at the beginning of each academic year. At that time, students will be required to sign an agreement to adhere to the standards. Each student will retain one copy of the agreement, and one copy will be filed in the student's file.
2. Violation of these standards will result in the following disciplinary action:
 - a. First Violation
 1. Student will be given an immediate oral warning by the faculty member. The incident will be documented by the faculty member on the *Violation of Standards of Safe Clinical Practice* form. One copy of this form will be given to the student, and one copy will be kept in the student's record.
 2. At the discretion of the faculty member, the student may be required to leave the clinical unit for the remainder of that day. The student may be given an alternative assignment.
 3. If this violation is of a serious nature, it may be referred to the Associate Dean and the Dean of Nursing for further disciplinary action as in b. and c. below.
 - b. Second Violation
 1. The faculty member will document the incident on the *Violation of Safe Clinical Practice* form. Following discussion of the incident with the student, the faculty member will forward a copy of the form to the Associate Dean for review and recommendation regarding further action.
 2. The recommendation of the Associate Dean will be forwarded to the Dean of Nursing for review and decision regarding reprimand or dismissal. This disciplinary action process will be documented and placed in the student's record.

(continued)

- c. If the student has not been dismissed and remains in the program following the above disciplinary action, any additional violation will be documented and referred as above to the Associate Dean and the Dean of Nursing for disciplinary action, which may include dismissal from the program.
- d. The rights of students will be safeguarded as set forth in the XXXXXX University *Code of Student Rights, Responsibilities, and Conduct* published in the current XXXXXX *University Student Handbook*.

interpretation to a specified clinical objective avoids recording extraneous information, which is an ineffective use of the teacher's time. Anecdotal notes should record both positive and negative behaviors so as not to give the impression that the teacher is biased against the student. Students should review these notes and have an opportunity to comment on them; used in this way, anecdotal notes are an effective means of communicating formative evaluation information to students (Case & Oermann, 2004; Oermann & Gaberson, 2009, pp. 267–269). Some sources recommend that both teacher and student sign the notes.

Writing anecdotal notes for every student, every day, is unnecessarily time consuming. An effective, efficient approach might be to specify a minimum number of notes to be written for each student in relation to specified objectives. A student whose performance is either meritorious or cause for concern might prompt the instructor to write more notes.

Records of student-teacher conferences likewise are summaries of discussions that focused on areas of concern, plans to address deficiencies, and progress toward correcting weaknesses. These conferences should take place in private and should address the teacher's responsibility to protect patient safety, concern about the student's clinical deficiencies, and a sincere desire to assist the student to improve. During the conference, the student has opportunities to clarify and respond to the teacher's feedback. At times, an objective third party such as a department chairperson or program director may be asked to participate in the conference to witness and clarify the comments of both teacher and student. The conference note should record the date, time, and place of the conference; the names and roles of participants; and a summary of the discussion, recommendations, and plans. The note may be signed only by the teacher or by all participants, according to institutional policy or guidelines (Johnson & Halstead, 2005).

Because they contain essentially formative evaluation information, anecdotal notes and conference notes should not be kept in the student's

permanent record. Teachers should keep these documents in their private files, taking appropriate precautions to ensure their security, until there is no reasonable expectation that they will be needed. In most cases, when the learner successfully completes the program or withdraws in good academic standing, these records can be discarded (again, taking appropriate security precautions). It is unlikely that successful learners will appeal favorable academic decisions. However, it is recommended that anecdotal records and conference notes be kept for longer periods when there is a chance that the learner may appeal the grade or other decision. The statute of limitations for such an appeal is a useful guide to deciding how long to keep those materials. It is recommended that teachers consult with legal counsel if there is a question about institutional policy on retention of records.

HIPAA Requirements

The U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996 created new challenges for clinical nurse educators. Because of privacy concerns regarding disclosure of individually identifiable health information covered by this legislation, many health care facilities have adopted policies and procedures that may pose barriers to clinical teaching and learning.

Because individually identifiable health information increasingly is recorded, stored, and accessed in electronic form, concerns about the potential transfer of this information to a PDA and then to other devices may be a barrier to student use of PDAs in clinical settings. However, if PDA use by nursing students in clinical settings is primarily to access electronic reference books, this is not a HIPAA violation (Thompson, 2005). Additionally, if patient information must be entered into a student's PDA, a software program that encrypts data may be used to de-identify data (Kuiper, 2008).

Most health care organizations require nursing education programs to provide documentation that their students have been oriented to the requirements of HIPAA. If numerous clinical sites are used by a program, this requirement can be onerous if each agency requires students to attend or complete its own HIPAA orientation. Nursing education administrators may be able to negotiate with all clinical agencies to agree on the basic content of the required orientation, recognizing that the requirement could be met in various ways. Students typically are asked to sign a verification that they have been oriented to HIPAA requirements and that they agree to abide by those requirements. This orientation and

verification should be repeated at regular intervals (e.g., yearly or each semester).

Because health care agencies usually also require nursing education programs to provide verification that nursing students have met specified health requirements, this verification process may create HIPAA concerns. If the nursing education program collects, receives, or transmits students' individually identifiable health information, it could be deemed responsible for maintaining reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of the information and to protect against any reasonably anticipated threats to the security of the information and unauthorized uses or disclosures of it. Some clinical agencies request specific health data as evidence that students have met clinical health requirements, such as a rubella titer result. However, if the nursing education program complies with this request and the agency misuses the information in any way, both the education program and the clinical agency risk claims of unauthorized release or use of protected information about individual students.

Many nursing education programs avoid these potential complications by requiring a licensed health care provider to verify that a student has met all specified clinical health requirements. This verification, including dates for immunizations and a signed statement that the student's general health is adequate to allow full participation in the nursing program, is kept in the nursing education program files, but the raw data remain the property of the student and his health care provider. Another approach to resolving these concerns is to have all nursing students examined and tested by the student health service of the parent institution, with the raw data stored in that office and notification to the nursing education program that the clinical health requirements have or have not been met. It is wise to seek the advice of the school, college, or university counsel about how requirements for verification of students' health status by clinical agencies should be handled so that an appropriate policy can be developed and implemented.

SUMMARY

Because clinical teaching and learning take place in a social context, the rights of teachers, students, staff members, and patients sometimes are in conflict. These conflicts create legal and ethical dilemmas for clinical teachers. This chapter discussed selected ethical and legal issues related to clinical teaching.

Ethical standards such as respect for human dignity, autonomy, and freedom; beneficence; justice; veracity; privacy; and fidelity are important considerations for all parties involved in clinical teaching and learning. Students must learn to apply these standards to nursing practice, and teachers must apply them in their relationships with students as well as their teaching and evaluation responsibilities.

Specific ethical issues related to clinical teaching and learning include the presence of learners in a service setting, the need for faculty-student relationships to be based on justice and respect for persons, students' privacy rights, teaching competence, and academic dishonesty. Legal issues that have implications for clinical teaching and learning include educating students with disabilities, student rights to due process for academic and disciplinary decisions, standards of safe clinical practice, student and teacher negligence and liability, documentation and record keeping regarding students' clinical performance, and potential violations of HIPAA requirements with regard to student health information.

Suggestions were offered for preventing, minimizing, and managing these difficult ethical and legal situations. Laws and institutional policies often provide guidelines for action in specific cases. However, these suggestions should not be construed as legal advice, and teachers are advised to seek legal counsel in regard to specific questions or problems.

Exhibit 5.3

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- E.** Practice skilled oral and written (including electronic) communication that reflects an awareness of self and relationships with learners (e.g., evaluation, mentorship, and supervision)
- L.** Demonstrate personal attributes that facilitate learning (e.g., caring, confidence, patience, integrity, respect, and flexibility)
- Q.** Act as a role model in practice settings

2. Facilitate Learner Development and Socialization

- A.** Identify individual learning styles and unique learning needs of learners with these characteristics
 - 3.** at-risk (e.g., educationally disadvantaged, learning and/or physically challenged, social, and economic issues)

(continued)

- B. Provide resources for diverse learners to meet their individual learning needs
 - D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
 - E. Foster the development of learners in these areas
 - 3. affective
- 3. Use Assessment and Evaluation Strategies**
- D. Enforce nursing program standards related to admission and progression
 - J. Implement evaluation strategies that are appropriate to the learner and learning outcomes
 - O. Advise learners regarding assessment and evaluation criteria
 - P. Provide timely, constructive, and thoughtful feedback to learners
- 5. Pursue Continuous Quality Improvement in the Academic Nurse Educator Role**
- I. Acquire knowledge of legal and ethical issues relevant to higher education and nursing education
- 6. Engage in Scholarship, Service, and Leadership**
- A. Function as a Change Agent and Leader
 - 10. Use legal and ethical principles to influence, design, and implement policies and procedures related to learners, faculty, and the educational environment
 - C. Function Effectively within the Institutional Environment and the Academic Community
 - 4. Integrate the values of respect, collegiality, professionalism, and caring to build an organizational climate that fosters the development of learners and colleagues

REFERENCES

- Bavier, A. R. (2009). Holding students accountable when integrity is challenged. *Nursing Education Perspectives*, 30, 5.
- Brent, N. J. (2004a). The law and the nurse educator: A look at legal cases. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (pp. 813–846). Glen Ellyn, IL: College of DuPage Press.
- Brent, N. J. (2004b). The law and the nursing student: Answers you will want to know. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (pp. 847–860). Glen Ellyn, IL: College of DuPage Press.

- Case, B., & Oermann, M. H. (2004). Teaching in a clinical setting. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (pp. 126–177). Glen Ellyn, IL: College of DuPage Press.
- Corcoran, S. (1977). Should a service setting be used as a learning laboratory? An ethical question. *Nursing Outlook*, 25, 771–774.
- Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g; 34 CFR Part 99.
- Frank, B., & Halstead, J. A. (2005). Teaching students with disabilities. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 67–86). St. Louis, MO: Elsevier Health Sciences.
- Gardner, M. R., & Supple, P. D. (2010). *Handbook of clinical teaching*. Sudbury, MA: Jones and Bartlett.
- Harper, M. G. (2006). High tech cheating. *Nurse Educator Today*, 2, 672–679.
- Health Insurance Portability and Accountability Act of 1996. Public Law 104–191.
- Husted, G. L., & Husted, J. H. (2007). *Ethical decision making in nursing and health care: The symphonological approach* (4th ed.). New York: Springer Publishing.
- Johnson, E. G., & Halstead, J. A. (2005). The academic performance of students: Legal and ethical issues. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 41–66). St. Louis, MO: Elsevier Health Sciences.
- Kenny, D. (2007). Student plagiarism and professional practice. *Nurse Education Today*, 27, 14–18.
- Kiehl, E. M. (2006). Using an ethical decision-making model to determine consequences for student plagiarism. *Journal of Nursing Education*, 45, 199–203.
- Kohn, L., Corrigan, J., & Donaldson, M. (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press, Institute of Medicine.
- Kryder, C. (2009). Medical communicators: Did you tweet today? *AMWA Journal*, 24, 78–79.
- Kuiper, R. (2008). Use of personal digital assistants to support clinical reasoning in undergraduate baccalaureate nursing students. *CIN: Computers, Informatics, Nursing*, 26, 90–98.
- Langone, M. (2007). Promoting integrity among nursing students. *Journal of Nursing Education*, 46, 45–47.
- Lewenson, S. B., Truglio-Londrigan, M., & Singleton, J. (2005). Practice what you teach: A case study of ethical conduct in the academic setting. *Journal of Professional Nursing*, 21, 89–96.
- Morgan, J. E. (2001). Confidential student information in nursing education. *Nurse Educator*, 26, 289–292.
- O'Connor, A. B. (2006). Ethical and legal issues in nursing education. In *Clinical instruction and evaluation: A teaching resource* (2nd ed., pp. 293–312). Sudbury, MA: Jones and Bartlett.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- Skiba, D. J. (2008). Nursing education 2.0: Twitter & tweets. *Nursing Education Perspectives*, 29, 110–112.
- Southern Regional Education Board. (2004). *The Americans with Disabilities Act: Implications for nursing education*. Retrieved June 28, 2006, from <http://www.sreb.org/programs/nursing/publications/adareport.asp>

- Stokes, L., & Kost, G. (2004). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 325–348). St. Louis, MO: Elsevier Health Sciences.
- Theis, E. C. (1988). Nursing students' perspectives of unethical teaching behaviors. *Journal of Nursing Education*, 27, 102–106.
- Thompson, B. W. (2005). Infobytes: HIPAA guidelines for using PDAs. *Nursing 2005*, 35(11), 24.
- Tippett, M. P., Ard, N., Kline, J. R., Tilghman, J., Chamberlain, B., & Meagher, P. G. (2009). Creating environments that foster academic integrity. *Nursing Education Perspectives*, 30, 239–244.
- Williams, M. D. (2002). Fidelity and obligation in faculty practice. *Journal of Professional Nursing*, 18, 247–248.

Strategies for Effective Clinical Teaching

SECTION II

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6

Choosing Clinical Learning Assignments

One of the most important responsibilities of a clinical teacher is selecting clinical assignments that are related to desired outcomes, appropriate to students' levels of knowledge and skill, and challenging enough to motivate learning. Although directing a learner to provide comprehensive nursing care to one or more patients is a typical clinical assignment, it is only one of many possible assignments, and not always the most appropriate choice. This chapter presents a framework for selecting clinical learning assignments and discusses several alternatives to the traditional total patient care assignment.

PATIENT CARE VERSUS LEARNING ACTIVITY

When planning assignments, clinical teachers typically speak of selecting patients for whom students will care. However, as discussed in chapter 1, the primary role of the nursing student in the clinical area is that of learner, not nurse. Although it is true that nursing students need contact with patients in order to apply classroom learning to clinical practice, caring for patients is not synonymous with learning. In a classic study of the use of the clinical laboratory in nursing education, Infante (1985) took the position that nursing students are *learning to care* for patients; they are not

nurses with *responsibility for patient care*. Providing patient care does not guarantee transfer of knowledge from the classroom to clinical practice; instead, it often reflects work requirements of the clinical agency.

Many faculty members assume that caring for patients always constitutes a clinical assignment for students on every level of the nursing education program. Even in their earliest clinical courses, nursing students typically have responsibility for patient care while learning basic psychomotor and communication skills. However, given the high patient acuity level in most acute care settings, beginning-level nursing students are not ready to care for the typical patient in such environments, and this early responsibility for patient care often creates anxiety that interferes with learning.

As discussed in chapter 2, changes in health care, technology, society, and education influence the competencies needed for professional nursing practice. Learning outcomes necessary for safe, competent nursing practice today include cognitive skills of problem solving, decision making, critical thinking, and clinical reasoning, in addition to technical proficiency. If nurse educators are to produce creative, independent, assertive, and decisive practitioners, they cannot assume that students will acquire these competencies through patient care assignments. To produce these outcomes, clinical teachers should choose clinical assignments from a variety of learning activities, including participation in patient care.

FACTORS AFFECTING SELECTION OF CLINICAL ASSIGNMENTS

The selection of learning activities within the context of the clinical teaching process is discussed in chapter 4. Clinical activities help learners to apply knowledge to practice, develop skills, cultivate professional values, and become socialized to the role of professional nurse. Clinical assignments should be selected according to criteria such as the learning objectives of the clinical activity; needs of patients; availability and variety of learning opportunities in the clinical environment; and the needs, interests, and abilities of learners (Case & Oermann, 2004; O'Connor, 2006, pp. 114–120; Stokes & Kost, 2004).

Learning Outcomes

The most important criterion for selection of clinical assignments usually is the desired learning outcome. The teacher should structure each

clinical activity carefully in terms of the learning objectives, and each clinical activity should be an integral part of the course or educational program. In some nursing education programs, one set of course objectives applies to both the classroom and clinical learning outcomes; in others, separate but related sets of objectives are created to reflect the different emphases of “knowing that” (classroom learning outcome) and “knowing how” (clinical learning outcome) (O’Connor, 2006, p. 114).

Whatever method of specifying desired outcomes is used, it is essential that the instructor, students, and staff members understand the purpose and goals of each clinical activity. Depending on the level of the learner, students may have difficulty envisioning how broad program or course outcomes can be achieved in the context of a specific clinical environment. It is the instructor’s role to translate these outcomes into specific clinical objectives and to select and structure learning activities so that they relate logically and sequentially to the goals (Case & Oermann, 2004). The clinical instructor should share with each student the rationale for his or her specific clinical assignment to help students to focus on the learning opportunities presented by each unique assignment (O’Connor, 2006, p. 118).

Learner Characteristics

As discussed in chapter 4, the learner’s educational level or previous experience; aptitude for learning; learning style; and specific needs, interests, and abilities also should influence the selection of clinical assignments. The teacher must consider these individual differences; all learners do not have the same needs, so it is unreasonable to expect them to have the same learning assignments on any given day (Case & Oermann, 2004; Gardner & Suplee, 2010, p. 61; O’Connor, 2006, pp. 118–119).

For example, Student A learns skills at a slower pace than other students at the same level. The instructor should plan assignments so that this student has many opportunities for repetition of skills with feedback. If the objective is to learn the skills of medication administration, most students might be able to learn those skills in a reasonable amount of time in the context of providing care to one or more patients. Student A might learn more effectively with an assignment to administer all medications to a larger group of patients over the period of a day or more, without other patient care responsibilities. When the student has acquired the necessary level of skill, the next clinical assignment might be to administer medications while learning other aspects of care for one or more patients.

Students who are able to achieve the objectives of the essential curriculum (see chapter 1) rather quickly might receive assignments from the enrichment curriculum that allow them to focus on their individual needs. For example, a student who is interested in exploring perioperative nursing might be assigned to follow a patient through a surgical procedure, providing preoperative care, observing or participating in the surgery, assisting in immediate postoperative care in the postanesthesia care unit, and presenting a plan for home care in a postclinical conference. Taking learners' interests and professional development goals into account when planning enrichment activities will motivate students and individualize their learning experiences.

Needs of Patients

Patient needs and care requirements also should be considered when planning clinical assignments for students. In relation to the learning objective, will the nursing care activities present enough of a challenge to the learner? Are they too complex for the learner to manage?

Even if patients signed consents for admission to the health care facility that included an agreement to the participation of learners in their care, their wishes regarding student assignment and those of their family members should be respected (Case & Oermann, 2004). At times of crisis, patients and family members may not wish to initiate a new nurse-patient relationship with a nursing student or new employee orientee. Nursing staff members who have provided care to these patients often can help the clinical teacher determine whether student learning needs and specific patient and family needs both can be met through a particular clinical assignment.

As mentioned previously, the patient acuity level in a given clinical setting affects the selection of learning opportunities for nursing students. When the acuity level is high, it may not be possible for a clinical teacher to assign every student to learn to care for patients with many complex needs. In this case, some students may be assigned to apply their knowledge to the care of two or more relatively stable patients to develop their prioritization and time management skills, or two or more students may be assigned to plan, organize, deliver, evaluate, and document care for one patient with complex needs (Gardner & Suplee, 2010, pp. 60–61; O'Connor, 2006, pp. 119–120). Variations in student-patient ratio assignment options are described in more detail later in this chapter.

Timing of Activities and Availability of Learning Opportunities

Because the purpose of clinical learning is to foster application of theory to practice, clinical learning activities should be related to what is being taught in the classroom. Ideally, clinical activities are scheduled concurrently with relevant classroom content so that learners can make immediate transfer and application of knowledge to nursing practice. However, there is little evidence of a relationship between clinical learning outcomes and the structure, timing, and organization of clinical learning activities (Stokes & Kost, 2004).

The availability of learning opportunities to allow students to meet objectives often affects clinical assignments. The usual schedule of activities in the clinical facility may determine the optimum timing of learning activities. For example, if the learning objective for a new nursing student is “Identifies sources of information about patient needs from the health record,” it would be difficult for students to gain access to patient records at the beginning or end of a shift. Thus, scheduling learners to arrive at the clinical site at mid-morning may allow better access to the resources necessary for learning.

Some clinical settings, such as outpatient clinics and operating rooms, are available to both patients and students only on a daytime, Monday through Friday, schedule. In other settings, however, scheduling clinical learning assignments during evening or nighttime hours or on weekend days may offer students better opportunities to meet certain objectives. If the learning objective is, “Implements health teaching for the parents of a premature or ill neonate,” the best time for students to encounter parents may be during evening visiting hours or on weekends. Using these time periods for clinical activities also may avoid two or more groups of learners from different educational programs being in the same clinical area simultaneously, affecting the availability of learning opportunities.

Of course, learning activities at such times may conflict with family, work, and other academic schedules and commitments for both teachers and students (Stokes & Kost, 2004). In some cases (for example, with the use of preceptors), it is not necessary for the teacher to be present in the clinical setting with learners, thereby allowing more flexible scheduling of clinical activities. However, flexibility is necessary to take advantage of learning opportunities when they are available.

The clinical teacher should broadly interpret the objectives for a clinical course to take full advantage of the learning opportunities in

each clinical setting. If the instructor knows what concepts the students are learning in the classroom, he or she can find various clinical learning opportunities in different settings. For example, if the focus is wound healing, students could have learning activities involving patients with postoperative wounds, pressure ulcers, traumatic wounds, or arterial or venous chronic leg ulcers. It is not necessary for every student to have a similar learning opportunity if all learning activities enable students to apply the same concept in practice (Gardner & Suplee, 2010, p. 61; O'Connor, 2006, p. 114). In postclinical conference, students can be guided to discuss the various ways in which they applied a particular concept or principle; this debriefing activity will broaden their clinical knowledge and help them to identify similarities and differences among the various patient responses to a common alteration in health status.

OPTIONS FOR LEARNING ASSIGNMENTS

The creative teacher may select clinical assignments from a wide variety of learning activities. Several options for making assignments are discussed below.

Teacher-Selected or Learner-Selected Assignments

Although it is the teacher's responsibility to specify the learning objective, learners should have choices of learning activities that will help them achieve the objective (O'Connor, 2006, p. 119). Having a choice of assignment or at least a choice between options selected by the teacher motivates students to be responsible for their own learning and fully engage in the learning activity. Allowing learners to participate in selecting their own assignments also may reduce student anxiety.

Of course, the teacher should offer guidance in selecting appropriate learning activities through questions or comments that require students to evaluate their own needs, interests, and abilities. Sometimes teachers need to be more directive; a student may choose an assignment that clearly requires more knowledge or skill than the student has developed. In this case, the teacher must intervene to protect patient safety as well as to help the student make realistic plans to acquire the necessary knowledge and skill. Other students may choose assignments that do not

challenge their abilities; the teacher's role is to support and encourage such students to take advantage of opportunities to achieve higher levels of knowledge and skill (Gardner & Suplee, 2010, p. 65).

Skill Focus Versus Total Care Focus

As previously discussed, the traditional clinical assignment for nursing students is to give total care to one or more patients. However, not all learning objectives require students to practice total patient care. For example, if the objective is, "Assess patient and family preparation for postoperative recovery at home," the student does not have to provide total care to the postoperative patient in order to meet the objective. The student could meet the objective by interviewing the patient and family, observing a case manager's assessment of the patient and family's readiness for discharge or a physical therapist's assessment of the patient's ability to perform physical activities, and reviewing the patient's records. Additionally, total patient care is an integrative activity that can be accomplished effectively only when students are competent in performing the component skills.

As previously discussed, all students do not need to be engaged in the same learning activities at the same time. Depending on their individual learning needs, some students might be engaged in activities that focus on developing a particular skill, while others could be practicing more integrative activities such as providing total patient care.

For example, if students are learning physical assessment skills, some students could be assigned to practice auscultation by listening to breath, heart, and abdominal sounds of a variety of patients without having the responsibility of performing other patient care activities (O'Connor, 2006, p. 120). In postclinical conference, these students should share their insights about the commonalities and differences among their assessment findings and relate them to the patient's history and pathophysiology. A different group of students could perform assessment rounds during the next clinical practice day.

One advantage to assigning some students to learning activities that do not involve total patient care is that the clinical teacher is more available for closer guidance of students when they are learning to care for patients with complex needs. Staggering assignments in this way helps the clinical teacher better meet the learning needs of all students (Gardner & Suplee, 2010, pp. 60–61).

Student-Patient Ratio Options

Although the traditional clinical assignment takes the form of one student to one patient, there are other assignment options (Case & Oermann, 2004; O'Connor, 2006, pp. 119–120; Stokes & Kost, 2004). These options are described and compared below:

- *One student/one patient.* One student is responsible for certain aspects of care or for comprehensive care for one or more patients. The student works alone to plan, implement, and evaluate nursing care. This type of assignment is advantageous when the objective is to integrate many aspects of care after the student has learned the individual activities.
- *Multiple students/one patient.* Two or more students are assigned to plan, implement, and evaluate care for one patient. Each learner has a defined role, and all collaborate to meet the learning objective. Various models of dual or multiple assignment exist. For example, three students would read the patient record, review the relevant pathophysiology, and collaborate on an assessment and plan of care. Student A reviews information concerning the patient's medications, administers and documents all scheduled and p.r.n. (when-needed) medications, and manages the intravenous infusions. Student B focuses on providing and documenting all other aspects of patient care. Student C evaluates the effectiveness of the plan of care, assists with physical care when needed, interacts with the patient's family, and provides reports to appropriate staff members. Members of the learning team can switch roles on subsequent days. This assignment strategy is particularly useful when patients have complex needs that are beyond the capability of one student, although it can be used in any setting with a large number of students and a low patient census. Other advantages include reducing student anxiety and teaching teamwork and collaborative learning.
- *Multiple student/patient aggregate.* A group of students is assigned to complete activities related to a community or population subgroup at risk for certain health problems. For example, a small group of students might be assigned to conduct a community assessment to identify an actual or potential health problem in the aggregate served by the clinical agency. Clinical activities would include interviewing community residents and agency staff

members, identifying environmental and occupational health hazards, documenting the availability of social and health services, and performing selected physical assessments on a sample of the aggregate. The student group then would analyze the data and present a report to the agency staff and community members. Advantages of this assignment strategy include promoting a focus on the community as client, teaching collaboration with other health care providers and community members, and reinforcement of group process.

Management Activities

Some clinical assignments are chosen to enable learners to meet outcomes related to nursing leadership, management and improvement of patient care, and health care organizational goals. Undergraduate nursing students usually are introduced to concepts and skills of leadership and management in preparation for their future roles in complex health care systems. These students often benefit from clinical assignments that allow them to develop skill in planning and managing care for a group of patients. For example, a senior BSN student may enact the role of team leader for other nursing students who are assigned to provide total care for individual patients (Bradshaw, Rule, & Hooper, 2002). The student team leader may receive reports about the group of patients from agency staff, plan assignments for the other students, give reports to those students, supervise and coordinate work, and communicate patient information to staff members.

Master's and doctoral students may be preparing for management and administrative roles in health care organizations; their clinical activities might focus on enacting the roles of first-level or middle manager, patient care services administrator, or case manager. New staff nurse employees usually need to be oriented to the role of charge nurse; assignments to help them learn the necessary knowledge, skills, and attitudes should include practice in this role. Often, such clinical assignments involve the participation of a preceptor (chapter 13, Using Preceptors as Clinical Teachers and Coaches).

Guided Observation

Observation is an important skill in nursing practice, and teachers should provide opportunities for learners to develop this skill systematically.

Observing patients in order to collect data is a prerequisite to problem solving, clinical reasoning, and clinical decision making. To make accurate and useful observations, the student must have knowledge of the phenomenon and the intellectual skill to observe it: the what and how of observation. As a clinical learning assignment, observation should not be combined with an assignment to provide care. If students do not have concurrent care responsibilities, they are free to choose the times and sometimes the locations of their observations. The focus should be on observing purposefully in order to meet a learning objective.

Observation also provides opportunities for students to learn through modeling. By observing another person performing a skill, the learner forms an image of how the task or behavior is to be performed, which serves as a guide to learning. For this reason, it is helpful to schedule learners to observe in a clinical setting before they are assigned to practice activities. However, scheduling an observation before the learner has acquired the prerequisite knowledge is unproductive; the student may not be able to make meaning out of what is observed.

Written observation guidelines can be used effectively to prepare learners for the activity and to guide their attention to important data during the observation. Exhibit 6.1 is an example of an observation guide to prepare students for a group observation activity in an operating room. Note the explicit expectations that, before the observation, students will read, think critically, and anticipate what they will see. The presence of an instructor or other resource person to answer questions and direct students' attention to pertinent items or activities also is helpful. Students may be asked to evaluate the observation activity by identifying learning outcomes, what they did and did not like about the activity, and the extent to which their preparation and the participation of the instructor was helpful. Exhibit 6.2 is a sample evaluation tool for an observation activity.

Service Learning

Another option for clinical learning assignments is service learning. Service learning differs from volunteer work, community service, fieldwork, and internships. Volunteer and community service focus primarily on the service that is provided to the recipients, and fieldwork and internships primarily focus on benefits to student learning. Service learning intentionally combines the benefits to the community with student learning in ways that are mutually satisfying (Sedlak, Doheny, Panthofer, & Anaya,

Exhibit 6.1

EXAMPLE OF AN OBSERVATION GUIDE**Operating Room Observation Guide**

Purposes of the observation activity:

1. To gain an overview of perioperative nursing care in the intraoperative phase.
2. To observe application of principles of surgical asepsis in the operating room.
3. To distinguish among roles of various members of the surgical team.

General information:

You are expected to prepare for this observation and to complete an observation guide while you are observing the surgical procedure. Please read your medical-surgical nursing textbook, pp. 195–200, for a general understanding of nursing roles in the intraoperative phase.

Bring this observation guide and a pen or pencil on the day of your observation. The guide will be collected and reviewed by the instructor at the end of the observation activity.

Most likely, you will observe either a coronary artery bypass graft or an aortic valve replacement. Please review the anatomy of the heart, specifically the coronary vessels and valves. In addition, read the following pages in your medical-surgical nursing textbook: coronary artery disease, pp. 1058–1059 and 1069–1085; valvular heart disease (aortic stenosis), pp. 1131–1132 and 1135–1139.

After you have completed your reading assignment, attempt to answer the questions in the first section of the observation guide (Preparation of the Patient) related to preparations that take place before the patient comes to the operating room. Don't be afraid to make some educated guesses about the answers; we will discuss them and supply any missing information on the day of your observation.

Complete the remaining sections of the observation guide during your observation. The instructor will be available to guide the observation and to answer questions.

Preparation of the Patient

1. Who is responsible for obtaining the consent for the surgical procedure? Why?
2. Who identifies the patient when he or she is brought into the operating room? Why?
3. What other patient data should be reviewed by a nurse when the patient is brought to the operating room? Why?
4. Who transfers the patient from transport bed to the operating room bed? What safety precautions are taken during this procedure?
5. What is the nurse's role during anesthesia induction?

(continued)

6. What team members participate in the Universal Protocol? Identify elements of the protocol that protect the safety of this patient.
7. When is the patient positioned for the surgical procedure? Who does this? What safety precautions are taken? What special equipment may be used?
8. What is the purpose of the preoperative skin preparation of the operative site? When is it done? What safety precautions are taken?
9. What is the purpose of draping the patient and equipment? What factors determine the type of drape material used? What safety precautions are taken? Who does the draping? Why?
10. What nursing diagnoses are commonly identified for patients in the immediate preoperative and early intraoperative phases?

Preparation of Personnel

1. Apparel: Who is wearing what? What factors determine the selection of apparel? How and when do personnel don and remove apparel items? What personal protective equipment is used and why?
2. Hand antisepsis: Which personnel use hand antisepsis techniques to prepare for the procedure? When? Which method is used?
3. Gowning and gloving: What roles do the scrub person and the circulator play?

Roles of Surgical Team Members

1. Surgeons and assistants (surgical residents, interns, medical students)
2. Nurses
3. Anesthesia personnel
4. Others (perfusion technologist, radiologic technologist, pathologist, etc.)

Maintenance of Aseptic Technique

1. Movement of personnel
2. Sterile areas and items
3. Nonsterile areas and items
4. Handling of sterile items

Equipment

1. Lighting: Who positions it? How? When?
2. Monitoring: What monitors are used? Who is responsible for setting up and watching this equipment?
3. Blood/other fluid infusion: Who is responsible for setting up and monitoring this equipment?
4. Electrocautery: What is this equipment used for? Who is responsible for it? What safety precautions are taken?
5. Suction: What is this equipment used for? Who is responsible for setting up and monitoring it?

(continued)

6. Smoke evacuator: What is this equipment used for? Who is responsible for setting up and using it?
7. Patient heating/cooling equipment: What is this equipment used for? Who is responsible for setting up and monitoring it?
8. Other equipment

Intraoperative Nursing Diagnoses

1. What nursing diagnoses are likely to be identified for this patient in the intraoperative period?

Conclusion of Procedure

1. What elements of the Universal Protocol are implemented at this time?
2. How is the patient hand-off communication conducted? What personnel are involved? Were the essential elements included?
3. What nursing diagnoses are likely to be identified for this patient in the early postoperative period?

2003). Service learning is an academic credit-earning learning activity in which students:

- participate in an organized service activity that meets identified community needs and
- reflect on the service activity to gain a deeper understanding of course content, a broader appreciation of the discipline, and an enhanced sense of responsibility as a citizen (Bentley & Ellison, 2005).

Benefits of service learning to students include developing skills in communication, critical thinking, and collaboration; developing a community perspective and commitment to health promotion in the community; awareness of diversity and cultural competence; and professional development and self-discovery (Bentley & Ellison, 2005; Sedlak et al., 2003). Benefits to the community include having control of the service provided and recipients of service becoming better able to serve themselves and be served by their own actions.

The Pew Health Professions Commission (1993) report *Health Professions Education for the Future* recommended that service learning be incorporated into university nursing education to meet the increasing demand of community-based health care needs. As nursing education

EXAMPLE OF STUDENT EVALUATION OF A GUIDED OBSERVATION ACTIVITY*Student Evaluation of Operating Room Observation*

1. To what extent did you prepare for this learning activity?
 - I completed all assigned readings and attempted answers to all questions on the first section of the observation guide.
 - I completed all assigned readings and attempted to answer some of the observation guide questions.
 - I completed some of the assigned readings and attempted to answer some of the observation guide questions.
 - I didn't do any reading, but I tried to answer some of the observation guide questions before I came to the operating room.
 - I didn't do any reading, and I didn't answer any observation guide questions before I came to the operating room.

2. How would you rate the overall value of this learning activity?
 - It was excellent; I learned a great deal.
 - It was very good; I learned more than I expected to.
 - It was good; I learned about as much as I expected to.
 - It was fair; I didn't learn as much as I expected to.
 - It was poor; I didn't learn anything of value.

3. How would you rate the value of the observation guide in helping you to prepare for and participate in the observation?
 - Extremely helpful in focusing my attention on significant aspects of perioperative nursing care.
 - Very helpful in guiding me to observe activities in the operating room.
 - Helpful in guiding my observations but at times distracted my attention from what I wanted to watch.
 - Only a little helpful; it seemed like a lot of work for little benefit.
 - Not at all helpful; it distracted me more than it helped me to observe what was going on in the operating room.

4. How would you rate the helpfulness of the instructor who guided your operating room observation?
 - Excellent; helped me to analyze, synthesize, and evaluate the activities I observed.
 - Very good; answered my questions and focused my attention on important activities.
 - Good; was able to answer some questions, attempted to make the activity meaningful to me.
 - Fair; I probably could have learned as much without an instructor present.
 - Poor; distracted me or interfered with my learning; I could have learned more without an instructor present.

5. What was the most meaningful part of this learning activity for you? What was the most important or surprising thing you learned?

6. What was the least meaningful part of this observation activity? If there is something that you would change, suggest a specific change to make it better.

programs include more community-based learning activities, opportunities to incorporate service learning increase. Meaningful community-based service learning opportunities are based on relationships between the academic unit and the community to be served. For such partnerships to work effectively, there must be a good fit between the academic unit's mission and goals and the needs of the community.

As is true for any other clinical learning activity, planning for a service-learning activity begins with the teacher's decision that such learning activities would help students to achieve one or more course outcomes. The teacher should determine how many hours of clinical practice to allot to this activity, keeping in mind that the time spent in service learning would replace and not add to the total time available for clinical activities for that course.

Before students participate in a service-learning activity, they should be required to prepare a learning contract that includes:

- The name of the community agency or group
- The clients or recipients of that agency's or group's services
- The services to be provided by the student
- A service objective related to a need that has been identified by the community or the community recipient of the proposed service
- A learning objective that is related to a course outcome, goal, or competency that the activity would help the student to achieve (Sedlak et al., 2003)

Students may seek community groups and agencies where they believe they could meet their learning needs, or the instructor may develop a list of such agencies and groups appropriate for a specific course, from which students may choose a site. Examples of community settings and agencies that would be appropriate for service learning include daycare centers, extended care or assisted living centers, senior citizen centers, Meals on Wheels, the American Red Cross, Head Start, and a camp for children with disabilities, among many others (Bentley & Ellison, 2005; Sedlak et al., 2003).

Because service learning is more than expecting students to use some of their clinical practice hours for service projects, faculty members should plan to spend as much time planning these activities as they do traditional clinical learning activities. Even though the teacher will not be present with the students during the learning activity, the teacher must allow time to read and give feedback to students' reflective journal

entries about their experiences or to participate in face-to-face individual or group reflective sessions. Faculty members may require students to do presentations about their service-learning projects, which the teachers would observe and evaluate—another time requirement to consider. And faculty members also must continue to interact with members of the community to evaluate the outcomes of service learning from the perspective of the recipients of service and to continually nurture the partnerships that were established (Bentley & Ellison, 2005).

SUMMARY

This chapter presented a framework for selecting clinical learning assignments. Clinical teachers should select clinical assignments that are related to desired learning outcomes, appropriate to students' levels of knowledge and skill, and challenging enough to motivate learning. Providing comprehensive nursing care to one or more patients is a typical clinical assignment, but it is not always the most appropriate choice.

Clinical teachers typically speak of selecting patients for clinical assignments. However, the primary role of the nursing student in the clinical area is that of learner, not nurse. Caring for patients is not synonymous with learning. Nursing students are *learning to care* for patients; they are not nurses with *responsibility for patient care*. In fact, early responsibility for patient care often creates anxiety that interferes with learning.

Factors affecting the selection of clinical assignments include the learning objectives of the clinical activity; needs of patients; availability and variety of learning opportunities in the clinical environment; and the needs, interests, and abilities of learners. The most important criterion for selection of clinical assignments usually is the desired learning outcome. Each clinical activity should be an integral part of the course or educational program, and it is essential that the instructor, students, and staff members understand the goals of each clinical activity. Learning activities are selected and structured so that they relate logically and sequentially to the desired outcome.

Individual learner characteristics such as education level; previous experience; aptitude for learning; learning style; and specific needs, interests, and abilities should also influence the selection of clinical assignments. All learners do not have the same needs, so it is unreasonable to expect them to have the same learning assignments on any given day. Students who are able to achieve the objectives of the essential curriculum

quickly might receive assignments from the enrichment curriculum that allow them to focus on their individual needs and interests.

Patient needs and care requirements also should be considered when planning clinical assignments. The nursing care activities required by a patient may not present enough of a challenge to one learner and may be too complex for another. Patient wishes regarding student assignment should be respected. Nursing staff members who have provided care to these patients often can help the clinical teacher determine whether student learning needs and specific patient and family needs both can be met through a particular clinical assignment.

Another factor affecting the selection of clinical assignments is the timing and availability of learning opportunities. Ideally, clinical learning activities are scheduled concurrently with relevant classroom content so that learners can apply knowledge to nursing practice immediately. The usual schedule of activities in the clinical facility may determine the optimum timing of learning activities. Some clinical settings are available to both patients and students only at certain times. In other settings, however, scheduling clinical activities during evening or nighttime hours or on weekends provides better learning opportunities.

Alternatives for making clinical assignments include selection by teacher or learner, focus on particular skills or integrative patient care, various student-patient ratio options, management activities, guided observation, and service learning. Advantages and drawbacks of each alternative were discussed.

Exhibit 6.3

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A.** Implement a variety of teaching strategies appropriate to
 - 1. content setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- E.** Practice skilled oral and written (including electronic) communication that reflects an awareness of self and relationships with learners (e.g., evaluation, mentorship, and supervision)
- I.** Create opportunities for learners to develop their own critical thinking skills

(continued)

- L. Demonstrate personal attributes that facilitate learning (e.g., caring, confidence, patience, integrity, respect, and flexibility)
- Q. Act as a role model in practice settings

2. Facilitate Learner Development and Socialization

- A. Identify individual learning styles and unique learning needs of learners with these characteristics
 - 3. at-risk (e.g., educationally disadvantaged, learning and/or physically challenged, social, and economic issues)
- B. Provide resources for diverse learners to meet their individual learning needs
- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective

3. Use Assessment and Evaluation Strategies

- P. Provide timely, constructive, and thoughtful feedback to learners

REFERENCES

- Bentley, R., & Ellison, K. J. (2005). IMPACT of a service-learning project on nursing students. *Nursing Education Perspectives*, 26, 287–290.
- Bradshaw, M. J., Rule, R., & Hooper, V. (2002). A joint junior-senior clinical experience. *Nurse Educator*, 27, 56–57.
- Case, B., & Oermann, M. H. (2004). Teaching in a clinical setting. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (pp. 126–177). Glen Ellyn, IL: College of DuPage Press.
- Gardner, M. R., & Supplee, P. D. (2010). *Handbook of clinical teaching in nursing and health sciences*. Sudbury, MA: Jones and Bartlett.
- Infante, M. S. (1985). *The clinical laboratory in nursing education* (2nd ed.). New York: Wiley.
- O'Connor, A. B. (2006). Organizing and managing instruction in clinical practice settings. In *Clinical instruction and evaluation: A teaching resource* (2nd ed., pp. 103–146). Sudbury, MA: Jones and Bartlett.
- Pew Health Professions Commission. (1993). *Health professions education for the future: Schools in service to the community*. San Francisco: UCSF Center for the Health Professions.
- Sedlak, C. A., Doheny, M., Panthofer, N., & Anaya, E. (2003). Critical thinking in students' service-learning experiences. *College Teaching*, 51, 99–103.
- Stokes, L., & Kost, G. (2004). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 325–348). St. Louis, MO Elsevier Health Sciences.

7

Self-Directed Learning Activities

Some outcomes of clinical courses may be met by students through self-directed learning activities. These activities may involve instructional media such as videos on DVDs and CDs, computer-assisted instruction, virtual reality, Web-based methods, learning objects, independent study, and others. Faculty members have a wealth of instructional technologies to integrate in their clinical courses for students to acquire the prerequisite knowledge and skills, for review, and for learning new concepts and skills, among other uses.

Many individual differences among nursing students influence how they learn. Some students enter a clinical course with extensive knowledge and skills, while others may lack the prerequisite behaviors for engaging in the learning activities. Differences in learning styles, preferences for teaching methods, cultural and ethnic backgrounds, and pace of learning all suggest a need for self-directed activities that reflect these individual variations among learners. With these activities, the responsibility for learning rests with the student.

There are varied types of self-directed activities for use in clinical teaching. Many of these activities are based on multimedia and instructional technology; others, such as a literature review and critique, may not incorporate media. Self-directed activities may be required for completion by all students to meet the outcomes of the clinical course or

for use by individual students for reinforcement of learning, continued practice of skills, and remedial instruction. This chapter reviews self-directed learning activities appropriate for clinical teaching. The reader should recognize, however, that the activities involving multimedia are changing rapidly, and new technologies continually are being introduced for teaching and learning in clinical practice.

USING SELF-DIRECTED LEARNING ACTIVITIES

Self-directed learning activities are what the term suggests—activities directed by the students themselves. Although they are planned by the teacher as part of the clinical activities or recommended to meet specific learning needs, self-directed activities are intended for completion by the students on their own. These activities are typically self-contained units of instruction that students complete independently, often in a setting of their choice, and according to their own time frame. Computer-assisted instruction (CAI), for instance, may be completed in a computer or learning laboratory or at home at a time convenient for the student. The learner may move through the instruction at a fast or slow pace depending on the learning needs and may repeat content and activities until the competency is achieved. Many self-directed activities also include pre- and posttests for students to assess their progress and learning at the end of the instruction.

Self-directed activities may be planned for completion by all students to meet certain clinical outcomes or by students on an individual basis to reflect their particular learning needs. For some clinical courses and rotations, all students may be required to complete self-directed activities as a means of acquiring essential knowledge for practice and developing course competencies. These activities, then, would be integrated in the clinical course during its development.

When students lack prerequisite knowledge and skills or when remedial instruction is warranted for some students but not others, self-directed activities provide a means of meeting these learning needs without requiring all students to complete the same learning activities. In these instances, the self-directed activities assist individual students in gaining knowledge and skills they need for practice. Self-directed activities, therefore, are an important adjunct to clinical teaching.

Along with allowing students to learn in a setting of their choice and at a time convenient for them, self-directed activities encourage them to

assume responsibility for their own learning, an important outcome of nursing programs. As students progress through a nursing program, they may encounter outcomes that they are unable to meet because they lack the prerequisites for learning or need to review or practice their skills further. By identifying personal learning needs and seeking opportunities to meet them, students begin to develop skills they can use in the future when confronted with questions about nursing practice they are unable to answer and competencies they need to develop. Nursing programs provide the knowledge and competencies for entry into practice, but nurses need to be self-directed so they can keep current in their practice.

Although beneficial for students, self-directed learning requires their commitment and motivation. The teacher may plan strategies, such as periodic quizzes, to monitor student progress in completing the learning activities, provide feedback, and assist students in developing self-discipline. In some courses, faculty members may establish time frames for completion of certain activities to better monitor progress and assure completion by the end of the clinical course.

Using Self-Directed Activities for Cognitive Skill Development

Self-directed activities that depict clinical situations and patient care scenarios are particularly effective for promoting problem-solving and higher-level thinking skills. After viewing the clinical situation presented in media, multimedia, or through other technologies, students may be asked to:

- Identify the problems and issues to be solved and provide a supporting rationale.
- Identify alternative problems that might be possible in the clinical situation.
- Differentiate relevant and irrelevant information.
- Develop careful and pointed questions to further clarify the problems and issues.
- Identify additional data needed for decision making.
- Identify multiple approaches for solving the clinical problems and issues, possible alternative approaches, and advantages and disadvantages of each.
- Compare the various decisions possible in a clinical situation and their outcomes.

- Decide on the approach they would use or decision they would make and provide a rationale underlying their thinking.
- Examine how key concepts and theories apply to the clinical situation depicted in the media or multimedia.
- Analyze the clinical scenario using concepts and theories described in class, in readings, and through other learning activities as a way of transferring learning to clinical practice.
- Identify assumptions made and how these influenced thinking.
- Articulate different points of view (Oermann & Gaberson, 2009).

Using Self-Directed Activities for Value Development

Media and multimedia are effective for teaching students professional nursing values and for students to examine their beliefs and values that might influence their patient care. By viewing clinical situations depicted in video clips, at Web sites, and in other types of media, students can gain awareness of other people's circumstances and their own values and beliefs. Students enter nursing programs with personal values and preset ideas that may influence their care and decisions they make in clinical practice. Analysis of scenarios shown in media provides a safe way for students to become more aware of their own value systems and beliefs. Through open-ended questions and a safe environment in which to discuss beliefs and feelings, students can begin to explore their values and how they might affect decisions in clinical practice.

PLANNING SELF-DIRECTED ACTIVITIES

Although self-directed activities are completed by students independently, the teacher is responsible for planning those activities as part of the clinical course or recommending them for students to meet individual learning needs. Self-directed learning activities, similar to other types of clinical activities, should be consistent with the outcomes of the clinical course or competencies that students develop in that course. The main reason for their use in a course is their potential to assist students in achieving certain outcomes.

In planning self-directed activities, the teacher should consider the resources needed for their implementation. These resources include costs for developing materials, purchasing commercially available materials, and supporting software and hardware; equipment needed; space

such as computer and other laboratories considering the numbers of students in the program; other requirements associated with using a particular technology; and resources needed by students. Many of these activities are now done on the Web and are easily integrated into course management systems; however, students' computer resources need to be taken into account. The time required for completion is another consideration in planning these activities for a course. The teacher should monitor the time that students take for each activity so this information is available for planning at a later time.

One way of ensuring effective planning and use of self-directed activities in a clinical course is to follow the acronym PLAN:

Plan activities that assist students in meeting the outcomes of the clinical course, individual learning needs, or both.

Link these activities with the resources of the nursing program and those needed by students.

Assess prerequisite knowledge and skills for initiating the self-directed activities, students' progress as they complete them, and learning outcomes.

Never assume that students will learn at the same rate and in the same way; allow for individualization in types of learning activities, rates of learning, and outcomes.

When incorporating self-directed activities in clinical courses, students should have directions regarding specific activities to complete and due dates if required in the clinical course. It also is helpful to students to indicate how these particular activities promote achievement of the outcomes of the course and how they will be assessed, if at all.

TYPES OF SELF-DIRECTED LEARNING ACTIVITIES

It is beyond the scope of this chapter to describe in detail all of the self-directed activities available for clinical teaching, particularly when considering the rapid growth of computer, Web-based, and other instructional technologies. Although a number of self-directed methods are reviewed in this chapter, they are only a sampling of these methods and discussion of how they might be used in clinical teaching. In the

chapter, self-directed activities are categorized as instructional media, multimedia, learning objects, and independent study. There are different ways of grouping these methods for presentation; this categorization represents only one way. The reader also should recognize that many of these methods use more than one technology; for instance, a computer simulation may include video, audio, and other media.

Instructional Media

Many types of media are available for clinical teaching. Media include models; still visuals such as photographs, charts, posters, and handouts; moving visuals such as DVDs; and audio media such as CDs, real audio, and podcasts (Zwirn & Muehlenkord, 2009). Exhibit 7.1 provides a list of different media that can be used in clinical teaching.

Instructional media and multimedia promote learning through different senses, facilitating comprehension of difficult concepts and complex skills. Media that depict patient scenarios help students understand how concepts and theories are used in clinical practice and give them an idea of what a clinical situation is like. This vicarious experience prepares learners for the reality of clinical practice. It also allows students to think critically about a situation and possible decisions that could be made.

Another important use of media in clinical teaching is the ability to present clinical situations involving ethical dilemmas and value conflicts for students to analyze. When media are used in this way, students gain experience in analyzing and responding to an ethical dilemma before encountering it in actual practice. Media for this purpose also provide a means for students to examine their values and beliefs that may influence care of patients and their interactions with staff and others in the practice setting.

Media are effective for showing clinical situations that would be inaccessible to students, close-up photographs, and procedures and technologies to be learned. With technological skills, media provide a way of demonstrating the use of equipment and how to carry out a procedure in the clinical setting, emphasizing critical elements of performance.

Multimedia

Multimedia include computer-assisted instruction; CD-ROMs, DVDs, and similar technologies; virtual reality; World Wide Web; and many others. Multimedia are the combination of video, audio, text, and graphics

Exhibit 7.1

TYPES OF INSTRUCTIONAL MEDIA

Models

Nonprojected still visuals

- Brochure and pamphlet
- Diagram
- Handout and other types of written materials
- Photograph
- Poster

Projected still visuals

- Document camera
- Digital camera
- Overhead transparency
- Slide
- Whiteboard

Audio technologies

- Audiotape
- CD
- Podcast
- Real audio

Video technologies

- CD
- DVD
- Film
- Video on Web

Multimedia

- CD-ROM
- Computer-assisted instruction and other computer technology
- DVD
- Podcast
- Virtual reality
- World Wide Web

(Zwirn & Muehlenkord, 2009). Multimedia, similar to media, may be used by all students to meet clinical learning outcomes or by individual students. Many multimedia programs are interactive, providing feedback to students on their responses and engaging students actively in the learning process. Carty and Ong (2006) suggested that the most important characteristic of multimedia was their ability to deliver effective and flexible instruction that attracted learners' interest, kept their attention, and accommodated different learning styles (p. 524).

Prior to using any multimedia for clinical teaching, the teacher should evaluate their content, including accuracy, organization, clarity in presenting the content, and comprehensiveness; relevance to the clinical course and clinical learning outcomes; usefulness for meeting individual student needs; currency in terms of clinical practice; extent of interaction between student and multimedia; cost; and resources needed for effective implementation (Exhibit 7.2). One other aspect of this evaluation relates to the appropriateness of the content for the clinical setting; with some multimedia, students may need to adapt interventions and procedures to their own clinical settings.

Exhibit 7.2

EVALUATION OF MEDIA AND MULTIMEDIA FOR CLINICAL TEACHING

Are the media and multimedia:

Relevant to the clinical course? Relevant to clinical learning outcomes? Relevant to clinical settings where students have practice?
Useful for meeting individual student needs?
Able to be modified or adapted to better meet the objectives and learner needs?
Of high technical quality (e.g., graphics, sounds, etc.)?

Is the content:

Accurate?
Organized logically?
Presented clearly?
Comprehensive?
In sufficient depth for clinical course and learners?
Up to date?

Does the instruction:

Provide for interaction with the student?
Give immediate feedback and reinforcement?
Maintain student interest?
Allow for entering and exiting the program as needed?
Adapt for individual student needs?

Is the cost (to the student or nursing education program or both) worth the investment?

Are there sufficient resources for implementation?

Computer-Assisted Instruction (CAI)

There are many types of CAI programs for use in nursing education. Computer-assisted instruction may be used to present new content important for clinical practice, to promote application of concepts and theories to simulated clinical situations, as a review prior to clinical practice, and to provide remedial instruction for individual students. With some CAI, students can practice problem solving and decision making in simulated scenarios. One main use of CAI is to guide students in applying concepts that they are learning in face-to-face and online courses to clinical situations and gaining experience in thinking through those situations before encountering them in clinical practice.

There are many CAI programs, and teachers need to be aware of what is available in their nursing education programs, clinical settings, or on the Web when they plan their courses. With this information, the faculty can integrate CAI within clinical courses and recommend specific programs to students when they need additional instruction or review. Often CAI programs incorporate questions for feedback to students, indicating which answers and decisions are correct or incorrect and why. The questions and answers also provide reinforcement for learning as students progress through the instruction. When not included with the CAI, faculty members can develop ways to provide feedback for student self-assessment. Another advantage of CAI is that students can pace themselves through the instruction.

Two types of CAI include tutorials and simulations.

- *Tutorials* instruct students on new concepts and generally include questions to review the content. Students then get feedback based on their responses. Tutorials using branching techniques allow students to move forward to learn new content or backward if remedial instruction is needed. For clinical teaching, tutorials may be used to present new content for practice or for remedial instruction.
- *Simulations* present a real-life situation for analysis and decision making. With a simulation, students make a series of clinical decisions similar to those needed in actual practice and receive immediate feedback on them. With some simulations, the learners' decisions influence subsequent information presented. Simulations are particularly appropriate for gaining practice in identifying data to collect, analyzing data in a simulated clinical situation,

identifying problems and interventions, evaluating outcomes, and developing critical thinking and technological skills.

Human patient simulators are being used increasingly in nursing education programs. These provide opportunities for students to develop knowledge and competencies for clinical practice, make clinical decisions in real time, develop technological skills not possible in many clinical settings, practice in a safe environment, develop collaboration skills, and achieve many other clinical outcomes (Campbell & Daley, 2009; Dillon, Noble, & Kaplan, 2009; Jeffries, 2005, 2006; Jeffries, McNelis, & Wheeler, 2008; Kardong-Edgren, Starkweather, & Ward, 2008). Simulations are discussed more extensively in chapter 8.

CD-ROMs, DVDs, and Related Technologies

Many CD-ROMs, DVDs, and related technologies are available for use in clinical teaching across all levels of nursing education. Some of these teach skills such as measuring vital signs, administering medications, and inserting and discontinuing IVs. For example, the multimedia program *IV Therapy* (FITNE Inc., 2009), which is available online or as a CD-ROM, teaches students about various delivery systems for IVs; uses videos to show how to start, maintain, and discontinue IVs; and explains complications of IV therapy and the nurse's role in preventing them.

With these types of multimedia programs, faculty members can expose students to care of patients and clinical situations that they may not have an opportunity to experience in the clinical setting. For example, not all students in a course may have a chance to care for a child with a critical illness or an adult patient with dialysis. By viewing a CD-ROM or DVD on care of these patients, students can acquire essential knowledge, learn about typical interventions and why they are used in the patient's care, review related medication and treatments, and analyze related clinical scenarios. They can be completed by students independently, not taking in-class or online instruction time.

Virtual Reality

In virtual reality, scenes that represent a real situation are displayed on a computer screen, and learners have an opportunity to actively participate in them. Visualization on the computer screen simulates what the patient or procedure would look like in an actual clinical situation. Often

the virtual reality system includes software packages with different scenarios to enhance students' learning and practice of skills. As students practice procedures, they receive audible feedback about their technique and decisions.

Schmidt and Stewart (2009) described how they introduced a virtual environment called Second Life in their accelerated nursing program, using it in their online courses as part of their class sessions, for discussions and meetings with students, and for other purposes. Eventually, the faculty intends to develop various clinical scenarios for analysis by students. In chapter 9, virtual reality is described in detail with examples of how it can be used in clinical education.

World Wide Web

The World Wide Web is a multimedia platform for accessing information that is organized in relationship to other information, enabling students to retrieve it quickly and easily through different paths. The Web gives learners access to evidence and literature related to patient care, enables them to find answers to questions about patient problems and clinical situations, and allows students to find information appropriate for their own learning needs and interests. The World Wide Web provides a wealth of instructional resources that can be used in clinical teaching, such as illustrations, photos, X rays, and video clips, among others. When learning about a clinical concept, students can be directed to a Web site to view that concept.

Many courses in nursing are now Web based. McHugh (2006) advised faculty members to make their Web courses multisensory and multidimensional, incorporating audio, video, photos, animation, and other multimedia in them. The Web has opened many opportunities for self-directed activities to support clinical learning. Students may communicate with each other in the clinical group and with the teacher through e-mail, Twitter, instant messaging, discussion boards, and computer conferences, and they may analyze cases and clinical issues in online discussions in small groups set up by the faculty member.

Students may be directed to Web sites related to the clinical objectives or to explore specific clinical issues faced in their practice. In the beginning of a clinical course, for example, students may explore sites relevant to the area of clinical practice, such as oncology nursing, and evaluate each site for its usefulness in caring for these patients, in patient education, and for their own learning. If resources are available,

self-directed activities on the Web are limited only by the teacher's creativity and willingness to explore new technologies.

GUIDELINES FOR USING MULTIMEDIA

With the wealth of multimedia available for clinical teaching, the teacher should first evaluate the quality and appropriateness of the multimedia for the intended learning outcomes. Not all multimedia are of high quality, nor are they all appropriate for the objectives or meeting learner needs. Other guidelines for using multimedia for clinical teaching are:

- Prepare objectives to be achieved through completion of the multimedia.
- Consider assigning or recommending selected parts of a multimedia program that are most appropriate for the learning outcomes rather than the entire program.
- When parts of a multimedia program are used and when students complete multiple learning activities, provide written guidelines for them to follow that include the sequence for completing the activities. These guidelines direct students through varied activities and segments of a program, similar to a map.
- Plan for some of the activities involving multimedia to be completed in pairs or small groups. Small group discussions about the content and possible answers to questions posed in the multimedia and the exchange of ideas about problems, approaches, and multiple ways of viewing clinical situations encourage problem solving, decision making, and critical thinking. These discussions can be done online.
- Consider carefully the resources needed for effective implementation of the multimedia. For programs completed in a computer or learning laboratory, students can work in pairs and small groups to ease the burden for adequate hardware and software.
- Develop questions for students to answer as they progress through the multimedia and at the end of the instruction if feedback questions and a posttest are not already included. If the teacher intends for the multimedia to be used independently by students, then answers with a rationale should be included with the questions. The teacher should first review the multimedia program, because many will have questions integrated throughout for student response.

Questions also may be written to link the multimedia to the specific clinical objectives and help students relate the content to the clinical setting and types of clients for whom they are learning to care.

- Provide an opportunity for students to evaluate the multimedia from a learner's perspective in terms of quality and usefulness in developing knowledge and skills for clinical practice.

FACULTY DEVELOPMENT

In many nursing education programs and clinical settings, nurse educators are not prepared to use new technologies in their teaching. There is a need in this area for faculty development, and educators should be alert to initiatives designed to introduce technologies in nursing education and prepare faculty for their use. There are Web-based resources that faculty members can use to get ideas about multimedia and other technologies for teaching and to keep current. For example, EDUCAUSE is a nonprofit organization to promote the use of technologies in higher education (<http://www.educause.edu/>).

LEARNING OBJECTS

Learning objects are small units of learning that are reusable—that is, one learning object may be used in different situations and courses and enhanced for more complex learning. With learning objects, the outcomes and content to be learned can be divided into small units of instruction that can be reused in different learning situations. Although learning objects are self-contained and thus can be completed independently, they also can be grouped together into broader and more extensive collections of content.

Learning objects are developed to teach a single learning concept or objective (Lynn, Bath-Hextall, & Wharrad, 2008). Many types of learning objects can be designed for use in clinical courses such as digital photographs of patients, conditions, procedures, and clinical situations; video clips to teach clinical concepts; case studies for analysis with critical thinking questions; hyperlinks to Web pages and Internet resources; simulations; interactive games; and units of content taught with multimedia.

Learning objects are valuable resources for use in distance education clinical courses and other Web-based courses. They can be stored in

repositories or libraries of learning objects. Because they can be reused, faculty members can access these repositories as they are planning their clinical courses and can direct students to them to meet individual learning goals. MERLOT (Multimedia Educational Resource for Learning and Online Teaching; <http://healthsciences.merlot.org/index.html>) is a free resource for faculty members and students that contains links to online learning objects in nursing with peer reviews and assignments.

INDEPENDENT STUDY

Independent study allows students freedom in deciding on their own learning goals, strategies for learning, and how the learning outcomes will be assessed as part of the clinical course. The teacher and student typically collaborate on the objectives to be met through independent study so they relate to the clinical goals and are reasonable within the time frame. A contract may be established between the teacher and student outlining the goals to be met through the independent study project, types of learning activities to be completed, assessment methods and products of learning to be submitted as part of the clinical course, and dates for completion of these. Independent study is particularly useful when students want to explore a new area of clinical practice or a patient problem and interventions in depth.

SUMMARY

Many clinical objectives and competencies may be met by students through self-directed learning activities. Whether planned by the teacher as part of the clinical activities or recommended to meet specific learning needs, self-directed activities are intended for completion by the students on their own. These activities are typically self-contained units that students complete independently, often in a setting of their choice and according to their own time frame. Self-directed activities encourage them to assume responsibility for their own learning, an important outcome of nursing programs.

Self-directed activities may be completed by all students to meet certain clinical competencies or by students on an individual basis to reflect their particular learning needs. Similar to other types of learning activities, they should be consistent with the outcomes of the clinical course.

In planning self-directed activities, the teacher should consider the resources needed for their implementation. These resources include costs for developing materials, purchasing commercially available materials, and supporting software and hardware; equipment needed; space such as computer laboratory space; other requirements associated with a particular technology; and resources needed by students. The time required for completion is another consideration in planning these activities for a course.

Self-directed activities are categorized as instructional media such as video clips; multimedia, including computer-assisted instruction, CD-ROM, DVDs, virtual reality, and the World Wide Web; learning objects; and independent study. Instructional media and multimedia promote learning through different senses, making it easier to comprehend difficult concepts. Media and multimedia that depict patient care scenarios help students understand how concepts and theories are used in practice and give them an idea of what a clinical situation is like. This vicarious experience prepares learners for the reality of clinical practice. Many new instructional technologies can be used for clinical teaching. It is up to the teacher to be creative and willing to integrate these into clinical courses.

Other types of self-directed activities are learning objects and independent study. Learning objects are small units of learning that are reusable—that is, one learning object may be used in different situations and courses. Independent study allows students freedom in deciding on their own learning goals, strategies for learning, and how the outcomes will be assessed as part of the clinical course.

Exhibit 7.3

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A.** Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- B.** Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education

(continued)

- C. Modify teaching strategies and learning experiences based on consideration of learners'
 - 2. past clinical experiences
 - 3. past educational and life experiences
- D. Use information technologies to support the teaching-learning process
- O. Use knowledge of evidence-based practice to instruct learners

2. Facilitate Learner Development and Socialization

- A. Identify individual learning styles and unique learning needs of learners with these characteristics
- B. Provide resources for diverse learners to meet their individual learning needs
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective

6. Engage in Scholarship, Service, and Leadership

- A. Function as a Change Agent and Leader
 - 2. Integrate a long term, innovative, and creative perspective into the academic nurse educator role
 - 8. Promote innovative practices in educational environments
 - 11. Adapt to changes created by external factors
 - 12. Support changes as an early adopter

REFERENCES

- Campbell, S. H., & Daley, K. M. (2009). *Simulation scenarios for nurse educator: Making it real*. New York: Springer Publishing.
- Carty, B., & Ong, I. (2006). The nursing curriculum in the information age. In V. K. Saba & K. A. McCormick (Eds.), *Essentials of nursing informatics* (4th ed., pp. 517–532). New York: McGraw-Hill.
- Dillon, P. M., Noble, K. A., & Kaplan, L. (2009). Simulation as a means to foster collaborative interdisciplinary education. *Nursing Education Perspectives*, 30, 87–90.
- FITNE Inc. (2009). *IV therapy*. Retrieved July 10, 2009, from http://www.fitne.net/vlrc4/iv_therapy.jsp
- Jeffries, P. R. (2005). A framework for designing, implementing, and evaluating simulations in nursing. *Nursing Education Perspectives*, 26(2), 28–35.
- Jeffries, P. R. (2006). Designing simulations for nursing education. In M. H. Oermann & K. T. Heinrich (Eds.), *Annual review of nursing education* (Vol. 4, pp. 161–177). New York: Springer Publishing.
- Jeffries, P. R., McNelis, A. M., & Wheeler, C. A. (2008). Simulation as a vehicle for enhancing collaborative practice models. *Critical Care Nursing Clinics of North America*, 20, 471–480.

- Kardong-Edgren, S., Starkweather, A., & Ward, L. (2008). The integration of simulation into a clinical foundations of nursing course: Student and faculty perspectives. *International Journal of Nursing Education Scholarship*, 5(1), article 26. doi: 10.2202/1548-923X.1603
- Lynn, J., Bath-Hextall, F., & Wharrad, H. (2008). Pharmacology education for nurse prescribing students: A lesson in reusable learning objects. *BMC Nursing*, 7(2). doi:10.1186/1472-6955-7-2.
- McHugh, M. (2006). Teaching a Web-based course: Lessons from the front. In J. M. Novotny & R. H. Davis (Eds.), *Distance education in nursing* (2nd ed., pp. 15–45). New York: Springer Publishing.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- Schmidt, B., & Stewart, S. (2009). Implementing the virtual reality learning environment: Second Life. *Nurse Educator*, 34, 152–155.
- Zwirn, E. E., & Muehlenkord, A. (2009). Using media, multimedia, and technology-rich learning environments. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (3rd ed., pp. 335–350). St. Louis, MO: Saunders.

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8

Clinical Simulation

SUZANNE HETZEL CAMPBELL

Clinical simulation is rapidly earning a place in nursing education as a valuable supplement to clinical practice with live patients. The National Council of State Boards of Nursing (NCSBN) reported that 5 states and Puerto Rico have enacted regulation changes to allow simulation as a substitution for clinical learning activities, 16 states give approval for such substitution on a case-by-case basis, and 17 states may consider it in the future (Nehring, 2008). State boards of nursing that approve specific substitutions count between 10% and 25% of simulation time as clinical experience (Jeffries, 2009). Simulation will never replace actual student contact with real patients, but it has the potential to make student and faculty time in clinical settings more valuable and cost effective.

With the growing shortage of nurses, alternatives to traditional training methods could not be more timely. An increased interest in nursing as a career has led to more applications to nursing education programs, but the number of nursing faculty members is not increasing at the same pace (American Association of Colleges of Nursing, 2009; Tanner, 2006a), creating capacity limits in classrooms and clinical settings. In addition, the health care environment has grown in complexity due to the increasing presence of technology in hospitals and, subsequently, patients with higher acuity levels who are older, frailer, and have more comorbidity. Patients are also spending less time in the hospital, so

students have less exposure to regular hospital situations and less of an opportunity to maintain and improve their skills (Magee, 2006). Finally, specialty clinical areas such as obstetrics, pediatrics, and intensive care units often limit nursing student activities to observation rather than hands-on patient care and restrict the number of students placed on those units. Nursing faculty members are thus challenged to prepare students for a complex environment where they must think critically, act quickly, and communicate effectively with multidisciplinary team members. Long orientation programs for new nurses are a thing of the past, and yet documentation of the education-practice gap points out that students need enhanced practice in numerous areas, including planning, implementing, and managing care for multiple patients and delegation and prioritization of care (Nursing Executive Center Nursing School Curriculum Survey, 2007). In fact, studies suggest that interactive nurse residency programs that incorporate simulation result in better graduate nurse retention and job satisfaction (Anderson, Linden, Allen, & Gibbs, 2009). This chapter will discuss clinical simulation as a valuable tool in the clinical education of nursing students.

BACKGROUND

Simulations are “activities that mimic reality of a clinical environment and are designed to demonstrate procedures, decision-making and critical thinking through techniques such as role-playing and the use of devices such as interactive videos or mannequins” (Jeffries, 2005, p. 97). Simulation allows faculty members to take specific information—such as a client’s personal characteristics; health information; family components; and physical, mental, and emotional state—and weave it into a real-life scenario that enhances a student’s comprehension of the material because it is meaningful (Hertel & Millis, 2002). In the case of clinical nursing scenarios, simulation provides an opportunity to suspend belief of what is real to produce a risk-free, hands-on opportunity to practice a clinical situation involving patient monitoring, management, communication, and multidisciplinary collaboration. Simulation activities can enhance learning, critical thinking, and practice in specific areas for individuals in a variety of professions.

The earliest uses of simulation in the health care field were primarily in medical education, including medical schools, emergency room training, anesthesia crisis management, residents in trauma rotations, and

first responders for cardiac care (Freeman et al., 2001; Gaba, Howard, & Fish, 2001; Marshall et al., 2001; Morgan, Cleave-Hogg, McIlroy, & Devitt, 2002).

In nursing, simulation has been used to teach clinical decision making, critical care, and cardiopulmonary resuscitation, to name a few (Cioffi, Purcal, & Arundell, 2005; Kappus, Leon, Lyons, Meehan, & Hamilton-Bruno, 2006; Long, 2005). Other clinical specialty areas using simulation to provide more structured experiences for students and staff are obstetrics and neonatal nursing (Bambini, Washburn, & Perkins, 2009; Norris, 2008; Yaeger & Arafah, 2008) and organ donation (Jacoby, Crosier, & Pohl, 2006).

The use of human patient simulators (HPSs) has increased due to the lower cost of the equipment and software and the acceptance and encouragement of this teaching method by leaders in nursing (Nehring, 2008, p. 109; Seropian, Brown, Gavilanes, & Driggers, 2004b). Using simulation-based pedagogy allows students to integrate psychomotor, critical thinking, clinical judgment, and communication skills and gain self-efficacy prior to entering the clinical setting, although research provides inconsistent results when attempting to measure these outcomes (Bambini et al., 2009; Brannan, White, & Bezanson, 2008; Chronister, 2008; Goldenberg, Andrusyszyn, & Iwasiw, 2005; Rhodes & Curran, 2005).

In addition, simulation offers an opportunity for evaluation and assessment of student skills for faculty members with options for remediation and continued learning (Greenawalt & Brzycki, 2007; Haskvitz & Koop, 2004). The active learning component of simulation also appeals to many of today's students, helping them to maintain engagement in the learning process and retain the material learned.

Various organizations have recognized simulation's value as a teaching technique. The Commission on Collegiate Nursing Education (CCNE) accreditation standards encourage the use of innovative teaching methods and the introduction of technology and informatics to improve student learning (CCNE, 2003). The National League for Nursing (NLN) listed simulation first under trends in a unit on teaching methods and approaches (Speziale & Jacobson, 2005). In addition, the NCSBN emphasized the need for nursing student clinical experiences with real patients but acknowledged the value of simulation that mimics clinical reality. The learner can dynamically experience a clinical situation while under the guidance of qualified faculty members who can provide feedback and facilitate reflection, thus improving actual patient contact (Cioffi,

2001, p. 478). Simulation is an innovative teaching method that uses technology and informatics, involves faculty guidance and feedback, and has the potential to increase the competency of nursing students and practicing nurses to provide safe patient care.

TYPES OF SIMULATION

There are different levels as well as a variety of types of simulation. The levels of simulation include low fidelity (less precise reproductions), such as a disembodied pelvis for catheter insertion simulation or a foam arm for intramuscular injection simulation, sometimes referred to as “task-trainers” (Limbs and Things, <http://www.limbsandthings.com/global/index.php>). Moderate-fidelity simulators provide some feedback to the student, such as heart and lung sounds, and work well when introducing students to beginning skills. High-fidelity simulators produce the most lifelike scenarios, reacting to student manipulations in realistic ways, such as speaking, coughing, and demonstrating chest movements and pulses. These are manufactured mainly by two companies: METI® (Sarasota, Florida; <http://www.meti.com>) produces a high-end HPS and a less costly Emergency Care Simulator (ECS); Laerdal/Medical produces SimMan® and VitalSim® (Stavanger, Norway; <http://www.Laerdal.com>). Another recent entrant to the market is Gaumard Scientific’s® HAL® and NOELLE® with newborn HAL® (Miami, Florida; <http://www.gaumard.com>). All the high-fidelity HPSs produced by these companies respond to pharmacological and physical manipulations, either manually or by preprogrammed software. The computer logs and potential for video recording interactions between students and HPSs provide concrete feedback for student learning, assessment, and evaluation.

The types of simulation can vary from the high-fidelity HPS models to computer-assisted instruction that includes live interaction with a simulated patient and decision making regarding care. These programs provide feedback to help students learn about the accuracy of their thinking and actions. Examples of computer-assisted simulations include MicroSim Inhospital® (Laerdal/Medical, <http://www.laerdal.com/nav/21475622/MicroSim.html>), SimClinic® (Elsevier, http://www.elsevier.com/wps/find/bookdescription.cws_home/704525/description#description), and Virtual IV® (Engum & Jeffries, 2003). Book publishers now offer options to enhance simulation, such as Elsevier/Mosby/Saunders’s “Virtual Clinical

Excursions” for Adult Health (see an example at <http://www.elsevier.com/wps/find/bookdescription.librarians/707251/description>) and “Simulation Learning Systems” (see a review at <http://www.reed-elsevier.com/brands/scienceandmedical/Pages/SimulationLearningSystem.aspx>) and Pearson’s “Real Nursing Simulations” (<http://vig.pearsonhighered.com/educator/academic/product/0,3110,0135042488,00.html>). These technologies can be used separately at a simulation center, incorporated into a hybrid course online, used in the classroom prior to a case study, or assigned in preparation for a simulation experience. The plethora of materials requires nurse educators to keep up with what is available to supplement planned clinical simulation activities, and faculty members need to keep in mind the learning objectives and desired outcomes.

Finally, electronic health record (EHR) use and its relationship to patient safety and staff efficiency and vigilance, as well as the role of the nurse in EHR use, has been documented (Valentine, 2005; Weir, Hoffman, Nebeker, & Hurdle, 2005). Some nursing programs are experimenting with the use of EHRs as a teaching tool to enhance clinical simulation. These scenarios provide students with in-depth information that adds to the realism of the experience. Students also gain practice navigating the software systems and learn to record their findings in this efficient and effective way. Individual communities or records have been created by faculty members using university or medical center resources to document the results of EHR in-class use (Donahue & Thiede, 2006; Fauchald, 2008; Sheets, 2006). In addition to the publisher simulation systems mentioned above, many of which contain EHRs, Cerner Corporation has developed “Academic Education Solutions” (http://www.cerner.com/public/Cerner_3.asp?id=29911), a clinical information system similar to that used in hospitals and clinics throughout the country. Another Web-accessible program is NurseSquared, a simulated EHR with embedded scenarios (<http://www.nursesquared.com/>). Similarities between these systems are that they provide more concrete use of clinical informatics, integrating simulation experiences with clinical information systems, thereby enhancing the clinical realism of scenarios. This exposes faculty members and students to clinical informatics beyond just Web-enhanced courses and truly meets the prescription for innovative teaching using technology. A survey by the National League for Nursing (2008), found that “Personal digital assistants (PDAs), software for care plans, and clinical information systems were the least likely to be incorporated into courses . . . suggest[ing] that little clinical informatics content or learning experiences are included in . . . registered nurse

programs” (p. 4). This is a challenge that can be met through the use of simulation and clinical information systems.

USING SIMULATION AS A TEACHING STRATEGY

The time has come when most nursing programs are required to integrate some form of simulation into their curriculum. This integration may be a result of external pressure (visiting prospective students asking to see the HPS), administrators recognizing the need, or faculty members who desire to keep up with the millennial generation of students. Still, more solid research is necessary to demonstrate how the use of simulation creates the desired outcomes in student learning and how simulation can best translate into clinical practice.

Prior to incorporating this innovative teaching method, there are steps to instituting a simulation program, including:

1. Developing a vision
2. Creating a business plan
3. Gaining stakeholder support
4. Constructing the lab and purchasing equipment
5. Training those involved
6. Developing curriculum
7. Providing faculty development
8. Developing policies and procedures (Seropian, Brown, Gavalanes, & Driggers, 2004a)

Best practices for the use of HPSs with novice nursing students have been proposed as: “1. Well-articulated learner outcomes; 2. Clear connection to course/clinical objectives; 3. Established ongoing training and supervision of faculty and staff members and participants; 4. Collaboration with student and faculty member in planning, implementation, and evaluation; and 5. Debriefing session after each HPS experience” (Bremner, Aduddell, Bennett, & VanGeest, 2006, p. 173). The timeline from planning to completion may run from many months to several years, depending on resources, administrative and faculty buy-in, and how smoothly the transition progresses. Integrating simulation throughout the curriculum as an educational tool that affects student learning requires not only time and perseverance but also specialists in the areas of simulation, debriefing, curriculum development and integration, and

scenario writing. Additional tasks include scheduling, equipment use, and assistance with audiovisual media (Seropian et al., 2004a, p. 173). For a comprehensive literature review on creating a nursing simulation laboratory, see Rothgeb (2008).

Advantages and Implications

Several advantages of simulation-focused pedagogy have been described above. Some studies reported that students' decreased anxiety and increased self-confidence after participating in simulations help them to interact more comfortably with patients when they are in clinical settings (Goldenberg et al., 2005; Owens & Walden, 2001; Smith & Roehrs, 2009). The opportunity to practice teamwork as students role-play helps them to take ownership for their role and enhances critical thinking skills, clinical performance, and competence (Lasater, 2007; Norris, 2008; Radhakrishnan, Roche, & Cunningham, 2007). These benefits should result in more productive orientation periods, smoother transitions from student to employee, or both, although empirical data to support that hypothesis are not yet available. In fact, in a review of the literature looking at simulations and self-efficacy, Leigh (2008, p. 11) concluded that nursing research lags behind other areas of simulation research. More research is necessary to examine the effect of simulations on nursing students' self-efficacy and the extent to which improved self-efficacy relates to clinical performance and patient safety.

Other advantages, from a program assessment perspective, include a controlled environment with reproducible and predictable results, especially if using a high-fidelity HPS with software. Once students and faculty members become familiar with the technology, it is less threatening to use, and it allows several students to experience the scenario in different ways at once. Some students find it to be less stressful than actual clinical activities, and it provides an engaging, even entertaining, learning experience (Seropian et al., 2004b).

Disadvantages and Challenges

Although simulation provides rich learning opportunities, it also presents challenges. Foremost are financial constraints when simulation involves purchasing the equipment and renovating buildings to accommodate the technology so that the scenarios can be run in a convenient and timely manner. There is added expense for maintenance of equipment

and consumables as well. If minimal renovations are required, the process may proceed more smoothly, and many programs are working with their available space. In addition, more federal funds are becoming available, and nursing programs are finding unique ways to raise funds for new labs and equipment, including grants, advisory boards, and partnerships (Appel, Campbell, Lynch, & Novotny, 2007; Harlow & Sportsman, 2007).

Other challenges include the fact that a simulation-focused curriculum requires more faculty, staff, and student development and training, as well as more time. The challenge to make simulation realistic is ever present. However, a vision of simulation-focused pedagogy, with the inherent tools available, is necessary for a meaningful and successful simulation program (Seropian et al., 2004a, 2004b).

Harlow and Sportsman (2007) used a discounted cash flow methodology to compare three stand-alone versus one regional simulation center for the education of nursing students. They found the faculty cost savings to be significant, but savings were outweighed by the investment costs. In addition, any shift in costs (e.g., decreased training costs as the faculty learns to use equipment) and capacity (e.g., increase in number of students) would result in more savings, and their study did not take into consideration the social welfare benefits, such as better health outcomes and increased patient safety. They suggested that a cost-benefit analysis would be more appropriate, but that requires research on the outcomes and benefits of simulation education. Recognizing that there are both advantages and challenges to the incorporation of simulation education, outlining the educational practices that support its use becomes the next important step.

Educational Practices

Today's millennial generation of nursing students requires a teaching pedagogy that is based on collaboration, increased participation, and a realistic immersion, recognizing their familiarity with the process of learning (Skiba, 2007). A variety of educational practices are useful when incorporating simulation into a nursing education program. By engaging learners directly in the simulation, active learning occurs. Providing constructive feedback during the debriefing session, allowing students to view a DVD recording of their performance, or getting suggestions and critiques from classmates who may be viewing them in a nearby classroom all provide feedback for enhanced student performance (Chronister, 2008; Henneman & Cunningham, 2005; Hravnak, Tuite, & Baldisseri,

2005; Johnson-Russell & Anderson, 2006). Acknowledging that students learn through many different styles, simulation allows the incorporation of different teaching strategies to appeal to these diverse needs.

But is simulation simply a teaching method? Does it have the potential to affect learning and student outcomes? Several education learning theories support simulation education, including constructivism learning theory, adult learning theory, brain-based learning theory, social cognitive learning theory, experiential learning theory, and novice-to-expert theory (Rodgers, 2007, pp. 71–109; Rothgeb, 2008, p. 490). Parker and Myrick (2009) urged nurse educators to reconsider the use of high-fidelity HPSs within the broad context of nursing pedagogy (process, critical thinking, clinical judgment), rather than approaching it simply as a teaching method. Kaakinen and Arwood (2009) argued that simulation is more than just a series of goals, objectives, methods, and student outcomes that evaluates simple skill acquisition taught by doing.

In a review of the literature, Kaakinen and Arwood (2009) examined 120 simulation manuscripts to determine whether nursing faculty members were using simulation as a teaching method or as a way to design learning opportunities. Of those articles, 94 described simulation as a teaching method or strategy; of the 16 that used learning as a purpose to design the simulation, only 2 considered that learning to be a cognitive task (p. 11). The authors' major assumption for the review was that simulations would focus on learning, but they found that "the majority of the simulation studies in this review did not consider student learning as cognitive and social processes that occur through a planned experience" (p. 12), and "none of the studies used research about how the brain acquires or learns concepts" (p. 17).

Jeffries and Rodgers (2007) created the Nursing Education Simulation Framework, taking into account what is known about learning and cognition in designing simulations (pp. 22–23). In addition, a Framework for Simulation Learning in Nursing Education was suggested by Daley and Campbell (2008) (Figure 8.1). This framework brings together a more eclectic combination of learning (Fink, 2003), ecological (Stokols, 1996), and nursing theories such as vigilance (Meyer & Lavin, 2005), caring (Eggenberger & Keller, 2008), and reflective practice (Tanner, 2006b).

Daley and Campbell (2009) provided a theoretical framework within which to further explore this new pedagogical method of education and test student-centered learning through simulation and its efficacy to affect student outcomes. This framework takes into consideration what the learner brings to the situation, in individual and cultural experiences, guided by ecological theory (Stokols, 1996), as well as the effect

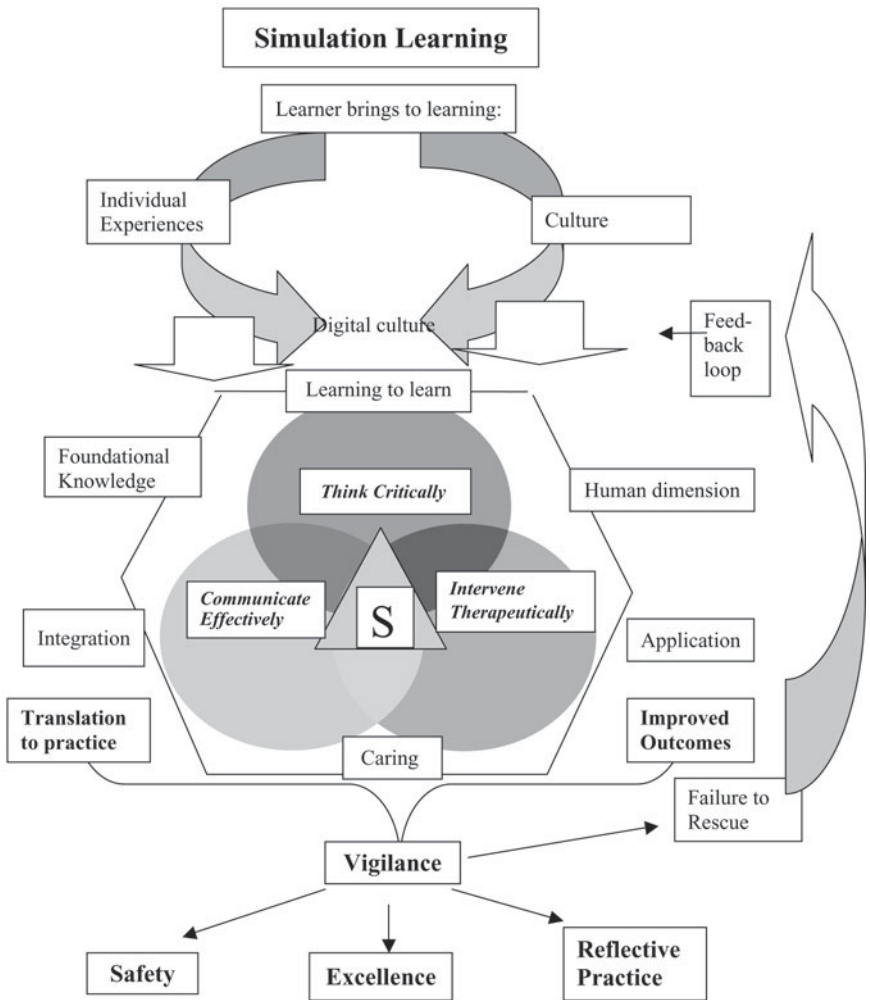


Figure 8.1 Simulation learning.

of the digital culture of the 21st century. The center of the framework houses simulation as the teaching tool that connects the students as they interact with three universal goals or learning outcomes for nursing programs: communicate effectively, think critically, and intervene therapeutically. The triangle of simulation identifies three fidelities to enhance the realism of the simulation: equipment fidelity, environmental fidelity, and psychological fidelity (Fritz, Gray, & Flanagan, 2007). In addition, the hexagon central to the framework represents Fink's (2003)

six dimensions: learning to learn, foundational knowledge, the human dimension, integration, application, and caring. These are said to provide a support structure around which simulations can be planned and include components that create significant learning experiences and reflect nursing. As faculty members consider these dimensions in the creation of their simulations, they will construct learning experiences that can enhance the transfer of knowledge. This framework provides guidance for program evaluation, measuring the degree to which students learn vigilance, for example, recognizing when patients need immediate and effective intervention. Other outcomes such as patient safety, nursing excellence, and the development of reflective practitioners who strive for lifelong learning and personal improvement round out the framework and relate the use of simulation beyond nursing education to nursing practice (Daley & Campbell, 2009, pp. 288–289). More research is needed to embrace the shift to simulation as a learning paradigm, beyond the perception of simulation as a teaching method and evaluation of skill mastery.

Finally, consideration must be given to faculty perception of the use of simulation in nursing education. A study by Akhtar-Danesh, Baxter, Valaitis, Stanyon, and Sproul (2009) using Q-sort methodology with 28 Canadian nursing faculty members from 17 schools found that, overall, they perceived simulation to be an important element in nursing education and useful in supporting learning. In the study, four types of individuals were identified among the faculty: positive enthusiasts, supporters, traditionalists, and help seekers. Additional support in the form of human resources and training to develop and implement the scenarios was identified as necessary to the use of this teaching modality. Faculty members recognized the need for time, practice, and the development of a repository of clinical simulations to aid them in this endeavor. Overall, few negative voices were heard, and clinical simulation was embraced as a way to support and enhance nursing education, albeit not ever replacing real clinical practice time (Akhtar-Danesh et al., 2009). The rest of the chapter will describe setting up a simulation center, creating scenarios, implementing simulations, debriefing, and evaluation.

SETTING UP A SIMULATION CENTER

Interest in creating simulation centers in nursing education programs and health care settings is increasing rapidly. With HPSs and software

becoming more affordable and the growing number and value of grants and donations available for the education of nurses, it is an ideal time to plan a simulation lab, regardless of the size of the nursing education program. The development of a center for simulation requires a program director to oversee the creation and implementation of the project; active participation from the lab director, who maintains and manages the simulation lab; and administrative and faculty buy-in to integrating simulation into the curriculum. If this is beyond the scope of your present situation, partnerships, collaboration, and regional simulation centers will be mentioned in the “Future Implications” section of this chapter.

In planning a simulation lab, first identify your vision: who will use the lab (students, undergraduate or graduate; staff nurses; other health care professionals) and what the labs will be used for prior to creating a concrete plan. If the lab is focused on the education of undergraduate and graduate student nurses, then acquiring grants to renovate the building and the equipment necessary to run simulations will be the priority. From the beginning, you should be working with faculty members and administrators to organize the staff support to keep it running when the grants are gone. A broader vision might include partnerships between a nursing education program and various health care facilities to allow orientation, training, and continuing staff development for their employees in the new simulation center. This could present a source of income to sustain the operation of the center. The use of simulation labs may be offered to relevant government and community disaster response organizations and groups for practice of emergency preparedness, either for a fee or as an in-kind donation. Universities that use simulation labs for evaluation and research often can provide graduate students to assist with running scenarios and collecting data (Larew, Lessans, Spunt, Foster, & Covington, 2006). Some software publishers allow use of their EHR systems for product testing (Fauchald, 2008). Other manufacturers of medical equipment such as pumps, ventilators, and medication dispensing systems may provide prototypes of their equipment for testing in the simulation lab.

Depending on the available resources, the quantity and type of simulation space varies greatly. The running of scenarios described later in this chapter assumes the use of a control room with a mirrored view into the simulation room and technologies to deliver video images of the scenario live into a classroom for observation and interaction with peers. Specialty labs may include an anesthesia and operating room with working ventilator and anesthesia machines, especially for academic centers with graduate programs that prepare Certified Registered Nurse

Anesthetists. Some specialty labs may be set up to convert easily between emergency department, intensive care, and acute care hospital room environments. Having separate rooms for medium-fidelity simulation practice and specialty care such as obstetrics (with a birthing bed) and neonatal intensive care (incubators with infant HPSs) will add to the number of students that can be accommodated as well as the variety of experiences that are available. In addition, a home care lab is ideal for practicing problem solving unique to this setting, such as patient transfer within a standard-size home bathroom and assessment of the home environment.

Nursing education programs affiliated with academic health centers may have standardized patients available to them. Practice with standardized patients can provide invaluable learning opportunities for students, especially nurse practitioners (Becker, Rose, Berg, Park, & Shatzer, 2006; Bosek, Li, & Hicks, 2007; Ebbert & Connors, 2004; Shawler, 2008). However, for students who do not have this option available, well-planned simulation experiences can help to meet their needs. Creative alternatives, such as visual and performing arts students, school improvisation group members, or retired professionals (e.g., actors, physicians, nurses, teachers), may be able to role-play as patients, family members, or interdisciplinary health care professionals to enhance simulation realism.

Nursing faculty members need to work closely with administrators and facilities managers to resolve space and design issues in the development of the plan. Touring other simulation labs and observing the running of scenarios, seeking advice from HPS vendors, and learning about the design of other labs through virtual tours on the Internet or during conference sessions are ways to gather ideas and gain inspiration. Beyond development of the space, specific policies and procedures related to the simulation lab need to be put into place. Some policies surrounding authorization for taping of students and confidentiality issues need to be established. Additionally, ground rules for professional behavior and attire (e.g., uniform, scrubs, lab coats) will enhance the realness of the experience.

GETTING STARTED CREATING SCENARIOS

Some basic ways to begin creating scenarios involve examining the institutional and nursing program mission statement, philosophy, and curricular objectives. When creating scenario objectives and guided reflection

questions, the program, course, and unit objectives can be used as guidelines. It is important to identify essential learning outcomes, taking into consideration social and demographic trends specific to the geographic area, and incorporating cultural sensitivity, spirituality, and ethical considerations. The level of the students, specific course objectives, and personal faculty clinical expertise all need to be considered when specifying an appropriate learning outcome. Other suggestions for creating scenarios include reviewing course evaluations, licensure and certification exam results by subject area, communication with clinical facilities, and other program evaluation data to identify essential learning needs of students (Chambers, 2006).

It is important to involve all faculty members in scenario writing, making content experts responsible for specific scenarios. Developing a template or blueprint for faculty members to use as they develop scenarios will increase consistency as well as encourage them to start with basic information (e.g., identifying three to five simulation objectives and learning outcomes). It helps to have a champion who empowers faculty colleagues to create lively and interesting scenarios. Campbell and Daley (2009, p. 55) used the following template to guide the writing of simulation scenarios:

Title

Include course description (generic), e.g., pain management, early medical/surgical course; 2nd-semester junior year BSN or 1st-semester first-year ADN

Focus area

Medical-surgical, obstetrics, pediatrics, intensive care units, senior scenario

Scenario Description

Include patient demographics (gender, age, race, religion, occupation, height and weight), pertinent past medical history, presenting symptoms, illnesses, injuries and recent surgeries, current medications, allergies, significant others, social history, mental health history

Scenario Objectives

AACN/NCSBN/NLN focus area or areas addressed (e.g., from AACN <http://www.aacn.nche.edu/Education/pdf/BEdraft.pdf>)

Setting the Scene

Equipment needed: Simulator, video recording device, medical equipment (e.g., patient monitor, oxygen hook-up, bandages, pulse oximeter, blood pressure cuff, and/or stethoscope), medical record (electronic or paper)

Resources needed: Textbooks, computer access for database search and evidenced-based practice, PDA for point of care decision-making—specifically, student and faculty instructions for preparation (any psychomotor skills or cognitive activities that would enhance student preparation)

Simulator level: High fidelity, moderate fidelity, static manikin, live patients, video clips; think outside the box!

Participants needed: number, roles identified, scripts (if possible)

Scenario Implementation

- Initial settings for Human Patient Simulator (HPS)—very specific,
- Required student assessments and actions—checklist of actions accomplished, objectives met, assessments demonstrated,
- Instructor interventions—how might the instructor facilitate student's success; any anticipated “out of protocol” occurrences; how are students oriented to the room, scenario, etc. to be most present to learn; how many students, and may students choose to take another turn? For example, may they practice until they master it?

Evaluative Criteria

- Refer back to clearly defined learning objectives,
- Determine how to evaluate if criteria have been met (develop a rubric for exceeded expectations, met objectives, below expectations).

In addition, faculty members are asked to outline guidelines for debriefing when creating the scenario; often these are revised after running the simulation. Once the scenario is written, faculty members need scheduled time with lab staff (equipment managers and information technology experts for the programming of equipment) for a rehearsal of the simulation on paper and then in real time. Reviewing scenarios for accuracy, current evidence-based practice guidelines, and unnecessary distracters will ensure the quality of the simulation experience for all and help to identify needed resources (e.g., faculty and staff support, props, space, and time). It is necessary to practice the scenario and ideal if students or faculty members are present for a practice session prior to running it live with the class.

Once a scenario has been written using the template, decisions need to be made regarding how to transfer it to the simulator. One option is running the simulator manually or on the fly, which allows flexibility and minimal time investment in advance because no prewritten programs are required. Running simulations manually does require a talented and dynamic team of information technology expert and instructor with content expertise who responds quickly to student interventions. This method may allow for a better evaluation of the learning that has occurred as students are encouraged to think critically and often choose options that faculty members never considered. Often these simulations lead to lively dialogue during debriefing.

Another option, preprogramming the scenario in an automatic mode, is more rigid and requires a knowledgeable individual to write the program, a considerable time investment in advance of implementation. The preprogrammed version allows the simulator to automatically respond to student interventions and produces clear event menus that can be standardized for evaluation and research. The advantage with this method is that scenarios can be used consistently over time, and a scenario, once created in a preprogrammed mode, can be modified to meet the needs of students at various levels and at various times throughout the program. In addition, objectives and distracters can be added, settings can be changed, and roles can be altered to create new and more complex scenarios from simpler ones (Chambers, 2006). This process supports simulation as a teaching method and provides learning outcome data that can compare students to each other and themselves to reveal changes over time.

SUGGESTED IMPLEMENTATION OF A SIMULATION

Student Preparation

Ideally, students have an assignment prior to the simulation, including, but not limited to, reading; viewing a videotape, DVD, or online presentation (possibly via podcast); and computer-assisted instruction. The simulation may begin with a few minutes of didactic information provided to a group of students in the classroom setting. Perhaps the teacher uses a scenario from MicroSim In-Hospital® (Laerdal/Medical) to prepare the students for similar critical thinking and actions that they will face in the simulation. Dividing the class into teams enhances

competitiveness and the desire to do well. Each group of students then learns the background of a patient (the HPS) and other information that they need to enact the scenario, and they are assigned roles. The teacher, controlling the simulation from a separate room if feasible, is able to use a preprogrammed scenario that changes vital signs to reflect student actions and records all events of the scenarios.

The variety of teaching styles incorporated in simulation—auditory, kinesthetic, visual, olfactory, and emotionally experiential—assists learners who might not gain as much from didactic methods. The simulation incorporates the teacher's presence, but during the actual time spent working with the HPS, teachers allow students to make mistakes and find their own way. Specific time frames for introduction of the scenario and preparation for it, actual running of the simulation, and debriefing must be carefully calculated ahead of time. Actual time on task should not vary greatly between students. Opportunities for collaboration are present in the preparatory period, when students work together in groups, and in role-playing during the scenario, where each student has a different part to play. Learning continues as students review and critique their own and other students' performances. Some students report that, although they are uncomfortable enacting a scenario, they understand the value of peer observation and shared learning experiences (Russell & Campbell, 2006).

Implementing Simulation

The implementation of simulation depends on the level of complexity, the level of technology, and the specific needs of individual courses. The beginning user may learn lung and heart sounds by performing assessments on a moderate-fidelity simulator. Simulation may first occur for the teaching of psychomotor skills in a health assessment or clinical techniques course (Ham & O'Rourke, 2004).

An intermediate user in a medical-surgical or specialty course would be better prepared to use simulation for patient care. Still, practice at this level would involve less complex procedures, such as the management of pain or other common symptoms (e.g., urinary tract infection symptoms) (McCausland, Curran, & Cataldi, 2004). The advanced user might incorporate intensive care and critical physiology simulations, such as severe asthma attack, ventilator assessment, or cardiac arrest (Henneman & Cunningham, 2005). In addition, advanced users might be studying specialty areas and populations using VitalSim® (Laerdal/

Medical) or SimBaby® (Laerdal/Medical) for obstetric and pediatric experiences (Clinton, 2006; Goetz & Nissen, 2005; McCartney, 2005; Ravert, 2006; Yaeger & Arafah, 2008). For teaching care of a population as client, simulation has been used for mass casualty incident training (Kobayashi, Shapiro, Suner, & Williams, 2003). This type of training could be modified for two levels of students. Early in the program during a health care delivery system course, the focus would be on specific aspects of that system. Then, later in the program as part of public health and leadership courses, expectations of student performance would include triaging and taking on a leadership role.

The level of technology used in clinical simulation depends on several factors: faculty comfort, the technology available, and support for the use of technology. Nursing education programs that have access to information technology (IT) support (ideally, designated IT staff members), are making the most progress with incorporating simulation smoothly. In addition, university services that support academic excellence with resources and specialists can assist with faculty development, and other departments can help incorporate components that will make the simulation feel more real.

For example, faculty members in a university department of communication may be able to assist nursing faculty members with the dialogue component of scenarios. Performing arts faculty members and students can add to the contextual experience by role-playing distraught family members; nursing faculty members might apply some of their rich clinical experience by playing a spouse, parent, or child of the HPS. The more assistance nurse educators receive with the planning and implementation of the scenarios, the better the learning experience for teachers and students alike. When it comes to the level of technology used, faculty members should start simple and then increase complexity. Many nursing education programs have started by running a few simple scenarios on the fly (not using preprogrammed software), and have found that increasing complexity in small increments was not as hard as initially feared.

Curricular Integration

Once a nursing education program has embraced simulation-focused pedagogy, the next question is where to use simulation in the courses and in the curriculum. As faculty members outline the type of material to be covered, they can better determine where and when it should be

placed in the course. Deciding whether the simulation will be introductory material or supplementary to the class is up to individual teachers. Using a curriculum grid to outline courses, examining threads, content, and key areas of importance, will allow for a coordinated mapping of potential simulation activities. Working in collaboration with other nursing education programs or clinical sites will assist with the planning and implementation phase (Berryman, Armstrong, & Zenoni, 2006). Making use of some of the resources mentioned previously and software with already created simulations may be a good place to start as well. There are many simulations created for medical-surgical nursing and few for specialty areas. Campbell and Daley (2009) outline 17 simulation scenarios in a variety of areas (e.g., psychiatric-mental health, obstetric, pediatric, home care, older adult) and supply ideas for simplifying or increasing the complexity. For faculty members who don't know where to start, these scenarios may provide incentive to create their own. Alternatively, they can be used as templates to build upon, allowing faculty members to add their unique expertise as they become more comfortable with a program. It is ideal to provide the faculty with release time to revamp courses within a simulation-focused pedagogy, including scenario development and implementation. Other options include half-day and full-day retreats for training, scenario writing, and simulation implementation (Bandali, Parker, Mummery, & Preece, 2008; Kardong-Edgren, Starkweather & Ward, 2008).

DEBRIEFING AND GUIDED REFLECTION

The last, but perhaps most important, area involves debriefing and providing an opportunity for guided reflection of the simulation. This has been identified as crucial for students' learning and satisfaction with their simulation experience and requires adequate time to be effective. Jeffries (2005, p. 101) outlined the following key components: "a debriefing activity . . . reinforces the positive aspects of the experience and encourages reflective learning, which allows the participant to link theory to practice and research, think critically, and discuss how to intervene professionally in very complex situations." Identifying important concepts or curricular outcomes will help in planning the questions for debriefing; once again, a general template will allow consistency among students and faculty. Objectives for debriefing include answering student questions to help them clarify their thinking, releasing any emotional tension, and linking the

simulation to real life while reinforcing specific teaching points (Fritzsche, Leonard, Boscia, & Anderson, 2004). The instructor's role during debriefing is that of facilitator rather than evaluator. Prior to debriefing, the teacher should review the objectives of the simulation and discuss confidentiality as well as teacher expectations for student participation in evaluating themselves and their group members (Haskvitz & Koop, 2004). Initial questions to guide reflection may focus on:

- Students' primary misconceptions
- Anything they missed on report or other information they needed from report or the patient to act more effectively
- Evaluation of their knowledge and skill capabilities to manage the situation and any areas requiring further practice
- What went well
- What they would do differently the next time
- Emphasis on what was correct, appropriate, and safe (Rothgeb, 2008, p. 492)

Additional questions might probe further into specifics about students' familiarity with the patient's condition, the environment, the techniques, interventions, or medications used during the scenario. Asking students to identify content that helped them succeed in the scenario and where they received it from (classroom, computer-assisted instruction, presentations, scenario preparation) will guide the teacher to improve the scenario and student preparation guidelines for the next time it is used. Having students examine communication and team collaboration as well as their own reactions, emotions, and professional behavior during the scenario will help them to critically assess their performance (Johnson-Russell & Anderson, 2006).

Finally, some closing statements about what students identified as going well, areas they need to work on, areas of improvement, and take-home points will help to summarize the experience. Thanking students for their participation and stating the teacher's appreciation for their attention, efforts in enacting the scenario, and shared reflections provides positive reinforcement. Using anonymous surveys for evaluation also will provide important information for future simulation development and performance (Johnson-Russell & Anderson, 2006).

Much research has been done on debriefing. Bond et al. (2006) looked at emergency medicine residents and compared their decision making related to technical debriefing versus cognitive debriefing. Harvard

University's Center for Medical Simulation has introduced the Debriefing Assessment for Simulation in Health Care (DASH) to better assess and improve debriefing and offered Web-based training sessions in 2009 (Simon, Rudolph, & Raemer, 2009). In addition, Dreifuerst (2009) did an extensive concept analysis of the essentials of debriefing and provided suggestions for research and a foundation for the development of strategies for debriefing. Owen and Follows (2006) developed a debriefing checklist based on the mnemonic GREAT to assure that best practices are applied in simulations of medical emergencies. In brief, GREAT stands for:

Guidelines, evidence-based or local policy or both

Recommendations, such as those in published reviews if guidelines are unavailable

Events: participants reflect on the simulation and identify important events

Analysis: recognize if signs were identified, treatments given similar to guidelines, effective use of resources demonstrated, and so on

Transfer of knowledge to clinical practice: learning to improve patient care, key take-home messages (Owen & Follows, 2006, p. 488)

They found that this method encouraged practitioners to use guidelines to benchmark their practice and improve patient care, not just during simulations but after real clinical events as well. In general, debriefing provides the opportunity for learning to occur. As students reflect on why they do something in a clinical situation, they can be guided to recognize alternative options and outcomes. They can also consider other situations where this action may be appropriate. In addition, more complex issues of ethics, social justice, communication, delegation, spirituality, and cultural competence can be addressed during debriefing, facilitated by expert faculty members who have the opportunity to share the art of nursing care. Theory can be reintegrated, best practices and agency protocols can be evaluated, and students can learn about error management.

EVALUATING SIMULATIONS

Evaluating simulations involves multiple components. One component reflects students' performance and whether they met the objectives and

demonstrated the skills and knowledge identified as important outcomes for that scenario. Another component is evaluation of the simulation itself and whether it met the objectives for which it was developed. As the simulation is running, it is possible to identify areas that are working and areas that are a challenge. The dynamic process of the simulation allows for some modification while it is running, but careful note-taking during and after running the scenario as well as after the debriefing session with students will document changes necessary to enhance the effectiveness of the simulation. Finally, asking for student feedback both in the debriefing and anonymously in a written format will allow further revisions and improvement. Reviewing student feedback with faculty members soon after the scenario is run provides the best opportunities for change and revision.

For student evaluation, computer-generated logs can be created by the automated setting of a high-fidelity HPS, with an option for the teacher to type comments while students are performing the scenario. In addition, video recording of the scenarios will provide concrete information about students' actions, knowledge, and skill. Evaluation can include the use of checklists, rating scales, or any other form for consistent scoring and grading among faculty members. Evaluation should be part of the template creation for each simulation and could follow a specified format within each nursing program. Student behaviors can be listed in a table and checklists next to each behavior as it is done—for example, independent, with prompting, and appropriate order. This way, faculty members and lab staff can keep track of whether students provide the care independently and in the correct order throughout the scenario. Debriefing will be enriched with this information because students will be provided with concrete, constructive, and immediate feedback without embarrassment.

This type of individualized evaluation assumes that a student is one-on-one with the HPS being tested on competencies for a specific situation. The other option is that simulation is used during class time to reinforce content and engage the students, in which case it probably involves more than one student with classmates observing (either live or a DVD recording). In this situation, peers observing can be given an assignment. For example, the following questions were used for students in a women's health course who were observing a postpartum hemorrhage scenario that four of their classmates were participating in. It could fit many simulations:

1. What did you initially notice about the patient and her surroundings? What problems did you identify?

2. What would you have included in the problem-focused assessment that was not included?
3. What additional data would you have collected that [were] not collected?
4. What priority problem did you identify for this patient? What are the potential problems for this patient?
5. What further education and support would you give to this patient? (Campbell, 2008)

Evaluation of this type of group-experienced simulation can still include student behavior checklists for those participating, and the instructor can take notes during the debriefing and reflect on them to revise the simulation to better meet students' learning needs. The benefit of the debriefing for the entire class is determined by the depth and breadth of the discussion and how it fits with class objectives, assignments, and the faculty's goals for learning.

Finally, there are new software programs that are designed to streamline the evaluation process. One example is Education Management Solutions' integrated clinical skills assessment software, which incorporates audio-visual systems to provide simulation training center management solutions. This software digitally captures audio and video of scenarios, allowing faculty members to bookmark, debrief, remediate, fill out checklists electronically, and generate performance evaluation reports. In addition, both the hardware and software integrate with patient simulators, standardized patients, and virtual reality applications (<http://www.ems-works.com>). This is just the beginning of resources for nursing education programs to incorporate simulation into clinical education. We must better demonstrate the connection between simulation education and student learning to justify the cost in resources, faculty time, and student expenses.

FUTURE IMPLICATIONS

Many aspects of simulation pedagogy have been covered in this chapter, but there are some future implications to consider, which I will address only briefly to encourage dialogue and research. All these areas are worthy of future study.

- For nursing education programs that cannot build a lab from scratch, consider creating partnerships with local agencies, col-

laborating with other schools or medical centers, or negotiating with regional simulation centers (Metcalf, Hall, & Carpenter, 2007). Benefits of multidisciplinary collaboration include enhancing communication, organizing the community, and building relationships by pooling resources (Magee, 2006, p. 46).

- Further research demonstrating the efficacy of simulation education must be provided to rationalize the expense and use of resources. How can simulation be used as an educational tool to meet the desired student learning outcomes and clinical competencies, and how will we measure its efficacy in those areas?
- Faculty support, resources, and curricular integration require administrative support and affordable simulation software and evaluation systems that streamline faculty efforts.
- More research and support is necessary for the use of electronic health records and scenario implementation.
- Further exploration of interactive nurse residency programs should be a priority as nursing faculty members and agency staff seek to decrease the education-practice gap (Anderson et al., 2009; Diefenbeck, Plowfield, & Herrman, 2006).

SUMMARY

A shift in the educational paradigm toward a competency-based training model for nursing depends on demonstrating the impact of simulation-based education on performance and knowledge transfer (Magee, 2006, p. 45). A pedagogical framework should be developed with relevant variables that can be studied in a systematic way. The models proposed in this chapter, in Jeffries and Rodgers (2007), and in Daley and Campbell (2009) provide starting points for further research. Potential outcomes in nursing students to be studied include increased knowledge, increased skill performance, greater learner satisfaction, enhanced critical thinking, and improved self-confidence (Jeffries, 2005, p. 102).

The use of clinical simulation in nursing education is increasing rapidly. There are a variety of methods, uses, and forms, but the main objective is to provide a safe, nonthreatening environment for students to learn clinical skills, critical thinking, decision making, and collaboration. Nurse educators encounter a variety of opportunities and challenges as they shift from didactic, content-focused teaching styles to more dynamic, simulation-focused pedagogy for teaching and learning. The learning curve for the development and running of scenarios may be high, but

the outcomes in student learning and increased self-confidence as well as enhanced faculty-student interaction make the effort worthwhile. It is expected that clinical simulation will allow for increased ease of transition from student to employee roles, increased student comfort and competence with technology in the workplace, and improved patient safety.

Exhibit 8.1

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A. Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 4. desired learner outcomes
- B. Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education
- C. Modify teaching strategies and learning experiences based on consideration of
 - 2. past clinical experiences
 - 3. past educational and life experiences
- D. Use information technologies to support the teaching-learning process
- J. Create a positive learning environment that fosters a free exchange of ideas
- O. Use knowledge of evidence-based practice to instruct learners

2. Facilitate Learner Development and Socialization

- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective

3. Use Assessment and Evaluation Strategies

- E. Use a variety of strategies to assess and evaluate learning in these domains
 - 1. cognitive
 - 2. psychomotor
 - 3. affective

(continued)

6. Engage in Scholarship, Service, and Leadership

A. Function as a Change Agent and Leader

2. Integrate a long term, innovative, and creative perspective into the academic nurse educator role.
5. Participate in interdisciplinary efforts to address health care and education needs
 - a. within the institution
 - b. locally
6. Implement strategies for change within the
 - a. nursing program
7. Create a culture for change within the nursing program
8. Promote innovative practices in educational environments
11. Adapt to changes created by external factors
12. Support changes as an early adopter

B. Engage in Scholarship of Teaching

1. Exhibit a spirit of inquiry about teaching and learning, student development, and evaluation methods
2. Use evidence-based resources to improve and support teaching
3. Develop an area of expertise in the academic nurse educator role

REFERENCES

- Akhtar-Danesh, N., Baxter, P., Valaitis, R. K., Stanyon, W., & Sproul, S. (2009). Nurse faculty perceptions of simulation use in nursing education. *Western Journal of Nursing Research, 31*, 312–329.
- American Association of Colleges of Nursing. (2009). *Nursing shortage fact sheet*. Retrieved July 30, 2009, from <http://www.aacn.nche.edu/media/pdf/NrsgShortageFS.pdf>
- Anderson, T., Linden, L., Allen, M., & Gibbs, E. (2009). New graduate RN work satisfaction after completing an interactive nurse residency. *Journal of Nursing Administration, 39*, 165–169.
- Appel, N., Campbell, S. H., Lynch, N., & Novotny, J. (2007). Creating effective advisory boards for schools of nursing. *Journal of Professional Nursing, 23*, 343–350.
- Bambini, D., Washburn, J., & Perkins, R. (2009). Outcomes of clinical simulation for novice nursing students: Communication, confidence, clinical judgment. *Nursing Education Perspectives, 30*, 79–82.
- Bandali, K., Parker, K., Mummery, M., & Preece, M. (2008). Skills integration in a simulated and interprofessional environment: An innovative undergraduate applied health curriculum. *Journal of Interprofessional Care, 22*, 179–189.
- Becker, K. L., Rose, L. E., Berg, J. B., Park, H., & Shatzer, J. H. (2006). The teaching effectiveness of standardized patients. *Journal of Nursing Education, 45*, 103–111.
- Berryman, J. F., Armstrong, G., & Zenoni, L. (2006, June). *Colorado's collaborative approach to develop a work, education and lifelong learning simulation center*. Paper presented at the 11th Biennial North American Learning Resource Centers

- Conference: Nursing Education on the Move: Technology, Creativity, and Innovation, Philadelphia, PA.
- Bond, W. F., Deitrick, L. M., Eberhardt, M., Barr, G. C., Kane, B. G., Worrirow, C. C. et al. (2006). *Academic Emergency Medicine*, 13, 276–283.
- Bosek, M. S., Li, S., & Hicks, F. D. (2007). Working with standardized patients: A primer. *International Journal of Nursing Education Scholarship*, 4(1), Article 16.
- Brannan, J. D., White, A., & Bezanson, J. L. (2008). Simulator effects on cognitive skills and confidence levels. *Journal of Nursing Education*, 47, 495–500.
- Bremner, M. N., Aduddell, K., Bennett, D. N., & VanGeest, J. B. (2006). The use of human patient simulators: Best practices with novice nursing students. *Nurse Educator*, 31, 170–174.
- Campbell, S. H. (2008, September–December). *Post-partum assessment: Student Assessment Sheet*. Unpublished scenario assessment used in NS 314 Nursing care of women and the childbearing family, Fairfield University.
- Campbell, S. H., & Daley, K. (Eds.). (2009). *Simulation scenarios for nurse educators: Making it real*. New York: Springer Publishing.
- Chambers, K. (2006, June). *Simulation in nursing education: The basics*. Paper presented at the 4th Annual Laerdal® Northeast Simulation User's Group Meeting, Mashantucket, CT.
- Chronister, C. (2008). Qualitative findings related to perceptions and confidence from videotaping and debriefing teaching techniques. *Critical Care Nurse*, 28(2), e42.
- Cioffi, J. (2001). Clinical simulations: Development and validation. *Nurse Education Today*, 21, 477–486.
- Cioffi, J., Purcal, N., & Arundell, F. (2005). A pilot study to investigate the effect of a simulation strategy on the clinical decision making of midwifery students. *Journal of Nursing Education*, 44, 131–134.
- Clinton, J. (2006). Special delivery: Jefferson welcomes SimBaby. *Nursing Spectrum, Philadelphia Tri-State Edition*, 15(2), 16–17.
- Commission on Collegiate Nursing Education. (2003). *Standards for accreditation of baccalaureate and graduate nursing programs*. Retrieved June 22, 2006, from <http://www.aacn.nche.edu/Accreditation/NewStandards.htm>
- Daley, K., & Campbell, S. H. (2008). *Framework for simulation learning in nursing education*. Working paper, Fairfield University School of Nursing, Fairfield, CT.
- Daley, K., & Campbell, S. H. (2009). Framework for simulation learning in nursing education. In S. H. Campbell & K. Daley (Eds.), *Simulation scenarios for nurse educators: Making it real* (pp. 287–290). New York: Springer Publishing.
- Diefenbeck, C., Plowfield, L., & Herrman, J. (2006). Clinical immersion: A residency model for nursing education. *Nursing Education Perspectives*, 27, 72–79.
- Donahue, B., & Thiede, K. (2006, June). *Integrating the electronic health record into high fidelity clinical simulations*. Paper presented at the 11th Biennial North American Learning Resource Centers Conference: Nursing Education on the Move: Technology, Creativity, and Innovation, Philadelphia, PA.
- Dreifuerst, K. T. (2009). The essentials of debriefing in simulation learning: A concept analysis. *Nursing Education Perspectives*, 30, 109–114.
- Ebbert, D. W., & Connors, H. (2004). Standardized patient experiences: Evaluation of clinical performance and nurse practitioner student satisfaction. *Nursing Education Perspectives*, 25, 12–15.

- Eggenberger, T. L., & Keller, K. B. (2008). Grounding nursing simulations in caring: An innovative approach. *International Journal for Human Caring*, 12(2), 42–46.
- Engum, S., & Jeffries, P. (2003). Intravenous catheter training system: Computer-based education vs. traditional learning methods. *American Journal of Surgery*, 186, 67–74.
- Fauchald, S. K. (2008). CIN Plus. An academic-industry partnership for advancing technology in health science education. *CIN: Computers, Informatics, Nursing*, 26, 4–8.
- Fink, L. D. (2003). *Creating significant learning experiences: An integrated approach to designing college courses*. San Francisco: Jossey-Bass.
- Freeman, K., Thompson, S., Allely, E., Sobel, A., Stansfield, S., & Pugh, W. (2001). A virtual reality patient simulation system for teaching emergency response skills to U.S. Navy medical providers. *Prehospital & Disaster Medicine*, 16, 3–8.
- Fritz, P. Z., Gray, T., & Flanagan, B. (2007). Review of manikin-based high-fidelity simulation in emergency medicine. *Emergency Medicine Australasia*, 20, 1–9.
- Fritzsche, D., Leonard, N., Boscia, M., & Anderson, P. (2004). Simulation debriefing procedures. *Developments in Business Simulation and Experiential Learning*, 31, 337–338.
- Gaba, D. M., Howard, S., & Fish, K. (2001). Simulation-based training in anesthesia crisis management (ACRM): A decade of experience. *Simulation & Gaming*, 32, 175–193.
- Goetz, M., & Nissen, H. (2005). Educational innovations. Building skills in pediatric nursing: Using a child care center as a learning laboratory. *Journal of Nursing Education*, 44, 277–279.
- Goldenberg, D., Andrusyszyn, M., & Iwasiw, C. (2005). The effect of classroom simulation on nursing students' self-efficacy related to health teaching. *Journal of Nursing Education*, 44, 310–314.
- Greenawalt, J., & Brzycki, D. (2007). *Establishing a simulation center for healthcare education: A primer for faculty, administrators and IT staff*. Retrieved August 1, 2009, from <http://download.101com.com/CAM/conf/2007/Greenawalt-Brzycki.pdf>
- Ham, K., & O'Rourke, E. (2004). Clinical strategies. Clinical preparation for beginning nursing students: An experiential learning activity. *Nurse Educator*, 29, 139–141.
- Harlow, K. C., & Sportsman, S. (2007). An economic analysis of patient simulators for clinical training in nursing education. *Nursing Economic*, 25, 24–29.
- Haskvitz, L., & Koop, E. (2004). Educational innovations. Students struggling in clinical? A new role for the patient simulator. *Journal of Nursing Education*, 43, 181–184.
- Henneman, E., & Cunningham, H. (2005). Using clinical simulation to teach patient safety in an acute/critical care nursing course. *Nurse Educator*, 30, 172–177.
- Hertel, J., & Millis, B. (2002). *Using simulations to promote learning in higher education*. Sterling, VA: Stylus.
- Hravnak, M., Tuite, P., & Baldisseri, M. (2005). Expanding acute care nurse practitioner and clinical nurse specialist education: Invasive procedure training and human simulation in critical care. *AACN Clinical Issues: Advanced Practice in Acute & Critical Care*, 16, 89–104.
- Jacoby, L., Crosier, V., & Pohl, H. (2006). Providing support to families considering the option of organ donation: An innovative training method. *Progress in Transplantation*, 16, 247–252.
- Jeffries, P. (2005). A framework for designing, implementing, and evaluating simulations used as teaching strategies in nursing. *Nursing Education Perspectives*, 26, 96–103.

- Jeffries, P. R. (2009). Guest editorial: Dreams for the future for clinical simulation. *Nursing Education Perspectives*, 30, 71.
- Jeffries, P. R., & Rodgers, K. J. (2007). Theoretical framework for simulation design. In P. Jeffries (Ed.), *Simulation in nursing education* (pp. 21–33). New York: National League for Nursing.
- Johnson-Russell, J., & Anderson, M. (2006, June). *Not just an afterthought: The art of debriefing/guided reflection*. Paper presented at the 11th Biennial North American Learning Resource Centers Conference: Nursing Education on the Move: Technology, Creativity, and Innovation, Philadelphia, PA.
- Kaakinen, J., & Arwood, E. (2009). Systematic review of nursing simulation literature for use of learning theory. *International Journal of Nursing Education Scholarship*, 6, 1–20.
- Kappus, L., Leon, V., Lyons, A., Meehan, P., & Hamilton-Bruno, S. (2006). Simulation training: An innovative way to teach critical care nursing skills. *Critical Care Nurse*, 26(2), S15.
- Kardong-Edgren, S., Starkweather, A. R., & Ward, L. D. (2008). The integration of simulation into a clinical foundations of nursing course: Student and faculty perspectives. *International Journal of Nursing Education Scholarship*, 5, 1–16.
- Kobayashi, L., Shapiro, M., Suner, S., & Williams, K. (2003). *Disaster medicine: The role of high fidelity medical simulation for mass casualty incident training*. Retrieved June 22, 2006, from http://www.findarticles.com/p/articles/mi_qa4100/is_200307/ai_n9268501/print
- Larew, C., Lessans, S., Spunt, D., Foster, D., & Covington, B. (2006). Innovations in clinical simulation: Application of Benner's theory in an interactive patient care simulation. *Nursing Education Perspectives*, 27, 16–21.
- Lasater, K. (2007). High-fidelity simulation and the development of clinical judgment: Students' experiences. *Journal of Nursing Education*, 46, 269–276.
- Leigh, G. T. (2008). High-fidelity patient simulation and nursing students' self-efficacy: A review of the literature. *International Journal of Nursing Education Scholarship*, 5(1), Article 37.
- Long, R. (2005). Using simulation to teach resuscitation: An important patient safety tool. *Critical Care Nursing Clinics of North America*, 17(1), 1–8.
- Magee, M. (2006). *State of the field review: Simulation in education*. Alberta Online Learning Consortium, Calgary AB. Retrieved July 29, 2009, from <http://ccl-cca.ca/NR/rdonlyres/C8CB4C08-F7D3-4915-BDAA-C41250A43516/0/REV.pdf>
- Marshall, R., Smith, J., Gorman, P., Krummel, T., Halck, R., & Cooney, R. (2001). Use of a human patient simulator in the development of resident trauma management skills. *Journal of Trauma*, 51, 17–21.
- McCartney, P. (2005). The new networking: Human patient simulators in maternal-child nursing. *MCN: The American Journal of Maternal Child Nursing*, 30, 215.
- McCausland, L., Curran, C., & Cataldi, P. (2004). *Use of a human simulator for undergraduate nursing education*. Retrieved June 20, 2006, from <http://www.bepress.com/ijnes/vol11/iss1/art23/>
- Metcalfe, S. E., Hall, V. P., & Carpenter, A. (2007). Promoting collaboration in nursing education: The development of a regional simulation laboratory. *Journal of Professional Nursing*, 23, 180–183.
- Meyer, G., & Lavin, M. A. (2005). Vigilance: The essence of nursing. *Online Journal of Issues in Nursing*, 10(3), 38–51.

- Morgan, P., Cleave-Hogg, D., McIlroy, J., & Devitt, J. (2002). Simulation technology: A comparison of experiential and visual learning for undergraduate medical students. *Anesthesiology*, *96*, 10–16.
- National League for Nursing. (2008). *Position statement: Preparing the next generation of nurses to practice in a technology-rich environment: An informatics agenda*. Retrieved July 31, 2009, from http://www.nln.org/aboutnln/positionstatements/informatics_052808.pdf
- Nehring, W. M. (2008). U.S. boards of nursing and the use of high-fidelity patient simulators in nursing education. *Journal of Professional Nursing*, *24*, 109–117.
- Norris, G. (2008). The midwifery curriculum: Introducing obstetric emergency simulation. *British Journal of Midwifery*, *16*, 232–235.
- Nursing Executive Center Nursing School Curriculum Survey. (2007). Bridging the preparation-practice gap: Quantifying new graduate nurse improvement needs. Washington, DC: Advisory Board Company.
- Owen, H., & Follows, V. (2006). GREAT simulation debriefing. *Medical Education*, *40*, 488–489.
- Owens, L., & Walden, D. (2001). Peer instruction in the learning laboratory: A strategy to decrease student anxiety. *Journal of Nursing Education*, *40*, 375–377.
- Parker, B. C., & Myrick, F. (2009). A critical examination of high-fidelity human patient simulation within the context of nursing pedagogy. *Nurse Education Today*, *29*, 322–329.
- Radhakrishnan, K., Roche, J. P., & Cunningham, H. (2007). Measuring clinical practice parameters with human patient simulation: A pilot study. *International Journal of Nursing Education Scholarship*, *4*(1), Article 8.
- Ravert, P. (2006, June). *Implementation of perinatal scenarios with use of high-fidelity patient simulator*. Paper presented at the 11th Biennial North American Learning Resource Centers Conference: Nursing Education on the Move: Technology, Creativity, and Innovation, Philadelphia, PA.
- Rhodes, M., & Curran, C. (2005). Use of the human patient simulator to teach clinical judgment skills in a baccalaureate nursing program. *CIN: Computers, Informatics, Nursing*, *23*, 256–264.
- Rodgers, D. L. (2007). *High-fidelity patient simulation: A descriptive white paper report*. Retrieved August 2, 2009, from <http://sim-strategies.com/downloads/Simulation%20White%20Paper2.pdf>
- Rothgeb, M. K. (2008). Creating a nursing simulation laboratory: A literature review. *Journal of Nursing Education*, *47*, 489–494.
- Russell, A., & Campbell, S. H. (2006, June). *Partnerships between nursing and technology*. Paper presented at the Partnerships in Progress: Pathways to the Future in Nursing, Fairfield, CT.
- Seropian, M., Brown, K., Gavilanes, J., & Driggers, B. (2004a). An approach to simulation program development. *Journal of Nursing Education*, *43*, 170–174.
- Seropian, M., Brown, K., Gavilanes, J., & Driggers, B. (2004b). Simulation: Not just a manikin. *Journal of Nursing Education*, *43*, 164–169.
- Shawler, C. (2008). Educational innovations: Standardized patients: A creative teaching strategy for psychiatric-mental health nurse practitioner students. *Journal of Nursing Education*, *47*, 528–532.
- Sheets, D. (2006, June). *Using a CIS format for case studies in classroom and simulated lab*. Paper presented at the 11th Biennial North American Learning Resource

- Centers Conference: Nursing Education on the Move: Technology, Creativity, and Innovation, Philadelphia, PA.
- Simon, R., Rudolph, J., & Raemer, D. (2009, January). *Assessing and improving debriefing: A practical workshop using the Debriefing Assessment for Simulation in Healthcare (DASH)*. Workshop presented at the 9th Annual International Meeting on Simulation in Healthcare: Captivate and Motivate Through the Power of Simulation, Orlando, FL.
- Skiba, D. J. (2007). Nursing education 2.0: Second Life. *Nursing Education Perspectives*, 28, 156–157.
- Smith, S. J., & Roehrs, C. J. (2009). High-fidelity simulation: Factors correlated with nursing student satisfaction and self-confidence. *Nursing Education Perspectives*, 30, 74–78.
- Speziale, H. J. S., & Jacobson, L. (2005). *Trends in registered nurse education 1998 to 2008: A report of a national study on basic RN programs*. Retrieved July 31, 2009, from <http://nl.n.allenpress.com/pdfserv/i1536-5026-026-04-0230.pdf>
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, 10, 282–298.
- Tanner, C. (2006a). Changing times, evolving issues: The faculty shortage, accelerated programs, and simulation. *Journal of Nursing Education*, 45, 99–100.
- Tanner, C. (2006b). Thinking like a nurse: A research based model of clinical judgment in nursing. *Journal of Nursing Education*, 45, 204–211.
- Valentine, K. (2005). Electronic medical records promote caring and enhance professional vigilance. *International Journal for Human Caring*, 9, 121.
- Weir, C., Hoffman, J., Nebeker, J., & Hurdle, J. (2005). Nurse's role in tracking adverse drug events: The impact of provider order entry. *Nursing Administration Quarterly*, 29, 39–44.
- Yaeger, K. A., & Arafteh, J. (2008). Making the move: From traditional neonatal education to simulation-based training. *Journal of Perinatal & Neonatal Nursing*, 22, 154–158.

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9

Virtual Reality and Game-Based Clinical Education

ERIC BAUMAN

Clinical skills for nursing students traditionally have been cultivated through a combination of laboratory experiences and direct observation of skilled clinicians in actual clinical practice. Over time, nursing students gradually increase their role and responsibility for the care of patients under the tutelage of instructors and mentors (Gould & Bauman, in press). New and emerging pedagogy suggests that virtual worlds and game-based learning platforms are ideal places to introduce true multidisciplinary learning among students from various health sciences disciplines for a variety of purposes. Today's students are well situated to take advantage of innovative technology to enhance and fuel their academic experience. Most current students grew up in the age of the Internet, and they embrace digital culture. They are likely to have a high degree of media literacy and adaptability (Squire, 2006; Squire, Giovannetto, Devane, & Durga, 2005; Thoman & Jolls, 2004). Furthermore, today's learners are accustomed to multimedia environments and are comfortable using them for academic, personal, and professional gain. In fact, students have come to expect that technology, including Web- and simulation-based education, be integrated in to their curricula (Bauman, 2007; Campbell & Daley, 2009; Nelson & Blenkin, 2007).

Simulation-based education, whether experienced in a physical laboratory setting or in a virtual reality environment, has been used to

introduce nursing students and other health sciences students to a wide breadth of technical and nontechnical or behavioral skills required for clinical practice (Nelson, Sadler, & Surtees, 2005; Small et al., 1999). Moreover, simulation-based learning has come to play an increasingly important role in preparing students for real-world clinical education. The once relatively static nursing skills lab has evolved into a dynamic, created environment (Bauman, 2007) capable of providing students with situated designed learning activities (Gee, 2003; Squire, 2006) that may better prepare learners for their transition from students to professional clinicians. In other words, use of created environments and designed experiences may accelerate students' transition from novice to advanced beginner and even entry into practice.

Although simulation and virtual reality–based learning does not take place in an actual clinical environment, it does provide learners with knowledge through their lived experiences in contextually rich environments that encourage reflection. Environments that support designed experiences that strive to authentically replicate clinical practice settings should be seen and treated as clinical environments. In this way, these environments may support and provide a foundation for learning during future clinical experiences that novices will later encounter during their transition from novice to expert (Benner, 1984).

Because this chapter introduces terminology that may be unfamiliar to most readers, terms commonly used in discussing virtual reality and game-based environments are defined in Exhibit 9.1. For the context of this discussion, a *created environment* refers to a learning environment that has been specifically engineered to produce sufficient authenticity and environmental fidelity to allow for the suspension of disbelief. Environmental fidelity should promote and support the immersion of learners as they engage in the educational activity in a meaningful way relevant to future practice (Campbell & Daley, 2009; Flanagan, Nestel, & Joseph, 2004; Halamek et al., 2000; Seropian, 2003). For example, if lesson objectives are to be later applied to a critical care environment, then the created environment ought to mimic in an authentic way an actual critical care environment. Furthermore, sufficient environmental fidelity should drive psychological fidelity, the ability of learners to not only suspend disbelief but actively engage their environment and later apply simulation-based educational experiences to actual clinical practice (Bauman, 2007; Gaba, 2004).

The *designed experience* approaches learning as performance where students learn through being and doing. In a designed experience, task

Exhibit 9.1

GLOSSARY OF TERMS USED IN VIRTUAL REALITY AND GAME-BASED CLINICAL EDUCATION

Term	Definition
<i>Avatar</i>	The term <i>avatar</i> is originally from Greek mythology. The gods would take the shape of mortals in the form of human avatars to walk the earth. In video games and virtual environments, an avatar transcends two planes of existence: the real world and the <i>in world</i> or virtual world. The avatar or player-character is the embodiment of the person playing the game. Players live in and interact with the virtual or game-based environment through their avatars. Contemporary game-based and virtual reality avatars are often highly malleable and can be customized by individual players. Some will relate the avatar to a player's in-world alter ego.
<i>Bot</i>	The term <i>bot</i> originated from early work related to artificial intelligence. It can be used for any automated software agent that behaves in an artificially autonomous manner. Bots were often used as early versions of <i>nonplayer characters</i> in text-based virtual worlds. The term <i>bot</i> also includes agents such as Web browser spider bots and Internet Relay Chat Bots (IRC Bot), commonly referred to as <i>chat bots</i> . Spider bots mine Web pages to collect and analyze data, while chat bots simulate conversations with game players.
<i>Console-based game</i>	Games played on dedicated videogame platforms, such as, but not limited to, the Sony PlayStation, Nintendo Wii, or Microsoft Xbox.
<i>Created environment</i>	An environment that has been specifically engineered to replicate an actual existing environment, producing sufficient authenticity and environmental fidelity to allow for the suspension of disbelief. Simulated environments, whether fixed in the case of mannikin-based simulation laboratories, or existing in virtual reality, are created environments.
<i>Designed experience</i>	A designed experience is engineered to include structured activities targeted to facilitate interactions that drive anticipated experiences. In other words, the experience embodies structured activity and the environment in which the activities take place. Many theme parks are based in part on the theory of designed experience.
<i>Easter egg</i>	Novel facets of virtual reality and game-based environments that provide useful information, tangible reward, or entertainment value of some kind. They are often integrated into environments to provide just-in-time information and to promote a sense of environmental exploration.

(continued)

<i>Game-based platform</i>	An environment that provides a narrative and system of rewards for accomplishing specific tasks and objectives. Game-based platforms use virtual environments to stage the game. Not all virtual reality environments are game-based.
<i>Haptic</i>	Refers to tactile touch sensation. In virtual reality and game-based environments, it specifically refers to the touch sensation feedback that the learner or player receives from the game or environment. In console-based video games, haptic feedback often occurs through vibrations in the hand-held game controller.
<i>In-world</i>	Refers to the game or virtual reality environment. Interactions that are taking place in-world are occurring within the confines of the game or virtual environment.
<i>Massively multiplayer online game (MMOG)</i>	Video games that are designed to support hundreds of thousands of players simultaneously. MMOGs generally provide at least one constant environment and by necessity are played on the Internet (online). Although many MMOGs are designed to be played using personal computers, many console-based video games also have MMOG capability. MMOGs are sometimes referred to as <i>MOGs</i> (multiplayer online games).
<i>Nonplayer character (NPC)</i>	In-world agents of and from the game or virtual environment. NPCs are a function of programming and do not exist outside of the game or virtual environment. NPCs are in-world characters that the players' (learners') avatars interact with. This term originated from paper-based role-playing games like Dungeons and Dragons. It is a narrower definition than bot; however, there is often a blurring between the definitions of bot and NPC.
<i>Projective identity</i>	The hybrid identity synthesized from the player's real-world identity and in-world identity. It is the identity that the player adopts within the context of the virtual or game world. The projective identity represents a reconciliation of the player's in-world and real-world experiences.
<i>Real world</i>	Refers to the environment that we live in, not the game or virtual world. One often contrasts in-world experiences with real-world experiences.

Note: The assistance of I. Alex Games, PhD, Assistant Professor of Telecommunications, Information Studies, and Media at Michigan State University, in the preparation of this exhibit is gratefully acknowledged.

orientation takes place in a situated environment where learners embody not only the task at hand but also the character completing the task (Squire, 2006). The designed experience embodies structured activities as well as the environment in which these activities take place.

Educational designers of designed experiences supply a scaffold that provides cues and rules for targeted behaviors. In other words, designers attempt to set up specific interactions that create certain types of experiences for players (learners). However, students in a created environment will ultimately co-create their own lived experiences. For example, a librarian might host a workshop that is designed to show students the lost art of finding and checking out a book. The skill and knowledge required to complete this task (checking out a book) can be demonstrated and even acquired through structured learning activities. However, a student's experience in the library during the seminar, reading the book, and interpreting the book represents a unique encounter that embodies and encompasses the organized activities associated with actually locating and checking out the book.

A successful example of an environment based on designed experiences that many people are familiar with is the modern theme park. Theme parks are designed to promote certain types of experiences for their patrons. The environmental conditions of the theme park may promote roles such as adventurer, inventor, or superhero, but, in the end, the experience is unique because it belongs to the individual.

Virtual reality and game-based learning environments attempt to facilitate learners' experiences by providing targeted activities to promote objective-based interactions. When learners take advantage of virtual reality and game-based learning, they will construct meaning based in part on game or environment trajectory and on their own agendas—goals, mores, and reflection on past experiences. Well-crafted designed experiences will accommodate multiple trajectories by providing just-in-time and on-demand information to facilitate in-world problem solving (Squire, 2006).

The designed experience is essential to clinical education because it provides educators with the opportunity to assist students with the difficult task of affinity group acculturation and indoctrination. The designed clinical learning activity can provide nursing students with important professional cues related to the conduct associated with the profession that they are seeking to join. In addition, the focus on learning through designed learning activities allows teachers to guide students within situated contexts of practice that are relevant to specific clinical areas (Games & Bauman, in press; Gee, 2003).

In general, traditional simulation-based education has been helpful in preparing students for technical skill development and advanced clinical learning, and in preparation for independent practice. Simulation is most often employed throughout the health professions, including

nursing, to prepare students for situations that involve high risk but occur infrequently (DeVita, 2005; Gaba, Howard, Fish, Smith, & Sowb, 2001; Helmreich, 2000). Management of complex, high-risk patient care situations such as trauma resuscitation, cardiac resuscitation, and crisis management traditionally have been taught through didactic preparation, followed by direct hands-on learning activities (Gaba, 2004; Lee et al., 2003; McLellan, 1999). Real-life learning activities cannot be produced on demand, nor is it ethical or feasible to allow students to direct the care of patients in crisis (Flanagan et al., 2004; Friedrich, 2002; Hammond, 2004). This raises the important question of how to adequately teach and prepare for crises that we know will occur during clinical learning activities and future professional practice.

Unfortunately, students are not exposed to all of the relevant clinical educational opportunities needed to prepare them for the transition from novice to expert (Benner, 1984; Larew, Lessans, Spunt, Foster, & Covington, 2006). This is not to imply that graduate nurses should enter their profession as experts, but, rather, new graduates or novice clinicians ought to be poised to enter nursing as a profession with valuable experiences to build on as they strive for clinical expertise. Clinical encounters of educational value need not be left to chance; rather, these situations can be created and designed through simulation-based technology, including *virtual reality* and *Web-based environments*, to ensure that all students have the opportunity to achieve desired learning outcomes (Bauman, 2007; Campbell & Daley, 2009; Friedrich, 2002; Games & Bauman, in press; Gordon, Oriol, & Cooper, 2004; Lane, Slavin, & Ziv, 2001; Shapiro & Simmons, 2002; Ziv, Wolpe, Small, & Glick, 2003).

To date, most simulation-based learning in the health sciences has focused on mannikin-based simulation taking place in physical spaces—simulation laboratories. Until recently, most virtual reality and computer-based simulation has been limited to task training. In nursing, task-specific or partial task trainers have generally focused on the development of psychomotor skills. Examples of such task-oriented psychomotor skill development include, but are not limited to, psychomotor skills such as catheterization and intravenous cannulation. In addition, more complex task trainers are often used to introduce and train clinicians in the use of technology-specific equipment and procedures, such as intubation, ultrasound, endoscopy, and laparoscopy (Bauman, 2007; Cooper & Taqueti, 2004; Glavin & Maran, 2003; Gould & Bauman, in press; Seropian, 2003). However, although task trainers taking advantage

of virtual reality and computer-based simulation have greatly improved in terms of visual, haptic (touch sensation feedback), and environmental fidelity (Nicholson, Chalk, Funnell, & Daniel, 2006), they generally do not provide an integrated clinical learning experience (Gaba, 2004). In other words, task trainers do not provide students with immersive learning opportunities that represent the actual clinical practice of nursing or any other profession. This is not to say that task trainers are not important tools for clinical education. Surgical training has included elements of virtual reality training since the early 1990s (Satava, 1993). Today, virtual reality surgical simulation has become widely accessible and has been demonstrated to be a valid assessment of skill acquisition and improved operating room performance of surgical residents (Grantcharov, 2008; Seymour et al., 2002). Nurse educators have begun to embrace virtual reality task training technology and have demonstrated success using it for clinical education (Tsai et al., 2008).

THE PARADIGM SHIFT TOWARD VIRTUAL REALITY AND GAME-BASED LEARNING

The flexibility and adaptability of game- and virtual reality-based platforms has led to a dramatic increase in the amount of health sciences content found in virtual worlds such as *Second Life*, a massively multiplayer online game (MMOG), as well as more traditional video game platforms (Games & Bauman, in press; Mezko, 2007; Schitai, 2004; Taekman, Segall, Hobbs, & Wright, 2007; Woodford, 2008). As virtual worlds become diverse, interactive, and easy to use, disciplines such as nursing and other health sciences have begun to occupy and use them as spaces designed to teach disciplinary content to students.

The flexibility of virtual environments allows instructional designers to create learning environments that are responsive to learners' needs. This makes virtual worlds uniquely suited for education within professional communities of practice such as nursing. Virtual and Web-based environments immerse students into future practice roles in created environments that model real-world clinical practice (Bauman, 2007; Nelson & Blenkin, 2007). Virtual reality immersion requires students to try on different identities as members of a virtual community (Bartle, 2004; Games & Bauman, in press; Gee, 2003). The ability to model and situate human factors or behavioral skills can lead to valuable insight and perspective for nursing and other clinical sciences students. Competencies

such as communication, diversity, professionalism, and teamwork can be modeled and developed in a virtual world. Collaboration and teamwork can occur among learners in a virtual world regardless of proximity or location (Gould & Bauman, in press; Nelson & Blenkin, 2007).

The faculty of the University of Wisconsin–Oshkosh College of Nursing has created a virtual learning center in Second Life to facilitate its online collaborative bachelor of science in nursing programs. Virtual reality environments located in Second Life include classrooms, faculty offices, a welcome center, public health offices, and a disaster scene. Tacoma Community College in Tacoma, Washington, uses a Second Life Web-based community to introduce students to various aspects of nursing practice (Skiba, 2009).

Faculty members of the University of Illinois at Chicago found that using Web-based learning environments for clinical education was an efficient and cost-effective method for delivering content to a large, distributed population of learners while maintaining a high level of participant satisfaction (York, Stapleton, & Sandlow, 2003). The Second Life Institute for Clinician Education, also known as SLICE2 (<http://www.slice2.com>), is a virtual clinic found within the virtual world of Second Life (Exhibit 9.2). SLICE2 hosts learning activities designed to assist health sciences students to improve their skills in communication, teaching, teamwork, lifelong learning, practice management, patient safety, and other areas identified as important practice competencies. This virtual learning space includes a virtual standardized patient laboratory where students interact with avatars that are being played by trained standardized patients. Each virtual encounter is debriefed in the virtual world at the conclusion of the learning experience, just as in more traditional simulation or standardized patient encounters taking place in a fixed physical space. Educational activities and debriefing sessions can be recorded easily through in-world video capture for further review. The importance of this feature will be discussed later in the chapter. SLICE2 was created and is independently managed by Gerald R. Stapleton, a member of the faculty and director of distance education with the University of Illinois at Chicago Department of Medical Education, where he continues to explore the potential for learning activities offered in virtual environments.

Virtual Heroes (<http://www.virtualheroes.com>) *Zero Hour: America's Medic* is a personal computer-based game designed to teach and prepare first responders for disasters, naturally occurring and otherwise. This game has a sophisticated scoring matrix designed to evaluate players'

SAMPLE SECOND LIFE INSTITUTE FOR CLINICIAN EDUCATION (SLICE2) SCREEN IMAGES

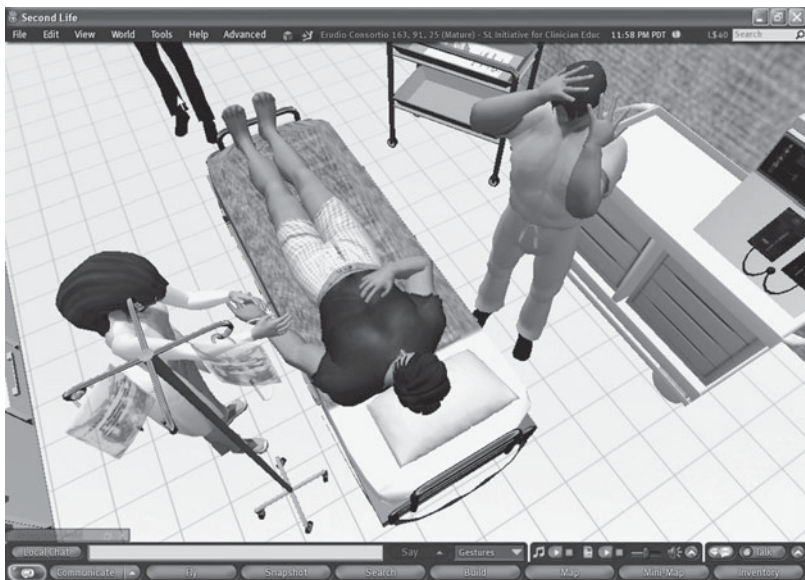
Screen shot from SLICE depicting an interaction taking place among a patient and two clinicians. Note the footwear of the female clinician. The risks and policies of open-toed footwear should be discussed in the scenario debriefing of this encounter.



The clinical encounter continues as a physical assessment takes place.



A discussion of the clinical history and physical finding takes place with the patient.



An IV in the patient's arm is checked, and the patient is reassured. Note that another opportunity for discussion is depicted. The female clinician is not wearing gloves while checking the IV, and the male clinician's response to this part of the encounter also warrants further discussion.

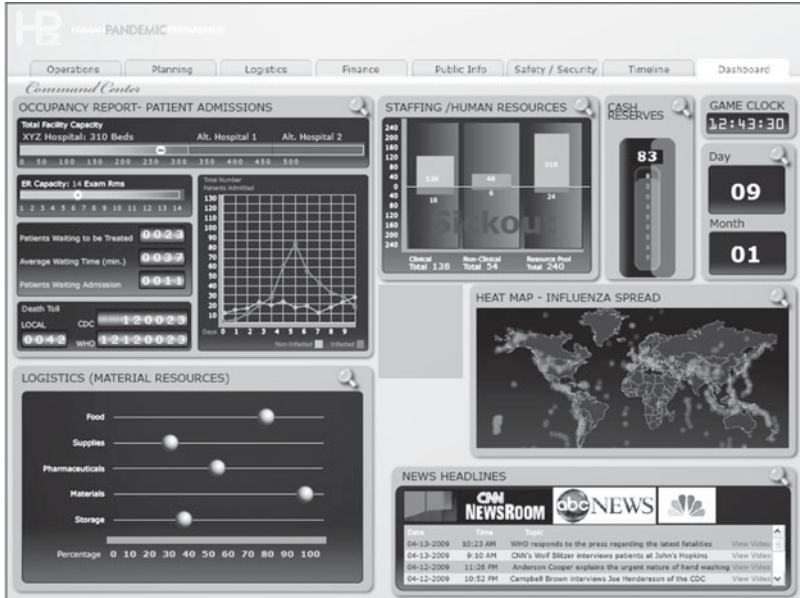
Note: Gerald R. Stapleton, MS, is gratefully acknowledged for providing the images for this exhibit. Stapleton is a faculty associate and director for distance education at the University of Illinois at Chicago College of Medicine, Department of Medical Education, and the independent creator and manager of SLICE2, a virtual reality clinical training center found within Second Life.

(learners’) performance while completing tasks such as triage and treatment of nonplayer characters’ complaints and injuries. The development and design of this game was based on field research culled from numerous public safety agencies responsible for disaster response.

Pandemic is a dashboard-style computer-based simulation game produced by SimQuest (<http://www.simquest.com>). *Pandemic* provides a learning environment for hospital and institution administrators and supervisors to work through an influenza pandemic (Exhibit 9.3). The scoring matrix of this game encourages players to address elements such as staffing, hospital dynamics, and the economic impact of their decisions. In this way, the players’ decisions influence future game play. For example, decreasing patient mortality may also increase employee morbidity, thereby complicating staffing needs.

Exhibit 9.3

SCREEN IMAGES FROM HUMAN PANDEMIC PREPAREDNESS (SIMQUEST)



Dashboard graphic from Human Pandemic Preparedness. The graphic illustrates various data streams available to players as they negotiate and manage an influenza pandemic.

(continued)



By clicking on different windows found on the dashboard, the depth of available data expands. In this example, a news story is viewed and provides fidelity to engage the player.

Note: Bob Waddington, chief operations officer of SimQuest LLC, is gratefully acknowledged for providing the Human Pandemic Preparedness graphics for this exhibit.

Today's students are well positioned to take advantage of multimedia instructional technology. Traditional-age students have lived their entire lives using technology such as computers and mobile devices. Nontraditional students can harness the power of technology to overcome barriers such as distance and time (Bauman, 2007; Campbell & Daley, 2009; Games & Bauman, in press).

THEORY SUPPORTING VIRTUAL REALITY AND GAME-BASED LEARNING

Both traditional and contemporary learning frameworks, including experiential learning models (Benner, 1984; Kolb, 1984; Schön, 1983), socially situated cognition and identity (Gee, 2003), and designed experiences

(Squire, 2006) provide support for virtual reality learning environments. In turn, these theories provide support for the emergence of a new theory that provides a contemporary perspective on culture and diversity for nursing and other health sciences curriculum design and educational intervention for contemporary learning environments such as virtual worlds.

Games and Bauman (in press) proposed an *Ecology of Culturally Competent Educational Design in Virtual Worlds* as a method to design, implement, and evaluate learning activities that address the complex relationships that exist between game components, culture, identity, and learning. There are four key elements to this theory: activities, contexts, narratives, and characters. These four elements are imperative not only to nursing education but also for the acculturation or indoctrination of students of all professions represented among the clinical health sciences. Acculturation conveys the expectations of practice to undergraduate and graduate students. Technical proficiency in skill-based activities represents only one expectation associated with practice. Web, virtual reality, and game-based learning environments can provide important cues and learning opportunities related to the contexts and roles that students will be expected to develop and master in order to attain professional expertise and acceptance as a clinician in today's complex health care environment (Benner, Tanner, & Chesla, 2009; Gould & Bauman, in press).

Ecology of Culturally Competent Educational Design in Virtual Worlds Activities

Activity or interactivity found within the learning environment is the essential element that differentiates successful video games and virtual environments from more traditional didactic learning modalities. Participation in virtual or created spaces is only meaningful when learners can actively engage their environment in a meaningful way.

In Second Life, communities organize themselves around a variety of activities, including commerce (selling a variety of virtual goods, such as clothing for avatars or buildings for parcels), gambling, and education. In the virtual world game *World of Warcraft*, millions of people with common objectives hone their skills to work collaboratively to achieve community objectives such as battling monsters and finding treasure. These activities allow communities of players to use the rich contexts of the game and its environment to self-organize and define their identity around common player characteristics and affinity groups (Gee, 2003).

Among the health sciences, virtual spaces include settings such as operating rooms and even entire virtual hospitals where learners can practice many of the activities germane to the health professions they seek to join (Taekman et al., 2007).

However, most virtual spaces used for educational purposes lack a sense of intuitive interactivity. Existing virtual spaces are often limited to simple and standardized activities centered on observation or multimedia dissemination of didactic content. Existing spaces seldom accurately represent the diversity and cultural interactions that occupy real-world clinical practice. Static environments can be very visually appealing, but without intuitive activity, important learning opportunities related to probing and discovery are not reinforced. It is through interaction that nursing students come to understand the collaborative and distributed nature of professional nursing (Bauman, 2007; Gee, 2003).

Educational designers must consider and evaluate how the design process can create engaging interactive communities that accurately represent the cultural relevance associated with group and individual differences found in actual clinical space. The malleability of the virtual world allows for custom-designed patient-clinician encounters that can be manipulated in ways simply not readily available in standard models of clinical education. Virtual patients can be modeled to represent various cultural facets.

In spaces like *Second Life* and other game-based virtual environments, it is possible to use software to produce complete digital movies of game play, the interactions that occur among players and their environments as well as avatars and nonplayer characters. These movies can later be used for debriefing, reflection, and evaluation (Kinzer, Cammack, Labbo, Teale, & Sanny, 2006). Situated learning activities and the experiences they facilitate in the virtual world should provide a bridge for learners to travel from the virtual world to actual communities of practice (Games & Bauman, in press; Gould & Bauman, in press).

Contexts

When new teaching spaces are created, educators must take into account how those spaces will be represented and interpreted by those who occupy them. Furthermore, educators should anticipate the possible assumptions that can be made about the contexts of created spaces, the activities found in them, and designed experiences that they offer learners. Educators bear the responsibility for providing environments

that safely facilitate the transfer of knowledge and desired behavioral change (Games & Bauman, in press).

Context is an important element to consider when developing and evaluating virtual reality–based learning environments, because students will interpret virtual reality encounters as a function of previous experience and their relationship with the community or culture they find themselves in. Virtual learning environments should select for and promote known key features and patterns that support actual real-world practice. However, educators should not be surprised when students mirror poor technique or undesirable behavior that coexists in real-world academic and clinical settings. The virtual world may provide students with interesting ethical questions where boundaries and discourse can be explored. This differs from more traditional didactic models of education where students are seen as empty vessels to be filled with domain-specific knowledge. Lessons designed for virtual learning environments will be more successful if they are situated within the professional context in which students will eventually recall them during future clinical practice (Gisoni, Smith-Coggins, Harter, Soltysik, & Yarnold, 2004).

Virtual and game-based environments can foster effective learning practices, because gaming media allow designers to implement curricula guided by how players feel about and come to understand the situated context of interactive learning environments (Squire, 2006). Players (or learners) will interpret the context of their current experiences taking place in the virtual environment based on their previous experience. The role of safe, deliberate practice in situated created environments may provide context for future practice (Cooper & Taquiti, 2004; Gee, 2003; Squire, 2006; Wayne et al., 2006).

Narratives

Video game and virtual world scholars have come to recognize the power that narratives have in the creation of meaningful learning (Gee, 2003). Narratives provide people's memories with a collection of patterns that help them recognize and make sense of the world (Bruner, 1991; Gee, 1991). Pattern recognition is a key component marking a critical difference among novices and experts. Through their lived and situated experience, experts come to recognize patterns that often lead them to conclusions much more quickly than novices. This may explain why experts may not perform as well as students (novices) on a test, but

often clinically outperform novices (Benner, 1984; Gee, 2003; Murray et al., 2002).

Narrative provides learning situations with valuable cues to direct student performance in the virtual world. One might grasp this importance by thinking of the narrative as the background information that would be provided to students during a case-based learning scenario. However, instead of simply providing a didactic presentation of the patient's history by reading it to students, the virtual environment provides educators with the opportunity to seed the virtual space with an emerging narrative that unfolds based on the students' interaction with the environment as well as with others concurrently occupying the environment. Good video games encourage and reward players for exploring their environment, for leaving no stone unturned. Exploration often yields *Easter eggs*, novel facets of the environment that may provide useful information, tangible reward, or entertainment value of some kind. This sort of game play helps players (learners) to become engaged and vested in the virtual world.

Narratives also assist players in the negotiation and reconciliation of their identities, particularly *projective identities*. The projective identity emerges to represent learners' reflection on assumptions and implications associated with the reconciliation of their virtual and real-world identities. This reflection represents an essential opportunity to study aspects of cultural framing of self and other (Games & Bauman, in press; Gee, 2003). Understanding cultural framing is important for nursing students, because they are learning how to interact in new, different, and often uncomfortable contexts where culture and diversity can play important roles in physiological and psychological outcome (Schitai, 2004; Tervalon & Murray-Garcia, 1998; Thom et al., 2006). Further, cultural framing influences not only patient outcome but also facets of professional development and future work settings (Benner et al., 2009).

Through narrative, the Virtual Heroes game *Zero Hour: America's Medic* places the player in the role of a paramedic responding to a mass casualty disaster. This game constructs a narrative that situates the player's virtual identity as a paramedic in a multicultural context. *Zero Hour: America's Medic* allows the game administrator to track decisions that may have been made based in part on gender and race rather than clinical necessity (Gould & Bauman, in press). The virtual environment in this case provides several aspects of narrative that simply may not exist in actual clinical environments. Teachers, mentors, and preceptors will not have reliable access to disasters, natural or otherwise, for teaching

purposes. Many clinical education settings simply do not provide culturally diverse environments. Additionally, many learners may become immersed in settings representing cultural differences and diversity for the first time as nursing students. Virtual encounters with culture and diversity may prepare them for actual encounters with patients and colleagues in real clinical settings.

Narratives also provide spaces for reflection on the consequences of one's decision making. Learners can be encouraged to see the consequences of their action or inaction from multiple perspectives. The virtual world can provide different narrative endings based on learners' ongoing interaction with their environment. In this way, students are able to engage in deliberate decision making that will produce varying scenario outcomes. This type of deliberate practice is not available in the real clinical world. In actual clinical encounters, mentors and instructors must often make sure that optimal care is provided to patients on the first encounter. In actual or real-world clinical settings, students are often relegated to the role of observer. When students care for real patients, they do not have the luxury of revisiting the same clinical encounter in order to make a better or different decision. Virtual environments allow students to take responsibility for their decisions in a situated but safe context. Instructors can monitor students' progress as they adjust their behavior and decision making to negotiate more acceptable outcomes. This allows the teacher to guide students while letting them develop competence, confidence, and expertise through reflection on past experience. In this sense, for students inhabiting the virtual world, an error simply becomes an opportunity for behavioral change—learning.

Negotiating responsibilities related to virtual identities existing within situated narratives can involve sophisticated cognitive effort and critical thinking strategies. For example, in *Second Life*, some communities of experienced players induct novices into domain-specific environments found in the virtual world by requiring them to customize their in-world characters, known as avatars, with specific visual characteristics that project an expected role identity. This virtual experience provides novices (nursing students) with a model for professional development and practice in the actual clinical setting. This common process found in game play could be used to promote professional acculturation and identity and role development among the health sciences. For example, a virtual operating room that has been engineered to provide an interactive procedural simulation could serve as an introduction and orientation to roles and expectations associated with perioperative nursing. Elements

of this environment could include everything from hand antisepsis and gowning to the surgical time-out. Preprogrammed nonplayer characters in virtual environments can provide cues based on learners' actions to direct the in-world learning experience. Furthermore, learning activities in the virtual world can be engineered as situated interactions to promote designed experiences that emphasize specific curriculum objectives (Gould & Bauman, in press). It should be pointed out that players will take part in the unfolding of their own narrative experiences, because their actions (e.g., hand antisepsis or sterile technique) can be designed to affect the virtual patient outcome.

Characters

The fluidity and malleability of virtual environments applies not only to the look and feel of virtual teaching spaces but also to learners' identities. In most virtual worlds, players interact with others and the environment by controlling their avatars. Design characteristics for many video games and virtual environments make it possible for players to shape and design their avatars. These custom-made avatars will become the conduits for interaction with others inhabiting the virtual world. In this sense, platform and game designers and instructional staff and faculty members are not the only ones creating the virtual learning environment. Although students occupying virtual spaces are easily prohibited from changing the space they occupy, the very nature of the virtual world allows and encourages participants to develop virtual identities that may or may not mirror their actual physical attributes and persona.

The ability to try on multiple identities may be of great value for the design of learning experiences involving culture and diversity. One could imagine a lesson in which students play the role of patients belonging to a different culture from their own. Avatars could be designed to evoke students' preconceived notions of culture and identity. In the same way, instructors could facilitate behavioral responses from students that represent either cultural competence or cultural clichés and stereotypes (Games & Bauman, in press; Gould & Bauman, in press). Character design and assignment allows individuals to adopt the appearance and persona of cultural groups other than their own and experience others' lived experiences. Reflection on this experience may help students to develop understanding and skills related to culture and diversity that they can bring to future clinical practice.

Designed experiences that have the potential to evoke strong emotional responses must include guided debriefing sessions to diffuse and mitigate those responses (Bauman, 2007; Thiagarajan, 1992). The debriefing not only ensures that targeted objectives have been met but also encourages further reflection by students and teachers. Video capture of in-world interactions and behavior can serve as an important tool to facilitate debriefings and further reflection.

In virtual worlds, it is possible to create and program nonplayer characters, also known as *bots*, to interact independently with players' avatars (Turkle, 1995). Bots can be designed to engage in a wide variety of activities and behaviors, ranging from the portrayal of a cadre of signs and symptoms to engaging in conversations with others. Even though bots are limited in terms of their programming context, their presence can add a degree of authenticity to virtual settings, making it easier for players to embody their in-world identities. Well-designed conversations with bots can produce enough fidelity to provide the illusion of conversation with real people. Interaction with bots in virtual spaces provides players with meaning, because these interactions represent familiar patterns from known experiences and portray them in the virtual world. Familiar patterns, in turn, provide players with cues for decision making. One of the first and most famous bots ever created was Weizenbaum's ELIZA (Weizenbaum, 1966). ELIZA was meant to be a parody of a Rogerian psychotherapist who would answer players' questions with questions that were included as part of the game design to provide the illusion of actual person-to-person interaction. The fidelity of this bot-based interaction was strong enough to convince players that they were actually conversing with another player-based avatar (Games & Bauman, in press).

The mores and social constructs that direct the creative expression of students designing their avatars and the rules that govern professional behavior expected by the community they seek to join must be negotiated, evaluated, and reconciled. Virtual characters and their identities can provide students with a degree of anonymity, encouraging participation by those who may otherwise shy away from participation in the real world. Instructional staff may wish to keep students' avatars anonymous to other players while tracking their actual identities for the purposes of evaluation.

However, the malleable nature of avatars in virtual worlds coupled with anonymity can lead to inappropriate behavior, particularly in teaching spaces designed to acculturate students to professional practice.

Identity with one's professional affinity group is an important tenet of learning (Gee, 2003). There may be very good reasons to provide consistent boundaries across virtual and actual learning spaces related to identity and professional acculturation.

Social mores in virtual worlds can be confusing, particularly when the original purpose of existing commercial platforms designed for social networking and entertainment is changing to facilitate professional and academic experiences. Should students be required to enter virtual spaces as is, using their real name, race, age, and gender? Just as instructors develop guidelines for appearance and conduct in real-world clinical spaces, they must also be able to exert and maintain control over certain aspects of student avatar design. Interestingly, this type of control could be designed as part of an unfolding narrative. For example, if a student's avatar is dressed in a manner inconsistent with institution policy, consequences should be accurately and concurrently situated within the context of both the virtual and real worlds. Put simply, if professional attire is required when seeing patients in clinic, then the virtual clinic should adhere to the same rules.

One can imagine how lessons in professional conduct related to character appearance and behavior could be further situated in a number of contexts. For example, should players in the virtual world fail to adhere to expected personal protective precautions, they may have a significant exposure, leading to illness. In this way, a violation of policy becomes another facet of learning rather than a punitive consequence related to the inexperience of a novice learner.

Clearly, the importance of activities, contexts, narratives, and characters as facets or elements of an ecology for culturally competent design are dynamic. Readers should view learning in the virtual world as game play. Successful game play will provide a basis for activities to occur in a situated context that lends meaning to the characters participating in an authentic narrative.

ADVANTAGES TO VIRTUAL REALITY AND WEB-BASED LEARNING

Virtual reality and video game-based learning opportunities solve some of the conundrums associated with fixed learning spaces like traditional nursing and mannikin-based simulation laboratories. This is not to say that virtual reality environments are better than other teaching

modalities. Rather, advancements in media technology increasingly allow educators to customize and integrate virtual reality and game-based learning into nursing and other types of clinical curricula. It is essential that educators learn to use the pedagogical approach that best meets student needs and curricular objectives. In this sense, pedagogical primacy should be dynamic to best prepare students for the transition to professional practice while instilling the value of lifelong learning on their journey from novice to expert.

Online and virtual reality learning environments may be able to address problems associated with learning in a fixed time and space. Virtual spaces simply exist in time and space. Within reason, students can be allowed to access virtual spaces at their convenience. Students can take advantage of vetted just-in-time learning when time is no longer a fixed barrier. While many programs are now adopting mobile mannikin-based simulation laboratories, distance continues to be a limiting factor associated with providing traditional simulation-based education. The flexibility of the virtual world moves clinical educational models toward concepts consistent with adult learning, such as self-reliance and autonomous learning (Merriam & Caffarella, 1999).

Although there is a cost associated with designing or changing the purpose of virtual environments for clinical education, it may be significantly less than mannikin-based simulation laboratories. Consider that introductory high-fidelity mannikin-based simulators often cost more than \$30,000, while more sophisticated models can cost well over \$100,000. This does not take into account related costs associated with space allocation, other equipment, and personnel needed to authentically situate a physical environment. One can easily understand how a modest fixed location or mobile simulation center could cost well over \$1 million to build and successfully integrate into clinical curricula.

Game-based and virtual reality environments use the benefits of technology to provide learners with important opportunities that otherwise may not be available. Simulation-based learning environments can offer consistent, safe experiences for students throughout a curriculum and over time (Friedrich, 2002; Gordon et al., 2004; Lane et al., 2001; Shapiro & Simmons, 2002; Ziv et al., 2003). Learning spaces existing in virtual reality offer an important addition and opportunity for clinical education. This observation is not unique to virtual reality simulation learning (Seymour et al., 2002); it is a strong and consistent argument for simulation-based learning in general (Gould & Bauman, in press).

Virtual learning spaces provide a higher degree of malleability and versatility than fixed spaces. A number of virtual-world and gaming platforms exist whose original purpose can be changed to include clinical education. These options ought to be explored as we gain a better understanding of how nursing instructors and others can use virtual worlds most effectively in ways that promote the transfer of knowledge and desired behavioral change.

VIRTUAL REALITY AND TRUE MULTIDISCIPLINARY LEARNING AND PRACTICE

The terms *clinical practice* and *clinician* have been liberally used throughout this chapter. These terms have been used with deliberate intent. Clinicians and clinical educators in different professions including, but not limited to, nursing and medicine are often educated in the absence of one another. Nursing students and medical students rarely inhabit the same learning environments at the same time and are largely isolated from one another in clinical settings. A careful review of textbooks intended for different health sciences students will yield a large degree of duplication. All undergraduate nursing students must learn how to complete a history and physical examination, as do medical students, physician assistant students, and advanced practice nursing students. Furthermore, all of these clinicians will eventually share the same clinical space with overlapping and interdependent practices.

Perhaps one of the most difficult transitions for clinicians is the first step from student to professional practitioner. This is not to imply that graduating students should enter their professions as experts, but, rather, novice clinicians should be able to enter their professions with valuable experiences to build on as they attain clinical expertise. When nursing students and other health sciences students are largely segregated from each other as they are learning their professions, how can we expect them to work well together or even understand each other's roles in actual practice? Yet the reluctance to provide multidisciplinary education across the health sciences persists.

The landmark 1999 report *To Err is Human* estimated that between 44,000 and 98,000 patients die annually in the United States as a direct result of medical error (Kohn, Corrigan, & Donaldson, 1999). System

failures and human factors are most often responsible for error-related morbidity and mortality (Leape et al., 1991). Technical competency in the absence of behavioral skill related to communication and crisis management will not mitigate these tragedies. Yet today the clinical professions continue to struggle with the enormous professional, monetary, and emotional cost of human error. We must find better ways to prepare clinicians for practice. It has become apparent that caregivers must work together to mitigate clinical errors (Leape, 2009). To work effectively together as caregivers, students must learn together throughout their academic preparation.

The virtual environment may provide an ideal platform for expanding the boundaries of multidisciplinary education. The anonymity of virtual worlds may provide the impetus to overcome barriers that promote segregated education. In the video game *America's Medic: Zero Hour*, who is playing the game is irrelevant. The transfer of knowledge from the game to the player is not artificially privileged. Students across multiple disciplines are free to learn from the game. The concepts of triage or crisis management are not specific to any profession; they are clinically agnostic. A game or virtual world does not privilege itself, nor does it care who inhabits it. The relevance of game play is more dependent on good game design than it is on who designed the game or who is playing the game. Environments that focus on the elements of culturally competent educational design (activities, contexts, narratives, and characters) can be created to include designed experiences with interactions and activities representing different facets of situated relevance across disciplines.

CONCLUSION

The environment in which the clinical components of nursing are taught has changed dramatically in the past 10 years. As educators, we are reminded of the importance of translational education that adequately prepares nurses and other clinicians for the actual environments that they will work in. We continue to look for objective evidence to demonstrate that students have acquired a variety of technical and behavioral skills and competencies.

Technical skills are sometimes the easiest to teach and evaluate, whether using traditional methods of instruction or technology such as

simulation. The dynamics of health care have dramatically changed the way we learn and practice nursing. Student opportunities for meaningful clinical placement have become more limited and more competitive. We often struggle to adequately prepare students for real-world clinical practice. Graduate nurses and those with new advanced practice credentials are entering a practice field that is extremely complex and dynamic.

Today's nurses must accept a tremendous amount of personal responsibility and liability. Fortunately, they are well positioned to take advantage of educational strategies that use technology for personal and professional gain. Nursing leaders and educators must come to understand that many traditional models of nursing education are no longer adequate or even appropriate to teach the complex skills and competencies demanded of today's health care professionals. Virtual reality-based clinical education is already being integrated into a variety of health sciences curricula. As the fidelity and availability of emerging technology increases, virtual reality is likely to become a standard in nursing education.

SUMMARY

Virtual reality and game-based clinical education represents a paradigm shift in teaching pedagogy for many nursing and other health sciences instructors. Virtual reality and game-based environments take advantage of contemporary media technology. Although many instructors may be hesitant to embrace this technology, it is important to know that many, if not most, of today's students approach learning with a high degree of media and technology literacy. Many students are not only proficient and comfortable with technology like Web-based and virtual reality learning, they have come to expect it as part of discipline-specific curricula such as nursing.

Virtual reality and game-based learning environments provide highly malleable environments that can be customized to promote specific clinical content that is simply not available in real-world clinical settings. A variety of task-oriented virtual reality simulators are already being used for discipline-specific instruction such as surgical training and psychomotor-specific procedural nursing practice skills such as intravenous cannulation. The number of virtual reality task trainers will only increase as visual and haptic fidelity increases and costs decrease.

However, virtual reality and game-based learning environments also can be developed that may excel in the promotion of nontechnical or behavioral skills, which arguably are just as important as the technical skills that many associate with clinical practice. Further, virtual environments reduce some of the barriers associated with traditional mannikin-based simulation, such as time, location, and cost.

This chapter discussed various traditional and contemporary theories that support learning in virtual environments. Several theories embracing reflective learning and practice were discussed. In addition, other contemporary learning theories specific to virtual and game-based learning environments were introduced, explored, and discussed. These theories included socially situated cognition and identity, designed experiences, and ecology of culturally competent educational design in virtual worlds. The importance of activities, contexts, narratives, and characters were stressed not only as a benchmark for culturally competent educational design but also as essential to providing translational experiences to facilitate the progression of student to clinician and provide an impetus for lifelong learning.

While this chapter advocated the use of technology that supports virtual reality and game-based learning environments, it emphasized the need to choose pedagogical methods, including mannikin-based simulation and traditional didactic learning to best meet curricula objectives and students' needs. Nurse educators must recognize that some traditional teaching strategies may no longer be feasible or appropriate in today's ever-changing and technology-laden clinical environments.

Finally, the chapter urged teachers and educational leaders to rethink and embrace multidiscipline teaching among the clinical health sciences and proposed that virtual environments may be well suited for multidisciplinary education. Virtual reality and game-based learning environments are not discipline-specific. Virtual environments do not know or care who is occupying them. The transfer of available knowledge need not and should not be privileged by clinical discipline.

The use of technology, including virtual reality and game-based learning, is likely to become even more prevalent throughout clinical education. The key to its successful inclusion in curricula is integration rather than addition. In other words, the use of technology for the sake of technology that has not been well thought out and designed is likely to be frustrating for teachers and learners alike. This chapter has provided insight into how and why virtual reality and game-based learning can be integrated into the clinical curriculum.

Exhibit 9.4

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES**1. Facilitate Learning**

- A. Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 3. desired learner outcomes
- B. Use teaching strategies based on
 - 1. educational theory
- C. Modify teaching strategies and learning experiences based on consideration of
 - 1. cultural background
- D. Use information technologies to support the teaching-learning process
- I. Create opportunities for learners to develop their own critical thinking skills

2. Facilitate Learner Development and Socialization

- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- H. Encourage professional development of learners

6. Engage in Scholarship, Service, and Leadership

- A. Function as a Change Agent and Leader
 - 2. Integrate a long term, innovative, and creative perspective into the academic nurse educator role.
 - 5. Participate in interdisciplinary efforts to address health care and education needs
 - a. within the institution
 - b. locally
 - 6. Implement strategies for change within the
 - a. nursing program
 - 8. Promote innovative practices in educational environments
 - 11. Adapt to changes created by external factors
 - 12. Support changes as an early adopter

REFERENCES

- Bartle, R. (2004). *Designing virtual worlds*. Indianapolis, IN: New Riders Games.
- Bauman, E. B. (2007). High fidelity simulation in healthcare (Doctoral dissertation, The University of Wisconsin–Madison, 2007). *Proquest Dissertations and Theses*, Section 0262, Part 0350. (Publication No. AAT 3294196)
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Benner, P., Tanner, C., & Chesla, C. (2009). *Expertise in nursing: Caring, clinical judgment, and ethics*. New York: Springer Publishing.
- Bruner, J. (1991, Autumn). The narrative construction of reality. *Critical Inquiry* 18, 1–20.
- Campbell, S. H., & Daley, K. M. (2009). *Simulation scenarios for nurse educators: Making it real*. New York: Springer Publishing.
- Cooper, J. B., & Taqueti, V. R. (2004). A brief history of the development of mannequin simulators for clinical education and training. *Quality and Safety in Health Care*, 13(Suppl. 1), i11–i18.
- DeVita, M. (2005). Organizational factors affect human resuscitation: The role of simulation in resuscitation research. *Critical Care Medicine*, 33, 1150–1151.
- Flanagan, B., Nestel, D., & Joseph, M. (2004). Making patient safety the focus: Crisis resource management in the undergraduate curriculum. *Medical Education*, 38, 56–66.
- Friedrich, M. J. (2002). Practice makes perfect: Risk-free medical training with patient simulators. *Journal of the American Medical Association*, 288(2808), 2811–2812.
- Gaba, D. M. (2004). The future vision of simulation in health care. *Quality and Safety in Health Care*, 13(Suppl. 1), i2–i10.
- Gaba, D. M., Howard, S. K., Fish, K., Smith, B., & Sowb, Y. (2001). Simulation-based training in anesthesia crisis resource management (ACRM): A decade of experience. *Simulation & Gaming*, 32, 175–193.
- Games, I., & Bauman, E. (in press). Virtual worlds: An environment for cultural sensitivity education in the health sciences. *International Journal of Web Based Communities*.
- Gee, J. P. (1991). Memory and myth: A perspective on narrative. In A. McCabe & C. Peterson (Eds.), *Developing narrative structure* (pp. 1–26). Mahwah, NJ: Erlbaum.
- Gee, J. P. (2003). *What video games have to teach us about learning literacy*. New York: Palgrave Macmillan.
- Gisondi, M. A., Smith-Coggins, R., Harter, P. M., Soltysik, R. C., & Yarnold, P. R. (2004). Assessment of resident professionalism using high-fidelity simulation of ethical dilemmas. *Academic Emergency Medicine*, 11, 931–937.
- Glavin, R. J., & Maran, N. J. (2003). Integrating human factors into the medical curriculum. *Medical Education*, 37(Suppl. 1), 59–64.
- Gordon, J. A., Oriol, N. E., & Cooper, J. B. (2004). Bringing good teaching cases “to life”: A simulator-based medical education service. *Academic Medicine*, 79, 23–27.
- Gould, J., & Bauman, E. (in press). Virtual reality in medical education. In S. Tsuda, D. J. Scott, & D. B. Jones (Eds.), *Textbook of simulation, surgical skills and team training*. Woodbury, CT: Cine-Med.
- Grantcharov, T. P. (2008). Is virtual reality simulation an effective training method in surgery? *Nature Clinical Practice*, 5, 232–233.

- Halamek, L. P., Kaegi, D. M., Gaba, D. M., Sowb, Y. A., Smith, B. C., Smith, B. E., et al. (2000). Time for a new paradigm in pediatric medical education: Teaching neonatal resuscitation in a simulated delivery room environment. *Pediatrics*, *106*, E45.
- Hammond, J. (2004). Simulation in critical care and trauma education and training. *Current Opinion Critical Care*, *10*, 325–329.
- Helmreich, R. L. (2000). On error management: Lessons from aviation. *British Medical Journal*, *320*(7237), 781–785.
- Kinzer, C. K., Cammack, D. W., Labbo, L. D., Teale, W. H., & Sanny, R. (2006). Using technology to (re)conceptualize preservice literacy teacher education: Considerations of design, pedagogy and research. In M. C. McKenna, L. D. Labbo, R. D. Keiffer, & D. Reinking (Eds.), *International handbook of literacy and technology* (Vol. 2). Mahwah, NJ: Erlbaum.
- Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (1999). *To err is human*. Washington, DC: National Academy Press.
- Kolb, D. (1984). *Experiential learning: Experience as the source of learning and development*. Upper Saddle River, NJ: Prentice Hall.
- Lane, J. L., Slavin, S., & Ziv, A. (2001). Simulation in medical education: A review. *Simulation & Gaming*, *32*, 297–314.
- Larew, C., Lessans, S., Spunt, D., Foster, D., & Covington, B. (2006). Innovations in clinical simulation: Application of Benner's theory in an interactive patients care simulation. *Nursing Education Perspectives*, *27*, 16–21.
- Leape, L. L. (2009). Errors in medicine. *Clinica Chimica Acta*, *404*(1), 2–5.
- Leape, L. L., Brennan, T. A., Laird, N., Lawthers, A. G., Localio, A. R., Barnes, B. A., et al. (1991). The nature of adverse events in hospitalized patients: Results of the Harvard Medical Practice Study II. *New England Journal of Medicine*, *265*, 377–384.
- Lee, S. K., Pardo, M., Gaba, D., Sowb, Y., Dicker, R., Straus, E. M., et al. (2003). Trauma assessment training with a patient simulator: A prospective, randomized study. *Journal of Trauma Injury Infection and Critical Care*, *55*, 651–657.
- McLellan, B. A. (1999). Early experience with simulated trauma resuscitation. *Canadian Journal of Surgery*, *42*, 205–210.
- Merriam, S. B., & Caffarella, R. S. (1999). *Learning in adulthood: A compressive guide* (2nd ed.). San Francisco: Jossey-Bass.
- Mezko, B. (2007). *Top 10: Virtual medical sites in Second Life!* Retrieved November 7, 2008, from <http://sciencereoll.com/2007/06/17/top-10-virtual-medical-sites-in-second-life/>
- Murray, D., Boulet, J., Ziv, A., Woodhouse, J., Kras, J., & McAllister, J. (2002). An acute care skills evaluation for graduating medical students: A pilot study using clinical simulation. *Medical Education*, *36*, 833–841.
- Nelson, D. L., & Blenkin, C. (2007). The power of online role-play simulations: Technology in nursing education. *International Journal of Nursing Scholarship*, *4*, 1263–1277.
- Nelson, L., Sadler, L., & Surtees, G. (2005). Bringing problem based learning to life using virtual reality. *Nurse Education in Practice*, *5*, 103–108.
- Nicholson, D. T., Chalk, C., Funnell, W.R.J., & Daniel, S. J. (2006). Can virtual reality improve anatomy education? A randomised controlled study of a computer-generated three-dimensional anatomical ear model. *Medical Education*, *40*, 1081–1087.
- Satava, R. M. (1993) Virtual reality surgical simulator: The first steps. *Surgical Endoscopy*, *7*, 203–205.

- Schitai, A. (2004). Caring for Hispanic patients interactively: Simulations and practices for allied health professionals. *Journal for Nurses in Staff Development* 20, 50–55.
- Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.
- Seropian, M. A. (2003). General concepts in full scale simulation: Getting started. *Anesthesia and Analgesia*, 97, 1695–1705.
- Seymour, N. E., Gallagher, A. G., Roman, S. A., O'Brien, M. K., Bansal, V. K., Andersen, D. K., et al. (2002). Virtual reality training improves operating room performance. *Annals of Surgery*, 236, 458–464.
- Shapiro, M. J., & Simmons, W. (2002). High fidelity medical simulation: A new paradigm in medical education. *Medicine & Health, Rhode Island*, 85, 316–317.
- Skiba, D. J. (2009). Nursing education 2.0: A second look at Second Life. *Nursing Education Perspectives*, 30, 129–131.
- Small, S. D., Wuerz, R. C., Simon, R., Shapiro, N., Conn, A., & Setnik, G. (1999). Demonstration of high-fidelity simulation team training for emergency medicine. *Academic Emergency Medicine*, 6, 312–323.
- Squire, K. (2006). From content to context: Videogames as designed experience. *Educational Researcher*, 35(8), 19–29.
- Squire, K., Giovanetto, L., Devane, B., & Durga, S. (2005). From users to designers: Building a self-organizing game-based learning environment. *Technology Trends*, 49(5), 34–42.
- Taekman, J. M., Segall, N., Hobbs, G., & Wright, M. C. (2007). 3DiTeams: Healthcare team training in a virtual environment. *Anesthesiology*, 107, A2145.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9, 117–125.
- Thiagarajan, S. (1992). Using games for debriefing. *Simulation and Gaming*, 23, 161–173.
- Thom, T., Haase, N., Rosamond, W., Howard, V. J., Rumsfeld, J., Manolio, T., et al. (2006). Heart disease and stroke statistics—2006 update: A report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. *Circulation*, 113, e85–e151.
- Thoman, E., & Jolls, T. (2004). Media literacy: A national priority for a changing world. *American Behavioral Scientist*, 48, 18–29.
- Tsai, S. L., Chai, S. K., Hsieh, L. F., Lin, S., Taur, F. M., Sung, W. S., et al. (2008). The use of virtual reality computer simulation in learning Port-a-Cath injection. *Advances in Health Sciences Education*, 13, 71–87.
- Turkle, S. (1995) *Life on the screen. Identity in the age of the Internet*. New York: Touchstone.
- Wayne, D. B., Butter, J., Siddall, V. J., Fudala, M. J., Wade, L. D., Feinglass, J., et al. (2006). Mastery learning of advanced cardiac life support skills by internal medicine residents using simulation technology and deliberate practice. *Journal of General Internal Medicine*, 21, 251–256.
- Weizenbaum, J. (1966). ELIZA: A computer program for the study of natural language communication between man and machine. *Communications of the ACM*, 9(1), 36–45.
- Woodford, P. (2008). Medicine's not-so-secret Second Life: Public health education thrives in so-called "virtual worlds." *National Review of Medicine* 4(6). Retrieved

November 7, 2008, from http://www.nationalreviewofmedicine.com/issue/2007/03_30/4_advances_medicine_6.html

York, J. W., Stapleton, G., & Sandlow, L. J. (2003). A Web-based core curriculum to meet certification and training needs for medical residents. *Journal for Asynchronous Learning Networks*, 7(2), 96–104.

Ziv, A., Wolpe, P. R., Small, S. D., & Glick, S. (2003). Simulation-based medical education: An ethical imperative. *Academic Medicine*, 78, 783–788.

10

Case Method, Case Study, and Grand Rounds

Clinical practice provides opportunities for students to gain the knowledge and skills needed to care for patients; develop values important in professional practice; and develop cognitive skills for processing and analyzing data, deciding on problems and interventions, and evaluating their effectiveness. Ability to apply concepts and theories to clinical situations, solve clinical problems, arrive at carefully thought out decisions, and provide safe, quality care are essential competencies gained through clinical practice. Case method, case study, and grand rounds are teaching methods that help students meet these learning outcomes. Case method and case study describe a clinical situation developed around an actual or a hypothetical patient for student review and critique. In case method, the case provided for analysis is generally shorter and more specific than in case study. Case studies are more comprehensive in nature, thereby presenting a complete picture of the patient and clinical situation. Grand rounds involve the observation and often interview of a patient or several patients in the clinical setting, through a Webcast of grand rounds conducted elsewhere or a multimedia program.

CASES AND GRAND ROUNDS FOR DEVELOPING COGNITIVE SKILLS

With cases and grand rounds, students can apply concepts and theories to clinical situations, identify patient and other types of problems, propose varied approaches for solving them, weigh them against the evidence, and choose the most appropriate approaches. These methods provide experience for students in analyzing clinical situations and thinking through possible decisions.

Problem Solving

The nursing literature contains various perspectives on problem solving, decision making, critical thinking, and clinical judgment. In general, problem solving is the ability to solve clinical problems, some relating to the patient and others that arise from clinical practice. Problem solving begins with recognizing and defining the problem, gathering data to clarify it further, identifying possible approaches, weighing them against evidence, and choosing the best one considering patient needs and responses (Oermann & Gaberson, 2009).

Viewed as a cognitive skill, problem solving can be developed through experiences with patients, such as in grand rounds, or via simulated cases, such as case method and study. The student does not need to provide hands-on care to develop problem-solving skills. By observing and discussing patients during grand rounds and analyzing cases, students gain experience in understanding patient problems and the clinical situation and deciding on approaches to use. Cases and grand rounds expose students to clinical situations that they may not encounter in their own clinical practices.

In clinical practice, nurses make many important decisions when caring for patients, families, and communities. They decide on data to collect and what they mean, problems and their priority, interventions, resources, and effectiveness of interventions. Tanner (2006) referred to this cognitive process as clinical reasoning: the process of generating different alternatives, weighing them against evidence, and deciding on the most appropriate approach to use. With cases and rounds, students can practice these skills: they can generate possible alternatives, weigh them against evidence, consider the consequences of each, then arrive at a decision following this analysis.

Critical Thinking

Critical thinking enables the nurse to make reasoned and informed judgments in the practice setting and decide what to do in a given situation. It is purposeful and informed reasoning in clinical practice and in other settings (Alfaro-LeFevre, 2008). Critical thinking is a judgment process. Nurses and other clinicians decide what to believe or do in a particular situation based on available evidence and using the knowledge and skills they acquired through their education and practice; that process also involves weighing the likely consequences of different actions and evaluating their effectiveness (Facione & Facione, 2008). Critical thinking also can be viewed as reflective thinking about patient problems when the problem is not obvious or the nurse knows what is wrong but is unsure what to do. Through critical thinking, the learner:

- Considers multiple perspectives to care
- Critiques different approaches possible in a clinical situation
- Weighs approaches against evidence and patient responses
- Arrives at sound judgments
- Raises questions about issues to clarify them further
- Resolves issues with a well-thought out approach (Alfaro-LeFevre, 2008; Facione & Facione, 2008; Oermann & Gaberson, 2009; Oermann, Truesdell, & Ziolkowski, 2000)

Clinical Judgment

Tanner (2006) developed a model of clinical judgment in nursing that incorporates concepts of problem solving, decision making, and critical thinking. In this model, clinical judgment involves interpreting a patient's needs and problems and deciding on actions and approaches, taking the patient's responses into consideration. The clinical judgment process includes four aspects: (1) noticing, grasping the situation; (2) interpreting, understanding the situation in order to respond; (3) responding, deciding on actions that are appropriate or that no actions are needed; and (4) reflecting, being attentive to how patients respond to the nurse's actions.

This model provides a framework for guiding students' reflections of how they think about clinical situations, interpret them, and arrive at decisions. In simulated cases, students can describe what they would expect to find in the clinical situation in the case (noticing), the meaning of the

data in the case, and appropriate interventions or why they would take no action. In grand rounds, students can observe a patient's responses to actions and reflect on how they influence subsequent decisions. The model provides a framework for coaching students in how they think about clinical situations.

CASE METHOD AND STUDY

Case method and case study serve similar purposes in clinical teaching; they provide a simulated case for student review and critique. In case method, the case provided for analysis is generally shorter and more specific than in case study.

Case Method

In case method, short cases are developed around actual or hypothetical patients followed by open-ended questions to encourage students' thinking about the case. Short cases are used to avoid directing students' thinking in advance (Oermann, 2008). Depending on how the case is written, case method is effective for applying concepts and other types of knowledge to clinical practice and for promoting development of cognitive skills. With cases, students can analyze patient data, identify needs and problems, and decide on the best approaches in that situation after weighing the evidence. Cases also assist students in relating course content to clinical practice and integrating different concepts and theories in a particular clinical situation. Examples of case method are presented in Exhibit 10.1.

Case Study

A case study provides an actual or hypothetical patient situation for students to analyze and arrive at varied decisions. Case studies typically are longer and more comprehensive than in case method, providing background data about the patient, family history, and other information for a more complete picture. For this reason, students can analyze case studies in greater depth than with case method and present a more detailed rationale for their analysis. In their critique of the case study, students can describe the concepts and theories that guided their analysis, how they used them in understanding the case, and the literature they reviewed. Examples of case studies are presented in Exhibit 10.2.

Exhibit 10.1

EXAMPLES OF CASE METHOD

Mrs. F has moderate dementia. She lets the nurse practitioner do a pelvic examination because she has a “woman’s problem.” The examination shows an anterior wall prolapse. While helping Mrs. F to get dressed, the nurse practitioner observes that, as soon as the patient stands up, urine begins leaking onto the floor. Mrs. F appears embarrassed.

1. List and prioritize Mrs. F’s problems. Provide a rationale for how the problems are prioritized.
2. Develop a plan of care for Mrs. F.

Your patient is admitted from the Emergency Department with severe headache, right-sided weakness, and aphasia. Her temperature is normal, pulse 120, respirations 16, and blood pressure 180/120.

1. What are possible reasons for these symptoms? Provide an explanation for your answer.
2. What additional data would you collect on admission to your unit? Why is this information important to planning the patient’s care?

Mrs. B, 29 years old, is seen for a prenatal checkup. She is in her 24th week of pregnancy. The nurse practitioner notes swelling of the ankles and around Mrs. B’s eyes. Mrs. B has not been able to wear her rings for a week because of swelling. Her blood pressure is 144/96.

1. What are possible problems Mrs. B might be facing? List all possible problems given the above information.
2. What additional data should be collected at this time? Why?

You are working in a pediatrician’s office. Mrs. C brings her son in for a check-up after a severe asthma attack a month ago that required emergency care. When you ask Mrs. C how her son is doing, she begins to cry softly. She tells you she is worried about his having another asthma attack and this time not recovering from it. When the pediatrician enters the examination room, Mrs. C is still crying. The physician says, “What’s wrong? Look at him. He’s doing great.”

1. What would you say to Mrs. C, if anything, in this situation?
2. What would you say to the pediatrician, if anything?

You have a new patient, 81 years old, with congestive heart failure. The referral to your home health agency indicates that Mr. A has difficulty breathing, tires easily, and has edema in both legs, making it difficult for him to get around. He lives alone.

1. What are problems you anticipate for Mr. A? Include a rationale for each of these problems.

At your first home visit, you find Mr. A sitting in a chair with his feet on the floor. During your assessment, he gets short of breath talking with you and has to stop periodically to catch his breath.

(continued)

1. Describe at least three different nursing interventions that could be used in Mr. A's care.
2. Specify outcome criteria for evaluating the effectiveness of the interventions you selected.
3. What would you teach Mr. A?
4. Select one of your interventions and review the evidence on its use. What are your conclusions about the effectiveness of the intervention?
5. Identify one published research study that relates to Mr. A's care. Critique the study and describe whether you could use the findings in caring for Mr. A and similar patients.

Mrs. M is a 42-year-old elementary school teacher with a history of inflammatory bowel disease. She calls the clinic for an appointment because of diarrhea that has lasted for 2 weeks. The nurse answering the phone tells Mrs. M to stop taking all of her medications until she is seen in the clinic.

1. Do you agree or disagree with the nurse's advice to Mrs. M? Why?

You have been working in the clinical agency for nearly 6 months. Recently you noticed a colleague having difficulty completing his assignments on time. He also has been late for work on at least three occasions. Today you see him move from one patient to the next without washing his hands.

1. What are your options in this situation?
2. Discuss possible consequences of each option.
3. What would you do? Why is this the best approach?

As you record a patient's vital signs in the electronic medical records, she asks you to show the computer screen to her husband so he can read about the diagnoses they are ruling out.

1. What would you say to this patient?
2. What principles guide your decision? Provide a rationale for your response.

Mrs. J brings her 8-year-old daughter, Laura, into the office for her annual visit. In reviewing the immunization record, the nurse notices that Laura never received the second dose of the MMR vaccine. The nurse tells the mother not to worry; Laura can get the second dose when she is 11 or 12 years old.

1. Do you agree or disagree with the nurse's advice to the mother? Provide a rationale for your decision.

Read the following statements: One in three adults and one in five adolescents are overweight. Being overweight is prevalent among certain racial and ethnic groups.

1. What additional information do you need before identifying the implications of this statement for your community?
2. Why is this information important?

The heart failure clinic at your hospital has been effective in reducing the number of readmissions, but, to save costs, the hospital is closing it. As the nurse practitioner in that clinic, write a report about why the clinic should remain open, with data to support your position. To whom would you send that report and why? Then write a report from the perspective of the hospital administration supporting closure of the clinic.

Exhibit 10.2

EXAMPLE OF CASE STUDY

Mary, 44 years old, is seen in the physician's office with hoarseness and a slight cough. During the assessment, Mary tells the nurse that she also has shortness of breath, particularly when walking fast and going up the stairs. Mary has never smoked. Her vital signs are: blood pressure 120/80; heart rate 88 beats per minute; respirations 32 per minute; and temperature 36.6° C (97.8° F).

Mary is married with two teenage daughters. She works part-time as a substitute teacher. Mary has always been health conscious, watching her weight and eating properly. She tells the nurse how worried she is because she has read about women getting lung cancer even if they never smoked.

1. The physician orders a combined PET/CT scan. What is a PET/CT scan, and why was it ordered for Mary?
2. What would you say to Mary prior to the scan to prepare her for it?

A few weeks later, Mary is diagnosed with lung adenocarcinoma.

1. What treatments are used for this type of cancer?
2. Select one of those treatments, explain what it is, and describe the standard nursing care for patients receiving it.
3. Add data about Mary and her family to the above case. Modify your care plan to reflect Mary's individual needs at this time.
4. What resources are available in your community for Mary?

It is now 3 months after the initial diagnosis. Finish this case study by describing Mary's condition and your nursing care for her.

Using Case Method and Case Study in Clinical Courses

Short cases, as in case method, and longer case studies can be integrated in clinical courses throughout the curriculum to assist students in applying concepts and knowledge they are learning in their courses to clinical situations of increasing complexity. In beginning clinical courses, teachers can develop cases that present problems that are relatively easy to identify and require standard nursing interventions. At this level, students learn how to apply concepts to clinical situations and think through them. Students can work as a group to analyze cases; explore different perspectives of the case, what students noticed about it, and their interpretations; and discuss possible approaches to use.

In the beginning, the teacher should “think aloud,” guiding students through the analysis, pointing out significant aspects of the case and his or her own expectations and interpretations. By thinking aloud, the

teacher can model the clinical judgment process step by step through a case. As students progress through the curriculum, the cases can become more complex with varied problems and approaches that could be used in the situation.

Students can analyze cases in a postclinical conference, as an independent activity, or online either individually or in small groups. They can share resources they used to better understand the case. If cases are analyzed individually, further discussion about the case can occur with the clinical group as a whole, or students can post their thoughts and responses online for others to reflect and comment on.

Based on the questions asked about the case, cases can be used to meet many different learning outcomes of a clinical course. For example, if the goal of the case is to guide students in interpreting data, then questions might ask students to identify significant information in the situation and explain what the data mean. Cases are effective as an instructional method, and they also can be graded similar to essay items.

Complexity of Cases for Review

Cases may be of varying levels of complexity. Some cases are designed with the problems readily apparent. With these cases, the problem is described clearly, and sufficient information is included to guide decisions on how to intervene. Nitko and Brookhart (2007) called these cases well structured: They provide an opportunity for students to apply knowledge to a clinical situation and develop an understanding of how it is used in practice. Cases of this type link knowledge presented in class, online, and through readings to practice situations. With well-structured cases, there usually is one correct answer that students can identify based on what they are currently learning in the clinical course or learned in previous courses and experiences.

Well-structured cases are effective for students beginning a clinical course in which they have limited background and experience. These cases give students an opportunity to practice their thinking before caring for an actual patient.

Most patient care situations, however, are not that easily solved. In clinical practice, the problems sometimes are difficult to identify, or the nurse may be confident about the patient's problem but unsure how to intervene. These are problems in Schön's (1990) swampy lowland, ones that do not lend themselves to resolution by a technical and rational approach. These are cases that vary from the way the problems and

solutions were presented in class and through readings. For such cases, the principles learned in class may not readily apply, and clinical judgment is required for analysis and resolution.

Nitko and Brookhart (2007) referred to these cases as ill structured, describing problems that reflect real-life clinical situations faced by students. With ill-structured cases, different problems may be possible; there may be an incomplete data set to interpret; or the need and problem may be clear, but multiple approaches may be possible. Exhibit 10.3 presents examples of a well-structured and an ill-structured case.

Developing Cases

Case method and study have two components: a case description and questions to answer about the case or its analysis. In case method, the situations described are typically short and geared to specific outcomes

Exhibit 10.3

WELL-STRUCTURED AND ILL-STRUCTURED CASES

Well-Structured Case

Mrs. D, 53 years old, reports having bad headaches for the last month. The headaches occur about twice weekly usually in the late morning. Initially, the pain began as a throbbing at her right temple. Her headaches now affect either her right or left eye and temple. The pain is so severe, she usually goes to bed. Mrs. D reports that her neck hurts, and the nurse notes tenderness in the posterior neck on palpation.

1. What type or types of headache might Mrs. D be experiencing?
2. Describe additional data that should be collected from Mrs. D. Why is this information important to deciding what is wrong with Mrs. D?
3. Select two interventions that might be used for Mrs. D. Provide evidence for their use.

Ill-Structured Case

Ms. J, 35 years old, calls for an appointment because she fell yesterday at home. She has a few bruises from her fall and a tingling feeling in her legs. Ms. J had been at the eye doctor's office last week because of double vision.

1. What do you think about this patient?
2. What are possible problems that Ms. J might be experiencing?
3. Plan additional data to collect to better understand those problems and explain why that information is important.

to be met. Case studies include background information about the patient, family history, and complete assessment data to provide a comprehensive description of the patient or clinical situation.

The case should provide enough information for analysis without directing the students' thinking in a particular direction. The case may be developed first, then the questions, or the teacher may draft the questions first, then develop the case to present the clinical situation. Once students have experience in analyzing cases, another strategy is for students to develop a case scenario based on data provided by the teacher. In this method, students need to think about what patient needs and problems might fit the data, which promotes their critical thinking.

The questions developed for the case are the key to its effective use. The questions should be geared to the outcomes to be met. For instance, if the intent of the case method or study is for students to analyze laboratory data, apply physiological principles, and use concepts of pathophysiology for the analysis, then the questions need to relate to each of these. Similarly, if the goal is to improve skill in responding to clinical situations, then the questions should ask about possible actions to take for the situation, including no immediate intervention, and evidence to consider in deciding on actions. With most cases, questions should be included that focus on the underlying thought process used to arrive at an answer rather than the answer alone.

Cases can be written for the development of specific cognitive skills. In designing cases to promote problem solving, the teacher should develop a case that asks students to:

- Identify patient and other problems apparent or expected in the case
- Suggest alternative problems that might be possible if more information were available and identify the information needed
- Identify relevant and irrelevant information in the case
- Interpret the information to enable a response
- Propose different approaches that might be used
- Weigh approaches against the evidence
- Select the best approaches for the case situation
- Provide a rationale for those approaches
- Identify gaps in the literature and evidence as related to the case
- Evaluate the effectiveness of interventions
- Plan alternative interventions based on analysis of the case

An example of a case for problem solving is:

Ms. G, a 56-year-old patient admitted for shortness of breath and chest pain, is scheduled for a cardiac catheterization. She has been crying on and off for the last hour. When the nurse attempts to talk to her, Ms. G says, “Don’t worry about me. I’m just tired.”

1. What is one problem in this situation that needs to be solved?
2. What assumptions about Ms. G did you make in identifying this problem?
3. What additional information would you collect from the patient and her medical records before intervening? Why is this information important?

Other cases can provide experience with making decisions about clinical situations. A case may present a clinical situation up to the point of a decision, then ask students to analyze the case and arrive at a decision. Or the case may describe a situation and decision, then ask whether students agree or disagree with it. For both of these types, the questions should lead the students through the decision-making process, and students should include a rationale for their responses.

For decision making, the teacher should develop a case that asks students to:

- Identify the decisions needed in the case
- Identify information in the case that is critical for arriving at a decision
- Specify additional data needed for a decision
- Examine alternative decisions possible and the consequences of each
- Arrive at a decision and provide a rationale for it

An example of a case intended for decision making is:

The charge nurse on the midnight shift in a large hospital assigns a nurse new to the unit to work with Ms. P, an experienced RN. Ms. P, however, is irate that she needs to orient a new nurse when she is so busy herself. Ms. P tells the new nurse that she is too busy to work with her tonight. When learning this, the charge nurse reassigns the new nurse to another RN.

1. Do you agree or disagree with the charge nurse’s decision? Why?
2. Describe at least two strategies you could use in this situation. What are advantages and disadvantages of each?
3. How would you handle this situation?

Exhibit 10.4

STRATEGIES FOR DEVELOPING CASE STUDIES FOR CRITICAL THINKING*Develop cases that:*

Present an issue for analysis, a question to be answered that has multiple possibilities, or a complex problem to be solved.

Have different and conflicting points of view.

Present complex data for analysis.

Present clinical situations that are unique and offer different perspectives.

Describe ethical issues and dilemmas.

Ask students to:

Analyze the case and provide a rationale for the thinking process they used for the analysis.

Examine the assumptions underlying their thinking.

Describe the evidence on which their reasoning was based.

Describe the concepts and theories they used for their analysis and *how* they applied to the case.

Analyze the case from their own points of view and then analyze the case from a different point of view.

Analyze the data and draw possible inferences given the data.

Specify additional information needed and why it is important.

Analyze the clinical situation, identify multiple perspectives possible, and examine assumptions made about the situation that influenced thinking.

Propose alternative approaches and consequences.

Weigh alternatives and arrive at a decision. Critique an issue from a different point of view.

Case method and case study also meet critical thinking outcomes. There are a number of strategies that teachers can use when developing cases that are intended for critical thinking. These are listed in Exhibit 10.4.

An example of a case for critical thinking is:

You are a nurse practitioner working in a middle school. Ms. S, a 16-year-old, comes to your office for nausea and vomiting. She says she feels

“bloated.” She confides in you that she is pregnant and asks you not to tell her parents.

1. What are your options at this time?
2. What option would you choose to implement? Why?
3. Choose another option that you listed for question 1. What are the advantages and disadvantages of that approach over your first choice?

Cases also can be written with the intent to promote clinical judgment skills. Using Tanner’s (2006) model of clinical judgment, cases can ask students to:

- Describe what they notice in the clinical situation that demands attention
- Explain the clinical situation based on their prior and current learning
- Interpret the meaning of the data
- Suggest possible courses of action, if any, that would be appropriate
- Provide a rationale for taking no action or to support the proposed actions
- Hypothesize how patients might respond to each of those actions
- Reflect on their own thinking and decisions

An example of a case for this purpose is:

You make a home visit to an 86-year-old patient who lives alone and is having problems concentrating, loss of memory, crying spells, and fatigue. You recommend a follow-up visit with the primary care physician. The patient is diagnosed with depression and treated with a selective serotonin reuptake inhibitor. Two weeks later, you visit the patient and learn she still has fatigue and now also has loss of appetite and difficulty sleeping.

1. What do you notice in this situation?
2. Provide alternative explanations for the patient’s current symptoms of fatigue, loss of appetite, and difficulty sleeping.
3. Discuss the case with a peer and compare interpretations. Decide on next steps to be taken by the home health nurse.

Unfolding Cases

A variation of case study is unfolding cases in which the clinical situation changes, thereby creating a simulation for students to analyze. Ulrich

and Glendon (2005) proposed writing three paragraphs. The first paragraph sets the context of the case, including background information about the patient and others, a description of the clinical situation, and questions for discussion by students. After the initial analysis of the case by the students, the next paragraph is revealed, changing the scenario in some way. Students then critique the new information and answer related questions. After reading the last paragraph, students complete a reflective writing exercise in which they project future learning needs and share individual feelings and reactions to the case. Unfolding cases also can be used in staff development (Ulrich & Glendon, 2002).

GRAND ROUNDS

Grand rounds involve the observation and often interview of a patient or several patients in the clinical setting, a Webcast of grand rounds conducted elsewhere, or a multimedia program of the grand rounds. Grand rounds provide an opportunity to observe a patient with a specific condition, discuss assessment and interpretation of data, and propose interventions and changes in the plan of care. Rounds are valuable for examining issues facing patients, families, and communities and for exposing students to situations they may not encounter in their clinical experiences. Grand rounds may involve nursing students and staff members only or be interdisciplinary.

Nursing grand rounds also can be used for staff education. Gittens, Guilfoile, and Longo (2007) described nursing grand rounds at Cincinnati Children's Hospital Medical Center. The objective of the grand rounds is to bring up-to-date information in monthly educational sessions to nurses worldwide. Their grand rounds are available live in the classroom, via the intranet and Internet; by videotape; and on public access television. They also can be done by independent study via the intranet and Internet. Other settings use grand rounds for highlighting nurses' clinical expertise and promoting best practices (Iacono, 2008).

Rather than conducting rounds in the clinical setting, faculty members may decide to use Webcasts of grand rounds that are available. For example, Public Health Grand Rounds is a series of Webcasts that present case studies on public health issues (North Carolina Institute for Public Health, 2009). These would be valuable for use in a community health nursing course.

Grand rounds enable students to:

- Identify patient problems and issues in a clinical situation
- Evaluate the effectiveness of nursing and interdisciplinary interventions
- Share clinical knowledge with peers and identify gaps in their own understanding
- Develop new perspectives about the patient's care
- Gain insight into other ways of meeting patient needs
- Think critically about the nursing care they provide and that given by their peers
- Dialogue about patient care and changes in clinical practice with peers and experts participating in the rounds

Sedlak and Doheny (2004) described a clinical teaching strategy that uses peer review during student-led rounds to promote critical thinking. At the end of each clinical day, groups of three to four students conduct walking rounds in place of a postclinical conference. Students describe briefly important physical and psychosocial assessment data, nursing diagnoses, interventions, and outcomes while other students listen. They then introduce their patients to the group of students, if possible. After leaving the patient's room, students ask questions and discuss the patient's care, identifying areas needing further clarification.

Regardless of whether the rounds are conducted in the clinical setting or viewed on a Webcast, the teacher should first identify the outcomes that students should meet at the end of the rounds. The outcomes guide the teacher in planning the rounds and their focus. Second, it should be clear why the particular patient or clinical situation was selected for grand rounds. Third, the questions asked after rounds should encourage students to think critically about the patient and care, compare this case to the textbook picture and other patients for whom students have cared, and explore alternative interventions and perspectives of the situation. The final area of discussion should focus on what students have learned from this experience and new insights they have gained about clinical practice. Students might write a short paper reflecting on their learning and new perspectives.

Grand rounds may be conducted by an advanced practice nurse, a staff nurse, the teacher, a student, or another health care professional. For student-led rounds, the teacher is responsible for confirming the plan with the patient. Patients should be assured of their right to refuse

participation and should be comfortable to tell those involved in the rounds when they no longer want to continue with it.

For grand rounds in the clinical setting, activities at the patient's bedside should begin with an introduction of the patient to the students, emphasizing the patient's contribution to student learning. If possible, the person conducting the rounds should include the patient and family in the discussion, seeking their perspective of the health problem and input into care. The teacher's role is that of consultant, clarifying information and assisting the student in keeping the discussion on the goals set for the rounds. Students should direct any questions to the teacher prior to and after the grand rounds, and sensitive issues should be discussed when the rounds are completed and out of the patient's presence.

SUMMARY

Case method and case study describe a clinical situation developed around an actual or hypothetical patient for student review and analysis. In case method, the case is generally shorter and more specific than in case study. Case studies are more comprehensive in nature, thereby presenting a complete picture of the patient and clinical situation.

With these clinical teaching methods, students apply knowledge to practice situations, identify needs and problems, propose varied approaches for solving them considering evidence, decide on courses of action, and evaluate outcomes. As such, case method and study provide experience for students in thinking through different clinical situations.

Grand rounds involve the observation of a patient or several patients in the clinical setting, in a Webcast, or in a multimedia program. Grand rounds may be conducted for nursing students and staff only or as an interdisciplinary activity. Rounds provide an opportunity to observe a patient with a specific condition, review assessment data, discuss interventions and their effectiveness, and make changes in the plan of care. Rounds also are valuable for examining issues facing patients and discussing ways of resolving them. Grand rounds, similar to case method and study, provide an opportunity for exploring patient problems and varied courses of action, analyzing care and proposing new interventions, and gaining insight into different clinical situations.

Exhibit 10.5

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES**1. Facilitate Learning**

- A. Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- B. Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education
- D. Use information technologies to support the teaching-learning process
- G. Model reflective thinking practices
- H. Model critical thinking
- I. Create opportunities for learners to develop their own critical thinking skills
- O. Use knowledge of evidence-based practice to instruct learners

2. Facilitate Learner Development and Socialization

- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective

3. Use Assessment and Evaluation Strategies

- E. Use a variety of strategies to assess and evaluate learning in these domains
 - 1. cognitive
 - 2. psychomotor
 - 3. affective

REFERENCES

- Alfaro-LeFevre, R. (2008). *Critical thinking and clinical judgment: A practical approach to outcome-focused thinking* (3rd ed.). St. Louis, MO: Saunders.
- Facione, N. C., & Facione, P. A. (Eds.). (2008). *Critical thinking and clinical reasoning in the health sciences: An international multidisciplinary teaching anthology*. Millbrae, CA: California Academic Press.
- Gittens, P., Guilfoile, J., & Longo, A. (2007). Spreading our wings around the world: Online nursing grand rounds independent study. *Journal of Pediatric Nursing*, 22, 151.

- Iacono, M. (2008). Showcasing nursing talent: Nursing grand rounds. *Journal of Peri-Anesthesia Nursing*, 23, 349–354.
- Nitko, A. J., & Brookhart, S. M. (2007). *Educational assessment of students* (5th ed.). Upper Saddle River, NJ: Pearson Education.
- North Carolina Institute for Public Health. (2009, March 24). *Public health grand rounds*. Retrieved July 11, 2009, from <http://www.publichealthgrandrounds.unc.edu/>
- Oermann, M. H. (2008). Using short cases for teaching “thinking” in a nursing course. In N. C. Facione & P. A. Facione (Eds.), *Critical thinking and clinical reasoning in the health sciences: An international multidisciplinary teaching anthology* (pp. 123–129). Millbrae, CA: California Academic Press.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- Oermann, M. H., Truesdell, S., & Ziolkowski, L. (2000). Strategy to assess, develop, and evaluate critical thinking. *Journal of Continuing Education in Nursing*, 31, 155–160.
- Schön, D. A. (1990). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.
- Sedlak, C. A., & Doheny, M. O. (2004). Critical thinking: What’s new and how to foster thinking among nursing students. In M. H. Oermann & K. T. Heinrich (Eds.), *Annual review of nursing education* (Vol. 2, pp. 185–204). New York: Springer Publishing.
- Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education*, 45, 204–211.
- Ulrich, D. L., & Glendon, K. J. (2002). Managers forum. Unfolding case study instruction. *Journal of Emergency Nursing*, 28, 246–247.
- Ulrich, D. L., & Glendon, K. J. (2005). *Interactive group learning: Strategies for nurse educators* (2nd ed.). New York: Springer Publishing.

11

Discussion and Clinical Conference

Discussions with learners and clinical conferences provide a means of sharing information, developing critical thinking skills, and learning how to collaborate with others in a group. Discussion is an exchange of ideas for a specific purpose; clinical conference is a form of group discussion that focuses on some aspect of clinical practice. Teachers and students engage in many discussions in planning, carrying out, and evaluating clinical learning activities. Similarly, there are varied types of clinical conferences for use in teaching. Effective conferences and discussions require an understanding of their goals, the types of questions for encouraging exchange of ideas and higher-level thinking, and the roles of the teacher and students.

DISCUSSION

Discussions between teacher and student, preceptor and orientee, and nurse manager and staff occur frequently but do not always promote learning. Often these discussions involve the teacher telling the learner what to do or not to do for a patient. Discussions, though, should be an exchange of ideas through which the teacher, by asking open-ended questions and supporting learner responses, encourages students to arrive at

their own decisions or to engage in self-assessment about clinical practice. Discussions are not intended to be an exchange of the teacher's ideas *to* the students. In a discussion, both teacher and student actively participate in sharing ideas and considering alternative perspectives.

Discussions give learners an opportunity to interact with one another, critique each other's ideas, and learn from others. For that reason, discussions are an effective method for promoting critical thinking. The teacher can ask open-ended and thought-provoking questions, which encourage higher-level thinking if students perceive that they are free to discuss their own ideas and those of others involved in the discussion. The teacher is a resource for students, giving immediate feedback and further instruction as needed. Discussions also provide a forum for students to explore feelings associated with their clinical practice and simulation experiences, clarify values and ethical dilemmas, and learn to interact in a group format. Those outcomes are not as easily met in a large group setting. Over a period of time, students learn to collaborate with peers in working toward solving clinical problems.

Creating a Climate for Discussion

An important role of the teacher is to develop a climate in which students are comfortable discussing concepts and issues without fear that the ideas expressed will affect the teacher's evaluation of their performance and subsequent clinical grade. Similarly, discussions between preceptor and orientee and between manager and staff should be carried out in an atmosphere in which nurses feel comfortable to express their own opinions and ideas and to question others' assumptions. Discussions are for formative, not summative, evaluation; they provide feedback to learners individually or in a small group to guide their learning and thinking. Without this climate for exchanging ideas, though, discussions cannot be carried out effectively, because students fear that their comments may influence their clinical evaluation and grade—or, for nurses, their performance ratings.

The teacher sets an atmosphere in which listening, respect for others' comments and ideas, and openness to new perspectives are valued. Learners need to be free to discuss their ideas with the teacher, who can guide their critical thinking through careful questioning. Without support from the teacher, students will not participate freely in the discussion; nor will they be willing to examine controversial points of view, critique different perspectives of care and decisions, or share misunderstandings

with the teacher and peers. To facilitate students' learning in the clinical setting, faculty members need to create an environment of mutual respect (Wolff, 2007).

Studies on teacher effectiveness highlight the importance of this interpersonal relationship between teacher and students. Conveying confidence in students and their ability to perform in clinical practice, demonstrating respect for students, being honest and direct with them, and encouraging students to ask questions and participate freely in discussions are important characteristics of effective clinical teaching. In a study by Gignac-Caille and Oermann (2001) of effective clinical teaching behaviors, the 10 most important characteristics identified by nursing faculty members were related to developing positive interpersonal relationships with students and teaching skills. Considering the many demands on students as they learn to care for patients, students need to view the teacher as someone who supports them in their learning. Providing support to students is a critical role of clinical teachers (Manias & Aitken, 2005).

Guidelines for Discussion

Discussions can be face to face in the clinical setting or conducted online. They can be carried out individually with learners or in a small group. The size of the group for a discussion can range from 2 to 10 people. Any larger group makes it difficult for each person to participate.

The teacher is responsible for planning the discussion to meet the intended outcomes of the clinical course or specific goals to be achieved through the discussion. An effective teacher keeps the discussion focused; avoids talking too much, with students in a passive role; and avoids side-tracking. While the teacher may initiate the discussion, the interaction needs to revolve around the students, not the teacher. Rephrasing students' questions for them to answer suggests that the teacher has confidence in students' ability to arrive at answers and provides opportunities to develop critical thinking skills. Open-ended questions without one specific answer encourage critical thinking among both students and nurses (Oermann, Truesdell, & Ziolkowski, 2000).

The teacher also should be aware of the environment in which the discussion takes place. For discussions that are held face to face with students, chairs should be arranged in a configuration that encourages interaction, such as a circle, semicircle, or U shape. For some discussions, students may be divided into pairs or other small groups.

Exhibit 11.1

ROLES OF TEACHER AND STUDENT IN DISCUSSION*Teacher*

Plans discussion

Presents problem, issue, case for analysis

Develops questions for discussion

Facilitates discussion with students as active participants

Develops and maintains atmosphere for open discussion of ideas and issues

Monitors time

Avoids side-tracking

Provides feedback

Student

Prepares for discussion

Participates actively in discussion

Works collaboratively with group members to arrive at solutions and decisions

Examines different points of view

Is willing to modify own view and perspective to reach group consensus

Reflects on clinical experience and simulation

Identifies implications for own practice and development

Teacher and Student

Summarize outcomes of discussion and learning.

Identify implications of discussion for other clinical situations.

Exhibit 11.1 summarizes the roles of the teacher and students in clinical discussions.

Listed below are guidelines for planning a discussion and effectively using it with students in clinical practice:

- Identify the outcomes and goals to be achieved in the discussion considering the time frame.
- Plan questions for structured discussions ahead of time. They may be written for the teacher only or also for students. If not

written, the teacher should think about the questions to ask, their order, and important content to discuss prior to beginning the interaction.

- Plan *how* the discussion will be carried out. Will all students in the clinical group participate, or will they be divided into smaller groups or pairs, then share the results of their individual discussions to the clinical group? Will the discussion be held in the clinical setting or conducted online?
- Sequence questions according to the desired outcomes of the discussion.
- Ask open-ended questions that encourage multiple perspectives and different lines of thinking.
- Think about how the questions are phrased before asking them.
- Ask questions to the group as a whole or ask for volunteers to respond. If questions are directed to a specific learner, be sensitive to his or her comfort in responding and do not create undue stress for the student. If this occurs, the teacher should provide prompts or cues for responding.
- Wait a few seconds between the question and request for students to answer it during face-to-face interactions.
- Give students time to answer the questions. If no one responds, the teacher should try rephrasing the question.
- Reinforce students' answers, indicating why they were or were not appropriate for the question.
- Give nonverbal and verbal feedback to encourage student participation without overusing it.
- Avoid interrupting the learner, even if errors are noted in the line of thinking or information.
- Correct students' errors in thinking when they are finished answering the question. It is critical that the teacher give feedback to students and correct their errors without belittling them. The goal is to focus on the answer and errors in reasoning, not on the student.
- Listen carefully to students' responses and make notes to remember points made in the discussion. The teacher should tell students ahead of time that any notes are for use only during the discussion, not for student evaluation or other purposes. The notes should be destroyed so students are assured of their freedom to respond in discussions.
- Assess own skill in directing discussions and identify areas for improvement.

Discussions may begin with questions raised by the teacher or by students, or discussions may be integrated with other instructional methods, such as case scenarios, simulations, games, role-play, and media clips. Case scenarios, for instance, may be critiqued and then discussed by students in a clinical conference, either as part of the clinical practicum or online at a later time. Or students may play a game and complete a role-play exercise, followed by discussion. Media clips provide an effective format for presenting a clinical situation for analysis and discussion.

Purposes of Discussion

In a discussion, the teacher has an opportunity to ask carefully selected questions about students' thinking and the rationale used for arriving at decisions and positions about issues. Discussions promote several types of learning depending on the goals and structure:

1. Development of problem-solving, critical thinking, and clinical judgment skills
2. Debriefing of clinical experiences and following simulations
3. Development of cooperative learning and group process skills
4. Assessment of own learning
5. Development of oral communication skills

Every discussion will not necessarily promote each of these learning outcomes. The teacher should be clear about the intent of the discussion so it may be geared to the particular outcomes to be achieved. For instance, discussions for critical thinking require carefully selected questions that examine alternative possibilities and “what if” types of questions. This same type of questioning, however, may not be necessary if the goal is to develop cooperative learning or group process skills.

Development of Cognitive Skills

An important purpose of discussion is to promote development of problem-solving, critical thinking, and clinical judgment skills. Discussions are effective because they provide an opportunity for the teacher to gear the questioning toward each of these skills. Not all discussions, though, lead to these higher levels of thinking. The key is the type of questions

asked by the teacher or discussed among students—questions need to encourage students to examine alternative perspectives and points of view in a given situation and to provide a rationale for their thinking. Exhibit 11.2 presents strategies for directing discussions toward development of higher-level cognitive skills.

In these discussions, students can be given a hypothetical or real clinical situation involving a patient, family, or community to critique and identify potential problems. Students can then discuss possible decisions in that situation, consequences of different options they considered as part of their decision making, and other points of view. Discussions are particularly valuable in helping students analyze ethical dilemmas, consider different points of view, and explore their own values and beliefs.

Exhibit 11.2

DISCUSSIONS FOR COGNITIVE SKILL DEVELOPMENT

Ask students to:

Identify problems and issues in a real or hypothetical clinical situation.

Identify alternative problems possible.

Assess the problem and clinical situation further.

Differentiate relevant and irrelevant information for the problem or issue being discussed.

Discuss their own point of view and others' points of view.

Examine their own assumptions and those of other students.

Identify different solutions, courses of action, and consequences of each.

Consider both positive and negative consequences.

Compare possible alternatives and defend the choice of one particular solution or action over another.

Take a position about an issue and provide a rationale both for and against that position.

Identify their own biases, values, and beliefs that influence their thinking.

Identify obstacles to solving a problem.

Evaluate the effectiveness of interventions and approaches to solving problems.

Debriefing of Clinical Experiences

Discussions provide an opportunity for students to report on their clinical learning activities; describe and analyze the care they provided to patients, families, and communities; and reflect on their practice. In these discussions, students receive feedback from peers and the teacher about their clinical decisions and other possible approaches they could use with their patient's care. Debriefing also provides an opportunity to share feelings about clinical practice and develop support systems for students (Stokes & Kost, 2009). Issues related to patients, staff, and others may be examined by the group.

Debriefing clinical experiences allows students to share feelings and perceptions about their patients and clinical situations in a comfortable environment. In distance education courses, online discussions are critical to provide a way for students to share their experiences with peers, learn about resources from each other that they might use in their own patient care, and keep faculty members apprised of students' experiences (Roehm & Bonnel, 2009). Online discussions in traditional clinical courses can be used to meet these same goals.

Debriefing also occurs after a simulation and is a critical component of simulation. In the debriefing discussion, the teacher and students examine and reflect on the experience. Through this reflection, guided by the teacher, students develop their clinical reasoning and judgment skills (Dreifuerst, 2009). Typically, the educator focuses the debriefing discussions on the intended learning outcomes and goals of the simulation (Jeffries & Rogers, 2007). Debriefing also enables the teacher to identify performance gaps and provide feedback, discussion, and instruction to close those gaps in learning and performance (Rudolph, Simon, Raemer, & Eppich, 2008).

Development of Cooperative Learning Skills

Group discussions are effective for promoting cooperative learning skills. In cooperative learning, students work in small groups to meet predetermined goals (Johnson & Johnson, 2003). Students are actively involved in their learning and foster the learning of others in the group. Stiles (2006) emphasized that, in cooperative learning, the success of the group of students who are working together depends on the success of each student in that group; students are accountable for their own learning as well as how much each person in their group learns. Cooperative

learning activities promote interdependence among the students as well as individual accountability and group processing (DaRos-Voseles, Collins, Onwuegbuzie, & Jiao, 2008).

Discussions using cooperative learning strategies begin with the teacher planning the discussion, presenting a task to be completed by the group or a problem to be solved, developing an environment for open discussion, and facilitating the discussion. Students work cooperatively in groups to propose solutions, complete the task, and present the results of their discussions to the rest of the students. Students can work in pairs or small groups to avoid too large a group for discussion.

Assessment of Own Learning

Discussions provide a means for students to assess their own learning, identify gaps in their understanding, and learn from others in a non-threatening environment. Students can ask questions of the group and use the teacher and peers as resources for their learning. If the teacher is effective in developing an atmosphere for open discussion, students, in turn, will share their feelings, concerns, and questions as a beginning to their continued development.

Development of Oral Communication Skills

The ability to present ideas orally, as well as in written form, is an important outcome to be achieved by students in clinical courses. Discussions provide opportunities for students to present ideas to a group, explain concepts clearly, handle questions raised by others, and refine presentation style. Participation in a discussion requires formulating ideas and presenting them logically to the group.

Students may make formal presentations to the clinical group as a way of developing their oral communication skills. They may lead a discussion and present on a specific topic related to the outcomes of the clinical course. Discussion provides an opportunity for peers and the teacher to give feedback to students on how well students communicated their ideas to others and to improve their communication techniques.

Exhibit 11.3 presents an assessment form that students may use to rate the quality of presentations and provide feedback on ability to lead a group discussion. This form is not intended for summative or grading purposes, but instead is designed for giving feedback to students following a presentation to the clinical group.

Exhibit 11.3

EVALUATION FORM FOR RATING PRESENTATIONS IN CONFERENCES

Name _____

Title of Presentation _____

Rate each of the behaviors listed below. Circle the appropriate number and give feedback to the presenter in the space provided.

Behavior	Rating				
	1 To a limited extent	2	3	4	5 To a great extent
<i>Leadership Role in Conference</i>					
1. Leads the group in discussion of ideas	1	2	3	4	5
2. Encourages active participation of peers in conference	1	2	3	4	5
3. Encourages open discussion of ideas	1	2	3	4	5
4. Helps group synthesize ideas presented	1	2	3	4	5
Comments:					
<i>Quality of Content Presented</i>					
5. Prepares objectives for presentation that reflect clinical goals	1	2	3	4	5
6. Presents content that relates to objectives and is relevant for students' clinical practice	1	2	3	4	5
7. Presents content that is accurate and up to date	1	2	3	4	5
8. Presents content that reflects theory and research	1	2	3	4	5
Comments:					
<i>Quality of Presentation</i>					
9. Organizes and presents material logically	1	2	3	4	5
10. Explains ideas clearly	1	2	3	4	5
11. Plans presentation considering time demands, needs of clinical group, and type of conference (face to face vs. online)	1	2	3	4	5

(continued)

12. Emphasizes key points	1	2	3	4	5
13. Encourages students to ask questions and reflect on responses	1	2	3	4	5
14. Answers students' questions accurately	1	2	3	4	5
15. Supports alternative view-points and encourages their discussion	1	2	3	4	5
16. Is enthusiastic	1	2	3	4	5
Comments:					

Level of Questions

The level of questions asked in any discussion is the key to directing it toward the intended learning outcomes. In most clinical discussions, the goal is to avoid a predominance of factual questions and focus instead on higher-level and open-ended questions. Teachers can use a framework such as Bloom's taxonomy to sequence questions in a discussion or can level those questions in a more general way, beginning with recall (low level) and progressing through clarifying to critical thinking (high level).

The taxonomy of the cognitive domain, related to knowledge and intellectual skills, was developed by Bloom (Bloom, Englehart, Furst, Hill, & Krathwohl, 1956) many years ago but is still of value today for developing test items and for leveling questions. Learning in the cognitive domain includes the acquisition of facts and specific information, concepts and theories, and higher-level cognitive skills (Oermann & Gaberson, 2009). The cognitive taxonomy includes six levels that increase in complexity: knowledge, comprehension, application, analysis, synthesis, and evaluation. Because these levels are arranged in a hierarchy, recall of specific facts and information is the least complex level of learning, and evaluating clinical situations and making judgments is the most complex.

The cognitive taxonomy is useful in asking questions in a discussion or planning questions for student response, because it levels them along a continuum from ones requiring only recall of facts to higher-level questions requiring synthesis of knowledge and evaluation. The teacher may begin by asking students factual questions and then progress to

questions that are answered based on comprehension and understanding, the application of knowledge to clinical practice, analysis, synthesis of material from different sources, and evaluation.

A description and sample questions for each of the six levels of the cognitive taxonomy follow. Sample words for use in developing questions at each level are presented in Exhibit 11.4.

Exhibit 11.4

QUESTION CLASSIFICATION

Level	Types of Questions	Sample Words for Questions
1. Knowledge	<i>Recall</i> Questions that can be answered by recall of facts and previously learned information	Define, identify, list, name, recall
2. Comprehension	<i>Understand</i> Questions that can be answered by explaining and describing	Describe, differentiate, draw conclusions, explain, give examples of, interpret, tell me in your own words
3. Application	<i>Use</i> Questions that require use of information in new situations	Apply, relate, use
4. Analysis	<i>Divide into component parts</i> Questions that ask student to break down material into its component parts, to analyze data and clinical situations	Analyze, compare, contrast, detect, identify reasons and assumptions, provide evidence to support conclusions, relate
5. Synthesis	<i>Develop new ideas and products</i> Questions or directives that ask students to develop new ideas, plans, products	Construct, create, design, develop, propose a plan, suggest a new approach
6. Evaluation	<i>Evaluate</i> Questions that require student to make a judgment based on criteria	Appraise, assess, critique, evaluate, judge, select on basis of

1. Knowledge: Recall of facts and specific information; memorization of facts.
“Define the term percussion.”
“What is this type of dysrhythmia called?”
2. Comprehension: Understanding; ability to describe and explain.
“Tell me about your patient’s shortness of breath.”
“What does this potassium level indicate?”
3. Application: Use of information in a new or novel situation; ability to use knowledge in a new situation.
“Why are these interventions the most effective ones for your patient?”
“Tell me about your patient’s problems and related pathophysiological changes. Why are each of these changes important for you to monitor?”
4. Analysis: Ability to break down material into component parts and identify the relationships among them.
“What are possible reasons for the patient’s adverse events following transfer from the neonatal intensive care unit?”
“What assumptions did you make about this family that influenced your decisions? What are alternative approaches to consider?”
5. Synthesis: Ability to develop new ideas and materials; combining elements to form a new product.
“Tell me about your plan to improve prenatal care for the women who come to your clinic. Why is your plan better than the existing services?”
“Develop a discharge plan for patients after hip replacement.”
6. Evaluation: Judgments about value based on internal and external criteria; evaluating extent to which materials meet predetermined criteria.
“Take a position for or against closing the clinic and shifting patients to the other center. Provide a rationale for your position.”
“What is the impact on patients and families of providing one less home care visit?”

Questions for discussions should be sequenced from low to high level. The taxonomy provides a schema for asking progressively higher-level questions (Profetto-McGrath, Smith, Day, & Yonge, 2004). These

higher-level questions cannot be answered by memory alone and often have more than one answer. Higher-level questions ask students to apply information they have learned to patient care or a clinical scenario, analyze a complex clinical situation, synthesize content, or evaluate options and alternatives.

An example of a progression of questions using the taxonomy follows:

Knowledge: “Define the gate control theory of chronic pain.”

Comprehension: “Explain the physiological mechanisms underlying this theory of pain.”

Application: “Tell me about an intervention you are using for your patient and how its use and effectiveness may be explained by the gate control theory.”

Analysis: “Your patient seems more agitated. What additional data have you collected? What are possible reasons for this response?”

Synthesis: “Develop a pain management plan for your patient now and for his discharge home.”

Evaluation: “You indicated that your patient’s pain continues to increase. What alternative pain interventions do you propose? Why would these interventions be more effective? Describe the evidence you reviewed on these new approaches you are considering for your patient.”

Research suggests that teachers by nature do not ask high-level questions of students. Typically, the questions asked in a discussion focus on recall and comprehension rather than higher levels of thinking (Hsu, 2007; Profetto-McGrath et al., 2004). Although the intent of clinical discussions may be to improve analytical thinking, this goal will not be met with questions that are answered by memorization of facts and specific information. Careful questioning with attention to using higher-level questions encourages students to think critically (Oermann, 2008; Profetto-McGrath et al., 2004).

In a study by Hsu (2007), faculty members asked mainly knowledge and comprehension questions in postclinical conferences. This finding is similar to other research on nurse educators’ use of questions. Bell-Scriber

and Morton (2009) emphasized that, because clinical teachers tend to ask low-level questions, new faculty members need to be taught how to ask questions at higher cognitive levels. In their institute to prepare new clinical faculty in their school of nursing, they have weekly online discussions with new faculty. In those online discussions are prompts that ask faculty to reflect on the level of questions they used with students and how they created a climate for discussion.

Socratic Method

The Socratic method also may be used as a basis for discussion. Socratic questions raise issues for students to consider, require analytical thinking to respond, and promote critical thinking. Socratic thinking allows the student to form connections among ideas (Elder & Paul, 2002). Socratic questions are an effective strategy when students are puzzled about a patient's problem and approaches to use or are faced with a problematic area of thinking.

Socratic questions are open ended, with multiple responses possible. The questions ask students to consider different alternatives and varied points of view and to defend their choices. Usually, no one answer is correct. After exploring these answers with students, the teacher can ask them to make connections to other clinical scenarios and to generalize learning from one patient and clinical situation to others. Examples of connecting questions are:

- “How is your assessment of Ms. J similar to the patient you cared for last week with the same diagnosis?”
- “What patterns do you find in the data?”
- “What are similarities in nursing interventions for Mrs. P and what you learned about in class? In what ways does your nursing care differ and why?”

One outcome of this line of questioning is to increase students' understanding of difficult concepts by having them arrive at a general understanding of a clinical problem and approaches that are applicable to other possible situations. Bowles (2006) suggested that the teacher prepare statements with inaccurate content related to the course. Students are guided to correct the statements, with the teacher discussing their answers using Socratic questioning.

Exhibit 11.5

SOCRATIC QUESTIONS*Clarification Questions*

- Tell me about your patient. What is his or her primary problem?
- Of all your patient's problems, what is the most important one? Why?
- Explain what you mean by _____.

Questions to Probe Assumptions

- Tell me one decision you made today for your patient. Why did you decide on that?
- You appear to be assuming that _____. Why did you make that assumption?
- What assumptions did you make about this patient? The family? Is that always true?

Questions to Probe Reasons

- What are possible reasons for _____?
- Why do you think _____?
- What evidence did you use to guide your thinking?

Questions on Differing Perspectives

- What are other possible interpretations? Perspectives?
- What are alternative approaches that might be used? Why might these be as or more effective than your interventions?
- Describe one other way of interpreting this clinical situation.

Questions on Consequences

- What effect would _____ have on your patient?
- Describe different approaches that could be used and possible results.
- Think about a decision you made today. Now describe one alternative decision and why that might be a good approach.

Another model for using Socratic questions in a discussion is based on a taxonomy by Paul (1993). This model suggests different types of questions a teacher can ask to encourage critical thinking:

- Questions of clarification
- Questions that probe assumptions
- Questions that probe reasons and evidence

- Questions about differing viewpoints or perspectives
- Questions that probe implications and consequences (Elder & Paul, 2002; Paul, 1993)

Exhibit 11.5 provides sample questions in each category that the teacher might use in clinical discussions.

CLINICAL CONFERENCES

Clinical conferences are discussions in which students share information about their clinical experiences, engage in critical thinking about clinical practice, lead others in discussions, and give formal presentations to the group. Some clinical conferences involve other disciplines and provide opportunities to work with other health care professionals in planning and evaluating patient care. Conferences serve the same goals as any discussion: develop problem-solving, critical thinking, and clinical judgment skills; debrief clinical experiences; develop cooperative learning and group process skills; assess own learning; and develop oral communication skills. Guidelines for conducting clinical conferences are the same as for discussion and therefore are not repeated here.

There are many types of clinical conferences. *Preclinical conferences* are small group discussions that precede clinical learning activities. In preclinical conferences, students ask questions about their clinical learning activities, seek clarification about their patients' care and other aspects of clinical practice, and share concerns with the teacher and with peers. Preclinical conferences assist students in identifying patient problems, setting priorities, and planning care; they prepare students for their clinical activities. An important role of the teacher in preclinical conferences is to assure that students have the essential knowledge and competencies to complete their clinical activities. In many instances, the teacher needs to instruct students further and fill in the gaps in students' learning. Preclinical conferences may be conducted on a one-to-one basis with students or as a clinical group.

Postclinical conferences are held at the conclusion of clinical learning activities. Postclinical conferences provide a forum for analyzing patient care and exploring other options, thereby facilitating critical thinking. Postclinical conferences may be used for peer review and critiquing each other's work. They are not intended as substitutes for classroom instruction with the teacher lecturing and presenting new content to students.

A similar problem often occurs with guest speakers who treat the conference as a class, lecturing to students about their area of expertise rather than encouraging group discussion.

Clinical conferences also can focus on ethical and professional issues associated with clinical practice. Conferences of this type encourage critical thinking about issues that students have encountered or may in the future. In these conferences, students can analyze events that occurred in the clinical setting, ones in which they were personally involved or learned about through their clinical experience. A student can present the situation to the group for analysis and discussion. The discussion should focus on varied approaches that might be used and how to decide on the best strategy. “What if” questions are effective for this type of conference.

Students and faculty members alike are often fatigued at the end of the clinical practicum. To actively involve students in postclinical conferences, Glendon and Ulrich (2004) recommended simulations, role-play, storytelling, and writing exercises that the teacher connects to the learning experiences of students. Rather than each student sharing what he or she did in clinical practice, discussions that focus on higher-level learning and critical thinking and that involve each student are more effective.

Debates provide a forum for analyzing problems and issues in depth, analyzing opposing viewpoints, and developing and defending a position to be taken. In a debate, students should provide a rationale for their decisions. Debates developed around clinical issues give students an opportunity to prepare an argument for or against a particular position and to take a stand on an issue.

Setting for Clinical Conferences

Clinical conferences can be face to face in the clinical or academic setting, or they can be conducted online. Hamera and Wright (2004) evaluated the effectiveness of an online clinical conference for students enrolled in their advanced psychiatric mental health nursing course. In their online clinical conferences, students raised important issues about their practice and were involved in the discussions. One disadvantage identified by students was a lack of spontaneity compared to traditional face-to-face conferences.

Another strategy is to combine traditional with online postclinical conferences. After clinical conferences, Hermann (2006) had students continue their reflection on their clinical experience and answer

a question she posted online. She found that students' reflection was more in depth and meaningful in the online discussions than the traditional ones, particularly in relation to their values, empathy, and personal development.

In a study by Cooper, Taft, and Thelen (2004) comparing online and face-to-face clinical conferences, students reported that in online discussions they could participate more and that the conferences were more convenient. Students also reported that online conferences provided more opportunities to reflect on and discuss ethical issues. Students were able to achieve the outcomes of the clinical conferences through their online discussions.

SUMMARY

Discussions are an exchange of ideas in a small group format. Discussions provide a forum for students to express ideas, explore feelings associated with their clinical practice, clarify values and ethical dilemmas, and learn to interact in a group format. Over a period of time, students learn to collaborate with peers in working toward solving clinical problems.

The teacher is a resource for students. By asking open-ended questions and supporting learner responses, the teacher encourages students to arrive at their own decisions and to engage in self-assessment about clinical practice. The teacher develops a climate in which students are comfortable discussing concepts and issues without fear that the ideas expressed will affect the teacher's evaluation of their performance and subsequent clinical grade.

Discussions promote several types of learning: developing higher-level thinking skills; debriefing clinical experiences; developing cooperative learning and group process skills; assessing own learning; and developing oral communication skills. Debriefing following simulation is a critical aspect of using simulation in nursing education. These discussions typically focus on the intended goals of the simulations and guide students' reflection of the experience.

The level of questions asked in any discussion is the key to directing it toward the intended learning outcomes. In most clinical discussions, the goal is to avoid a predominance of factual questions and focus instead on clarifying and higher-level questions. Questions for student response may be leveled along a continuum from ones requiring only recall of facts to higher-level questions requiring synthesis of knowledge and evaluation.

Clinical conferences are discussions in which students analyze patient care and clinical situations, lead others in discussions about clinical practice, present ideas in a group format, and give presentations to the group. Conferences serve the same goals as any discussion. They can be held face to face, online, or through use of other technologies.

Exhibit 11.6

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A. Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- B. Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education
- C. Modify teaching strategies and learning experiences based on consideration of learners
 - 3. past educational and life experiences
- E. Practice skilled oral and written (including electronic) communication that reflects an awareness of self and relationships with learners (e.g., evaluation, mentorship, and supervision)
- F. Communicate effectively orally and in writing with an ability to convey ideas in a variety of contexts
- G. Model reflective thinking practices
- H. Model critical thinking
- I. Create opportunities for learners to develop their own critical thinking skills
- J. Create a positive learning environment that fosters a free exchange of ideas
- O. Use knowledge of evidence-based practice to instruct learners

2. Facilitate Learner Development and Socialization

- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- F. Adapt teaching styles and interpersonal interactions to facilitate learner behaviors
- G. Assist learners to engage in thoughtful and constructive self and peer evaluation

REFERENCES

- Bell-Scriber, M., & Morton, A. (2009). Clinical instruction: Train the trainer. *Nurse Educator*, *34*, 84–87.
- Bloom, B. S., Englehart, M. D., Furst, E. J., Hill, W. H., & Krathwohl, D. R. (1956). *Taxonomy of educational objectives. The classification of educational goals. Handbook I: Cognitive domain*. White Plains, NY: Longman.
- Bowles, D. J. (2006). Active learning strategies...not for the birds! *International Journal of Nursing Education Scholarship*, *3*(1), Article 22. doi: 10.2202/1548-923X.1184
- Cooper, C., Taft, L. B., & Thelen, M. (2004). Examining the role of technology in learning: An evaluation of online clinical conferencing. *Journal of Professional Nursing*, *20*, 160–166.
- DaRos-Voseles, D., Collins, K., Onwuegbuzie, A., & Jiao, Q. (2008). Effect of self-perception on performance of graduate-level cooperative groups in research methodology courses. *Journal of Instructional Psychology*, *35*, 254–259.
- Dreifuerst, K. (2009). The essentials of debriefing in simulation learning: A concept analysis. *Nursing Education Perspectives*, *30*, 109–114.
- Elder, L., & Paul, R. (2002). *The miniature guide to the art of asking essential questions*. Santa Rosa, CA: Foundation for Critical Thinking.
- Gignac-Caille, A. M., & Oermann, M. H. (2001). Student and faculty perceptions of effective clinical instructors in ADN programs. *Journal of Nursing Education*, *40*, 347–353.
- Glendon, K., & Ulrich, D. (2004). Dear Florence: Tips and strategies for faculty. *Nurse Educator*, *29*, 45–46.
- Hamera, E., & Wright, T. (2004). Evaluation of the content and interaction in an online clinical conference for students in advanced psychiatric mental health nursing. *Archives of Psychiatric Nursing*, *18*(1), 4–10.
- Hermann, M. (2006). Technology and reflective practice: The use of online discussion to enhance postconference clinical learning. *Nurse Educator*, *31*, 190–191.
- Hsu, L-L. (2007). Conducting clinical post-conference in clinical teaching: A qualitative study. *Journal of Clinical Nursing*, *16*, 1525–1533.
- Jeffries, P. R., & Rogers, K. J. (2007). Theoretical framework for simulation design. In P. R. Jeffries (Ed.), *Simulation in nursing: From conceptualization to evaluation* (pp. 21–33). New York: National League for Nursing.
- Johnson, D. W., & Johnson, F. P. (2003). *Joining together: Group theory and group skills* (8th ed.). Boston: Pearson.
- Manias, E., & Aitken, R. (2005). Clinical teachers in specialty practice settings: Perceptions of their role within postgraduate nursing programs. *Learning in Health and Social Care*, *4*, 67–77.
- Oermann, M. H. (2008). Ideas for postclinical conferences. *Teaching and Learning in Nursing*, *3*, 90–93.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- Oermann, M. H., Truesdell, S., & Ziolkowski, L. (2000). Strategy to assess, develop, and evaluate critical thinking. *Journal of Continuing Education in Nursing*, *31*, 155–160.
- Paul, R. W. (1993). *Critical thinking: How to prepare students for a rapidly changing world*. Santa Rosa, CA: Foundation for Critical Thinking.

- Profetto-McGrath, J., Smith, K. B., Day, R. A., & Yonge, O. (2004). The questioning skills of tutors and students in a context based baccalaureate nursing program. *Nurse Education Today*, 24, 363–372.
- Roehm, S., & Bonnel, W. (2009). Engaging students for learning with online discussions. *Teaching & Learning in Nursing*, 4, 6–9.
- Rudolph, J. W., Simon, R., Raemer, D. B., & Eppich, W. J. (2008). Debriefing as formative assessment: Closing performance gaps in medical education. *Academic Emergency Medicine*, 15, 1010–1016.
- Stiles, A. S. (2006). Cooperative learning: Enhancing individual learning through positive group process. In M. H. Oermann & K. T. Heinrich (Eds.), *Annual review of nursing education* (Vol. 4, pp. 131–159). New York: Springer Publishing.
- Stokes, L. G., & Kost, G. C. (2009). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (3rd ed., pp. 283–299). St. Louis, MO: Saunders.
- Wolff, A. (2007). Tutoring problem-based learning: A model for student-centered teaching. In L. E. Young & B. L. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment* (pp. 242–278). Philadelphia: Lippincott Williams & Wilkins.

Clinical Teaching
Strategies for
Selected Contexts

SECTION
III

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12

Quality Clinical Education for Graduate Nursing Students at a Distance: One Exemplar

SUSAN E. STONE AND MICKEY GILLMOR-KAHN

Distance education has become a respected and effective method of providing higher education in the United States. A recent survey of higher education institutions reported exponential increases in distance education: over 66% of schools reported offering fully online, partially online, or other distance education courses (Parsad & Lewis, 2008). Allen and Seaman (2008) reported that online enrollments are growing at a substantially faster rate than overall higher education enrollments and that the disciplines with the highest proportion of programs offered entirely online included health careers. Nursing is following the trend. This is reflected in increasing pressure for schools to add distance learning options for nursing students (Gruendemann, 2007). Students choose distance education programs for a variety of reasons, including issues related to distance from, and therefore access to, traditional university programs as well as the convenience of any time, any place learning opportunities. Many distance learning programs operate asynchronously, allowing students to choose what time of the day or week they will participate. This makes distance learning programs especially attractive to adult learners who may be working or raising families or both while furthering their education (Johnson-Talbert, 2009). Several studies have shown that online learning is at least as effective as traditional classroom learning (Legg, Adelman, Mueller, & Levitt, 2007).

But what about clinical education? The content in advanced practice nursing (APN) programs depends heavily on acquiring not only the didactic knowledge base but also a set of necessary clinical skills. Ultimately, students must be able to demonstrate that they can apply the critical thinking process and function as safe, beginning-level practitioners in a clinical environment. This is the segment of their education that cannot be completely taught or learned using computer technologies. This chapter will provide some ideas and examples of how to design and implement an effective clinical education program that fits well with the distance education model, using the master of science in nursing (MSN) program at the Frontier School of Midwifery and Family Nursing (FSMFN) as an exemplar.

The effectiveness of APN education depends on the student being able to acquire clinical skills. This requires the availability of clinical sites and preceptors. It is best if the site is located in or near the student's own community. Although nurse educators have been able to provide didactic education to students who live almost anywhere using Internet technologies, schools typically have had affiliations only with clinical sites located geographically close to their campus.

FSMFN confronted this dilemma in 1989 when it transitioned its nurse-midwifery education program to a completely community-based model. We were challenged to build an effective program with the student's own community used as a classroom. Since that time, FSMFN has graduated more than 1,500 nurse midwives and nurse practitioners representing every state in the United States and seven other countries using a distance education format.

A DESCRIPTION OF FSMFN

FSMFN is a private, nonprofit, nonresidential community-based, distance education graduate school offering master of science in nursing and doctor of nursing practice degrees and postmaster's certificates in specialty areas including nurse-midwife, family nurse practitioner, and women's health care nurse practitioner. The mission of the school is to provide a high-quality education that prepares nurses to become competent, entrepreneurial, ethical, and compassionate nurse-midwives and nurse practitioners who will provide primary care for women and families. Our graduates serve those residing in all areas of the world, with a focus on rural and medically underserved populations. The program is designed

to offer flexibility in graduate education for mature, self-directed adult learners who prefer independent study or who are unable to relocate to existing programs offering the nursing specialties provided by FSMFN. Our graduate program is based on the concept of community-based distance learning. The core concept is that students learn best in their home environment. We strive not only to keep students in the communities that they plan to serve upon graduation, but also to design learning activities that require students to examine the resources and needs of their communities. The community becomes a key learning environment.

Although FSMFN offers an ADN-to-MSN option and a postmaster's doctor of nursing practice program, the following discussion will focus on the MSN and the postmaster's certificate programs. These are the programs that prepare graduates for entry into practice as either a certified nurse-midwife (CNM), a family nurse practitioner (FNP), or a women's health care nurse practitioner (WHCNP).

Students begin their program of study by coming to the Hyden, Kentucky, campus to attend a 4-day orientation called *Frontier Bound*. The orientation includes an introduction to the school and the initial courses, meetings with their advisors, computer and library instruction, and, most importantly, establishing connections with each other as well as with the faculty and staff so that students will not feel isolated when they return home. Students return to their communities, where they complete Web-based courses for Level I, the foundational courses for practice, and Level II, the foundational courses for clinical management. Students interact with each other, faculty, staff, and alumni using the FSMFN Web portal system, named the *Banyan Tree*, for course work, social support, and scholarly inquiry into practice issues. Level III includes an 8-day, on-campus session called *Clinical Bound*, during which students complete courses requiring intensive skill training and verification of beginning clinical skills. Level IV then focuses on clinical practice and the course work that is best suited for learning while in practice. Problem solving and developing independent decision-making skills are integral parts of the clinical practicum.

A challenge in the development of this program was the recruitment of qualified preceptors who were working in clinical sites that are geographically available to distance learners. The first step was to identify potential preceptors in these communities. How could that be done? After much discussion, we concluded that the best person to identify clinical sites in the student's community is the student. Students were given basic guidelines regarding an acceptable preceptor site. The

student then had to identify a preceptor who is certified in the appropriate advanced practice nursing specialty. Amazingly enough, this system of students identifying local preceptors has facilitated the establishment of over 1,500 clinical sites across the United States. The plan worked and has continued to be effective for more than 20 years. Today the same process is used effectively for the nurse-midwifery, family nurse practitioner, and women's health care nurse practitioner program options.

ESTABLISHING THE CLINICAL SITE

Identifying the preceptor is only the first step in a lengthy endeavor to secure quality clinical learning opportunities for each student. The process involves a series of checks and balances designed to assure that students receive the education that they need and that the preceptors' needs for support, guidance in teaching and evaluation, and rewards are met.

The process includes many steps. First the student identifies the preceptor. Preceptors are often identified through the hospital or outpatient settings where the student works, local professional organization lists, word of mouth, an online search, and sometimes through the telephone book. Faculty and staff members assist students in identifying appropriate sites by offering information regarding sites that have been successfully used in the past. We also provide guidance regarding site selection based on the student's interests or past experiences. For example, a midwifery student who has experience only in a high-risk obstetrical setting will be encouraged to seek out a low-risk setting such as a freestanding birthing center. In addition, staff will provide lists of preceptor sites in a specific geographic region that already hold contracts with the school. Students call the preceptor to ask if he or she would be willing to consider precepting a student. If the practitioner is agreeable, the student sends the preceptor's contact information to the school.

The school employs 22 regional clinical coordinators (RCCs) who are the key to providing a quality clinical learning opportunities for the student. RCCs are faculty members who provide the essential link between the clinical site and the school. These are expert, clinical faculty members whose main focus is the evaluation of clinical sites and mentoring of both students and preceptors through the clinical experience. Each RCC covers a specific geographic territory. Most RCCs are part-time faculty members who are expert clinicians in clinical practice in the region that they cover. Other faculty members do RCC work as a

part of their full-time faculty workload. The fact that RCCs live in the region that they cover is an added advantage, because they often know many of the providers and they are aware of the regional issues that affect practice. RCCs are paid on a per-event basis. They receive a per-hour rate for travel and time at a clinical site plus all expenses. They also receive a biweekly fee for each student under their supervision during their clinical experience.

The school has a packet of information describing the role of the clinical preceptor, the clinical experience requirements, a site evaluation report form, and the required contract. The information is sent via the postal service but is also available via the FSMFN Web site.

Upon receiving notification from the student of a potential preceptor, a school staff member immediately sends the preceptor a letter of introduction from the school as well as a preceptor packet. It is important to establish the best way to communicate with each preceptor. Some prefer telephone and some prefer e-mail. The preceptor is asked to complete a site evaluation report that is designed to give the school information about the clinical site, including location, number and type of clinicians, number and types of patients seen at that site, learning activities available for the student, and the type of site (hospital clinic, rural health clinic, freestanding birth center, etc.).

The next step is a preclinical site visit conducted by the RCC. In some cases, the RCC goes to the clinical site to evaluate the practice for its educational potential in preparing nurse-midwifery or nurse practitioner students and to orient the preceptor to the teaching role. The site visit is held on a typical clinical day, providing an opportunity for the RCC to see the practice in action. An additional important component of the preclinical site visit involves the establishment of a relationship between the preceptor and the RCC. The RCC completes the following activities at a preclinical site visit:

- A tour of the physical facilities including the hospital or birth center
- A review of the practice guidelines to confirm that they are current and appropriate
- A review of a sample of patient records completed by the preceptor
- A review, with the preceptors, of all FSMFN policies and materials regarding students and the clinical experience
- An opportunity for the preceptors to ask any questions they may have

Recently, we have been pilot-testing the concept of conducting pre-clinical site evaluations via telephone when an on-site visit is difficult to accomplish due to long distances. The RCC conducts a telephone interview with the preceptor. Topics reviewed include:

- Contact information
- Practice relationships
- Practice assessment
- Student resources
- Documentation

The preceptor then has an opportunity to ask questions about the school and precepting requirements, and the RCC reviews policies, forms, and evaluation requirements. Although it is difficult to gain a thorough understanding of the practice from a phone site evaluation, much information can be obtained, and the RCC and preceptor establish a beginning relationship. This method of preclinical site evaluation is currently being assessed for its effectiveness compared to an on-site visit. If a phone pre-clinical site evaluation was performed, the RCC expands the information gathered when she or he conducts the clinical site visit with the student (see below).

Contractual Arrangements With Clinical Sites

The contract between the school and the clinical site is designed to spell out the responsibilities of each participant. The school has a standard contract that is sent with the information packet. In many cases, the contract is signed and sent back without question. In some cases, the site will send back its own contract and request that the school sign this. In that case, the school and its lawyers review the proposed contract to make sure it meets the school's requirements. This can be a lengthy process. If the student will be participating in clinical experiences in both a clinic and a hospital that are separate entities, then two separate contracts may be required. It is important that the contract address, at the minimum, the following issues:

- That the student will be under the supervision of the preceptor. It should be clear that the preceptor is the faculty member, and there will not be another faculty member from the school on site to supervise the student.

- Both the school and the clinical site carry a program of insurance. FSMFN requires sites to carry at least the same amount of coverage as FSMFN. Certificates of insurance are exchanged by the school and the clinical site as a part of the contractual agreement.
- A bilateral indemnity clause such as the following:
 - SCHOOL will defend, indemnify, and hold the agency harmless from any and all losses, claims, liabilities, damages, costs, and expenses (including reasonable attorney's fees) to the extent caused solely by the negligence of SCHOOL, its agents, employees, or students in connection with this agreement or by any breach or default in the performance of the obligations of SCHOOL hereunder.
 - CLINICAL SITE will defend, indemnify, and hold SCHOOL harmless from any and all losses, claims, liabilities, damages, costs, and expenses (including reasonable attorney's fees) to the extent caused solely by the negligence of the agency, its agents, employees, or students in connection with this agreement or by any breach or default in the performance of the obligations of the agency hereunder.
- Language specifying that the student and RCC have been trained in Health Insurance Portability and Accountability Act (HIPAA) rules and regulations and will abide by the same.
- Language stating that the clinical site and its staff retain full responsibility for the care of its patients; for example, "Nothing in this agreement shall be construed to shift the ultimate responsibility for patient care from the agency, its physicians, and its other health care professionals."

The school employs credentialing coordinators who attend to all the clinical contracts, maintain the credentials of preceptors, and keep track of all other quality checks and balances required by the clinical education. In some cases, the credentialing coordinator must consult with the school's legal counsel regarding contract issues. These credentialing issues can be complex, because we are dealing with students from all 50 states and the military, and regulations are often different from state to state.

FSMFN students are not allowed to provide care at a clinical site until the contract is in place. They may visit the site to observe but are instructed that they may not participate in clinical care until the contract is approved by both the school and the site.

THE PRECEPTOR INTERVIEW

Preceptors should have a face-to-face interview with every student prior to agreeing to the precepting arrangement. Many misunderstandings, including misperceptions about the skills, abilities, and experience of a particular student, can be avoided with good preparation. Prior to meeting with the preceptor, the student sends a clinical skills checklist and current curriculum vita to the preceptor. The clinical skills checklist details the student's prior experience with clinical skills that will be required during the practicum. The student identifies whether he or she has no experience, some experience, or great experience in each skill. In the adult learning model, students bring a wide variety of skills to the learning experience. The skills checklist helps the preceptor to discern a particular student's skill level in different areas.

The FSMFN student then makes an appointment to meet with the preceptor. The purpose of the meeting is for the preceptor to interview the student, explain the logistics of the clinical site, and determine whether there is a good match between the student and the preceptor. The preceptor is encouraged to ask many questions of the student and is given a form to guide the interview. Sample questions may include:

1. Why do you want to be a CNM/FNP/WHCNP?
2. What advanced practice settings have you been exposed to in the past and in what capacity?
3. How do you respond when someone critiques your performance?
4. Tell me why we should agree to precept you?
5. Do you anticipate any constraints on your time when you are in the clinical setting?

The preceptor also informs the student of the responsibilities at this site, including expectations for arrival, dress, and schedule. If there seems to be a good match at the end of the interview, the preceptor completes the preceptor interview form and submits it to the school with a signed agreement stating that the preceptor has agreed to precept this student.

CREDENTIALING OF PRECEPTORS

Once the preceptor agrees to precept the student, the credentialing process begins. Requirements of the process are defined by the school's

accrediting agencies. In the case of FSMFN, these include the American College of Nurse-Midwives Division of Accreditation, the National League for Nursing Accrediting Commission, and the Southern Association of Colleges and Schools. Credentialing is an important process, because students must be assured that they are receiving instruction from qualified faculty members. The preceptors are appointed as clinical faculty members of the school. They must submit their original transcripts, their curriculum vitae, and their licenses to the school.

Most preceptors are not happy about this paperwork, so FSMFN strives to make it as easy as possible. For example, the credentialing coordinator can now check the preceptor's current license in most states through an online search. If the preceptor completes the release form for the original transcript and returns it to the school, the credentialing coordinator completes the transcript request to the preceptor's school of graduation and FSMFN pays the transcript fees.

TEACHING PREPARATION FOR PRECEPTORS

Preceptors who complete preparation for teaching have been found to be better prepared to function effectively in the teaching role (Zahner, 2006). Therefore, FSMSN requires that preceptors complete teaching preparation. They can do this by completing a preceptor training course offered by FSMFN called "Act of Hope; Labor of Love: The Handbook for Precepting Frontier Students." The course is designed as a modular continuing education program and covers such topics as adult learning theory, learning styles, orienting the learner, teaching techniques, tips for successful precepting, evaluation, and dealing with difficulties in clinical teaching. The course can be accessed at <http://www.midwives.org/ActofHope>. Preceptors may also use other available courses developed by other schools and professional organizations.

PRECEPTOR REWARDS

Rewarding preceptors for their work with students is important. Hyrkas and Shoemaker (2007) found that meaningful rewards for preceptors are associated with increased commitment to the role. Rewards can come in many different forms such as faculty appointment, access to library resources, free tuition for continuing education, luncheons,

awards, and access to free university services such as cultural or sports events (Hetzell-Campbell & Hawkins, 2007).

Providing monetary compensation to clinical preceptors has been debated. This has become a contentious issue for some due to the fact that some programs are prohibited from providing monetary compensation by the organizational rules of their parent university (Raisler, O'Grady, & Lori, 2003). At FSMFN, we believe that, when sending students out to distance sites where the preceptor will have primary responsibility for the student's clinical education, some form of preceptor compensation should be considered. Therefore, FSMFN offers preceptors an honorarium for precepting students. If a school cannot offer monetary compensation, other rewards should be considered such as those mentioned above. Preceptors in remote sites often greatly appreciate services such as access to online libraries or online continuing education. Acknowledgement of the critical role of preceptors in teaching students can improve preceptor commitment as well as help preceptors feel valued and appreciated.

FINAL PREREQUISITES TO STUDENTS BEGINNING CLINICAL PRACTICE

All of the above preparatory work for the clinical experience is accomplished during the 12 to 18 months when FSMFN students are completing their Level I and II courses. During Level III, students return to campus for the 8-day Clinical Bound session. Clinical Bound is held eight times each year so that, as students complete Level II at their own pace, they can register to attend Clinical Bound.

Clinical Bound focuses on refining and utilizing the knowledge that students have acquired during their online studies. Students practice physical exam skills, microscope skills, and suturing skills. They also do role-plays and interactive case studies in a classroom with FSMFN faculty members. They use simulators to practice all types of physical exams skills such as Leopold maneuvers and examinations of the heart, lungs, breast, vagina, and prostate as appropriate to the specialty. The pregnant Noelle model allows midwifery students to practice the hand skills necessary to assist a woman in childbirth. They visit the home of Mary Breckinridge and learn more about the history of the Frontier Nursing Service and its meaning to the development of advanced practice nursing in the United States.

During 2007, The FSMFN faculty and staff developed a project that involves using personal digital assistants (PDAs) to enhance clinical practice. The National League for Nursing (2008) has called for nursing to transform the educational process with the goal of educating nurses to use technology to seek and use information at the point of care. The PDA has the potential to allow and encourage students to acquire knowledge by mining data and making decisions at the point in time when they are needed (McLeod & Mays, 2008). In 2008, we received a Health Resources System Administration, Division of Nursing grant that allowed the implementation of the long-awaited PDA project. The grant allowed us to supply PDAs to two Clinical Bound groups. Subsequent groups have been required to purchase PDAs. The PDAs are loaded with software that allows students to access clinical information, including evidence-based resources, directly from their PDAs. The software is free to students whether they were given a PDA or purchase their own PDA. FSMFN also purchased software allowing students to record their clinical experiences, their clinical hours, and their self-evaluations. The students' information is uploaded to a central data site where the RCCs and the preceptors can view it and add comments. Students are oriented to the use of the PDA to access information and collect data during Clinical Bound.

The credentialing coordinators check to make sure students' health records, including required immunizations, are up to date and that they have completed the required online background check prior to starting their clinical experience. Students review the clinical contract with their credentialing coordinator so that they clearly know what the site requirements are.

Students participate in sessions regarding HIPAA and Occupational Safety and Health Administration regulations. They also attend a session called "Transition to Clinical," in which they learn about expectations in the clinical setting; the school's clinical evaluation tools; and the requirements regarding completing daily, weekly, and monthly evaluation tools. At the conclusion of the Clinical Bound experience, students return to their communities equipped with the necessary knowledge and skills to begin their clinical learning activities.

THE STUDENT CLINICAL EXPERIENCE

When students complete Clinical Bound, they are ready to begin their clinical learning activities. A preclinical meeting between the student

and the preceptor should occur prior to the student starting any clinical activity. A substantial amount of time may have elapsed between the preceptor interview and the student completing Clinical Bound. Both student and preceptor need to be brought up to date. During this meeting, the student and preceptor should discuss the following:

1. The student's background, progress through the program, and any special areas identified as needing the attention of the preceptor.
2. A plan for orientation to each clinical setting and any documentation and credentialing that the site requires, such as copies of the nursing license, proof of immunity to rubella or other diseases, hospital identification badge, keys, and so on. Directions to each site and parking information are also helpful.
3. The practice guidelines for the practice. It is desirable for the student to make or purchase a copy to review and carry. If there are no specific written guidelines, the protocol or resources that the preceptor uses should be identified for the student.
4. Appropriate professional attire for the setting or settings.
5. How to communicate with the preceptor if ill or unable to attend clinical learning activities for another urgent reason.
6. Introduction to or description of other providers in the practice and any relevant issues concerning their needs and availability.
7. Any expectations and opportunities for attending staff meetings, case reviews, grand rounds, and so on.
8. Any special considerations in dealing with patients or with hospital, office, or clinic personnel.

Schedule and Assignments

Students start their clinical practice with many different levels of expertise. Some feel confident, and some are anxious. We have found that the following recommendations help students and preceptors begin the experience on solid ground.

- Students begin in the setting with a single preceptor. Although there may be several preceptors at a site, it is best if the student spends a minimum of 2 weeks with one preceptor prior to involvement with another at the site.
- Some observation time should be built into the first few days of clinical learning activities. Even though some students may be eager to jump in and get started, an initial period of observation is

strongly recommended. This helps the student to understand the environment and role expectations of the particular setting.

- Preceptors should bring a clinical schedule to the first meeting, show it to the student, and plan a schedule for the first 3 to 4 weeks. Depending on the structure of the educational program, students may still have course work to complete and, therefore, may need to limit the amount of time spent in the clinical setting. Others will have completed their course work and will be able to make a full-time commitment to clinical practice. It is important to recognize, however, that students are not only performing skills in the clinical setting, but coping with role change and integration of academic knowledge and clinical realities. A full clinical schedule may be too much at the beginning.
- The preceptor should review the student's expectations for the clinical experience. In addition to a review of the requirements of the educational program, this should include what the student wishes to accomplish during her or his time at the site and when she or he hopes to finish.

Length of Clinical Experience

The length of the clinical experience will be defined by both the professional organizations and the educational program. The professional organizations generally suggest between 500 and 600 hours. Most advanced practice nurse programs require more than this minimum. There have been recent discussions among APN leaders about the required number of hours that programs should be requiring students to complete and whether the current guidelines offered by the professional organizations are valid. Research is necessary to identify the length of clinical experience necessary to assure graduates who are safe, beginning-level practitioners (Bray & Koozer-Olson, 2009). At FSMFN, students must meet three goals in order to complete their clinical experience. First, they must complete at least 675 hours; second, they must complete a defined number of clinical learning activities; and, third, they must have a signed statement from their preceptors that they are functioning at the level of a safe, beginning-level clinician. Clinical learning activities are defined for each discipline. The nurse-midwifery students complete the following clinical activities:

- 10 preconception care visits
- 30 new antepartum visits

- 140 return antepartum visits
- 40 labor management experiences
- 40 births (which may include 4 observations)
- 40 newborn assessments
- 20 breast-feeding support visits
- 40 postpartum visits (2 hours to 14 days)
- 30 postpartum visits (2 to 8 weeks)
- 40 common health problems
- 30 family planning visits
- 25 non-postpartum gynecologic visits
- 25 perimenopausal or postmenopausal visits

Some of these categories overlap, and a single visit may count in more than one category.

The family nurse practitioner students must complete 675 hours and the following clinical activities:

- 10 new antepartum visits
- 30 returning antepartum visits
- 50 speculum or bimanual examinations
- 10 newborn exams
- 30 infant or toddler exams
- 30 school-age exams
- 10 adolescent exams
- 300 patient visits for episodic or wellness care
- 150 patient visits for chronic illness care

The women's health care nurse practitioner students must complete 675 hours and the following clinical activities:

- 30 new antepartum visits
- 120 return antepartum visits
- 50 postpartum visits (less than 8 weeks)
- 300 gynecologic care visits
- 100 primary care visits

Not all clinical sites will be able to provide the required number of clinical opportunities in all areas. Some students need to work with more than one preceptor or more than one site or both to complete

the required learning activities. An interview, orientation, and observation period are appropriate expectations at the beginning of learning activities at each new clinical site. At FSMFN, students may not use more than three clinical sites without special permission from their department chair.

Engaging the Student Academically While in the Clinical Setting

FSMFN students must be able to complete the required Level IV course work and complete their clinical learning activities at the same time. This can be challenging. It is imperative that preceptors have a good understanding of what is required of the student. Written materials provided to the preceptor can help to accomplish this goal. It is helpful to provide these via both a paper document and online. We have found that preceptors like the paper version initially so that they can sit down and read through it. Having the document online provides ready access to the information if the preceptor would like to refer to it at some future point when the paper copy is not at hand. In addition to the written material, it is helpful for the school faculty member to explain to the preceptor exactly what is expected of the student upon starting clinical practice. At Frontier, RCCs either talk to or e-mail preceptors (some communicate very well with e-mail, and others prefer the telephone) every 2 to 3 weeks about the student's progress and the expectations of the next few weeks. If students still have significant academic course work pending at the beginning of clinical learning activities, students are expected to do less clinical practice and more course work. For example, they may attend the clinical site 2 to 3 days per week. Later, when the course work is completed, they may carry a full schedule of clinical activities.

Traditionally, nurse-midwifery students at FSMFN have carried a heavy load of clinically related courses during the first months of clinical practice. At the request of students, however, during 2009, a curriculum revision resulted in moving the vast majority of didactic courses to preclinical levels so that students can focus on their clinical experiences during the practicum. While attending clinical learning activities, students are enrolled in clinical courses that include case study presentations using clinical situations they have encountered. Strategies that facilitate student-to-student interactions and faculty-student interactions are critical to learning success (Mancuso-Murphy, 2007). In a distance

learning environment, developing strategies to achieve these interactions takes careful planning.

The faculty at FSMFN has developed assignments that require students not only to use their experiences in the clinical setting to complete learning activities, but to share these experiences with their classmates. For example, midwifery students may interview a pregnant woman regarding her experience of pregnancy and then post the interview in the class forum. Other students respond with thoughtful questions and comments about the interview. Another assignment requires students to present in the course online forum an interesting case that they have seen in their clinical practice. Students choose a person they have cared for who experienced a complication or variation of normal. Variations can include medical or psychosocial issues. They are asked to briefly present the relevant background information: basic identifying information (using initials or a pseudonym to protect the patient's identity) and pertinent historical information. The student describes the complication or variation of normal, its presentation, and any related risk factors present. The student then opens the case for discussion by indicating what question or questions he or she wants respondents to consider. Some examples might include: "Do you agree with the assessment made?" "Do you agree that this situation requires intervention?" "What interventions are appropriate?" All students and faculty members are welcome to comment and participate in the discussion. The presenter is then required to discuss the responses, the actual management, the outcome, and what he or she learned from this situation.

These activities provide a variety of benefits: They supplement student learning. They help students at a distance to maintain contact with the learning community. They provide an outlet for discussion and examination of complex clinical situations with their faculty and fellow students. Faculty members strive to maintain a supportive environment in their course forums so that students feel safe openly discussing their experiences and their questions about the experiences.

Choosing the Precepting Style

Preceptors and students need to communicate well regarding competence, confidence, and commitment so that an appropriate precepting style can be selected. Blanchard's *Styles of Leadership and Developmental Levels* can be very helpful in thinking about choices of precepting styles (Blanchard, 2008). Blanchard described a method of adapting

one's leadership style to the needs of those being led, stating that, as people learn new skills, they proceed through four developmental levels. The developmental level is determined by one's competence (skills and knowledge) and commitment (confidence and enthusiasm). The levels are described as follows:

- D1 Enthusiastic and ready to learn
- D2 Some disillusionment and decreased commitment as they learn that the task is more difficult than they expected
- D3 Learning continues with increased knowledge and skills. Commitment fluctuates from excitement to insecurity
- D4 High level of competence, motivation, and commitment

Leaders should adapt their style of leadership to match the developmental level (Exhibit 12.1). Leadership styles include S1—Directing; S2—Coaching; S3—Supporting; and S4—Delegating (Blanchard, 2008). At FSMFN, we have found that this model works well when precepting students.

Students move through the developmental levels from enthusiastic beginner with little knowledge but high motivation, through intermediate levels of competence and, often, decreased motivation. Eventually they achieve a level of competence where, ideally, both skills and motivation are high. Precepting styles need to adjust to the needs of the student at each level of competence and commitment. Early on, the student needs specific direction, time to observe, and careful coaching.

Exhibit 12.1

MATCHING LEADERSHIP STYLE TO DEVELOPMENTAL LEVEL

Student Developmental Level	Preceptor Leadership Style
D1 Enthusiastic, ready to learn	S1 Directing
D2 Some disillusionment and decreased commitment as task is perceived as more difficult than expected	S2 Coaching
D3 Increasing knowledge and skills. Commitment fluctuates from excitement to insecurity.	S3 Supporting
D4 High level of competence, motivation, and commitment	S4 Delegating

As students progress, the preceptor gives less direction and allows the student more independence while still providing support and encouragement. For specific new skill acquisition, the preceptor reverts to a more directive or coaching style as the situation demands. Cultural and learning style differences may need to be taken into consideration. Some students will be impatient with a request to observe, wanting to jump in right away and perform tasks. Others will be reluctant to step in until they have observed the preceptor's methods and interactions several times. Some students will need to be pushed to apply their knowledge; others will need direction to find the learning available in observation of a skilled practitioner.

Student Evaluation

Evaluating students in the clinical setting is an ongoing challenge for preceptors and the school faculty. Goals of evaluation include identification of student strengths and problem areas as well as documentation of student progress. In addition, evaluation of student competence and commitment can assist the preceptor in selecting an appropriate precepting style. Evaluation in a distance setting has its own challenges. School faculty members must develop working relationships with clinical preceptors who are at a distance. Contact between the school faculty member and the preceptor during the student's clinical experience needs to be timely and consistent. Preceptors need to know how to reach the designated school faculty member for concerns and support. At the same time, teaching and student evaluation can be time-consuming for the preceptor, and the school needs to avoid imposing unnecessary additional reporting burdens. When working at a distance, e-mail communication can be helpful to busy preceptors and faculty members alike, as long as all is going well. When problems arise, there is no substitute for direct communication by telephone and, if necessary, in person.

Various tools have been developed by schools to assist in the evaluation process. The FSMFN believes that student self-evaluation is essential and requires written evaluation and reflection on clinical experiences on a daily basis. This provides a venue for mature self-evaluation, reflection, and plans for improvement. The student's self evaluation is shared with the preceptor, who may comment or add suggestions. Involvement of the preceptor in daily written assessments provides an opportunity for reflection, planning, oversight, and documentation. The form used

to document this daily evaluation is called the Daily Developmental Assessment Tool. While self-identification of areas needing improvement can be stressful for students, we believe that this self-critique is the basis for a mature practitioner's growth and should be fostered by the educational program.

Goals of evaluation include:

- Identification of student strengths
- Identification of areas where the student needs more experience and support
- Identification of serious deficiencies
- Documentation of the strengths and areas for improvement as they are identified
- Documentation of the resolution of problem areas
- Identification of the level of student competence
- Identification of the level of student confidence and commitment
- Assisting the preceptor in selecting an appropriate precepting style as related to the student's developmental level

Documentation of Student Clinical Experiences and Hours

FSMFN also requires a Monthly Developmental Assessment Tool (MDAT), which allows the student and preceptor to review and document the student's progress in a more detailed and specific format. The MDATs describe domains of learning with specific behaviors to be accomplished in each domain. Because four stages are delineated, the student and preceptor are able to see and document student progress toward independence. Both the daily and monthly forms may be viewed at the FSMFN Web site at <http://www.midwives.org/actofhope/7AppendD.shtm>.

As of 2008, all clinical evaluation and record keeping has moved to an online format. Students input all required data in a PDA, which they later transfer electronically to an online data bank. All evaluation forms are uploaded to the system, where the RCC reviews and comments on them to assess overall progress. Student clinical learning activities are similarly documented in the PDA and then uploaded to the system. To validate the number of clinical hours and learning activities, each month, the student prints the documentation of hours and activities, the preceptor cosigns it, and this hard copy is mailed to the RCC. Nurse-midwifery

students also document births in a paper birth log, which is cosigned by the preceptor. In addition, the RCC talks with the student by phone at least every other week during the clinical practicum.

An important piece in the evaluation of the student practicum occurs at a clinical site visit. At the FSMFN, all students routinely receive an on-site, in-person visit from their RCC during their clinical practicum. Ideally, this visit is scheduled midway through the clinical period so that the RCC has an opportunity to assess and support the student and the preceptor, the student does not feel that the visit is a “final exam,” and there is time for remediation if necessary. The purposes of the clinical site visit are to:

- Provide supplemental and formative evaluation of the student’s clinical progress, including documentation in patient records
- Assess the teaching-learning relationship between student and preceptor
- Foster ongoing development of preceptors as instructors
- Provide support and information to the FSMFN student and clinical faculty member

The RCC makes the appointment with the practice director or the student’s primary preceptor, as appropriate, at some time after the student has been in supervised clinical practice. Scheduling site visits is an important issue. The site visit must be scheduled at a time that is mutually agreeable to the student, the preceptor, and the RCC. RCCs often travel long distances to attend a site visit. It is not unusual for air travel to be required. Preceptors need to know this when the visit is being arranged so that they commit completely to that date, knowing that it will not be easy to reschedule.

Written confirmation of the details and plans for the site visit—its date, time, location, and the needed materials—should be sent to both the preceptor and student at least 1 month ahead of time. Patients should be informed that a site visit is planned and given the opportunity to decline participation.

The RCC observes while the student and preceptor see patients in the clinical site. The role of the RCC is one of observer. It is important to be clear that the preceptor is responsible for the care given and for the teaching. The RCC as site visitor may offer advice and praise as appropriate. Comments or suggestions about the care given can be

shared with the student, but it is best if this is done after the day is over or at a lunch break.

Typically, students are quite nervous during a site visit, and the RCC needs to make allowance for that nervousness. After a few patient encounters with the RCC observing, the student usually begins to relax. A few well-chosen words of praise early on can help with this.

Ideally, the clinical site schedule would include a variety of patient types. For nurse-midwifery and women's health care nurse practitioner students, this would include an initial pregnancy or gynecological exam, return prenatal visits at various gestations, postpartum or family planning visits, problem gynecological visits, and well-woman visits. Midwifery students may also be observed assessing newborns. If events allow, the RCC may accompany the student and preceptor as they attend a birth, but this is not a requirement of the site visit due to logistical concerns. For FNP students, observations would include health maintenance visits, acute visits, and chronic visits including follow-up visits with patients of a variety of ages and both genders.

The RCC also plans time to meet separately with the preceptor and with the student; time to tour the facilities, including the hospital or birth center, if applicable; and time to review the nurse-midwifery practice or nurse practitioner guidelines or protocols and student charting from all settings. Scheduled time alone with the preceptor or preceptors provides an opportunity to ask questions; discuss student progress; present any issues or concerns; and receive information about teaching and learning styles, precepting styles, developmental stages, and expectations of the school for clinical faculty members.

The RCC also meets separately with the student and gives feedback regarding charting, clinical skills, and communication skills. Plans for the remainder of the student's clinical practicum are developed with the student and the preceptor.

At the FSMFN, the site visit also provides an opportunity for the student to do a formal case presentation for the RCC. The students are advised of this requirement ahead of time and are provided with guidelines so they can prepare. Nurse-midwifery students are asked to present an intrapartum case. Nurse practitioner students present an interesting case from their clinical experience. The case should include some problematic aspect, which could be psychosocial or medical but should focus on issues that can be managed by the nurse-midwife or nurse practitioner, not simply those requiring referral to medical management.

Site visit reporting is important to educational goals and evaluation. The site visit report should be filed promptly and shared with appropriate faculty members and administrative personnel as well as filed with the student's records at the school. If any significant site or student problems are identified, the RCC consults promptly with the department chair or others as designated by the school.

Evaluation of student charting occurs during the clinical site visit by the RCC. The RCC also reviews charting soon after the student begins clinical learning activities and until the preceptor and the school faculty member agree that the student is charting appropriately. FSMFN requires students to write subjective, objective, assessment, and plan (SOAP) notes on each patient encounter at the time of the encounter. The preceptor reviews the SOAP note and cosigns. The note is then placed in either the chart or a student notebook for review by the RCC at the time of the site visit. Each month, the student uploads to the RCC copies of two SOAP notes from each type of clinical activity (with patient names removed). Although the RCC is not present daily with students in the clinical situation, evaluation of SOAP charting allows the RCC, as well as the preceptor, to see students' thought processes and improve their charting skills while helping them to mature as practitioners.

When reviewing SOAP charting off site, the RCC is able to assess whether students are gathering appropriate data, how they interpret the data, and whether the plans are appropriate to the students' assessment. Despite instruction and practice in SOAP charting during the academic portions of the program, many students still struggle with differentiating data collection (subjective and objective) from interpretation (assessment), and both of these from the plan of care of the patient. Frequently, the SOAP note will have a plan, but no data suggesting that a plan is needed, or the note may show data and even an assessment of a problem, but no plan. Through pointed questions and suggestions, the RCC can help students see the deficiencies in their charting and why complete documentation is important.

Because mature practitioners often do not provide full SOAP charting, the student may not be producing complete SOAP notes. Often students model their charting on what the preceptor does, not recognizing that, for educational purposes, the school requires more documentation. Of course, increasingly, funding sources are also requiring more documentation than in the past. Thorough SOAP notes also can provide the documentation needed for billing purposes. In sites where charting is done by checklists or a computerized database, requiring students to

do some handwritten SOAP notes still allows the preceptor and RCC to assess the student's internal processes of data collection, assessment, and planning.

Diagnosis and Remediation of Learning Difficulties During Clinical Activities

Students in distance education have learning issues just as those in on-site education do. Recognizing them and finding ways to help the student overcome them at a distance present special challenges.

FSMFN has developed a tool for this purpose, which has proven very helpful. When a preceptor, student, or the RCC recognizes a problem, the FSMFN Problem ID Sheet is used. This form may be accessed at the FSMFN Web site at <http://www.midwives.org/actofhope/7AppendD.shtm>

The student and preceptor each fill out a Problem ID Sheet separately, and then get together to discuss their responses and develop a joint Problem ID Sheet. Their joint Problem ID Sheet is then forwarded to the RCC. When both student and preceptor can agree on the problem, its domain, and possible solutions, there may be no need for further intervention. Frequently, simply naming the problem and thinking about solutions together is enough to accomplish the goal.

For example, consider student MS: She told the RCC that she felt the preceptors were "breathing down her neck," didn't allow her to do anything on her own, were treating her like "a baby," and were hypercritical of her care. The preceptors believed that MS didn't understand her role, was haughty and arrogant, did procedures without their supervision, and resented their teaching. They were on the verge of telling her that she couldn't work with their patients any longer.

The RCC recommended they each complete a Problem ID Sheet and then meet to discuss them. Both student and preceptors agreed that there was a communication problem regarding the student's independence and dependence, that MS was very self-critical, and that she was not allowing herself time to learn but expected herself to already be an accomplished practitioner. Through the Problem ID process, the student came to recognize that her role as a student was different from her role as a staff nurse and that supervision and instruction were part of the process rather than a criticism of her skills. The student also acknowledged the preceptors' primary role with the patients and their need to protect both the patients and their practice.

For their part, the preceptors recognized that they were inconsistent in their instructions and expectations of the student. Their previous student had just graduated and was highly accomplished. They initially unconsciously expected MS to have the same skills as the last student at graduation and were frustrated and disappointed to need to give such close and specific direction. Recognizing that MS needed more supervision than the previous student at the end of her clinical experience, they then overcompensated and didn't want to allow MS any decision making at all. This frustrated MS.

Having identified these issues, student and preceptors, with the RCC's guidance, were then able to set a plan in place where the student agreed not to do anything without specific approval of the preceptors. The preceptors in turn agreed to allow her to propose more of the plan of care with each patient.

Discussion with the RCC helped the student recognize that she was not an independent practitioner at that point in her education and that she could allow herself the time to learn without expecting perfection. Expert-to-novice conflicts are common for experienced nurses returning to graduate school, where they are once again beginners (Forbes, 2004). At the same time, the preceptors learned through discussions with the student and the RCC that this student needed clear guidelines regarding expectations and space to form her own plan for discussion with the preceptors. They also became aware that her rapid-fire speech pattern was a cultural difference that did not necessarily mean that she was hostile.

The student then wrote up a Learning Plan (Exhibit 12.2) describing her current view of the problem, the plan for remediation, and a date for another discussion to review the situation. Frequent communication with the RCC helped both the student and preceptors through this transition

Exhibit 12.2

LEARNING PLAN FORMAT

(generated by the student with faculty assistance)

1. Identify the problem.
2. Identify the resources necessary to solve the problem.
3. Set measurable goals.
4. Evaluate goals at least weekly.

period. In the end, communication improved as the result of this intervention, the student was clear about her boundaries in this role, the preceptors recognized the student's current developmental stage, and the student was able to remain in the site to complete her clinical learning activities.

Unresolved Problems: Problem Site Visits and Performance Plans

When the student and preceptors cannot agree on the problem, when one or the other does not believe there is a problem, or when the Problem ID Sheet and Learning Plan process does not produce an improvement in the situation, then further intervention from the school is necessary.

An emergency site visit allows the RCC to assess the situation in person, to facilitate a discussion between the preceptor or preceptors and the student, and, if the problem is in motor skills or knowledge base domains, to observe the student's skills and interactions. In these circumstances, the site visitor will not have the luxury of many weeks of advance planning. Flexibility in scheduling can be crucial, putting pressure on the school to accommodate this requirement. For this type of site visit, the goal is a clear discussion of the student's and the preceptor's views of the situation. The RCC acts as a facilitator for the discussion, helping the preceptor and student communicate the issues and, if possible, develop a plan for remediation.

After discussions with the preceptors and the student, the RCC and department chair draw up a Performance Plan for the student (Exhibit 12.3). It delineates expected behaviors in specific terms and sets deadlines for accomplishment of the goals and a date for review. The content of the Performance Plan should be as specific as possible, and dates for review should be adhered to scrupulously.

Occasionally, when preceptors and students disagree, it can seem impossible to determine the reality of the situation. Sometimes it becomes apparent that the best solution will be to transfer the student to a different site to allow other preceptors to perform an assessment. Occasionally, the student will need to relocate to attend this new clinical site. This is difficult for both the student and the new preceptor, but it can mean the difference between graduation and withdrawal of a student. Preceptors who are willing to take on students with problems for assessment and disposition should be treasured by the school. Their job is formidable. In many situations, however, a skilled preceptor with different expectations and a fresh relationship with the student can help the

Exhibit 12.3

PERFORMANCE PLAN FORMAT**(developed by the faculty member for the student)**

1. Identify the problem.
2. Identify specific behaviors that are expected from the student.
3. Set dates for accomplishment of each behavior.
4. Set evaluation dates.

student overcome ingrained problems identified in the previous clinical site. Occasionally, there has simply been a personality clash between a preceptor and a student, and a fresh start solves the problem.

Rarely, problems cannot be resolved, and the student needs to withdraw from the program. When that happens, excellent documentation of the student's problems becomes critical to help the student understand the problem and to avoid litigation. The careful use of evaluation tools throughout all students' clinical experiences can avoid major problems in these difficult situations.

Closing the Loop on Clinical Evaluation

The clinical practicum must be evaluated at each step of the program. This starts with the preclinical site visit to evaluate the learning environment at the clinical site. Can the site meet the needs of the student? Evaluation continues as the student completes self-evaluations that are reviewed by the preceptor. The monthly evaluation meeting between the student and the preceptor provides a checkpoint where both the student and preceptor can assess the student's overall progress and set new goals for the coming month. Having these evaluations available to the RCC monthly allows the RCC to review the student's progress and the documentation. Having students track their clinical hours and the number of activities completed assures that students receive the necessary number of learning opportunities. The clinical site visit allows the RCC to evaluate the student's progress and the student-preceptor interactions.

When students have completed all of the required clinical hours and clinical learning activities and they are functioning at stage four in all the objectives listed on the Monthly Developmental Assessment Tool,

they are ready to end the clinical practicum. At FSMFN, preceptors are asked to sign a declaration of safety form that states that the student is functioning as a safe, beginning-level practitioner. Preceptors are sent an evaluation tool designed to assess their satisfaction with the RCC's clinical site visit and their overall experience working with the school faculty. Students are asked to evaluate their preceptor, the learning experience at the clinical site, and the RCC. All of these evaluations assist the school in assessing and improving the effectiveness of the clinical education.

SUMMARY

Organizing, supervising, and evaluating the clinical learning activities for distance learners provide challenges for administration, faculty members, clinical preceptors, and students. Good planning and attention to excellent communication can overcome many of the challenges. In fact, it can sometimes offer students and preceptors support that may not occur in a traditional setting where easy communication is assumed. Clarity about preceptor, student, and faculty roles can reduce confusion and anxiety. Programs implementing distance learning must plan for adequate resources that will allow the communication and the necessary travel to clinical sites. Adding the role of a regional clinical coordinator to oversee the clinical practicum has been a critical factor in the success of the programs at FSMFN.

Exhibit 12.4

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A. Implement a variety of teaching strategies appropriate to
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- C. Modify teaching strategies and learning experiences based on consideration of learners'
 - 1. cultural background
 - 2. past clinical experiences

(continued)

- I. Create opportunities for learners to develop their own critical thinking skills
 - N. Develop collegial working relationships with clinical agency personnel to promote positive learning environments
- 2. Facilitate Learner Development and Socialization**
- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
 - G. Assist learners to engage in thoughtful and constructive self and peer evaluation
- 3. Use Assessment and Evaluation Strategies**
- D. Enforce nursing program standards related to admission and progression
 - E. Use a variety of strategies to assess and evaluate learning in these domains
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
 - G. Use existing evaluation tools for assessing clinical practice and educational outcomes
 - J. Implement evaluation strategies that are appropriate to the learner and learning outcomes
 - O. Advise learners regarding assessment and evaluation criteria
 - P. Provide timely, constructive, and thoughtful feedback to learners
- 4. Participate in Curriculum Design and Evaluation of Program Outcomes**
- H. Maintain community and clinical partnerships that support the educational goals

REFERENCES

- Allen E., & Seaman, J. (2008). *Staying the course: Online education in the United States*. Sloan Consortium 2008. Retrieved August 4, 2009, from http://www.sloan.org/publications/survey/pdf/staying_the_course.pdf
- Blanchard, K. (2008). Situational leadership. *Leadership Excellence*, 25(5), 19.
- Bray, C., & Koozer-Olson, K. (2009). Family nurse practitioner clinical requirements: Is the best recommendation 500 hours? *Journal of the American Academy of Nurse Practitioners*, 21, 135–139.
- Forbes, V. J. (2004). From expert to novice: The unnerving transition from experienced RN to neophyte APN. *Journal of Holistic Nursing*, 22, 180–185.
- Grudemann, B. (2007). Distance learning and perioperative nursing. *AORN Journal*, 85, 574–586.

- Hetzel-Campbell, S., & Hawkins, J. (2007). Preceptor rewards: How to say thank you for mentoring the next generation of nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, 19, 24–29.
- Hyrkas, K., & Shoemaker, M. (2007). Changes in the preceptor role: Re-visiting preceptors' perceptions of benefits, rewards, support, and commitment to the role. *Journal of Advanced Nursing*, 60, 513–524.
- Johnson-Talbert, J. J. (2009). Distance education: One solution to the nursing shortage? *Clinical Journal of Oncology Nursing*, 13, 269–270.
- Legg, T., Adelman, D., Mueller, D., & Levitt, C. (2007). Constructivist strategies in on-line distance education in nursing. *Journal of Nursing Education*, 48, 64–69.
- Mancuso-Murphy, J. (2007). Distance education in nursing: An integrated review of on-line nursing students' experiences with technology-delivered instruction. *Journal of Nursing Education*, 46, 252–260.
- McLeod, R., & Mays, M. (2008). Back to the future: Personal digital assistants in nursing education. *Nursing Clinics of North America*, 43, 583–592.
- National League for Nursing Board of Governors. (2008, May). *Position statement: Preparing the next generation of nurses to practice in a technology-rich environment: An informatics agenda*. Retrieved August 1, 2009, from http://www.nln.org/aboutnln/PositionStatements/informatics_052808.pdf
- Parsad, B., & Lewis, L. (2008). *Distance education at degree-granting postsecondary institutions: 2006–07* (NCES 2009–044). Washington, DC: National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education.
- Raisler, J., O'Grady M., & Lori, J. (2003). Clinical teaching and learning in midwifery and women's health. *Journal of Midwifery and Women's Health*, 48, 398–406.
- Zahner, S. (2006). Partnerships for learning population-based public health nursing: Web-delivered continuing education for public health nurse preceptors. *Public Health Nursing*, 23, 547–554.

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13

Using Preceptors as Clinical Teachers and Coaches

As discussed in chapter 4, the preceptor teaching model is an alternative to the traditional clinical teaching model. It is based on the assumption that a consistent one-to-one relationship between an experienced nurse and a nursing student or novice staff nurse is an effective way to provide individualized guidance in clinical learning as well as opportunities for professional socialization (Smedley & Penney, 2009; Stokes & Kost, 2004). Preceptorships have been used extensively with senior nursing students, graduate students preparing for advanced practice roles, and new staff nurse orientees, but they also have been used effectively with beginning nursing students (Gardner & Suplee, 2010; Stokes & Kost, 2004). This chapter discusses the effective use of preceptors as clinical teachers and coaches. The advantages and disadvantages of preceptorships are examined, and suggestions are made for selecting, preparing, evaluating, and rewarding preceptors.

PRECEPTORSHIP MODEL OF CLINICAL TEACHING

A preceptorship is a time-limited, one-to-one relationship between a learner and an experienced nurse who is employed by the health care agency in which the learning activities take place. The faculty member

may not be physically present during the learning activities; the preceptor provides intensive, individualized learning opportunities that improve the learner's clinical competence and confidence. Regardless of learners' levels of education and experience, preceptorships provide opportunities for socialization into professional nursing roles. They also enhance the personal and professional development of the preceptors (Burns & Paterson; Charleston & Happell, 2005; Smedley & Penney, 2009; Stokes & Kost, 2004).

The preceptor model is collaborative (Burns & Paterson, 2005). The teacher is a faculty member or educator who has overall responsibility for the quality of the clinical teaching and learning. The teacher provides the link between the educational program and the practice setting by selecting and preparing preceptors, assigning students to preceptors, providing guidance for the selection of appropriate learning activities, serving as a resource to the preceptor-student pair, and evaluating student and preceptor performance. The preceptor functions as a role model and provides individualized clinical instruction, coaching, support, and socialization for the learner. The preceptor also participates in evaluation of learner performance, although the teacher has ultimate responsibility for summative evaluation decisions (Gardner & Supplee, 2010; Smedley & Penney, 2009; Stokes & Kost, 2004).

USE OF PRECEPTORSHIPS IN NURSING EDUCATION

In academic programs that prepare nurses for initial entry into practice, preceptorships usually are used for students in their last semester, but providing preceptors for beginning students may have even greater benefits. Beginning students may gain from the individual attention of the preceptor and from assignments that help them to expand their basic skills, develop independence, and improve their self-confidence.

Preceptorships frequently are used in graduate programs that prepare nurses for advanced clinical practice, administration, and education roles. At this level, a preceptorship involves well-defined learning objectives based on the student's past clinical, administrative, and teaching experience. The student observes and participates in learning activities that demonstrate functional role components, allowing rehearsal of role behaviors before actually assuming an advanced practice, administrative, or teaching role. The preceptor must be an expert practitioner who can model the role functions of advanced practice nurses, including

decision making, problem solving, leadership, teaching, and scholarship. Chapter 12 includes a discussion of the use of preceptors in a graduate nursing program offered in a distance education format.

In many health care organizations, preceptors participate in the orientation of newly hired staff nurses. Preceptors in these settings act as role models for new staff nurses and support them in their transition into professional practice or socialization into new roles. Preceptors work individually with new staff nurses, but there is wide variation in the scope of the preceptor role. In some settings, the preceptor is a more experienced peer who works side by side with the orientee; in other settings, the preceptor role is more formally that of clinical teacher.

Research findings on the effectiveness of the preceptor teaching model are varied. Generally, studies indicate positive outcomes of students and new staff nurses working with preceptors. Some early studies showed no difference in student performance between students assigned to preceptors and those who were taught according to a traditional clinical teaching model. Some investigators presented anecdotal evidence from preceptors, teachers, and students that preceptorships enhanced student performance. Students who are assigned to preceptors usually report satisfaction due to increased confidence and independence (Stokes & Kost, 2004). However, students also may experience communication and interpersonal problems with their preceptors, and, if these conflicts are not resolved successfully, negative outcomes can result (Mamchur & Myrick, 2003). The decision to use preceptors for clinical teaching should be based on the perceived benefits to students, the educational program, and the clinical staff members after a careful evaluation of the potential advantages and disadvantages.

ADVANTAGES AND DISADVANTAGES OF USING PRECEPTORS

The use of preceptors in clinical teaching has both advantages and disadvantages for the involved parties. Effective collaboration is required to minimize the drawbacks and achieve advantages for the educational program, clinical agency, teachers, preceptors, and students.

Preceptorships hold many potential advantages for preceptors and the clinical agencies that employ them. The presence of students in the clinical environment tends to enhance the professional development, leadership, and teaching skills of preceptors. While preceptors

enjoy sharing their clinical knowledge and skill, they also appreciate the stimulation of working with students who challenge the status quo and raise questions about clinical practice. The interest and enthusiasm of students often is rewarding to nurses who take on the additional responsibilities of the preceptor role (Smedley & Penney, 2009). Students may assist preceptors with research or teaching projects. In agencies that use a clinical ladder, serving as a preceptor may be a means of advancing professionally within the system. The preceptorship model also produces opportunities to recruit potential staff members for the agency from among students who work with preceptors.

The greatest drawback of preceptorships to agencies and preceptors usually is the expected time commitment. Some clinical agencies may not agree to provide preceptors because of increased patient acuity and decreased staff levels, or potential preceptors may decline to participate because of the perception that to do so would add to their workloads. Because of current economic conditions, health care agencies seeking to decrease costs and increase efficiency often make changes in nurses' working conditions, such as increased workloads, decreased number of work hours, decreasing numbers of full-time and increasing numbers of part-time and casual employees, and increased use of technology. These organizational changes often do not facilitate adding the preceptor role to an RN's workload (Gardner & Suplee, 2010, p. 56; Smedley & Penney, 2009; Yonge, Myrick, Ferguson, & Lughana, 2005). In one study, increased workload and the need to produce sufficient billable patient encounters were the most frequently cited reasons for nurse practitioners' declining to precept graduate nursing students (Amella, Brown, Resnick, & McArthur, 2001).

Students who participate in preceptorships enjoy a number of benefits. They have the advantage of working one-on-one with experts who can coach them to increased clinical competence and performance. Preceptorships also provide opportunities for students to experience the realities of clinical practice, including scheduling learning activities on evening and night shifts and weekends in order to follow their preceptors' schedules (Gardner & Suplee, 2010, p. 69). However, following their preceptors' schedules often creates conflicts with students' academic, work, and family commitments. Additionally, a preceptor's patient assignment may not be always appropriate for a student's clinical learning objectives.

Preceptorships offer many advantages for the educational program in which they are used. The use of preceptors provides more clinical

teachers for students and thus more intensive, individualized guidance of students' learning activities. Working collaboratively with preceptors also helps faculty members to stay informed about the current realities of practice; up-to-date clinical information benefits ongoing curriculum development.

Several disadvantages related to the use of preceptors may affect educational programs. Contrary to a common belief, teachers' responsibilities do not decrease when students work with preceptors. Initial selection of preceptors, preparation of preceptors and students, and ongoing collaboration and communication with preceptors and students require as much time or more as the traditional clinical teaching model. The preceptorship model requires considerable indirect teaching time for the development of relationships with agencies and preceptors and the evaluation of preceptors and students. When preceptors are used as clinical teachers, faculty members may be responsible for more students in several clinical agencies and feel uncertain whether students are learning the application of theory and research findings to practice.

SELECTING PRECEPTORS

The success of preceptorships largely depends on the selection of appropriate preceptors; such selection is one of the teacher's most important responsibilities. Most faculty members consider the educational preparation of the preceptor to be important; most academic programs require the preceptor to have at least the degree for which the student is preparing, although insistence on this level of educational preparation does not guarantee that learners will be exposed only to professional role models.

The desire to teach and willingness to serve as a preceptor are important qualities of potential preceptors. Nurses who feel obligated to enact this role usually do not make enthusiastic, effective preceptors. Additional attributes of effective preceptors, according to Gardner and Suplee (2010) and Stokes and Kost (2004), include:

- *Clinical expertise or proficiency, depending on the level of the learner.* Preceptors should be able to demonstrate expert psychomotor, problem-solving, critical thinking, clinical reasoning, and decision-making skills in their clinical practice. Nursing students and new staff nurses need preceptors who are at least proficient

clinicians; graduate students need preceptors who are expert clinicians, administrators, or educators, depending on the goals of the preceptorship.

- *Leadership abilities.* Good preceptors are change agents in the health care organizations in which they are employed. They demonstrate effective communication skills and are trusted and respected by their peers.
- *Teaching skill.* Preceptors must understand and use principles of adult learning. They should be able to communicate ideas effectively to learners and give descriptive positive and negative feedback.
- *Professional role behaviors and attitudes.* Because preceptors act as role models for learners, they must demonstrate behaviors that represent important professional values. They are accountable for their actions and accept responsibility for their decisions. Good preceptors demonstrate maturity and self-confidence; their approach to learners is nonthreatening and nonjudgmental. They welcome questions from learners and do not interpret them as criticisms or judgments about the practice setting or care approach. Flexibility, open-mindedness, enthusiasm about working with students, willingness to work with a diverse population of learners, and a sense of humor are additional attributes of effective preceptors.

The selection of preceptor and setting also should take into account the learner's interest in a specific clinical specialty as well as the need for development of particular skills. The teacher may collaborate with nurse managers to select appropriate preceptors. It is wise not to choose preceptors from newly established units or those with recent high staff turnover.

Potential preceptors for nursing students may be found in any clinical setting that meets the requirements of the nursing education program. The staff development or education department is a good first contact with an agency; some agencies ask that all requests for preceptors for nursing students be directed to a specified staff member who can suggest appropriate matches. Students may be able to suggest good potential preceptors from their work experience as nursing assistants or other unlicensed assistive personnel or from their contacts with nursing staff members in their previous clinical learning experiences. Alumni of the nursing education program are a rich source of potential preceptors;

many of them would like to give back to their alma mater and are flattered to be asked to preceptor students. They can be recruited at alumni association gatherings, by telephone or e-mail, or through an alumni newsletter (Gardner & Suplee, 2010, p. 70). Offering appropriate incentives and rewards to preceptors acknowledges the value of their time and effort and can be an effective recruiting tool at a time when employee benefits may be diminishing. A more complete discussion of rewards for preceptors is included later in this chapter.

PREPARING THE PARTICIPANTS

Thorough preparation of preceptors and students for their roles is key to the success of preceptorships. Teachers are responsible for initial orientation and continuing support of all participants; preparation can be formal or informal.

Preceptor Preparation

Preparation of preceptors may begin with a general orientation, possibly for groups of potential preceptors at the selected agency or for all preceptors working with students from one nursing education program. A preceptorship preparation program acknowledges the need for and commitment to the notion of collaboration in nursing education and supports the learning needs of preceptors to enable them to enact their role effectively and confidently (Smedley & Penney, 2009).

Content of a preceptorship preparation program may include the following information:

- Benefits and challenges of precepting
- Characteristics of a good preceptor
- Principles of adult learning
- Assessment of learner needs
- Clinical teaching methods, including motivating and challenging learners, dealing with difficult learning situations, and when to use coaching techniques
- Evaluation of learning, including how to give effective feedback and use of clinical evaluation tools
- The preceptor's role in developing and implementing an individualized learning contract, if used

- The academic program curriculum structure, framework, and goals (Gardner & Suplee, 2010, p. 70; Smedley & Penney, 2009; Stokes & Kost, 2004)

After preceptors have been selected, they need a specific orientation to their responsibilities. This orientation may take the form of a face-to-face or telephone conference with the teacher; written guidelines may be used to supplement the conference. Exhibit 13.1 is an example of written guidelines for preceptors of graduate nursing students. The conference and written guidelines may include information such as:

- *The educational level and previous experience of the student.* Graduate students need learning activities that build on their previous learning and experience in order to produce advanced practice outcomes. Beginning students may not have developed the knowledge and skill to participate in all of the preceptor's activities. Nurses who have served as preceptors for new staff nurses

Exhibit 13.1

SAMPLE GUIDELINES FOR A PRECEPTOR OF A GRADUATE NURSING STUDENT

The preceptor is expected to:

- Facilitate the student's entry into the health care organization
- Provide the student with an orientation to the organization
- After receiving the student's goals for the practicum, provide suggestions for how these goals can be accomplished
- Assist the student with identifying a project that is consistent with organizational needs and the student's interests, abilities, and learning needs
- Meet with the student at regular intervals to discuss progress on project and achievement of individual and course objectives
- Provide the student with regular feedback regarding his or her performance
- Communicate regularly with the faculty member regarding the student's progress

At the end of the preceptorship, provide a written evaluation of the student's performance related to goal achievement; clinical knowledge and skill; problem-solving and decision-making skills; communication and presentation skills; and interpersonal skills.

may have expectations for nursing student performance that are unrealistically high (Case & Oermann, 2004).

- *How to choose specific learning activities based on learning objectives.* The teacher may share samples of learning contracts or lists of learning activities to guide the preceptor's selection of appropriate activities for the student.
- *Scheduling of clinical learning activities.* A common feature of preceptorships is the scheduling of the student's learning activities according to the preceptor's work schedule. Preceptors should be advised of dates on which students and teachers may not be available because of school holidays, examinations, and other course requirements.
- How and under what circumstances to contact the course faculty member (Gardner & Suplee, 2010, p. 73).

New preceptors have learning needs much like those of students and new staff nurses; supportive role models and coaching are essential to success. In fact, the teacher needs to “precept the preceptor” (Mamchur & Myrick, 2003, p. 194). Preceptor programs for newly hired staff nurses may hold regular meetings of preceptors with staff development instructors and nurse managers to review material such as adult learning principles, teaching and evaluation strategies, and conflict resolution.

Student Preparation

Learners also need to understand the purposes and process of the preceptorship. They need an orientation to the process of planning individual learning activities, an explanation of teacher and preceptor roles, and a review of unit policies specific to student practice. At the beginning of the preceptorship, teachers should clarify evaluation responsibilities and expectations such as dates for learning contract approval, site visits, and conferences with faculty members.

IMPLEMENTATION

Successful implementation of preceptorships depends on mutual understanding of the roles and responsibilities of the participants. The teacher, student, and preceptor collaborate to plan and implement learning activities that will facilitate the student's goal attainment. Key to these

processes is frequent, clear, effective communication among the participants (Gardner & Suplee, 2010, pp. 73–74).

Roles and Responsibilities of Participants

Preceptors

Preceptors are responsible for patient care in addition to clinical teaching of the student. The preceptor is expected to be a positive role model and a resource person for the student. The clinical teaching responsibilities of the preceptor include creating a positive learning climate, including the student in activities that relate to learning goals, and providing feedback to the student and teacher.

Role model behaviors important for preceptors to demonstrate can be classified into four categories:

- **Technical skills**—demonstrates nursing care procedures; operation of equipment unique to that clinical setting; and evidence-based, current nursing practices
- **Interpersonal skills**—uses effective communication techniques with patients and family members; interacts with physicians in a collegial, confident manner; displays appropriate use of humor; demonstrates caring attitude toward patients; gives positive feedback; gives constructive negative feedback
- **Critical thinking**—listens carefully during change-of-shift reports and patient hand-offs and asks pertinent questions about patients' conditions; demonstrates proficient problem solving, decision making, critical thinking, and clinical reasoning
- **Professional role behaviors**—identifies self to patients at first contact, keeps patient information confidential, encourages discussion of ethical issues, demonstrates enthusiasm about nursing, demonstrates accountability for own actions (O'Connor, 2006b, pp. 137–138)

Sometimes preceptors experience conflict between the educator and evaluator roles, especially when precepting new staff members. If the learner is unable to perform according to expectations, the faculty member or staff development instructor must be notified so that a plan for correcting the deficiencies may be established. In one study,

preceptors were found to experience conflict in the preceptor-student relationship when they perceived a lack of competency on the part of the learner related to the learner's knowledge and skill level (Mamchur & Myrick, 2003). In some cases, the conflict is related to unrealistic expectations of the preceptor for student performance (Gardner & Suplee, 2010, p. 75).

When preceptors perceive that a student is unable to perform patient care tasks appropriately, they often are tempted to step in and take over by demonstrating the proper technique to the learner. This inclination may be due to the preceptor's concurrent responsibility of a patient care assignment and a genuine desire to share clinical knowledge and skill with the student. However, doing so interferes with both the student's and the patient's perceptions of the student as "authentic care providers" (Gardner & Suplee, 2010, p. 89). To support students as they learn to care for patients, preceptors should use a coaching process. In sports, coaches stand on the sidelines; they do not participate in or interfere with the game unless there is a risk of injury (e.g., the soccer coach who sees lightening on the horizon interrupts the game by getting the referee's attention to stop play and clear the field). A good preceptor, using coaching techniques, allows the learner to be in control of the patient situation and stands nearby, monitoring the unfolding situation, offering verbal cues when needed, asking questions to guide the student's problem solving, offering encouragement (e.g., "that's right," "keep going"), and then giving immediate feedback for the student to reflect on. The coach's expression of belief in students' capacity to succeed "instills in them an expectation of their own success" (O'Connor, 2006a, p. 250). Thus, effective coaching can help students feel more confident in their clinical abilities and see themselves as authentic care providers. However, if a student "freezes" because of overwhelming anxiety, an error, inadequate preparation, or an unexpected occurrence, the preceptor may need to intervene if this places the patient at risk. The preceptor may need to temporarily assume responsibility for the task the student was attempting to perform, beginning or taking the next step of the task, and then encouraging the student to continue while continuing to coach from the sidelines (Gardner & Suplee, 2010).

Students

The student is expected to be an adult learner, actively participating in planning his or her own learning activities (Gardner & Suplee,

2010, p. 71). Planning may take the form of a learning contract that specifies individualized objectives and clinical learning activities. Because the teacher is not always present during learning activities, the student must communicate frequently with the teacher; communication may take the form of a reflective journal that is shared with teacher on a regular basis. The student must notify the teacher immediately of any problems encountered in the implementation of the preceptorship. In one study of conflict in preceptorships, Mamchur and Myrick (2003) found that 20% of students experienced conflict in their preceptorships but did not acknowledge or report it. In fact, preceptorship has been found to be among the most stressful of nursing student experiences (Yonge, Myrick, & Haase, 2002). Students may not report conflict for several reasons:

- They perceive that they are expected to fit in to the practice setting with minimal disruption.
- They feel powerless and dependent upon the preceptor's evaluation to complete the clinical practicum successfully.
- They fear receiving an unfavorable reference from the preceptor for future employment in that clinical agency (Mamchur & Myrick, 2003).
- Important aspects of the preceptor's workplace culture and work conditions did not provide a positive, supportive, caring learning environment (Smedley & Penney, 2009).

The student's responsibilities also include self-evaluation and evaluation of the preceptor's teaching effectiveness, as will be discussed later in this chapter.

Teachers

As previously discussed, the teacher is responsible for making preceptor selections, pairing students with preceptors, and orienting preceptors and students. The teacher is an important resource to preceptors and students to assist in problem solving. The teacher must be alert to any sign of conflict in the student-preceptor relationship and promptly take a proactive role in resolving it. If a conflict cannot be resolved to the satisfaction of student, preceptor, and faculty member, the student's well-being should take precedence, and, if necessary, the student should be reassigned (Mamchur & Myrick, 2003).

Teacher availability is particularly important if a problem arises at the clinical site that the preceptor and student cannot resolve. The teacher must make arrangements for consultation via telephone, e-mail, or pager. The teacher also arranges individual and group conferences with students and preceptors and visits the clinical sites as needed or requested by any of the participants. If students submit reflective journal entries, the teacher responds to them with feedback that helps students to evaluate their progress. Teachers have responsibility for the final evaluation of learner performance with input from preceptors, and they evaluate the effectiveness of preceptors with input from students.

Planning and Implementing Learning Activities

A common strategy for planning and implementing students' learning activities in the preceptorship model of clinical teaching is the use of an individualized learning contract. A learning contract is an explicit agreement between a teacher and student that clarifies expectations of each participant in the teaching-learning process. It specifies the learning goals that have been established, the learning activities selected to meet the objectives, and the expected outcomes and criteria by which they will be evaluated. In a preceptorship, the learning contract is negotiated among the teacher, student, and preceptor and guides the planning and implementation of the student's learning activities. Exhibit 13.2 is an example of a learning contract format that could be adapted for any level of learner.

As discussed previously, effective communication among the preceptor, student, and teacher is critical to the success of the preceptorship. Communication between teacher and student may be facilitated by the student's keeping a reflective journal and sharing it with the teacher on a regular basis. In the journal, the student describes and analyzes learning activities that relate to the objective, reflecting on the meaning and value of the experiences. The journal entries may be recorded in a computer file, on paper, on audiotape, or posted to an online discussion board; the teacher responds via the same medium. Additionally, the student and teacher have telephone, e-mail, or face-to-face contact as necessary for the teacher to give consultation and guidance. Similarly, the teacher and preceptor should have regular contact by telephone, e-mail, text messaging, or face-to-face meetings so that the teacher receives feedback about learner performance and offers guidance and consultation as needed.

Exhibit 13.2

LEARNING CONTRACT TEMPLATE

Student Information

Name and credentials:

Address:

Phone number:

Fax number:

E-mail address:

Teacher Information

Name and credentials:

Address:

Phone number:

Fax number:

E-mail address:

Preceptor Information

Name and credentials:

Address:

Phone number:

Fax number:

E-mail address:

Clinical Learning Objectives	Learning Activities and Resources	Evaluation Evidence, Responsibility, and Time Frame

Start date:

Completion date:

Student Signature _____ Date _____

Preceptor Signature _____ Date _____

Teacher Signature _____ Date _____

The realities of clinical and academic cultures present challenges to effective communication among teacher, preceptor, and student. Preceptors often work a variety of shifts, students often have complicated academic and work schedules, and teachers have multiple responsibilities in addition to clinical teaching. Flexibility and commitment to establishing and maintaining communication are essential to overcome these challenges.

EVALUATING THE OUTCOMES

Students, teachers, and preceptors share responsibility for monitoring the progress of learning and for evaluating outcomes of the preceptorship. Student performance may be evaluated according to the terms specified in the learning contract or through the clinical evaluation methods used by the educational program. If a learning contract is used, student self-evaluation usually is an important strategy for assessing outcomes. As discussed earlier, preceptors are expected to give feedback to the learner and to the teacher, but the teacher has the responsibility for the summative evaluation of learner performance.

An important aspect of evaluation concerns the teaching effectiveness of preceptors. Students are an important source of information about the quality of their preceptors' clinical teaching, but the teacher also should assess the degree to which preceptors were able to effectively guide the students' learning. A modified form of a teaching effectiveness tool used to evaluate clinical teachers may be used to collect data from students regarding their preceptors (Gardner & Suplee, 2010, pp. 73–74). Exhibit 13.3 is an example of a form for student evaluation of preceptor teaching effectiveness. Because each preceptor typically is assigned to one student at a time, it usually is impossible to maintain anonymity of student evaluations. Therefore, teachers may wish to share a summary of the student's evaluation, instead of the raw data, with the preceptor.

REWARDING PRECEPTORS

Preceptors make valuable contributions to nursing education programs, and they should receive appropriate rewards and incentives for their participation. At minimum, every preceptor should receive

Exhibit 13.3

SAMPLE TOOL FOR STUDENT EVALUATION OF PRECEPTOR TEACHING EFFECTIVENESS

Directions: Rate the extent to which each statement describes your preceptor's teaching behaviors by circling a number following each item, using the following scale:

- 4 = to a large extent
 3 = to a moderate extent
 2 = to a small extent
 1 = not at all

- | | | | | |
|---|---|---|---|---|
| 1. The preceptor was an excellent professional role model. | 4 | 3 | 2 | 1 |
| 2. The preceptor guided my clinical problem solving. | 4 | 3 | 2 | 1 |
| 3. The preceptor helped me to apply theory to clinical practice. | 4 | 3 | 2 | 1 |
| 4. The preceptor was responsive to my individual learning needs. | 4 | 3 | 2 | 1 |
| 5. The preceptor provided constructive feedback about my performance. | 4 | 3 | 2 | 1 |
| 6. The preceptor communicated clearly and effectively. | 4 | 3 | 2 | 1 |
| 7. The preceptor encouraged my independence. | 4 | 3 | 2 | 1 |
| 8. The preceptor was flexible and open-minded. | 4 | 3 | 2 | 1 |
| 9. Overall, the preceptor was an excellent clinical teacher. | 4 | 3 | 2 | 1 |
| 10. I would recommend this preceptor for other students. | 4 | 3 | 2 | 1 |

an individualized thank-you letter, specifying some of the benefits that the student received from the preceptorship. A copy of the letter may be sent to the preceptor's supervisor or manager to be used as evidence of clinical excellence at the time of the preceptor's next performance evaluation.

Other formal and informal ways of acknowledging the contributions of preceptors for nursing students and new staff members include:

- A name badge that identifies the nurse as a preceptor
- A certificate of appreciation, signed by the administrator of the nursing education program or the staff development program
- An annual preceptor recognition event, including refreshments and an inspirational speaker

- Free or reduced-price registration for continuing education programs offered by the nursing education program or clinical facility (Smedley & Penney, 2009)
- Travel expenses and registration fees to attend professional development conferences off-site
- Educational leave time for academic and continuing education courses
- Free or reduced-rate tuition for one or more academic courses (Smedley & Penney, 2009)
- Bookstore gift certificates
- Adjunct or affiliate faculty appointment
- Differential pay or adjustment of work schedule (e.g., exemption from weekend shifts) for preceptors who work with new staff members
- A gift such as a fruit basket or plant

SUMMARY

The use of preceptors is an alternative to the traditional clinical teaching model based on the assumption that a consistent relationship between an experienced nurse and a nursing student or novice staff nurse is an effective way to provide individualized guidance in clinical learning and professional socialization. Preceptorships have been used extensively with senior nursing students, graduate students preparing for advanced practice roles, and new staff nurse orientees.

A preceptorship is a time-limited, one-to-one relationship between a learner and an experienced nurse. The teacher may not be physically present during the learning activities; the preceptor provides intensive, individualized learning opportunities that improve the learner's clinical competence and confidence. The teacher has overall responsibility for the quality of the clinical teaching and learning and provides the link between the educational program and the practice setting. The preceptor functions as a role model and provides individualized clinical instruction, coaching, support, and socialization for the learner.

Preceptorships frequently are used for students in their last semester of academic preparation for entry into practice and for graduate students preparing for advanced clinical practice, administration, and education roles. In many health care organizations, preceptors participate in the orientation of newly hired staff nurses by

acting as role models and supporting new staff members' professional socialization.

The use of preceptors in clinical teaching has both advantages and disadvantages for the educational program, clinical agency, teachers, preceptors, and students. Benefits for preceptors and their employers include the stimulation of working with learners who raise questions about clinical practice, assistance from students with research or teaching projects, rewards through a clinical ladder system for participation as a preceptor, and opportunities to recruit potential staff members for the agency from among students who work with preceptors. The greatest drawback of preceptorships to agencies and preceptors usually is the expected time commitment.

Students experience the benefits of working one-on-one with clinical experts who can coach them to improved performance as well as opportunities to experience the realities of clinical practice. However, following their preceptors' schedules often creates conflicts with students' academic, work, and family commitments.

Preceptorships offer many advantages to teachers and educational programs. The use of preceptors provides more clinical teachers for students and thus more intensive guidance of students' learning activities. Working collaboratively with preceptors also helps faculty members to stay informed about the current realities of practice. Disadvantages include the amount of indirect teaching time required to select, prepare, and communicate with preceptors and students.

Selection of appropriate preceptors is important to the success of preceptorships. Most academic programs require the preceptor to have at least the degree for which the student is preparing. Desire to teach and willingness to serve as a preceptor are very important qualities of potential preceptors. Additional attributes of effective preceptors include clinical expertise or proficiency, leadership abilities, teaching skill, and professional role behaviors and attitudes.

Teachers are responsible for the initial orientation and continuing support of all participants; preparation can be formal or informal. A general orientation for potential preceptors may include information about benefits and challenges of precepting, characteristics of a good preceptor, principles of adult learning, clinical teaching and coaching techniques, evaluation methods, and the structure and goals of the nursing education program. After preceptors have been selected, they need a specific orientation to their responsibilities, including information about the student's educational level and previous experience, choosing specific learning activities based on learning objectives, and scheduling of clinical learning

activities. Learners also need an orientation that includes information about the purposes of the preceptorship, the process of planning individual learning activities, and an explanation of teacher and preceptor roles.

Successful implementation of preceptorships depends on mutual understanding of the roles and responsibilities of the participants. The preceptor is expected to be a positive role model and a resource person for the student. The responsibilities of the preceptor include creating a positive learning climate, including the student in activities that relate to learning goals, and providing feedback to the student and teacher. The student usually arranges the schedule of clinical learning activities to coincide with the preceptor's work schedule and is expected to participate actively in planning learning activities. Because the teacher is not always present during learning activities, the student must keep the teacher informed about progress through frequent communication. In addition to making preceptor selections and orienting preceptors and students, the teacher is an important resource to preceptors and students to assist in problem solving. Teachers must make adequate arrangements for communication with other participants.

A common strategy for planning and implementing students' learning activities is the use of an individualized learning contract—an explicit agreement between the teacher, student, and preceptor that specifies the learning goals, learning activities selected to meet the objectives, and the expected outcomes and criteria by which they will be evaluated. The learning contract guides the planning and implementation of the student's learning activities.

Students, teachers, and preceptors share responsibility for monitoring the progress of learning and for evaluating outcomes of the preceptorship. Student performance is assessed according to the terms specified in the learning contract or through the clinical evaluation methods used by the educational program, through self-evaluation, and through feedback from preceptors. The teacher is responsible for the summative evaluation of learner performance. Students are an important source of information about their preceptors' clinical teaching effectiveness, but the teacher also should assess the degree to which preceptors were able to effectively guide students' learning.

Preceptors should receive appropriate rewards and incentives for the contributions they make to the educational program. At minimum, every preceptor should receive an individualized thank-you letter, specifying some of the benefits that the student received from the preceptorship. Other formal and informal ways of acknowledging the contributions of preceptors were discussed.

Exhibit 13.4

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES**1. Facilitate Learning**

- A. Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- B. Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education
- E. Practice skilled oral and written (including electronic) communication that reflects an awareness of self and relationships with learners (e.g., evaluation, mentorship, and supervision)
- F. Communicate effectively orally and in writing with an ability to convey ideas in a variety of contexts
- I. Create opportunities for learners to develop their own critical thinking skills
- J. Create a positive learning environment that fosters a free exchange of ideas
- O. Use knowledge of evidence-based practice to instruct learners

2. Facilitate Learner Development and Socialization

- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- G. Assist learners to engage in thoughtful and constructive self and peer evaluation

3. Use Assessment and Evaluation Strategies

- E. Use a variety of strategies to assess and evaluate learning in these domains
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- N. Use assessment and evaluation data to enhance the teaching-learning process
- O. Advise learners regarding assessment and evaluation criteria
- P. Provide timely, constructive, and thoughtful feedback

REFERENCES

- Amella, E. J., Brown, L., Resnick, B., & McArthur, D. B. (2001). Partners for NP education: The 1999 AANP preceptor and faculty survey. *Journal of the American Academy of Nurse Practitioners, 13*, 517–523.
- Burns, I., & Paterson, I. M. (2005). Clinical practice and placement support: Supporting learning in practice. *Nurse Education in Practice, 5*, 3–9.
- Case, B., & Oermann, M. H. (2004). Teaching in a clinical setting. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (pp. 126–177). Glen Ellyn, IL: College of DuPage Press.
- Charleston, R., & Happell, B. (2005). Preceptorship in psychiatric nursing: An impact evaluation from an Australian perspective. *Nurse Education in Practice, 5*, 129–135.
- Gardner, M. R., & Supplee, P. D. (2010). *Handbook of clinical teaching*. Sudbury, MA: Jones and Bartlett.
- Manchur, C., & Myrick, F. (2003). Preceptorship and interpersonal conflict: A multidisciplinary study. *Journal of Advanced Nursing, 43*, 188–196.
- O'Connor, A. B. (2006a). Interpersonal issues in clinical nursing education. In *Clinical instruction and evaluation: A teaching resource* (2nd ed., pp. 247–292). Sudbury, MA: Jones and Bartlett.
- O'Connor, A. B. (2006b). Organizing and managing instruction in the clinical practice setting. In *Clinical instruction and evaluation: A teaching resource* (2nd ed., pp. 103–146). Sudbury, MA: Jones & Bartlett.
- Smedley, A., & Penney, D. (2009). A partnership approach to the preparation of preceptors. *Nursing Education Perspectives, 30*, 31–36.
- Stokes, L., & Kost, G. (2004). Teaching in the clinical setting. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 325–348). St. Louis, MO: Elsevier Health Sciences.
- Yonge, O., Myrick, F., Ferguson, L., & Lughana, F. (2005). Promoting effective preceptorship experiences. *Journal of Wound, Ostomy, and Continence Nursing, 32*, 407–412.
- Yonge, O., Myrick, F., & Haase, M. (2002). Student nurse stress in the preceptorship experience. *Nurse Educator, 27*, 84–88.

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14

Clinical Teaching in Diverse Settings

DIANE M. WINK

Nursing care occurs in diverse settings—multiple types of health care and non–health care locations where there are clients (individuals, families, communities) who can benefit from the services of a professional nurse. Professional nurses take on multiple roles as they work with clients of all ages, races, ethnic groups, and cultures. These clients have the full scope of health promotion, health maintenance, and acute, chronic, and rehabilitation care needs.

In an ideal world, all nursing students would have clinical learning activities in all settings, with all client groups, and in all professional nursing roles. In addition to preparation for the challenges of nursing practice today, students would be prepared to adapt to change as clients, health issues, care locations, and approaches to care evolve. Students would have opportunities to work with clients from cultures other than their own and implement care that recognizes the global influences on both health and illness.

Nurse educators and their students do not live in such an ideal world. All students cannot participate in all of these learning activities during their nursing education. Choices must be made with the hope that the breadth and depth of students' clinical learning activities result in the development of the core competencies and skills needed for safe and effective nursing practice. For students who are already nurses, their

clinical experiences must help them grow as professionals as they move to more advanced levels of practice.

Traditionally, much of clinical nursing education takes place in acute care settings. This approach has been increasingly challenged both because of the increasing shortage of placements in such sites and recognition that learning can occur in other settings. However, although respondent comments on a survey of clinical education in nursing conducted by the National League for Nursing (2008) indicated recognition of the value of observation, learning in a wide variety of settings, and students being able to learn without faculty members being present, faculty respondents still indicated they felt the traditional rotations through medical specialty areas with specific numbers of clinical hours in those areas were important. Traditional settings for the clinical education of nursing students include hospital units that provide care to adults in addition to selected community-based health care agencies such as home care and public health agencies. Because of decreasing length of inpatient stays and economic pressures to provide care in outpatient and community settings, limited (and, in some cases, decreased) numbers of clinical learning activities take place on units that provide care for children, individuals with psychiatric illnesses, and women and families during pregnancy and childbirth.

Clients in acute care settings have increasingly complex illnesses and receive high technology interventions in an attempt to repair, cure, or ameliorate illness and injury. Because of this high patient acuity and complexity, many sites do not allow for achievement of the full scope of clinical learning objectives. Collaboration with other disciplines, acting as a change agent, being a patient advocate, and the development of many key assessment and psychomotor skills can be difficult in a setting where all clients are critically ill. And because of the increasingly specialized nature of many acute care units (e.g., cardiovascular, orthopedic, endocrine), it is hard for students to see a broad scope of client problems when they have a finite number of clinical hours and a predetermined schedule. The use of diverse care sites is essential if students are to achieve all course and program objectives (Tanner, 2006).

Even when traditional acute care placements are appropriate, implementing clinical learning activities in such settings can be challenging. High demand for placements from nursing education programs (often with rapidly increasing enrollments) and other health professional programs has overwhelmed many acute care agencies. Both staff members and patients can be asked to interact with students 24 hours a day, 7 days

a week. As a result, acute care agencies often place limitations on the numbers of students per unit or the days and times that students can be present. In some cases, the mandated clinical group size is so limited that some students in a clinical group must be scheduled for observation activities elsewhere so that fewer students are on the unit, or the group size has to be kept very small, a remedy that usually is not economically feasible for the nursing education program.

However, the presence of nurses and the need for nursing care in locations other than acute care is well known. Today, patients outside of acute care institutions are sicker and have increased needs for nursing care. A report by the Health Resources and Services Administration (2004) on the employment of registered nurses showed that only 56.2% were employed in a hospital. The remaining nurses worked in nursing home or extended care facilities (6.3%), nursing education (2.6%), community and public health settings (10.7%), school health (3.2%), occupational health (0.9%), and ambulatory care (11.5%). The remaining 8.6% of nurses were employed in a wide variety of other settings (e.g., insurance, prisons, policy development) or did not respond.

As the patients and nurses have moved out of acute care settings (or, as some would say, as they remained in greater numbers in non-acute care settings), so have the clinical learning opportunities. Thus, while surgery once was performed almost exclusively in hospitals, many clients now have procedures in freestanding surgical centers. Patients once spent weeks recovering in hospitals after surgery or while recovering from trauma; they now recover at rehabilitation facilities or at home. No longer do patients who need long-term parenteral therapy or antibiotics stay in an inpatient facility. Full management of their care is carried out by nurses working in rehabilitation, long-term care, and home health settings.

Another driving force for the use of diverse settings for clinical teaching is a call to increase the cultural competencies of graduates of nursing education programs. For example, the American Association of Colleges of Nursing (AACN; 2006, p. 2) proposed that “Development of cultural competence in students and faculty occurs best in environments supportive of diversity and facilitated by guided experiences with diversity.” Their exemplar integrative experiences include activities such as:

- Participate in a cultural immersion experience
- Participate in community projects involving community members—for example, health fairs, community forums and meetings, and

the like—to understand concerns, values, and beliefs about health care

- Participate in or attend cultural celebrations or religious ceremonies to understand foundations of values

Clinical experiences in diverse settings help to achieve these goals.

CLINICAL LEARNING ACTIVITIES IN DIVERSE SETTINGS

Nursing care can be learned wherever students have contact with patients or clients. Learning objectives do not prescribe a specific setting where the learning activities must take place. The core components of a clinical learning activity can be present even in settings other than acute care hospital units and might include client contact; opportunities for students to have an active role in client assessment, goal setting, and then planning, implementing, and evaluating care; critical thinking and problem-solving opportunities; competent guidance (from the teacher or someone designated to take on the teaching role in that site); and skill development (intellectual as well as psychomotor).

Benefits

Placement of nursing students in diverse clinical settings has multiple benefits. These include preparing the student to be a part of the health care system in which the acute care hospital is but one part. Not only will students learn about these sites, they will develop the skills that these settings are best able to provide. For example, development of a psychomotor skill such as initiation of intravenous therapy and the many clinical assessment and decision-making skills that go with this routine procedure may best take place in a perioperative setting. Development of therapeutic communication competencies may be best achieved in rehabilitation settings where it is possible to have client contact over time. Care planning, evaluation, and revision may be best developed in a home health setting where care planning is fully integrated into client services. The home health setting also lends itself to development of collaboration skills as well as real-world knowledge about the impact of payer status and insurance reimbursement on the ability of the client to pay for (and, in many cases, receive) needed care.

Clinical learning activities in community-based settings allow nursing students to work with clients where the clients live and work. Students see the challenges that clients face as they implement self-care for health promotion and maintenance as well as care for their own and family members' acute and chronic illnesses. Collaboration with other members of the health care team is a natural, necessary, and active part of care delivery in community-based settings.

Nursing students can participate in creatively designed, rigorous, high-quality clinical learning activities almost anywhere. This chapter will give examples of diverse clinical learning activities, review some of the practical aspects of implementing clinical learning activities in diverse settings, address problems commonly faced in these placements, and suggest solutions for such problems.

EXAMPLES OF DIVERSE SETTINGS FOR CLINICAL LEARNING ACTIVITIES

Clinical learning activities in diverse settings include opportunities for students to meet specific learning objectives while caring for clients. Three categories will be used as examples of such activities. The first consists of patient care areas that are not used regularly as clinical learning sites. Some of these (e.g., the operating room) have been virtually eliminated as clinical learning sites in most nursing education programs, while others (e.g., outpatient clinics, nursing homes) are underused, despite the rich learning opportunities provided for students in these settings. The second category includes sites where provision of health care is not the prime focus of the site or agency. Examples are schools, camps, congregate meal sites, senior citizen programs, and apartment complexes. These sites may be extensively used in community-based nursing education curricula but can provide excellent clinical learning opportunities in all programs. Some of these activities may be service learning experiences if they reflect key components of service learning. See chapter 6 for information on planning high-quality service learning activities. The third category is the growing use of international clinical learning opportunities. These can be brief (often 1 week) placements in which students are part of a team providing a continuum of health services or extended placements in which the student lives for weeks to months in the country in which the clinical activities are based.

There are other clinical learning activities not included in this discussion. One is an observation in which students' objectives are best achieved while they maintain a nonparticipant role in the clinical setting. Another is a special event held as part of a clinical rotation, such as a trip to an art gallery or to attend a play, designed to help students increase a specific skill, competency, or self-awareness. Clinical observations and interactions that are part of a didactic course also are not included. Although potentially valuable as learning activities, riding in an ambulance with emergency medical service providers or visiting a hospital, clinic, or client group as part of a course (whether at home or in another country) is not a clinical learning activity if there is no client care in which the student participates.

Clinical Learning in Underused Patient Care Sites

With the diversity of clinical practice sites, there are many examples of clinical learning activities. Several will be used to illustrate how such sites can be optimized.

Outpatient Clinics

Outpatient settings such as primary care practices, specialty clinics, and rehabilitation programs often are difficult to use effectively as clinical learning sites because of the lack of RN role models and the difficulty of placing large numbers of students at one site, making clinical teaching by the faculty difficult. This can be addressed through placement of students in a single large clinical facility.

For example, in a community-based course that focused on development of assessment, client problem identification, and family-centered care, a nursing student group was placed at a Veterans Administration clinic. The site had multiple specialty and internal medicine clinics, each with a team of professionals who worked collaboratively with the other specialty teams. RNs in this clinic were responsible for basic client assessment as well as education and follow-up after provider visits. The RNs interacted with a wide range of providers, such as nurse practitioners, physician's assistants, and family practice and specialty physicians, as well as the clients and their families.

After orientation to the site, students rotated among the specialty clinics. The instructor was able to be on site throughout the clinical learning activity because the size of the clinic accommodated the

entire student group. Students changed specialty clinics each week, but the common staff and assessment tools, the fact that the providers (nurse practitioners, physicians, nurses, social workers) all worked in the same system, and the common client population made the transition smooth.

Regular student-faculty conferences allowed review of the challenges faced by clients and families that the students identified. Students also discussed patterns in assessment findings and interventions to address the ongoing health promotion and maintenance needs of the clients. Because of the wide range of health problems among the clients, content from the accompanying didactic courses was constantly reinforced. The students developed a rich array of skills, including completing health histories, focused physical assessments, administration of medications, and collaboration with families and other members of the health care team. They also gained an in-depth knowledge of a major subset of the health care system (B. Gross, personal communication, November 2005).

Operating Room

Most nursing education programs eliminated an operating room clinical rotation from their curricula many years ago, but, in doing so, nursing faculties have overlooked many rich clinical learning opportunities. Many of the hospitalized clients for whom acute care nurses provide care pass through the operating room at some time in their hospitalization. Knowledge about patients' surgical experiences can greatly enhance the knowledge and skill of the nurse caring for the patients both before and after surgery. AORN, the Association of periOperative Registered Nurses, has encouraged nursing education programs to increase use of perioperative settings as clinical learning sites (AORN, 2006, 2009).

AORN suggested that the perioperative environment is an ideal setting for teaching application of the nursing process and that perioperative clinical learning activities can contribute to the achievement of a wide variety of program outcomes. In addition to developing expected skills like aseptic technique, students see the use of the latest technology both in the surgical procedures and in the overall care of the surgical client. Perioperative settings also offer opportunities to study human factors and communication theories and to see the implementation of culturally competent care that meets the unique needs of individuals from other cultures. Possibly most important, students work with a team

that demonstrates the interdisciplinary collaboration essential for both safety and high-quality patient care in all settings (AORN, 2009). To help both perioperative staff members and nursing faculties implement such clinical learning activities, the AORN document includes sample outline learning outcomes for perioperative experiences and relates these to overall program competencies such as those of the AACN. Objectives and a content outline for a model perioperative nursing course; objectives for the clinical course; and a document that relates objectives to content, activities, and competencies are all provided.

Nursing students can develop a wide array of psychomotor skills in perioperative settings, such as catheter care, insertion and maintenance of intravenous lines, pain management, skin and wound care, and care of unconscious patients. A series of perioperative learning activities across the curriculum can help nursing education programs produce learning outcomes required to achieve and maintain accreditation (Sigsby, 2004). In addition, inclusion of perioperative learning activities in undergraduate nursing curricula will increase nurses' knowledge of clients' surgical experiences, regardless of the setting in which the nurses work, and may increase the number of nursing students who choose the perioperative specialty after graduation (Mitchell, Stevens, Goodman, & Brown, 2002; Sigsby & Yarandi, 2004).

In one study, knowledge of topics related to the nursing care of surgical patients (e.g., aseptic technique, safety, infection control, medication administration, and legal and ethical aspects of informed consent) was compared among students in a medical-surgical clinical course with and without a perioperative rotation. This knowledge was found to be equivalent or greater among students who had the perioperative rotation (Sigsby & Yarandi, 2004).

Another way to include more perioperative clinical learning activities is with an elective course in perioperative nursing, such as the one created by University of North Florida (Trice, Brandvold, & Bruno, 2007). Faculty members at University of North Florida worked with a local medical center to present an elective course in perioperative nursing. Each year, staff from the collaborating hospital, including those who were graduates of the program, spoke to students about the perioperative course. Applicants were interviewed and specifically accepted into the program. On average, only 6 of the 25 or more applicants were accepted to this externship. In addition to a study of the roles and responsibilities of the perioperative nurse, emphasis was placed on patient assessment, patient advocacy, and individualization of care. The externship course included

a 30- to 40-hour-per-week commitment for the clinical work with staff preceptors as well as didactic presentations in the form of 21 learning modules. The three-credit course met the requirement for an elective in the curriculum. Since its inception, the retention rate for nurses who participated in the externship is 89% (Trice et al., 2007).

Nursing Home

Competency in the care of older adults, including frail elderly individuals, is a desired outcome of all nursing curricula. Almost all graduates will be caring for elderly clients regardless of work setting. An under-used clinical learning setting for gaining these competencies is the nursing home or extended care facility.

Nursing homes provide an opportunity for students to practice multiple psychomotor skills and learn to provide long-term care to a single client. In this setting, observation of changes over time is possible while caring for clients with complex needs. But due to the stable nature of nursing home clients' health problems, nursing students are not likely to be overwhelmed by the complexity of the care. With a rich variety of clients, learning needs can be matched with clinical learning assignments as students provide holistic care over a full range of physical, psychological, spiritual, environmental, and financial areas (Chen, Melcher, Witucki, & McKibben, 2002). Nursing homes provide many opportunities for students to practice implementing care that has a long-term impact. Bowel and urinary continence programs, programs to improve nutrition, and interventions to increase social interaction are a few examples of such activities.

Another benefit of student clinical learning activities in nursing homes is their role in improvement of care for the residents of the facility. Faculty members can serve as clinical experts and role models, and students have the time needed to implement and support programs that help clients achieve objectives that are hard to reach in today's health care environment. The Texas Tech University Health Sciences Center faculty revised its curriculum to better integrate content on the care of older adults based on the work of the Hartford Foundation for Geriatric Nursing. A 30-hour practicum in long-term care was made part of a larger three-credit-hour clinical course taken in the senior year. Faculty members collaborate with a long-term care facility to create a "Teaching Nursing Home" experience. Students collaborate with a clinical preceptor to complete a variety of activities at the nursing home. These include

targeted psychological and physiological assessments of residents and the use of the Minimum Data Set for Long-term Care as well as review and assessment of client data in individual records. Analysis of the data and comparison of student assessments to data in the client records is another learning activity. The students also take an active role in the case management of selected clients.

There are some barriers to high-quality clinical learning experiences in nursing homes. One is the lack of nursing role models. Faculty members can overcome this by being role models themselves. In addition, students can use this opportunity to improve collaboration skills as they work with the wide variety of staff members, including nursing assistants, licensed practical or vocational nurses, RNs, physical therapists, occupational therapists, dietitians, social workers, and administrators. Negative attitudes of students toward elderly clients, either preexisting or as a result of the nursing home experience, are another concern. Again, the attitudes and approach of the faculty member can help prevent or address this issue (Chen et al., 2002).

Hospice

Competency in delivering end-of-life care is another of the expected student outcomes of nursing education. This can be difficult to achieve in classic clinical settings where students have limited exposure and opportunity to interact with dying clients and their families. A clinical learning activity in a hospice is an excellent way to expose students to the issues related to end-of-life care and to provide opportunities to develop many skills needed in all nursing roles and settings. For example, faculty members at one college developed a program in which students were teamed with a hospice worker to follow families receiving hospice services during an 8-week mental health course. Faculty members identified multiple course goals as well as AACN and End-of-Life Nursing Education Consortium competencies that would be met through this activity. These included development of effective and compassionate communication skills with the client, family, and team members; recognition of students' own attitudes and feelings about death; and demonstration of respect for the family while assisting them through end-of-life care.

Students met weekly with their assigned family with the support of both the course faculty and a hospice team member. Students were instructed to tell the families the length of time they would be working with them and that the students were there to talk about anything the

clients or families wanted to speak about. Weekly support groups with faculty members and peers offered additional assistance to students as they addressed issues and emotions of clients, families, and students that arose during this clinical learning activity. Evaluation of the learning activity was overwhelmingly positive, and achievement of AACN competencies was clear (Hayes, 2005).

Crisis Center

Agencies that care for psychiatric clients outside of acute care institutions now are the backbone of psychiatric care. They also offer rich clinical learning opportunities. DeLashmutt and Rankin (2005) described use of a crisis center during a psychiatric mental health clinical course developed to increase students' knowledge and understanding of poverty. Students spent 4 days of a semester-long psychiatric-mental health clinical course at a crisis-focused day shelter and multiresource advocacy center for poor and homeless individuals and families. Students completed specific reading and audiovisual assignments to support the clinical learning activity. There also were four focused postclinical conference discussions on the lived experience of mental illness, homelessness, feminization of poverty, and integration of concepts related to the clinical learning activity. In two of the conferences, guests such as a homeless individual or a formerly homeless mentally ill mother joined the students. Outcomes of the experience were examined using a pre- and postexperience questionnaire. Responses demonstrated that the students had experienced both personal and professional growth. The structured postclinical conferences contributed to this growth.

Community-Based Clinical Learning Activities

Almost all clients cared for by nurses in the acute care setting come from and return to the community. In addition, many issues, particularly related to health promotion and maintenance and care of chronic disease, are best addressed in community settings. Community settings also offer many learning opportunities for development of key skills and competencies that are hard to meet in the very intense acute care environment. For these reasons, inclusion of community-based clinical learning activities in the nursing curriculum is important.

Community-based learning activities often are implemented under the umbrella of service learning. In service learning, students work

collaboratively with community partners to meet both course and community objectives. Reflection on the experience and development of a sense of civic engagement are essential components. (See chapter 6 for an in-depth discussion of service learning.)

In many nursing education programs, often those with community-based curricula, students have clinical learning activities in a wide variety of agencies in a single community or geographic area. Students in community-based programs return to the community repeatedly during their nursing education and often have a final culminating project designed to address a specific health care need of the community (Kiehl & Wink, 2000; Matteson, 2000; Wink, 2003).

In a study of associate degree and baccalaureate nursing programs with community-based experiences, programs reported student clinical placements in a wide variety of settings. These included health departments, schools, home health agencies, and prisons. Students completed a wide variety of nursing interventions, including administration of immunizations and disease surveillance. It was not uncommon for students to work independently (with a faculty member making site visits) or under the supervision of preceptors part of the time (Frank, Adams, Edelstein, Speakman, & Shelton, 2005).

Two projects exemplifying how such activities can achieve both course and curricular objectives were implemented by students at the University of Central Florida. A homeless shelter was the clinical learning site for a small group of students who provided basic health screenings, referrals, and education in a clinical rotation in their junior year. In addition to learning about issues of homelessness, the students developed relationships with the residents and staff, honed their health history and physical assessment skills, and increased their knowledge of the chronic and acute physical and mental health problems of shelter residents. As a result, students identified a need for a program for the children in the shelter focusing on grief and loss. The students developed a program for the children that interpreted these concepts broadly to include loss of home, friends, and family as well as loss from death. In addition, during the presentation of the grief program, multiple episodes of pets dying or running away surfaced as a form of loss.

School-based clinical learning activities provide excellent opportunities for development of pediatric health assessment and promotion skills. This is enhanced if done in the context of an ongoing program that demonstrates the principles of family-centered care and public health nursing rather than being a one-time event when the students drop into a

school to take height and weight measurements or teach tooth-brushing. Schwartz and Laughlin (2008) described a program that is a long-term collaboration between the Creighton University School of Nursing and multiple K–12 schools. The students learn health assessment and promotion, disease prevention, and disease management in an environment where they see continuity of care. Through a program managed by a School of Nursing coordinator, faculty members and students provide school nursing services that meet standards of the state of Nebraska and the Association of School Nurses. These include vision, height, weight, hearing, blood pressure, dental, and scoliosis screenings each year. Disease prevention and management are implemented as the students participate in immunization review and the design and implantation of plans of care for children with various health conditions and those who need medications while at school (Schwartz & Laughlin, 2008).

Continuity of care occurs as the Creighton University students provide needed referrals based on outcomes of the screening. Their health education program is a part of the formal curriculum in the schools. The project started with collaborations with 15 elementary schools and is now a sustained collaboration with over 30 elementary, middle, and high schools. None of the schools has discontinued the program (Schwartz & Laughlin, 2008).

A similar ongoing collaboration between a school of nursing and a group of child care centers was described by Kataoka-Yahiro, Tessier, Ratliffe, and Matsumoto-Oi (2001). Faculty members and both undergraduate and graduate students from the University of Hawaii at Manoa developed a program through which the children at the centers were offered a series of four assessments for a low fee every 6 months. (This fee was based on the cost to provide the screenings, and neither the faculty nor students were paid for project participation.) Each child was assessed using the Denver II Developmental Screening, Denver Eye Screening, and Denver Audiometric Screening Tests, as well as the Denver Articulation Screening Exam. Written reports were provided to the parents or guardians. Referral arrangements were made with appropriate local agencies.

The nursing students completed an orientation to the clinical learning activities and specific classes on the use of the tools. The resulting experience was approximately one-fourth of the total clinical practicum for the courses. Faculty members were present for all screening events in order to verify that the tools were used correctly and to support the nursing students as they worked with the children.

The authors reported that, of children screened in their initial years of the program, none needed referral for developmental or vision concerns, 7% were referred for further evaluation of hearing, and 8.6% were referred for speech concerns. These referral rates were close to statewide referral rates for these problems. Advantages for the students included well-developed pediatric health assessment skills. Advantages for the faculty included enhanced faculty practice (Kataoka-Yahiro et al., 2001).

Community-based learning activities are not limited to baccalaureate programs; they can occur in associate degree programs also (Tagliareni & Speakman, 2003). Ligeikis-Clayton and Denman (2005) described a multisemester program in a community college in which students were placed with one of 15 agencies with four to six students per site. A service learning coordinator visited the sites, developed contracts, and managed the program. Nursing faculty members served as liaisons for one or two agencies each, with contact at least once per semester. The clinical hours for the project were hours previously used for observational community activities. Agency preceptors helped the students learn about the agency, its purpose, and challenges and worked with the students to identify projects and then carry them out. The service learning projects were discussed in postclinical conferences throughout the four semesters of the program.

Camps

Another community-based site that can meet many clinical learning objectives, particularly those related to the care of children with acute and chronic illnesses, is a camp. Use of summer camps for children for the clinical component of a community health course was described by Toften and Fonnesbeck (2002). The clinical learning activity took place in a camp of the student's choice: traditional, special needs, or one serving underprivileged youths.

In addition to the camp activities, students had opportunities to assess and treat children with hydration, sleep, nutritional, and communicable disease issues. They also learned about and then used the public health resources and local community agencies that helped them address the public health, environmental, and psychomotor needs of the children. To meet the community health objectives of the clinical learning activity, students completed a community assessment of the camp, its clients, and the surrounding community. Students worked with the

camp staff to identify a needed project that could be the focus of student work at the camps. Because this was an ongoing activity, projects often were the result of assessments initiated the year before (Toften & Fommesbeck, 2002).

Child Care Centers

Child care centers offer many opportunities for students to develop observation, developmental assessment, physical assessment, and teaching skills. Goetz and Nissen (2005) reported on use of a day care center as one of many sites during the clinical component of an introductory associate degree nursing program course focused on assessment of different age groups. The students were placed at the center for 2 days to meet specific objectives related to communication with children, assessment, and analysis of the child's physical and developmental status. Each student focused on one child per day and completed a well-child assessment under the direct observation of the instructor. All students also did teaching projects as small groups and participated in conferences in which they analyzed their observations and discussed how they had to modify approaches based on the unique characteristics of each child.

Senior Housing

Davis, Beel-Bates, and Jensen (2008) described a multicourse experience, the Longitudinal Elder Initiative, during which undergraduate students made multiple visits to older adults living in the community. This promoted sustained meaningful interactions with residents with a variety of lifestyles, physical abilities, and interests and provided opportunities for nursing students to assess the comorbidities and differences among individuals in an aging population. Students developed relationships with the older adults as they meet objectives, which change from course to course. After practicing basic assessment skills in first-semester visits, the students examined the health care needs of clients and their unique risk factors based on physical and psychosocial factors such as chronic illnesses, finances, and cognitive status in the second semester. Common problems associated with aging are examined in the third semester's visits, and planning for aging-in-place is the culminating activity. To support these activities, multiple assessment tools from the Hartford Foundation and other sources are posted on the course Web site.

This project allowed the students to interact with older adults in a way that helped them move beyond preconceived beliefs about their abilities. Through this experience, they had an opportunity to view the older adult “in a context of change over time” (Davis et al., 2008, p. 181) and document their learning in a longitudinal portfolio that fostered reflection on factors resulting in positive and negative changes over time. On self-evaluation, students expressed increased confidence and competence in the areas of nutrition, depression and anxiety, financial aspects, sleep problems, polypharmacy, support systems, and community resources when compared with students who did not have the Longitudinal Elder Initiative experience (Davis et al., 2008)

Graduate-Level Community-Based Clinical Activities

At the graduate level, the focus of clinical placements often is on the specific clinical specialization for which the student is being prepared. However, students also must learn how to collect and use community- and practice-based data that identify needed changes in practice structure and function to better care for the communities, families, and individuals served by their practice. The ability to plan, implement, and evaluate outcomes of changes also is essential.

An effective option for achieving desired learning outcomes is to incorporate practice at diverse sites (often sites where it is difficult or inappropriate for the students to do a formal or full clinical rotation) through service learning activities. Graduate students can collaborate with community partners, during which students meet course objectives while helping the community partner (e.g., a practice site) meet mutually agreed objectives. As a part of the process, students have an opportunity to reflect on their experiences and the relationship between the community and their learning.

At the University of Central Florida, master of science in nursing students in the nurse practitioner tracks work in small groups to complete a two-semester service learning project to address problems and issues identified by community partners. In one project, the students worked with a nurse practitioner–run heart failure treatment program that served uninsured and underinsured individuals. The practice had an increasing number of clients, and the small staff had little time to develop needed educational and treatment protocols. Students identified specific needed materials and produced them in a form that was easy to use in a busy clinic day.

Another group collaborated with a multisite clinic for uninsured, low-income individuals to expand a protocol book for use by volunteer providers. This project involved multiple student teams and extended over 2 years, as the students, providers, and site staff produced over 30 protocols that reflected the lab, diagnostic test, and free drugs available at the clinics' sites. Additional teams worked with the same agency to conduct a follow-up assessment (repeating a study done by a prior group) to assess the effectiveness of its procedures for communicating lab and diagnostic test results to patients. Their findings led to a revision in the clinic's procedures and tools that addressed unique situations at its different sites.

In another example, graduate students at the Frances Payne Bolton School of Nursing of Case Western Reserve University implemented a variety of projects as a part of the clinical education to prepare for advanced practice roles. A Community-Based Care Advisory Group (CBCAG) consisting of faculty members, graduate students, alumni, and community and agency representatives worked together to identify appropriate projects. Faculty and community partners received education through programs provided in collaboration with Campus Community Partnerships for Health and the Campus Compact initiative. Resultant projects included updating of a curriculum for a home health aide vocational program, assessments of homeless individuals followed by development of tools that could be used by agencies working to meet the needs of this vulnerable group, and implementation of health fairs in collaboration with school nurses. The project was evaluated by both student participants and CBCAG members. Over 80% of the students believed that the service was beneficial to the community and that they had a more diverse and inclusive view of community, better understanding of factors (including challenges and barriers) that impacted the agency's ability to function, and understanding of existing resources they could use as advanced practice nurses. Faculty members noted the value of the experience, especially their increased knowledge of and ability to work with many agencies (Narsavage, Batchelor, Lindell, & Chen, 2003).

International Sites

Clinical placements in international sites can be rich opportunities that expand students' comfort and competence in care of diverse clients beyond that which can be gained in coursework focusing on such content.

Learning activities that take place within the students' own cultures and familiar surroundings do not always help students meet goals relating to becoming culturally sensitive, because the clients' world views do not predominate (Saenz & Holcomb, 2009). Nursing students whose clinical activities take place within other cultures, in both developed and developing countries, are challenged intellectually and emotionally and must learn to manage culture shock.

Caffrey, Neander, Markle, and Stewart (2005) compared 32 undergraduate nursing students using the using the Caffrey Cultural Competence in Healthcare Scale. All students had classes that integrated cultural content. A small subset of the group (7 students) also had a 5-week immersion experience working in a nursing role in Guatemala. Student self-perceived knowledge and comfort with skills showed little change among those who had only the didactic content. However, the students who had the immersion experience had very large increases in all areas. While the authors acknowledged the impact of self-selection to participate in the immersion experience on the results, they also found no differences in scores of the two groups on pretesting. Differences did not appear until after the clinical work in the international setting was completed (Caffrey et al., 2005).

Wiegerink-Roe and Rucker-Shannon (2008) also reported on a course in which such an immersion occurred. Eight students spent 5 weeks in Guangzhou, China, at Jinan University as part of a four-credit-hour nursing class. To prepare, students completed readings and participated in class discussions that focused on the roles of health care professionals, the overall health care system, major health issues, and culture in China. Students lived on campus, where they participated in classes as well as studied the Chinese language. There were ongoing experiences within the Chinese health care system with a wide variety of providers. Because of the long-term nature of the experiences, the students had an increased scope and depth of knowledge of the culture, health care system, health practices, and the nursing profession in that country. The students reported a great deal of personal growth as they learned to function in a culture where communication, dietary practices, living accommodations, and overall social interaction styles were different from their own (Wiegerink-Roe & Rucker-Shannon, 2008).

A long-term view of the impact of an international clinical placement was provided by Duffy, Farmer, Ravert, and Huittinen (2005). They surveyed students 2 years after an international placement. The former participants in international placements reported a continued positive

impact on their professional and personal lives as well as increased cultural sensitivity. The specific nature of the international experience was found to make a difference in the nature of student response. Students reported concerns common to all clinical learning activities (e.g., fear of error and the unknown; not being familiar with the patient, patient problems, the agency, and agency policies). However, the students also showed progression in their knowledge and understanding of the other country and health care system as they moved from what the investigators called a “micro to a macro” view. The students began to see the bigger picture and how both nursing care and the health care system functioned.

There is evidence that student growth is greater after experiences in developing countries as compared to those in developed countries, although there is overall growth regardless of the nature of the placement (Thompson, Boore, & Deeny, 2000). In an extensive review of the literature on international placements, Button, Green, Tengnah, Johansson, and Baker (2005) found four benefits: learning cultural differences, comparing health care systems, comparing nursing practice, and personal development.

Regardless of the site or nature of the experience, the inherent limitations of student learning activities in other cultures must be considered. Even after a long-term experience in another country, can a person become culturally competent? Can someone understand the complexities of another culture? Is not a true understanding of a culture an evolving process that takes place over many years and extensive experience (Crigger & Holcomb, 2007)?

Students must be helped to comprehend how even the most generous care can result in harm to those they are working with. Inappropriate use of antibiotics and provision of care and interventions that cannot be sustained after the team departs are not appropriate, however well meaning (Crigger & Holcomb, 2007). When working in developing countries and any setting without a strong formal health care system, the World Health Organization (WHO) principles of rational prescribing must be considered: “Patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time, and at the lowest cost to them and their community” (WHO, 2002).

Preparation for clinical learning activities in other countries is essential, including student understanding of the environment and health care system in which they will be placed. Students need to be prepared for

the fact that nursing practice as well as the settings for that care will be different. An understanding of the overall culture, communication patterns, values of the community and country in which they will be placed, and knowledge of the health care system of that country and community is also essential. Even with extensive preparation, and regardless of whether the student goes to a developed or developing country, support from peers and faculty and an opportunity to debrief are needed (Button et al., 2005; Grant & McKenna, 2003).

Saenz and Holcomb (2009), from the University of Alabama at Birmingham School of Nursing, developed a five-module Web-based course that precedes, includes, and follows field activities in Honduras. The first module focused on epidemiology. Students studied the top 10 causes of morbidity and mortality in the area they were to visit. Included in the presentations was content on incidence, mode of transmission, ways to prevent illness, and barriers to effectively addressing these health problems, most of which the students had not been aware of. This module referenced major resources, including World Health Organization Web sites, and included a presentation by a local epidemiologist after arrival in Honduras.

Environmental health was the focus of the second module. After reviewing key principles of the impact of the environment on health, the students completed a windshield survey after arrival and visited a water treatment plant to increase their knowledge of the process for providing this essential resource. Major resources for this module included a review of environmental health-related content on sites of organizations such as the Pew Environmental Health Commission, Greenpeace, and the Sierra Club. The third module addressed community resources and ways in which poverty and both availability of and access to services impacts health. Sites such as the World Bank publication *Dying for a Change* were included readings. The final pretrip module focused on social welfare and the role of the nurse. Students studied how nurses and other health professionals are educated in Honduras, the structure of the health care system, and how the country responds to global health problems.

The in-country clinical learning opportunities included shadowing nurses and participating in health care and social welfare activities at various facilities. Students also worked with local nursing students and staff members to provide hands-on services via a health fair that served the sick and well. The final components of the experience were a reflective journal and debriefing after the trip, which helped the students

identify competence and ability of nursing staff as well as similarities and differences of health care systems.

Many practical aspects of learning activities at international sites must be addressed. The source institution for the nursing education program may have an international placement office that can assist with arrangements. Completion of necessary paperwork for that office staff is essential. This usually includes a waiver of responsibility of the source educational institution and a separate application for the international activity. Students also must be informed of costs, which usually include tuition for the course, transportation, housing and food costs at the site, and cost of day-to-day expenses, including local travel. Additional insurance for emergency health care and travel back home may be needed. Depending on the host country and type of site, verification of licensure of graduate nursing students and accompanying faculty members and protocols to cover any nursing care to be delivered by them may be needed.

Students will need passports with an expiration date well beyond the end of the planned learning activity. Additional immunizations often are required. Most immunization series must be started well in advance of the planned trip. Some trips, particularly those in developing countries, rural areas, or locations at higher altitudes than students' country of origin, may require physical conditioning as well.

Practical aspects of life at the distant site must also be addressed. These include appropriate clothing for clinical activities. What does a nurse or volunteer health care provider wear in the host country? What equipment will the student need to provide? For mission trips where the group will not be placed at a permanent health care site, are there materials that the students are expected to help gather or transport? Preparation for the day-to-day living conditions, including food and water safety, is essential. Housing also should be considered. Will the students be housed in a hotel, home, dormitory, or tent? Education related to personal safety, including both health and environmental risks, is essential.

Emergency planning also is essential. This includes what to do if a student becomes separated from the group as well as a frank discussion of what students and faculty members should do in case of a natural disaster or act of war or terrorism. Where should they go? When? Whom should they contact and how can that contact be completed?

Many international placements are a part of an ongoing partnership. For example, two university schools of nursing have reported

relationships with schools in Nicaragua (Riner & Beckleberg, 2001). Collaboration between these U.S. universities and their Nicaraguan counterparts produced outcomes such as student and faculty exchange activities focused on community and acute health care and development of an elective course for the U.S. nursing students. International clinical learning activities enabled U.S. nursing students to meet objectives of providing holistic care to culturally diverse populations.

PRACTICAL ASPECTS OF CLINICAL PLACEMENTS IN DIVERSE SITES

When looking at practical aspects of clinical placements in diverse sites, there are two major areas of concern. The first reflects the regulatory and accreditation requirements for clinical learning activities; the second is preparation of the agency, faculty, and students.

All clinical learning activities must meet the requirements of state law and regulations (often set by the board of nursing) as well as the policies and requirements of accreditation agencies, the nursing education program (or its parent institution), and the site at which the clinical activities are to take place.

Each nursing education program also has procedures in place that describe how contracts and similar formal communication with an agency are to be handled. While often clear from the school's perspective, this is not always the case from the agency's side. This is a very important point for agencies that usually do not negotiate such contracts and for which there is no clearly identified contact person. Some agencies that appear to be freestanding may be part of larger agencies. Where the agency is part of a larger entity (e.g., a hospital system, local government program, state health department, school district, or federal agency such as the Veterans Administration), it can be both difficult and time-consuming to get the contract signed by all relevant parties. This can affect areas such as student and faculty orientation and requirements for background checks. These items are especially important when dealing with smaller agencies that may not have procedures in place related to orientation or placement of students in their facilities. This is important to avoid conflicts when multiple programs (nursing and other health professionals) are seeking placements for the same time period.

Again, the policy of the larger organization that oversees the site may predominate. In some cases, the policy may require student orientation or check-off on items very peripheral or even irrelevant to the learning activity, but, because students are at one of the entity's sites, the policy for the overall entity must be followed.

Often smaller and nontraditional sites (e.g., day care settings, church programs, food kitchens) and even some formal agencies that do not have large staffs (e.g., day treatment programs for substance abusers, nursing homes, assisted living facilities) do not require or have a formal orientation program. The faculty member will need to work with the staff to determine what preparation the students need to optimize their learning as well as protect and provide the best care for the clients they will encounter. On the other hand, a larger institution (e.g., a major hospital system) may be the parent organization of smaller community-based programs, and students may need to complete the full agency orientation to be placed in even a small, peripheral program in the agency in addition to participating in a site-specific orientation. If these requirements become too onerous, expensive, or time-consuming, the value of clinical learning activities at these sites may be questioned by the nursing education program faculty and administration.

Legal aspects of clinical learning experiences are more fully explored in chapter 5, but a few aspects highly relevant to the use of diverse sites are presented in Exhibit 14.1.

Agency Preparation

Details of the clinical learning activity (when will students be there, what their learning goals are) must be communicated with the staff. Settings that rarely host nursing students and those that often have nursing students can both have problems getting this information to the staff members who will have the most contact with the students. Misunderstandings about student activities and objectives are common. Often student syllabi, clinical objectives, and guides to the clinical learning activity are provided to staff members who are not directly working with the students. A meeting with the staff and provision of multiple copies of these materials will facilitate communication.

Staff members and teachers need to identify a location for students to leave coats and other personal belongings in addition to a location for

AREAS OF CONCERN WHEN PLACING STUDENTS IN DIVERSE CLINICAL SITES

Legal and Regulatory Issues

- Does the experience meet requirements of relevant state law and accompanying regulations related to approval, contract, faculty ratios, nature of faculty guidance, and student scope of practice?
- Must the faculty member be present for clinical learning experiences for direct patient care to occur?
- Can preceptors be used in the setting and in the manner planned?
- Can the instructor delegate guidance and evaluation of students' learning to a registered nurse on staff at the agency if the instructor is not present but in the building? What if the instructor is not physically present?

Nursing Education Program Issues

- Is a contract required?
- Is travel reimbursement available?
- If the planned clinical learning activity will take place over more than the usual hours and day of a usual clinical activity (e.g., on parts of most days of the week depending on each student's rotation, during usual school breaks, on weekends), is this reflected in the faculty members' workload and compensation?
- Are there specific requirements of the education program's accreditation body (e.g., National League for Nursing Accrediting Commission, Inc.; Commission on Collegiate Nursing Education) that affect the planned clinical learning activity?

Agency Issues

- What are the agency's rules and policies related to nursing student clinical activities?
- Does the agency require a contract with the nursing education program? If so, who handles contracts with education programs?
- How are requests for clinical placements from multiple nursing education and other programs handled?
- What are the agency rules for student clearance (e.g., criminal background, child or elder abuse records, drug screening)?
- If screenings or background checks beyond the requirements of the nursing education program are required, who pays for them?
- Does the nursing education program need to document that students hold CPR or other certifications?
- What are the health requirements such as tuberculosis testing or immunizations?
- Are there specific Health Information Portability and Accountability Act or client privacy statements that must be completed?
- Does the agency need to keep a record of students for legal or regulatory purposes or to obtain future funding based on the value of student service to the organization? If yes, what is needed from the nursing education program?
- What is the required orientation?

student conferences. Where these facilities are not available, alternatives will have to be identified.

Faculty Preparation

Faculty members may need additional education, mentoring, and support as they implement clinical learning activities in some diverse settings. A highly skilled faculty member who is at ease teaching students to care for acutely ill clients in a critical care unit may not have the knowledge and skills needed to care for those clients in their homes a week after discharge while they are still receiving intravenous antibiotics. Like their students, faculty members may find that the fine points of adapting care to the home setting while respecting the family in their home and dealing with the virtual loss of the multiple support systems of the acute care setting will be new to them.

Gaines, Jenkins, and Ashe (2005) reported on a program to teach faculty members about the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDTP), the use of the Denver II Developmental Screening Tool (DDST-2), and vision and hearing screening. Specific faculty members attended one or more programs to become certified in the tool or area. They then worked together to certify additional faculty members and the students who would be implementing the screenings. All nine participants received trainer certification from the state department of health for vision and hearing screening. Five faculty members traveled to Denver, Colorado, to receive certification as master instructors for the DDST-2. Two faculty members completed a 5-day program on THSteps (Texas's version of the EPSDTP) and were approved to provide the THSteps course.

Organization and structure of clinical teaching outside of acute care settings will often be new to a faculty member. Some logistical issues will need to be addressed. If the students are not all in the same setting, how will faculty members do their clinical teaching activities at multiple sites; how will students and teachers communicate with each other; how will clinical conferences occur; what clinical paperwork will be submitted to the faculty member, and when and how; and how and when will it be returned to students? A faculty mentor would facilitate the adjustment of faculty members new to the experience.

Regardless of the answers to these questions, faculty members who teach nursing students in diverse sites, perhaps at different sites at the same time, have more complex obligations than those working in a single

site. For some sites, particularly those that are community based or international, work beyond the days, times, or even weeks when traditional clinical learning activities occur may be needed to maintain partnerships. Small grant funding—for example, from the local Area Health Education Consortium—can be used to pay faculty members for these additional responsibilities (Wink, 2003).

Student Preparation

When students have clinical learning activities in unfamiliar sites or where the learning opportunities are not immediately clear to them, they often report that expectations are not always clear. Provision of specific objectives, learning activities, preparation expectations, activity guides, and written expectations will greatly facilitate learning and make the expectations clear. This is especially true if the faculty member will not be present at the site at all times. See Exhibit 14.2 for an example of site-specific preparation, objectives, activities, and written expectations for a community-based experience.

Orientation is based on agency, site, and student needs. Regardless of where each student will be, a global orientation to the course expectations with a review of skills used frequently in the experiences will get everyone off to a good start. While each student will need orientation to the site where major clinical learning activities will take place, brief visits to each site used will help all members of the group put things in perspective when issues and challenges of specific sites are discussed in conferences among the clinical group members.

Student safety also will need to be addressed. This is an issue in all clinical activities but is especially important in situations where students may be in an unfamiliar area, making home visits, or going alone or in small groups to clinical sites. Teachers must provide explicit guidelines for student safety during learning activities and document them in the course syllabus. Safety guidelines for home visits and going alone or in small groups to clinical sites should address communication with faculty, agency, and client, including emergency contact information, need for clear travel directions and a reliable vehicle, and appropriate dress and behavior while in a client's home or at an agency or facility without an instructor present. The students also must be prepared for action needed if they find themselves in a dangerous situation, be it at an agency, out in the community, or at a client's home (Skillen, Olson, & Gilbert, 2003).

EXAMPLES OF INSTRUCTIONS TO STUDENTS AND OBJECTIVES FOR SPECIFIC CLINICAL SITES

For All Clinical Learning Activities

- Review objectives and activities as listed for each assignment and do assigned reading before arriving at the site.
- Creation of a summary sheet of key facts or bringing existing guides (e.g., immunization schedules or classification of hypertension in adults) is highly recommended.
- Be at the site at the time indicated by your instructor.
- Wear your uniform.
- Bring black pen, stethoscope, notebook, personal digital assistant, and pocket reference books as appropriate for the clinical learning activity.
- Work with the staff for an optimal learning experience.
- Have contact information for your instructor (beeper, cell phone number, etc.) with you at all times.

(Note: Your instructor may provide additional objectives or instructions for a specific site.)

Physician's Office and Health Care Clinic: Adult

This clinical learning activity will take place in a physician's office or an adult health care clinic to which you will return throughout the semester. Your instructor will visit the site each day and be available via beeper or cell phone the remainder of the time. You may complete assessments, documentation, and teaching as described below. You may administer immunizations, but no other medications, under the direct observation of the registered nurse identified by your instructor.

Course objectives met by this clinical learning activity:

1. Complete comprehensive health assessments of clients across the life span.
2. Identify relationships between health status of specific clients and pharmacological and other interventions.
3. Implement client-specific teaching plans based on assessment data.
4. Interpret laboratory findings in relation to client status.
5. Collaborate with the interdisciplinary health care team to plan and implement care.

Specific preparation before the clinical learning activity starts:

- Read chapters 12, 13, and 29 in the course text.
- Complete and submit to your instructor the immunization review packet in your course syllabus.

Bring with you:

- Adult immunization schedule (<http://www.cdc.gov/mmwr/PDF/wk/mm5345-Immunization.pdf>)

(continued)

- Recommendations for cholesterol (total cholesterol, low-density lipoprotein, high-density lipoprotein, triglycerides), blood pressure (<http://www.clevelandclinicmeded.com/diseasemanagement/nephrology/hypertension/table1htn.htm>)
- Recommendations for selected adult health screenings (p. xxx of *Community Health* text)
- Adult body mass index chart (<http://www.consumer.gov/weightloss/bmi.htm>)
- List of common lab test normal values: hemoglobin, glucose, HGB A1C (look in the appendix of text)
- Form to record the drug names and dosages so that you can complete the follow-up assignment on drugs (you create this!)

Objectives

At the completion of this clinical learning activity, students will be able to:

1. Identify local demographics and social trends that are influencing the dynamics and structure of the contemporary adult or older family.
2. Analyze the normative changes and nonnormative events that challenge adults and older families.
3. Measure, record, and analyze vital signs, height, weight, body mass index, and other assessment measurements.
4. Conduct a focused health history with patients to determine chief concern, level of pain, nutritional needs, safety issues, medication regimen (names of drugs, dosages, frequency, any problems taking the medications reported by clients), and health promotion and immunization history.
5. Record assessments on appropriate forms.
6. Implement and document health education with individual clients and families.
7. Explore information on the action, dosage range, nursing implications (including education needs), contraindications, cautions, and common side effects of selected medications.

Activities

During this clinical learning activity, students will work with staff members to:

1. Follow agency policy for client intake for the visit, including completion of initial assessments and placement of clients and charts with appropriate provider.
2. Review patient's chart for history, diagnoses, medications, and lab test results.
3. Follow patients through the physical exam to the end of the visit if provider and patient agree.
4. Implement health teaching after review with the registered nurse identified by your instructor.
5. Administer immunizations under the direct observation and guidance of the registered nurse identified by your instructor.

(continued)

Follow up

At the completion of this clinical learning activity, the students will:

- Discuss client interaction observations individually with the instructor or during clinical conference.
- Discuss client issues and needs identified during visits individually with the instructor or during clinical conference.
- Use a drug handbook to look up three medications taken by clients met at the office or clinic:
 - Name of the drug (brand and generic)
 - Usual indications (reason) for the drug being given
 - Why client is getting the drug
 - Side effects of the drug
 - Usual dosage

Submit these findings at the end of your journal for the week.

- Complete one subjective, objective, assessment, and plan note based on a client encounter during this clinical learning activity.
- Complete a nursing care plan for one client problem identified during this clinical learning activity.

Note: Adapted with permission from the University of Central Florida College of Nursing.

To facilitate student preparation and safety in community-based settings, the University of Alberta developed a four-pronged program. The first component was a detailed student checklist of activities that were part of preparation for the visit (personal preparation, agency preparation, and vehicle preparation) and the implementation of the visit (environmental surveillance and personal response to situations). The other three components were small-group learning discussions on topics such as examining risky situations and responses, a Web-based module, and a problem-based learning tutorial (Skillen et al., 2003).

SUMMARY

Nursing care occurs anywhere there are clients who need the services of a professional nurse, and nursing students can learn to provide care wherever they have contact with clients. Traditionally, much of clinical nursing education has occurred in acute care settings because of long-held assumptions about how nurses must be prepared to practice. However, decreasing length of inpatient stays, high patient acuity, economic

pressures to provide care in outpatient and community settings, and increasing competition with other educational programs for the same clinical sites have limited clinical learning opportunities located in traditional acute care settings. Using diverse sites for clinical learning activities can prepare nursing students for the challenges of contemporary nursing practice as clients, health needs, care locations, and approaches to care evolve.

This chapter discussed options for planning and providing clinical learning opportunities for undergraduate and graduate nursing students in a wide variety of clinical sites. Examples of clinical learning opportunities in three categories were presented. The first category included patient care areas that are not used regularly as clinical learning sites (e.g., the operating room, outpatient clinics, nursing homes, and extended care facilities) despite the rich learning opportunities for students in these settings. The second category included sites where provision of health care is not the prime focus of the site or agency, such as schools, camps, and apartment complexes. The third category is the growing use of international clinical learning opportunities.

Practical aspects of clinical placements in diverse sites also were discussed. Two main areas of concern are the need to meet regulatory and accreditation requirements and the need for adequate preparation of the agency, faculty, and students. Examples of methods and tools used for preparation of agency staff members, faculty members making the transition from traditional acute care sites, and nursing students were provided.

Exhibit 14.3

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A.** Implement a variety of teaching strategies appropriate to
 - 2.** learner needs
 - 4.** desired learner outcomes
- C.** Modify teaching strategies and learning experiences based on consideration of learners'
 - 1.** cultural background
 - 2.** past clinical experiences

(continued)

- E. Practice skilled oral and written (including electronic) communication that reflects an awareness of self and relationships with learners (e.g., evaluation, mentorship, and supervision)
 - F. Communicate effectively orally and in writing with an ability to convey ideas in a variety of contexts
 - N. Develop collegial working relationships with clinical agency personnel to promote positive learning environments
- 2. Facilitate Learner Development and Socialization**
- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- 4. Participate in Curriculum Design and Evaluation of Program Outcomes**
- H. Maintain community and clinical partnerships that support the educational goals
 - I. Create community and clinical partnerships that support the educational goals
 - J. Evaluate educational goal attainment through community and clinical partnerships
- 6. Engage in Scholarship, Service, and Leadership**
- A. Function as a Change Agent and Leader
 - 1. Model cultural sensitivity when advocating for change
 - 8. Promote innovative practices in educational environments

REFERENCES

- American Association of Colleges of Nursing. (2006). *Cultural competency in baccalaureate nursing education*. Retrieved September 23, 2009, from www.aacn.nche.edu/Education/pdf/competency.pdf
- AORN, the Association of periOperative Registered Nurses. (2006). *The value of clinical learning activities in the perioperative setting in undergraduate nursing curricula* [Position statement]. Retrieved September 1, 2009, from <http://www.aorn.org/about/positions/pdf/POS-Value%20Wo20Clinical%20Learning.pdf>
- AORN, the Association of periOperative Registered Nurses. (2009). *Primer for undergraduate perioperative education: Didactic and clinical activities for the perioperative setting*. Retrieved August 15, 2009, from <http://www.aorn.org/Education/EducationResources/PrimerForPerioperativeEducation/>
- Button, L., Green, B., Tengnah, C., Johansson, I., & Baker, C. (2005). The impact of international placements on nurses' personal and professional lives: Literature review. *Journal of Advanced Nursing*, 50, 315–324.
- Caffrey, R. A., Neander, W., Markle, D., & Stewart, B. (2005). Improving the cultural competence of nursing students: Results of integrating cultural content in the

- curriculum and an international immersion experience. *Journal of Nursing Education*, 44, 234–240.
- Chen, S., Melcher, P., Witucki, J., & McKibben, M. (2002). Nursing home use for clinical rotations. Taking a second look. *Nursing and Health Sciences*, 3, 131–137.
- Crigger, N., & Holcomb, L. (2007). Practical strategies for providing culturally sensitive, ethical care in developing nations. *Journal of Transcultural Nursing*, 18, 70–76.
- Davis, R., Beel-Bates, C., & Jensen, S. (2008). The longitudinal elder initiative: Helping students learn to care for older adults. *Journal of Nursing Education*, 47, 179–182.
- DeLashmutt, M. B., & Rankin, E. A. (2005). A different kind of clinical experience: Poverty up close and personal. *Nurse Educator*, 30, 143–149.
- Duffy, M. E., Farmer, S., Ravert, P., & Huittinen, L. (2004). International community health networking project: Two-year follow-up of graduates. *International Nursing Review*, 52(1), 24–31.
- Frank, B., Adams, M., Edelstein, J., Speakman, E., & Shelton, M. (2005). Community-based nursing education of prelicensure students: Settings and supervision. *Nursing Education Perspectives*, 26, 283–286.
- Gaines, C., Jenkins, S., & Ashe, W. (2005). Educational innovations. Empowering nursing faculty and students for community service. *Journal of Nursing Education*, 44, 522–525.
- Goetz, M. A., & Nissen, H. (2005). Educational innovations. Building skills in pediatric nursing: Using a child care center as a learning laboratory. *Journal of Nursing Education*, 44, 277–279.
- Grant, E., & McKenna, L. (2003). International clinical placements for undergraduate students. *Journal of Clinical Nursing*, 12, 529–535.
- Hayes, A. (2005). A mental health nursing clinical experience with hospice patients. *Nurse Educator*, 30, 85–88.
- Health Resources and Services Administration. (2004). *The registered nurse population: Findings from the 2004 National Sample Survey of Registered Nurses*. Retrieved August 15, 2009, from <http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/>
- Kataoka-Yahiro M., Tessier, K., Ratliffe, C., & Matsumoto-Oi, D. (2001). Learning-service community partnership model: A pediatric program evaluation. *Journal of Pediatric Nursing*, 16, 412–417.
- Kiehl, E., & Wink, D. M. (2000). Nursing students as change agents and problem solvers in the community. *Nursing and Health Care Perspectives*, 21, 293–297.
- Ligeikis-Clayton, C., & Denman, J. Z. (2005). Clinical issues. Service-learning across the curriculum. *Nurse Educator*, 30, 191–192.
- Matteson, P. (Ed.). (2000). *Community-based nursing education: The experiences of eight schools of nursing*. New York: Springer Publishing.
- Mitchell, L., Stevens, M., Goodman, J., & Brown, M. (2002). Establishing a collaborative relationship with a college of nursing. *AORN Journal*, 76, 842–848.
- Narsavage, G. L., Batchelor, H., Lindell, D., & Chen, Y. (2003). Developing personal and community learning in graduate nursing education through community engagement. *Nursing Education Perspectives*, 24, 300–305.
- National League for Nursing. (2008). Summary of the survey on clinical education in nursing. *Nursing Education Perspectives*, 29, 238–245.
- Riner, M. E., & Beckenberg, A. (2001). Partnering with a sister city organization for an international service-learning experience. *Journal of Transcultural Nursing*, 12, 234–240.

- Saenz, K., & Holcomb, L. (2009). Essential tools for a study abroad course. *Nurse Educator*, 34, 172–175.
- Schwartz, M., & Laughlin, A. (2008). Partnering with schools: A win-win experience. *Journal of Nursing Education*, 47, 279–282.
- Sigsby, L. (2004). Perioperative clinical learning experiences. *AORN Journal*, 80, 476–490.
- Sigsby, L., & Yarandi, H. (2004). A knowledge comparison of nursing students in perioperative versus other rotations. *AORN Journal*, 80, 699–707.
- Skillen, D., Olson, J., & Gilbert, J. (2003). Promoting personal safety in community health: Four educational strategies. *Nurse Educator*, 28, 89–94.
- Tagliareni, M. E., & Speakman, E. (2003). Community-based curricula at the ADN level: A service-learning model. In M. Oermann & K. Heinrich (Eds.), *Annual review of nursing education* (Vol. 1, pp. 27–41). New York: Springer Publishing.
- Tanner, C. (2006). The next transformation: Clinical education. *Journal of Nursing Education*, 45, 99–100.
- Thompson, K., Boore, J., & Deeny, P. (2000). A comparison of an international experience for nursing students in developed and developing countries. *International Journal of Nursing Studies*, 37, 481–492.
- Toften, K., & Fannesbeck, B. (2002). Camp communities: Valuable clinical options for BSN students. *Journal of Nursing Education*, 41, 83–85.
- Trice, L., Brandvold, C., & Bruno, E. (2007). Practice and education: Partnering to address the perioperative nursing shortage. *AORN Journal*, 86, 259–264.
- Weigerink-Roe, E., & Rucker-Shannon, M. (2008). Immersion in China. Lessons learned. *Nurse Educator*, 33(3), 71–74.
- Wink, D. (2003). Community-based curricula at BSN and graduate levels. In M. Oermann & K. Heinrich (Eds.), *Annual review of nursing education* (Vol. 1, pp. 3–25). New York: Springer Publishing.
- World Health Organization. (2002). *Promoting rational use of medicines: Care components*. Geneva, Switzerland: Author.

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Evaluation
Strategies in
Clinical Teaching

SECTION
IV

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15

Written Assignments

Written assignments enable students to learn about concepts relevant to clinical practice, develop higher-level thinking skills, and examine values and beliefs that may affect patient care. Written assignments about clinical practice combined with feedback from the teacher provide an effective means of developing students' writing abilities. Although writing assignments may vary with each clinical course, depending on the outcomes of the course, assignments may be carefully sequenced across courses for students to develop their writing skills as they progress through the nursing program. The teacher is responsible for choosing written assignments that support the learning outcomes of the course and meet other curriculum goals.

PURPOSES OF WRITTEN ASSIGNMENTS

Written assignments for clinical learning have four main purposes: (1) assist students in understanding concepts, theories, and other content that relate to care of patients; (2) develop higher-level thinking skills; (3) examine their own feelings, beliefs, and values generated from their clinical learning experiences; and (4) develop writing skills.

In choosing written assignments for clinical courses, the teacher should first consider the outcomes to be met through the assignments and the competencies that students need to develop in the course and nursing program. Writing assignments should build on one another to progressively develop students' skills. Another consideration is the number of assignments to be completed. How many assignments are needed to demonstrate mastery? It may be that one assignment well done is sufficient for meeting the outcomes of the clinical course, and students may then progress to other learning activities. Teachers should avoid using the same written assignments repeatedly throughout a clinical course and instead should choose assignments for specific learning outcomes.

Promote Understanding

In written assignments, students can describe concepts, theories, and other information relevant to the care of their patients and can explain how these concepts and theories guide their clinical decisions and judgments. Assignments for this purpose need a clear focus to prevent students from merely summarizing and reporting what they read. Shorter assignments that direct students to apply particular concepts to clinical practice may be of greater value in achieving this purpose than longer assignments for which students summarize readings they completed without any analysis of the meaning of those readings for their particular patients (Oermann, 2006).

Examples of written assignments to promote understanding of concepts, theories, and other information related to clinical practice are:

- Compare, in no more than three pages, two interventions appropriate for your patient in terms of their rationale and evidence. How will you evaluate their effectiveness?
- Read a research article related to care of one of your patients, critique the article, report on the analysis, and explain why the research findings are or are not applicable to the patient's care.
- Compare data collected from your patient with the description of that condition in your textbook. What are similarities and differences? Why?
- Select a family theory and complete an assessment of a family using this theory.

- Investigate systems in your clinical setting for preventing medication errors. Write a summary report with recommendations.

Develop Higher-Level Thinking Skills

Written assignments provide an opportunity for students to analyze patient and other problems they have encountered in clinical practice, evaluate their interventions, and propose new approaches. In writing assignments, students can analyze data and clinical situations, identify additional assessment data needed for decision making, identify patient needs and problems, propose approaches, compare interventions based on evidence, and evaluate the effectiveness of care. Writing assignments are particularly valuable for learning about evidence-based practice. Students can access and examine the evidence underlying different interventions and make decisions about the best approaches to use with their patients. Students can identify assumptions they made about patients' responses that influenced their clinical decisions, critique arguments, take a stand about an issue and develop a rationale to support it, and draw generalizations about patient care from different clinical experiences.

Assignments geared to critical thinking should give students freedom to develop their ideas and consider alternative perspectives. If the assignment is too restrictive, students are inhibited in their thinking and ways of approaching the problem.

Written assignments for developing higher-level thinking skills can be short, ranging from one to two paragraphs to a few pages. In developing these assignments, the teacher should avoid activities in which students merely report on the ideas and thinking of others. Instead, the assignment should ask students to consider an alternative point of view or a different way of approaching an issue. Short assignments also provide an opportunity for faculty members to give prompt feedback to students on alternative ways of thinking about the clinical situation (Oermann, 2006).

In addition to being short, the assignment should focus on meeting a particular learning outcome and should have specific directions to guide students' writing. For example, students may be asked to prepare a one-page paper comparing the physiological processes of asthma and bronchitis. Rather than writing on everything they read about asthma and bronchitis, students focus their papers on the physiology of these two conditions.

Examples of written assignments for developing higher-level cognitive skills follow:

- Describe in one paragraph significant information you collected from your patient and why it is important to your decisions about approaches to use with that patient.
- Select one need or problem you identified for your patient and provide a rationale for it. What is one alternative need or problem you might also consider and why? Complete this assignment in two typed pages.
- Identify a near miss (close call) or an unsafe practice that you experienced or observed in your clinical setting. Analyze what went wrong and practices that should have been used. Prepare a response integrating the concept of just culture.
- Identify an issue affecting your patient, family, or community. Analyze that issue from two different points of view. Provide a rationale for actions to be taken from both perspectives. How would you approach this issue and why?
- Identify a procedure you performed in your clinical setting. Find the written policy. Was your performance consistent with that policy? Why or why not? Are there deviations or workarounds you observed on the unit with that procedure? Write a report about what you learned.

Examine Feelings, Beliefs, and Values

Written assignments help learners examine feelings generated from caring for patients and reflect on their beliefs and values that might influence that care. Journals, for instance, provide a way for students to record their feelings about a patient or clinical activity and later reflect on these feelings. Assignments may be developed for students to identify their own beliefs and values and analyze how they affect their interactions with patients, families, and staff. Value-based statements may be given to students for written critique, or students may be asked to analyze an ethical issue, propose alternative courses of actions, and take a stand on the issue.

Examples of writing assignments that help students explore their feelings, beliefs, and values are:

- Identify an issue that affects patient care. Read about the issue, identify a journal that publishes articles in that area of clinical

practice, and write an editorial that describes how you would address the issue either as a nurse manager or in the role of a staff nurse.

- In your journal, write about your feelings about caring for your patient and other patients in this setting. In what way do those feelings influence your care?
- A peer tells you she forgot to give her patient the scheduled pain medications but is not telling her faculty member because the patient never complained of pain. What would you say to this individual? Why did you choose this approach?
- Think about the community in which you are currently practicing. How do your values, beliefs, and personal goals influence your practice in that community?

Develop Writing Skills

An important outcome of writing assignments is the development of skill in communicating ideas in written form. Assignments help students learn how to organize thoughts and present them clearly. This clarity in writing develops through planned writing activities integrated in the nursing program. As a skill, writing ability requires practice, and students need to complete writing assignments across clinical courses. All too often, writing assignments are not sequenced progressively across courses or levels in the program; students, then, do not have the benefit of building writing skills sequentially.

Writing-to-learn programs are designed to meet this need. In such programs, written assignments are sequenced across the nursing curriculum to improve students' writing skills, help them learn about content related to the course, and develop thinking and critical analysis skills. Luthy, Peterson, Lassetter, and Callister (2009) described an extensive program they developed to integrate writing competencies in a baccalaureate nursing program. Examples of written assignments include integrated literature reviews, analyses of ethical dilemmas, preparation of resumes, and others. In this program, some of the writing assignments, such as the literature reviews, are divided into smaller activities that then build on one another. With writing assignments incorporated throughout the curriculum, peer critique, and teacher feedback on writing, students develop their writing skills over time (Luthy et al., 2009). Students can begin with short assignments related to the clinical course, such as summarizing data they collected on a patient or preparing a report on

how their assessment or nursing care related to their textbook and other readings. In later assignments, students can complete literature reviews, evidence-based practice papers, critiques of research studies related to clinical practice, analyses of quality and safety problems on the unit, and term papers. In this way, the writing assignments become more complex and require advanced writing skills; they also provide variety for students.

A benefit of this planned approach to teaching writing is faculty feedback, provided through drafts and rewrites of papers. Drafts are essential to foster development of writing skill. Drafts should be critiqued by faculty members for accuracy of content, development of ideas, organization, clarity of expression, and writing skills such as sentence structure, punctuation, and spelling (Oermann, 2002).

Small group critique of each others' writing is appropriate particularly for formative purposes. Small group critique provides a basis for subsequent revisions and gives feedback to students about both content and writing style. Although students may not identify every error in sentence structure and punctuation, they can provide valuable feedback on content, organization, how the ideas are developed, and clarity of writing. When peers evaluate each others' papers, though, there may be wide variability in scoring and use of the criteria for evaluation (Giddens & Lobo, 2008). Peer review should be used for giving feedback only, not for determining a grade for the assignment.

TYPES OF WRITING ASSIGNMENTS FOR CLINICAL LEARNING

Many types of writing assignments are appropriate for enhancing clinical learning. Some assignments help students learn the content they are writing about but do not necessarily improve writing skill, and other assignments also promote competency in writing. For example, structured assignments such as care plans provide minimal opportunity for freedom of expression, originality, and creativity. Other assignments, though, such as term papers on clinical topics, promote understanding of new content and its use in clinical practice as well as writing ability.

Types of written assignments for clinical learning include concept map, concept analysis paper, short written assignments, nursing care plan, case method and study, evidence-based practice (EBP) papers, teaching plan, journal, group writing, and portfolio.

Concept Map

A concept map is a graphic or pictorial arrangement of key concepts related to a patient's care. By developing a concept map, students can visualize how signs and symptoms, problems, interventions, medications, and other aspects of a patient's care relate to one another. Concept maps help students organize patient information. They also can be used to teach concepts related to clinical practice rather than focusing on content. For example, Vacek (2009) presents the concept of psychosis and related nursing actions by using a concept map; if students understand the concept, they can provide care for these patients regardless of the health care setting and etiology.

Concept maps have many uses in clinical learning. First, students may complete a concept map from their readings to assist them in linking new information to their patients. The readings that students complete for clinical practice, and in nursing courses overall, contain vast amounts of facts and specific information; concept maps help students process this information in a meaningful way, linking new and existing ideas.

Second, concept maps are useful in helping students prepare for clinical practice. They can be developed prior to a clinical experience as a way of organizing assessment information, relating it to the patient's needs and problems, and planning nursing care. In preclinical conferences, students can present the maps for feedback from the teacher and from peers. Students can modify the maps as they provide care for patients. Used in this way, concept maps allow faculty members to assess students' ability to identify the priority data for a patient and relationships between problems and nursing care (Senita, 2008).

Third, concept maps may be developed collaboratively by students in clinical conferences. For this purpose, students may present a patient for whom they have provided care, and the clinical group then develops a concept map about that patient's care. Or the clinical group may develop a concept map about conditions or community problems they are learning about in the course. As another strategy, students can present the concept maps they developed for their patients, and the group can analyze and discuss them. Critiquing each others' concept maps enhances critical thinking, learning from one another, and group process; it also allows for feedback from the teacher and peers.

Concept maps are organized with specific concepts written under more general ones. Students first identify relevant concepts for their patients' care and then link these concepts. Different types of lines can be

used to illustrate the relationships among the concepts. Figure 15.1 and Figure 15.2 show concept maps. Concept maps are most appropriately used for formative evaluation, although students could write papers or present on the concepts in the maps, their interrelationships, and rationale, which then could be graded by faculty members.

Concept Analysis Paper

Concept analysis papers help students understand difficult concepts and how they are applied in patient care. For these papers, students identify and define a concept related to clinical practice, such as family-centered care or a problem such as pain. They then explore characteristics of the concept and how that concept would be seen in clinical practice. Students can write papers about the concept and can develop a model case or scenario that exemplifies its various characteristics. These papers can be used as term papers, because students need to review the literature as the basis for their analysis. As an example, an assignment might be to:

Identify a concept related to long-term care. Review the literature and provide a summary of the review. Define the characteristics of the concept—that is, how the concept would be seen in clinical practice, an organization, or the health care system. What are issues you learned about this concept? Discuss implications for nursing practice related to your concept.

Short Written Assignments

Short written assignments in clinical courses are valuable for promoting critical thinking and analysis. Short assignments avoid students' summarizing what others have written without thinking about the content themselves (Oermann, 2006). With a short assignment, students can analyze patient needs and problems, compare interventions with their evidence, explore decisions that might be made in a clinical situation, analyze an issue and approaches, and analyze a case scenario. Sample assignments are found in Exhibit 15.1.

Nursing Care Plan

Nursing care plans enable students to analyze patients' health problems and design plans of care. With care plans, students can record assessment data, identify patient needs and problems, select evidence-based

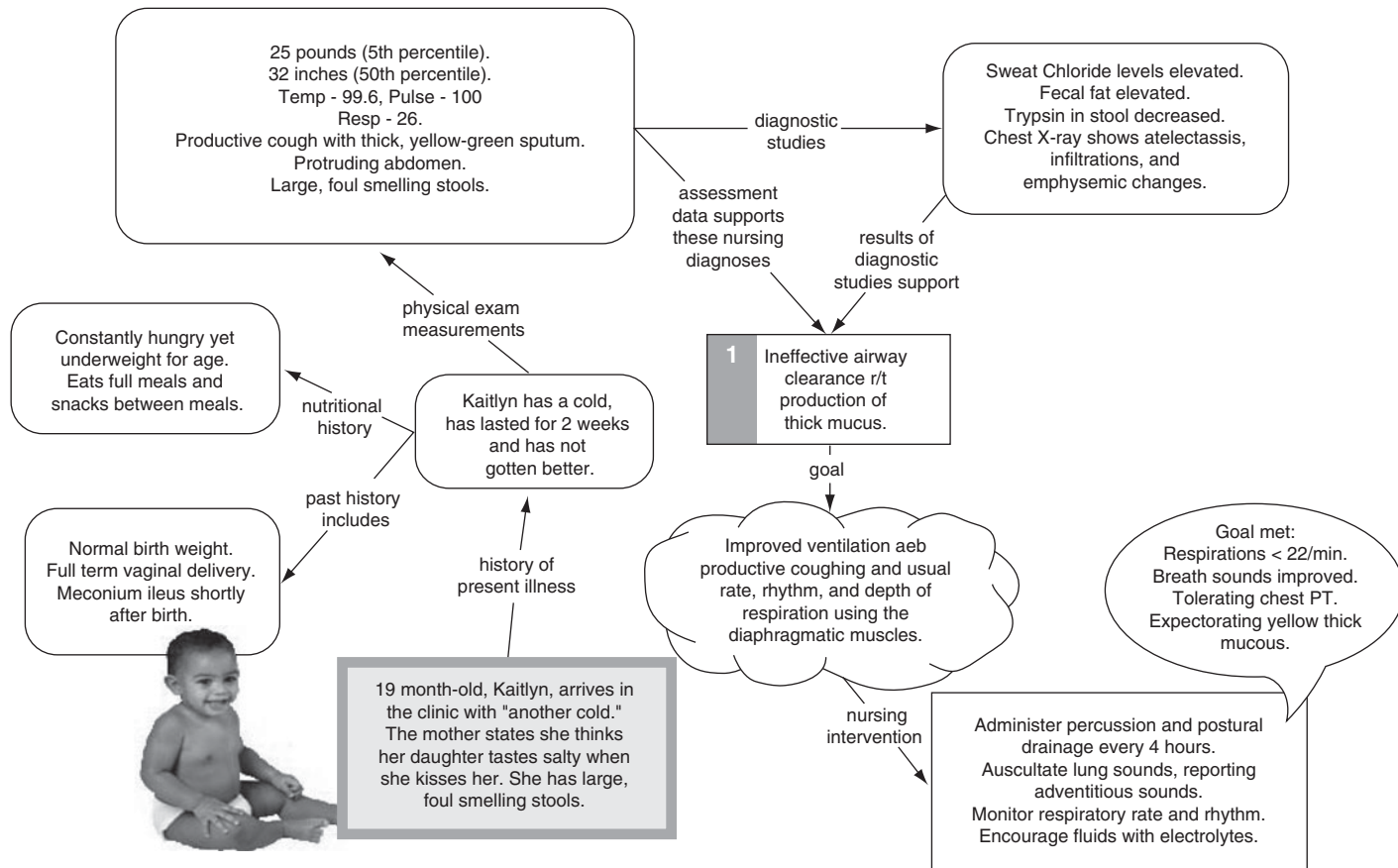


Figure 15.1 This concept map depicts the plan of care for a 19-month-old who has been diagnosed with cystic fibrosis. Developed by Deanne Blach, MSN, RN. Reprinted by permission Deanne Blach.

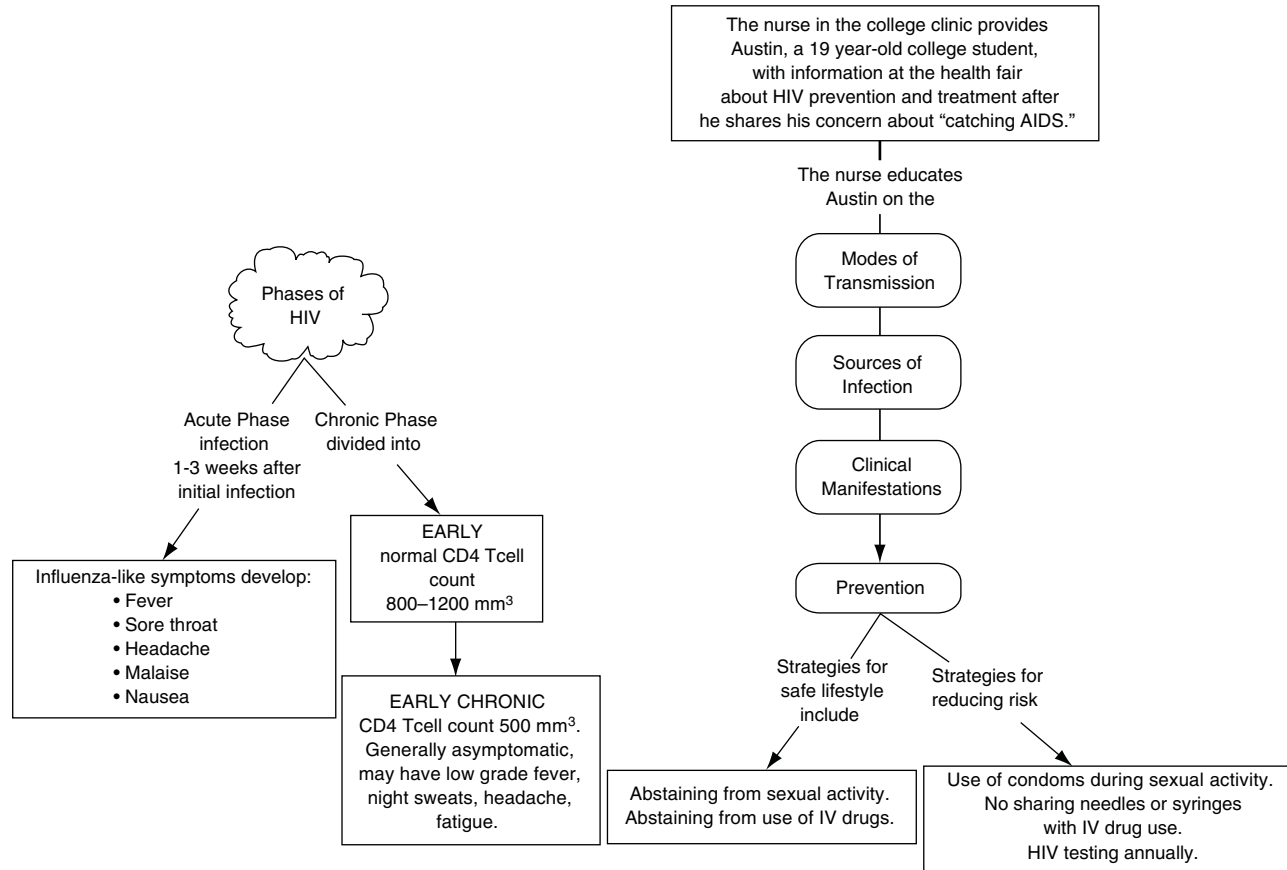


Figure 15.2 This concept map outlines health education about HIV prevention and treatment. Developed by Deanne Blach, MSN, RN. Reprinted by permission Deanne Blach.

Exhibit 15.1

EXAMPLES OF SHORT WRITTEN ASSIGNMENTS FOR CLINICAL COURSES

- The unit secretary is slow about notifying nursing staff when patients use their call bells. It appears that only the assigned staff will answer the call bells; other nurses and aides who happen to be close by the patient's room will not respond. Develop a quality improvement project to address this issue.
- Select an intervention or treatment you used in patient care. Search for evidence related to that intervention or treatment. What were your sources of evidence? Summarize the strength of the evidence and discuss what it means for patient care.
- Read the article on loneliness. In no more than one page, explain how you would use that concept in an assessment.
- Describe the concept of patient-centered care and its use in a community setting.
- In what ways did your patient's needs and problems compare to the description in your textbook?
- Your patient had a knee replacement and reports too much pain to go to physical therapy. Two hours ago, the prior nurse recorded in the medical record that the patient "had no pain and walked twice around the room." What are two different ways of approaching this situation? What would you do and why?
- Your patient is readmitted with congestive heart failure. He is agitated, and his respiratory rate is increasing rapidly. He is receiving oxygen by nasal cannula at 2 L/min. What additional data would you collect? What would you do next? Provide a rationale for your answer.
- Identify a decision you made in clinical practice involving either patients or staff. Describe the situation and why you responded that way. Propose another approach that could have been used.
- Describe the processes established in your clinical setting for medication reconciliation. How are those processes being implemented on your unit?

interventions, and identify outcomes to be measured. Care plans should be usable—they should guide students' planning of their patients' care, be realistic, and be able to be implemented in the health care setting.

Completing a written care plan may help the student identify nursing and other interventions for specific problems, but whether that same care plan promotes problem-solving learning and higher-level thinking is questionable. Often students develop care plans from their textbook or the literature without thinking about the content. Even if the care plan is an appropriate written assignment for the course outcomes, the question remains as to how many care plans students need to complete in

a clinical course to meet the learning goals. Once the goals have been achieved, then other written assignments may be more effective for clinical learning.

Case Method and Case Study

Case method and case study describe a clinical situation developed around an actual or a hypothetical patient for student review and critique. In case method, the case provided for analysis is generally shorter and more specific than in case study. Case studies are more comprehensive, thereby presenting a complete picture of the patient and clinical situation. After analyzing the case, students complete written questions about it; questions may be answered individually or by small groups of students. Case method and case study are discussed in detail in chapter 10.

Evidence-Based Practice Papers

Assignments in clinical courses can guide students' learning about EBP and its use in patient care. Studies continue to reveal the limited understanding of nurses about EBP, barriers to EBP, and nurses' reliance on colleagues for guidance with clinical decisions rather than on research and other sources of evidence (Beke-Harrigan, Hess, & Weinland, 2008; Estabrooks, Chong, Brigidear, & Profetto-McGrath, 2005; Gale & Schaffer, 2009; Pravikoff, Tanner, & Pierce, 2005; Spenceley, O'Leary, Chizawsky, Ross, & Estabrooks 2008). Clinical assignments that are integrated in courses throughout the nursing program foster students' knowledge about EBP and its importance in clinical practice.

A useful model for planning EBP assignments for clinical courses was developed by Pierce (2005). This model includes five steps, which Pierce suggested are critical to implementing EBP in a nursing curriculum:

1. Develop a researchable question about clinical practice.
2. Design and complete an evidence search.
3. Retrieve and evaluate the evidence.
4. Use the evidence for clinical decisions.
5. Evaluate effects of decision on patient outcomes.

Student assignments can be developed for each of these steps and integrated in clinical courses in the program. By using a model such as this one or another EBP model, teachers can plan assignments for each

clinical course in the curriculum, assisting students in integrating EBP into their practice. Exhibit 15.2 provides sample clinical assignments based on this model.

Heye and Stevens (2009) developed an innovative strategy for teaching EBP that is useful for a clinical course. In this strategy, students select a clinical topic from one of the Institute of Medicine priority areas; locate evidence from major bibliographic databases; categorize the evidence as primary research, an evidence summary, or a clinical practice guideline; and judge the strength of evidence. Following this analysis, students compare nursing practice with the evidence and identify gaps, if any. Students follow up with oral and poster presentations, which can be done with the clinical group or with the class as a whole, or they can be implemented online.

Teaching Plan

Teaching plans enable students to apply concepts of learning and teaching to patients, families, and communities. This is another type of written assignment that may be completed individually or in small groups. After developing the teaching plan, students may use it as a basis for their teaching. There are many formats for teaching plans, but typically the assignment would include objectives, content, teaching strategies, and evaluation strategies.

Journal

Journal writing assists students in relating theory to clinical practice, linking their classroom and online instruction to care of patients, and reflecting on their clinical learning activities. Journals help students make connections between theoretical knowledge and observations in the clinical setting (Van Horn & Freed, 2008). When students reexamine their clinical decisions and propose alternative actions, journaling also encourages the development of higher-level thinking skills and clinical judgment. Assignments in which students write in journals about their clinical practice can achieve many outcomes; some of these are listed in Exhibit 15.3.

Journals also are a good strategy for developing reflective practice (Blake, 2005; Epp, 2008). In a journal, students can reflect on their clinical experiences and reexamine them, improving their awareness of their own behaviors and responses within the context of the clinical

Exhibit 15.2

SAMPLE CLINICAL ASSIGNMENTS FOR LEARNING ABOUT EVIDENCE-BASED PRACTICE**Develop a Researchable Question About Clinical Practice**

Identify a problem of one of your patients. What additional information do you need to plan care, and why is this information critical to your decision making? How will you find this information?

Write a clinical question using PICO (patient, intervention, comparison, and outcome).

Think about a patient for whom you cared this week. Identify a question you had about that patient's care. List two sources of information to answer that question with a rationale for why these are appropriate. Discuss your question, sources of information, and rationale with a peer during postclinical conference. Are there other sources of information? Present to the clinical group.

Identify a change in practice needed on your unit. Why is it needed? What led you to this decision? Write a short paper (no more than one page).

Design and Complete an Evidence Search

List a question you had about a patient's care. Identify key words to search for an answer. Go to the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and modify your key words as needed. Complete the search in CINAHL, mapping out your search strategy. Summarize your findings. What would you do differently with this search the next time? Write a two- to three-page paper on this search and what you found.

Conduct the same search in MEDLINE. What are the differences, if any, in the results of your search? What did you learn about these two databases? Present in clinical conference.

Conduct a search using your PICO question. For this search start with PubMed Clinical Queries and describe your search strategy and results. Then continue your search in CINAHL. What evidence did you find related to your PICO question?

Identify a bibliographic database other than CINAHL or MEDLINE that you might use in your clinical practice—for example, PsycINFO. Identify a question that could be answered by searching in that database. Conduct the search and summarize your results. How could you use these results in clinical practice? What did you learn about this database? Present in the discussion board.

Retrieve and Evaluate the Evidence

Identify a question about clinical practice or a change in practice that might be indicated. Review the literature. What studies are relevant for inclusion in your review and why? Critique the evidence (consider validity, relevance,

(continued)

and applicability). Summarize your findings and develop a written proposal for use of this evidence to guide practice or why a practice change is not indicated.

Review clinical research studies in an area of nursing practice related to the course. Critically appraise those studies and synthesize findings. What are issues in implementing those findings in your clinical setting? What would you propose to facilitate implementation? Prepare a paper on your review and analysis.

Discuss how you can use the Cochrane Database of Systematic Reviews in your patient care. Select a nursing intervention and locate information about this intervention in Cochrane. Write a three- to four-page report on your findings.

Synthesize the evidence you found related to your PICO question and discuss its applicability to nursing practice.

Use the Evidence for Clinical Decisions

List interventions for one of your patients. What is the evidence base for each of these? Provide a rationale for their use based on the strength of the evidence. Include the sources of information you used to determine the evidence base. What evidence is missing, and what do you propose?

Review your patient's care. Select one problem not adequately met with current practices. Search for evidence to suggest a change in practice, evaluate the evidence, and write a paper about how you would change practice based on your review. What would you do differently next time you cared for that patient or patients with similar problems?

Select an intervention and find evidence using resources from the Joanna Briggs Institute. Describe the evidence you located. Did it help you make a decision about the effectiveness of the intervention? Why or why not? How would you use this information in your clinical practice? Prepare a short paper.

Evaluate Effects of Decisions on Patient Outcomes

For a practice change or evidence-based intervention you proposed in an earlier assignment, plan how you would evaluate its effect on patient outcomes. Present in online discussion.

Identify a question you had about your patient's care. Go to the National Guideline Clearinghouse. What evidence-based practice guidelines are relevant for this patient? If you implemented one of these guidelines in your clinical setting, what outcomes would you measure?

Implement one evidence-based intervention in patient care and evaluate its outcomes. Write a short (no more than two pages) report on your findings.

Note. Based on a model developed by S. T. Pierce in "Integrating Evidence-Based Practice Into Nursing Curricula," pp. 233–248, in *Annual Review of Nursing Education*, Vol. 3), edited by M. H. Oermann and K. T. Heinrich, 2005, New York: Springer Publishing.

Exhibit 15.3

USES OF CLINICAL JOURNALS

Document feelings related to clinical practice and reflect on their meaning. Describe perceptions of patients, families, communities, and clinical experiences with them.

Develop values and affective skills.

Analyze ethical issues and dilemmas.

Assess one's own knowledge and performance.

Identify gaps in learning and how to improve performance.

Analyze one's own actions and decisions following a clinical experience.

Record accomplishments in clinical practice.

Communicate with the clinical teacher, preceptor, and others involved in the experience.

environment. Callister, Luthy, Thompson, and Memmott (2009) found from an analysis of undergraduate students' reflective journals that the journals enabled students to explore their caring beliefs and how they implemented them with patients.

Through a reflective journal, students can:

- Find meaning in their clinical experiences
- Make connections between those experiences and their learning in class
- Gain values of the nursing profession and develop their own affective skills
- Learn about the perspectives of others
- Reflect on professional roles
- Develop writing and thinking skills
- Learn to care for self (Billings & Kowalski, 2006; Blake, 2005, p. 2)

Epp (2008) reviewed the literature on the effectiveness of reflective journals for promoting learning from clinical practice. Nine studies were analyzed. Those studies indicated that journals provided a means for undergraduate students to reflect on their clinical practice and that students learned from the assignment. The literature review also found that the ability to write reflectively improved when students used journaling over time. More research is needed, however, on the outcomes of this type of writing assignment.

There are different ways of structuring journals, and the decision should be based on the intended outcomes of using the journal in the clinical course. The first step for the teacher is to identify the learning outcomes to be met through journal writing, such as reflecting on clinical decisions or describing feelings in caring for a patient, and then how journal entries should be made. Students should understand what learning outcomes are being achieved through journaling so they can gear their entries to those goals. Journals can be done electronically with course management systems, e-mail, blogs, and by using software for this purpose. Electronic journaling makes it easier for teachers to provide prompt feedback, dialogue with students, and store the journals.

Journals typically are not graded but provide an opportunity for giving feedback to learners and developing a dialogue with them. Students have greater freedom in recording feelings, ideas, and responses when the journal is used only for feedback. Faculty members are responsible for providing thoughtful and prompt feedback similar to any written assignment.

Group Writing

Not all writing assignments need to be done by students individually. There is much to be gained with group writing exercises as long as the groups are small and the exercises are carefully focused. Short written assignments, such as analyzing an issue and reporting in writing the outcomes of the analysis or developing a protocol as a group, may be completed in clinical conferences. These group assignments provide opportunities for students to express their ideas to others in the group and work collaboratively to communicate the results of their thinking as a group in written form.

Portfolio

A portfolio provides an opportunity for students to present projects they completed in their clinical courses over a period of time. Portfolios may include evidence of student learning for a series of clinical learning activities over the duration of a clinical course or for documenting competencies in terms of overall course or program outcomes (Oermann & Gaberson, 2009).

There are two types of portfolios: best-work and growth and learning progress (Nitko & Brookhart, 2007). Best-work portfolios include materials and products developed by students in clinical practice that

demonstrate their learning and achievements. These portfolios reflect the best work of the students in the clinical course. In contrast, growth and learning progress portfolios include materials and products in the process of being developed. These portfolios serve as a way of monitoring students' progress in clinical practice (Oermann & Gaberson, 2009). With both types of portfolios, the teacher reviews them periodically and provides feedback on the materials and products in the portfolio.

The content of the portfolio depends on the goals to be achieved. Students may include in their portfolios any materials they developed individually or in a group that provide evidence of their achieving the outcomes of the clinical course or demonstrating the clinical competencies. Examples of these materials are:

- Documents that students developed for patient care
- Teaching plans and materials
- Papers written about clinical practice
- Selected journal entries
- Reports of group work and products
- Reports and observations made in the clinical setting
- A self-assessment
- Reflections of their patient care experiences and meaning to them
- Other products that demonstrate their clinical competencies and what they learned in the course

Exhibit 15.4 presents a process for developing a portfolio for a clinical course.

EVALUATING WRITTEN ASSIGNMENTS

Written assignments may be evaluated formatively or summatively. Formative evaluation provides feedback to students for their continued learning but not for grading purposes. Periodic assessment of drafts of papers and work in progress is formative in nature and is not intended for arriving at a grade. Summative evaluation of completed writing assignments is designed for grading the assignment, not for giving feedback to the student.

For written assignments that are not graded, the teacher's role is to give prompt and sufficient feedback for students to learn from the assignment. If the assignment will be graded at a later time, however, then criteria for grading should be established and communicated to the

DEVELOPING A PORTFOLIO FOR CLINICAL LEARNING

Step 1: Identify the purpose of the portfolio.

- Why is a portfolio useful in the course? What goals will it serve?
- Will the portfolio serve as a means of assessing students' development of clinical competencies, focusing predominantly on the growth of the students? Will the portfolio provide evidence of the students' best work in clinical practice, including products that reflect their learning over a period of time? Or, will the portfolio meet both demands, enabling the teacher to give continual feedback to students on the process of learning and projects on which they are working, as well as providing evidence of their accomplishments and achievements in clinical practice?
- Will the portfolio be used for formative or summative evaluation? Or both?
- Will the portfolio provide assessment data for use in a clinical course? Or, will it be used for curriculum and program evaluation?
- Will the portfolio serve as a means of assessing prior learning and therefore have an impact on the types of learning activities or courses that students complete, for instance, for assessing the prior learning of registered nurses entering a higher degree program or for licensed practical nurses entering an associate degree program?
- What is the role of the students, if any, in defining the focus and content of the portfolio?

Step 2: Identify the type of entries and content to be included in the portfolio.

- What types of entries are required in the portfolio, for example, products developed by students, descriptions of projects with which the students are involved, descriptions of clinical learning activities and reactions to them, observations made in clinical practice and analysis of them, and papers completed by the students, among others?
- In addition to required entries, what other types of content and entries might be included in the portfolio?
- Who determines the content of the portfolio and the types of entries? Teacher only? Student only? Or both?
- Will the entries be the same for all students or individualized by the student?
- What is the minimum number of entries to be considered satisfactory?
- How should the entries in the portfolio be organized, or will the students choose how to organize them?
- Are there required times for entries to be made in the portfolio, and when should the portfolio be submitted to the teacher for review and feedback?
- Will teacher and student meet in a conference to discuss the portfolio?

Step 3: Decide on the evaluation of the portfolio entries including criteria for evaluation of individual entries and the portfolio overall.

- How will the portfolio be integrated within the clinical evaluation grade and course grade, if at all?

(continued)

- What criteria will be used to evaluate, and perhaps score, each type of entry and the portfolio as a whole?
- Will only the teacher evaluate the portfolio and its entries? Will only the students evaluate their own progress and work? Or, will the evaluation be a collaborative effort?
- Should a rubric be developed for scoring the portfolio and individual entries? Is there one available in the nursing education program that could be used?

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learner. Any assignment that will eventually be graded should have clear, specific, and measurable criteria for evaluation. Some writing assignments, such as journals, do not lend themselves to grading and instead are best used for formative evaluation only.

Drafts

If drafts of written assignments are to be submitted, the teacher should inform students of each required due date. All written assignments benefit from prompt and specific feedback from the teacher. Feedback should be given on the quality of the content, as reflected in the criteria for evaluation, and on writing style if appropriate for the assignment. Students need specific suggestions about revisions, not general statements such as “Unclear objectives in teaching plan.” Instead, tell students exactly what needs to be changed; for instance, “Objective #1 in teaching plan is not measurable. Revise the verb; content is clear and relevant.” Drafts of written assignments are important because they serve as a means of improving writing and thinking about the content. Prompt, clear, and specific feedback about revisions is essential to meet this purpose. Drafts in most instances are used for feedback and therefore are not graded.

Criteria for Evaluation

The criteria for evaluation should relate to the learning outcomes to be met with the assignment. For example, if students write a short paper to meet the objective, “Compare interventions for nausea associated

Exhibit 15.5

**GENERAL CRITERIA FOR EVALUATING PAPERS
IN CLINICAL COURSES***Content*

Content is relevant to patient or clinical situation.
Content is accurate.
Significant concepts and theories are presented.
Concepts and theories are used appropriately for analysis.
Content is comprehensive.
Content reflects current research and evidence.
Hypotheses, conclusions, and decisions are supported.

Organization

Content is organized logically.
Ideas are presented in logical sequence.
Paragraph structure is appropriate.
Headings are used appropriately to indicate new content areas.

Process

Process used to arrive at approaches, decisions, judgments, and so forth is adequate.
Consequences of decisions are considered and weighed.
Sound rationale is provided based on theory and research as appropriate.
For papers analyzing issues, rationale supports position taken.
Multiple perspectives and new approaches are considered.

Writing Style

Ideas are described clearly.
Sentence structure is clear.
There are no grammatical errors.
There are no spelling errors.
Appropriate punctuation is used.
Writing does not reveal bias related to gender, sexual orientation, racial or ethnic identity, age, or disabilities.
Length of paper is consistent with requirements.
References are cited appropriately throughout paper.
References are cited accurately according to required format.

with chemotherapy,” criteria should relate to the appropriateness and evidence for the interventions selected for critique, how effectively the student compared them, the rationale developed for the analysis, and the like.

General criteria for evaluating written assignments in clinical courses are presented in Exhibit 15.5. These criteria need to be adapted based on the type of assignment and its intent. For assignments that are graded, students should have the criteria for evaluation and scoring protocol or rubric before they begin writing so they are clear about how the assignment will be assessed.

Grading Assignments

In grading written assignments, a scoring protocol should be developed based on the criteria established for evaluation. The protocol should include the elements to be evaluated and points allotted for each one. The scoring protocol must be used in the same way for all students. This is an important principle in grading written assignments to assure consistency across papers and to focus the evaluation on the specific criteria. Some teachers tend to be more lenient, and others tend to be more critical in their review of papers. A scoring protocol helps the teacher base the grade on the established criteria rather than some other standard. Teachers will be more consistent in grading papers if they first establish specific criteria for evaluation, then develop a scoring protocol based on these criteria, and then use that scoring protocol in the same way for each student.

For some papers, a scoring rubric can be developed to guide the evaluation. A rubric lists the criteria to be met in the paper or characteristics of the paper and the points given for their evaluation. Exhibit 15.6 shows an example of how a rubric for scoring papers is developed using the general criteria in Exhibit 15.5. There are different types of rubrics. With a holistic rubric, the teacher scores the paper as a whole without assessing individual parts of the paper. An analytic rubric guides the assessment of separate parts of the paper and then sums them for a total score (Mertler, 2003). For short written assignments in clinical courses, a protocol for scoring them is sufficient. However, for term papers or longer assignments, the teacher can develop a more detailed rubric for use in evaluating them.

Written assignments that are graded should be read anonymously if at all possible. This is sometimes difficult with small groups of students. Nevertheless, students can record on their papers their student numbers rather than their names. There is a tendency in evaluating papers and other written assignments, similar to essay items, for the teacher to

Exhibit 15.6

SAMPLE SCORING RUBRIC FOR PAPERS IN CLINICAL COURSES

<i>Content</i>		
Content relevant to patient or clinical situation, comprehensive, and in depth 5	Content relevant to patient or clinical situation with critical information included 4 3	Some content not relevant to patient or clinical situation, critical information missing, lacks depth 2 1
Content accurate 5	Most of content accurate 4 3	Major errors in content 2 1
Sound background developed from peer-reviewed articles and wide range of information sources 5	Textbook and Web sites predominant sources of information for developing background 4 3	Background not developed, limited support for ideas 2 1
Current research and evidence synthesized and integrated effectively 10-7	Current research and evidence summarized 6-4	Limited research and evidence in paper, not used to support ideas 3-1
<i>Organization</i>		
Purpose of paper well developed and clearly stated 3	Purpose apparent but not developed sufficiently 2	Purpose poorly developed, not clear 1
Content well organized and logically presented, organization supports arguments and development of ideas 10-7	Clear organization of main points and ideas 6-4	Poorly organized, content not developed adequately 3-1
Effective conclusions based on analysis 3	Conclusions based on summary of content, limited analysis 2	Poor conclusions, not based on content in paper 1

(continued)

Writing Style and Format		
Sentence structure clear, smooth transitions, correct grammar and punctuation, no spelling errors 10 – 7	Adequate sentence structure and transitions; few grammar, punctuation, and spelling errors 6 – 4	Poor sentence structure and transitions; errors in grammar, punctuation, and spelling 3 – 1
Professional appearance of paper, all parts included, length consistent with requirements 3	Paper legible, some parts missing or too short or too long considering requirements 2	Unprofessional appearance, missing sections, paper too short or too long considering requirements 1
References used appropriately, references current, no errors in references, correct use of APA style 6 5	References used appropriately but limited, most references current, some citations or references with errors or some errors in APA style 4 3	Few references and limited breadth, old references (not classic), errors in references, errors in APA style 2 1
Total Score _____ (Sum points for total score; maximum score 60)		

be influenced by a general impression of the student. This is called the halo effect. The teacher may have positive or negative feelings about the student or other biases that may influence evaluating and grading the assignment.

Another reason to read papers anonymously is to avoid a carryover effect, in which the teacher carries an impression of the quality of one written assignment to the next one that the student completes. If the student develops an outstanding paper, the teacher may be influenced to score subsequent written assignments at a similarly high level; the same situation may occur with a poor paper. The teacher therefore carries the impression of the student from one written assignment to the next. If there are multiple questions that students answered as part of a written assignment, the previous scores should be covered to avoid being biased about the quality of the next answer. In addition, the teacher should evaluate all students' answers to one question before proceeding to the next question (Oermann & Gaberson, 2009).

All written assignments should be read twice before scoring. In the first reading, it is important to note errors in content, omission of major content areas, problems with organization, problems with the process used for approaching the issue, and problems with writing style. Comments can be recorded on the student's paper with suggestions for revision. After reading through all of the papers, then the teacher should begin a second reading for scoring purposes. Reading the papers twice gives the teacher a sense of how students approached the assignment. This is important because, in some cases, the scoring protocol may need to be revised.

Papers and other types of written assignments should be read in random order. After the first reading, the teacher can shuffle the papers so they are read in a random order the second time. Papers read early may be scored higher than those read near the end (Oermann & Gaberson, 2009). Teacher fatigue also may set in and influence the grading of papers. Although this section discusses grading written assignments, the teacher should remember that many writing assignments will not be graded.

SUMMARY

Written assignments for clinical learning have four main purposes: to learn about concepts, theories, and other content related to clinical practice; develop thinking skills; examine values and beliefs that may affect patient care; and develop writing skills. Not all writing assignments achieve each of these outcomes. The teacher decides first on the outcomes to be met, then plans the writing assignment with these outcomes in mind.

Written assignments for critical thinking should be short. In developing these assignments, the teacher should avoid activities in which students merely report on the ideas of others; instead, the assignment should ask students to consider an alternative point of view or a different way of approaching an issue. Short assignments also provide an opportunity for faculty members to give prompt feedback to students.

Written assignments help learners examine feelings generated from caring for patients and reflect on their beliefs and values that might influence that care. They also help students learn how to organize thoughts and present them clearly. Some faculty members have developed writing-to-learn programs in which written assignments are sequenced across the nursing curriculum.

Many types of written assignments can be used for clinical learning. Concept map, concept analysis paper, short written assignments, nursing care plan, case method and study, evidence-based practice papers, teaching plan, journal, group writing, and portfolio were presented in this chapter.

Written assignments may be evaluated formatively or summatively. Formative evaluation provides feedback to students for their continued learning but not for grading purposes. Periodic assessment of drafts of papers and work in progress is formative in nature and is not intended for arriving at a grade. Summative evaluation of completed writing assignments is designed for grading the assignment, not for giving feedback to the student.

In grading written assignments, a scoring protocol or rubric should be developed based on the criteria established for evaluation. The scoring protocol and rubric are used in the same way for all students. Many written assignments, though, are best if assessed formatively and not graded.

Exhibit 15.7

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES

1. Facilitate Learning

- A.** Implement a variety of teaching strategies appropriate to
 - 1. content and setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- B.** Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education
- E.** Practice skilled oral and written (including electronic) communication that reflects an awareness of self and relationships with learners (e.g., evaluation, mentorship, and supervision)
- F.** Communicate effectively orally and in writing with an ability to convey ideas in a variety of contexts
- I.** Create opportunities for learners to develop their own critical thinking skills

(continued)

- J. Create a positive learning environment that fosters a free exchange of ideas
- O. Use knowledge of evidence-based practice to instruct learners

2. Facilitate Learner Development and Socialization

- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- G. Assist learners to engage in thoughtful and constructive self and peer evaluation

3. Use Assessment and Evaluation Strategies

- E. Use a variety of strategies to assess and evaluate learning in these domains
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- N. Use assessment and evaluation data to enhance the teaching-learning process
- O. Advise learners regarding assessment and evaluation criteria
- P. Provide timely, constructive, and thoughtful feedback

REFERENCES

- Beke-Harrigan, H., Hess, R., & Weinland, J. (2008). A survey of registered nurses' readiness for evidence-based practice: A multidisciplinary project. *Journal of Hospital Librarianship*, 8, 440–448.
- Billings, D., & Kowalski, K. (2006). Teaching tips. Journaling: A strategy for developing reflective practitioners. *Journal of Continuing Education in Nursing*, 37, 104–105.
- Blake, T. K. (2005). Journaling: An active learning technique. *International Journal of Nursing Education Scholarship*, 2(1), Article 7. doi: 10.2202/1548-923X.1116
- Callister, L., Luthy, K., Thompson, P., & Memmott, R. (2009). Ethical reasoning in baccalaureate nursing students. *Nursing Ethics*, 16, 499–510.
- Epp, S. (2008). The value of reflective journaling in undergraduate nursing education: A literature review. *International Journal of Nursing Studies*, 45, 1379–1388.
- Estabrooks, C. A., Chong, H., Brigidear, K., & Profetto-McGrath, J. (2005). Profiling Canadian nurses' preferred knowledge sources for clinical practice. *Canadian Journal of Nursing Research*, 37, 118–140.
- Gale, B., & Schaffer, M. (2009). Organizational readiness for evidence-based practice. *Journal of Nursing Administration*, 39, 91–97.
- Giddens, J., & Lobo, M. (2008). Analyzing graduate student trends in written paper evaluation. *Journal of Nursing Education*, 47, 480–483.

- Heye, M., & Stevens, K. (2009). Educational innovations. Using new resources to teach evidence-based practice. *Journal of Nursing Education, 48*, 334–339.
- Luthy, K., Peterson, N., Lassetter, J., & Callister, L. (2009). Successfully incorporating writing across the curriculum with advanced writing in nursing. *Journal of Nursing Education, 48*, 54–59.
- Mertler, C. A. (2003). *Classroom assessment: A practical guide for educators*. Los Angeles: Pyrczak.
- Nitko, A. J., & Brookhart, S. M. (2007). *Educational assessment of students* (5th ed.). Upper Saddle River, NJ: Pearson Education.
- Oermann, M. H. (2002). *Writing for publication in nursing*. Philadelphia: Lippincott Williams & Wilkins.
- Oermann, M. H. (2006). Short written assignments for clinical nursing courses. *Nurse Educator, 31*, 228–231.
- Oermann, M. H., & Gaberson, K. B. (2009). *Evaluation and testing in nursing education* (3rd ed.). New York: Springer Publishing.
- Pierce, S. T. (2005). Integrating evidence-based practice into nursing curricula. In M. H. Oermann & K. T. Heinrich (Eds.), *Annual review of nursing education* (Vol. 3, pp. 233–248). New York: Springer Publishing.
- Pravikoff, D. S., Tanner, A. B., & Pierce, S. T. (2005). Readiness of U.S. nurses for evidence-based practice. *American Journal of Nursing, 105*(9), 40–51.
- Senita, J. (2008). The use of concept maps to evaluate critical thinking in the clinical setting. *Teaching & Learning in Nursing, 3*(1), 6–10.
- Spenceley, S. M., O'Leary, K. A., Chizawsky, L. L., Ross, A. J., & Estabrooks, C. A. (2008). Sources of information used by nurses to inform practice: An integrative review. *International Journal of Nursing Studies, 45*, 954–970.
- Vacek, J. (2009). Using a conceptual approach with a concept map of psychosis as an exemplar to promote critical thinking. *Journal of Nursing Education, 48*, 49–53.
- Van Horn, R., & Freed, S. (2008). Journaling and dialogue pairs to promote reflection in clinical nursing education. *Nursing Education Perspectives, 29*, 220–225.

16

Clinical Evaluation and Grading

Nursing practice requires the development of higher-level cognitive skills, values, psychomotor and technological skills, and other competencies for care of patients across settings. Through clinical evaluation, the teacher arrives at judgments about students' competencies—their performance in practice. After establishing a framework for evaluating students in clinical practice and exploring one's own values, attitudes, and biases that may influence evaluation, the teacher identifies a variety of methods for collecting data on student performance. Clinical evaluation methods are strategies for assessing learning outcomes in clinical practice. Some evaluation methods are most appropriate for use by faculty members or preceptors who are on site with students and can observe their performance; other evaluation methods assess students' knowledge, cognitive skills, and other competencies but do not involve direct observation of their performance. This chapter describes the process of clinical evaluation in nursing, methods for evaluating clinical performance, and how to grade students in clinical courses.

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CONCEPT OF CLINICAL EVALUATION

Clinical evaluation is a process by which judgments are made about learners' competencies in practice. This practice may involve care of patients, families, and communities; other types of learning activities in the clinical setting; simulation activities; performance of varied skills in learning laboratories; or activities using multimedia. Most frequently, clinical evaluation involves observing performance and arriving at judgments about the student's competence. Judgments influence the data collected—that is, the specific types of observations made to evaluate the student's performance—and the inferences and conclusions drawn from the data about the quality of that performance. Teachers may collect different data to evaluate the same outcomes, and when presented with a series of observations about a student's performance in clinical practice, there may be minimal consistency in their judgments about how well that student performed.

Clinical evaluation is not an objective process; it involves subjective judgments of the teacher and others involved in the process. The teacher's values influence evaluation. This is most apparent in clinical evaluation, where teachers' values influence the observations they make of students and the judgments they make about the quality of their performance. Thus, it is important for teachers to be aware of their own values that might bias their judgments of students. For example, if the teacher prefers students who initiate discussions and participate actively in conferences, this value should not influence the assessment of students' competencies in other areas. The teacher needs to be aware of this preference to avoid an unfair evaluation of other dimensions of the students' clinical performance. Or, if the teacher is used to the fast pace of most acute care settings, when working with beginning students or someone who moves slowly, the teacher should be cautious not to let this prior experience influence expectations of performance. Faculty members and preceptors should examine their values, attitudes, and beliefs so that they are aware of them as they teach and assess students' performance in practice settings.

Clinical Evaluation Versus Grading

Clinical evaluation is not the same as grading. In evaluation, the teacher makes observations of performance and collects other types of data, then compares this information to a set of standards to arrive at a judgment.

From this assessment, a quantitative symbol or grade may be applied to reflect the evaluation data and judgments made about performance. The clinical grade, such as pass-fail or A through F, is the symbol to represent the evaluation. Clinical performance may be evaluated and not graded, such as with formative evaluation or feedback to the learner, or it may be graded. Grades, however, should not be assigned without sufficient data about clinical performance.

Norm- and Criterion-Referenced Clinical Evaluation

Clinical evaluation may be norm- or criterion-referenced. In norm-referenced evaluation, the student's clinical performance is compared with that of other students, indicating that the performance is better than, worse than, or equivalent to that of others in the comparison group or that the student has more or less knowledge, skill, or ability than the other students. Rating students' clinical competencies in relation to others in the clinical group—for example, indicating that the student was “average”—is a norm-referenced interpretation.

In contrast, criterion-referenced clinical evaluation involves comparing the student's clinical performance to predetermined criteria, not to the performance of other students in the group. In this type of clinical evaluation, the criteria are known in advance and used as the basis for evaluation. Indicating that the student has met the clinical outcomes or achieved the clinical competencies, regardless of how other students performed, represents a criterion-referenced interpretation.

Formative and Summative Clinical Evaluation

Clinical evaluation may be formative or summative. Formative evaluation in clinical practice provides feedback to learners about their progress in meeting the outcomes of the clinical course or in developing the clinical competencies. The purposes of formative evaluation are to enable students to develop further their clinical knowledge, skills, and values; indicate areas in which learning and practice are needed; and provide a basis for suggesting additional instruction to improve performance. With this type of evaluation, after identifying the learning needs, instruction is provided to move students forward in their learning. Formative evaluation, therefore, is diagnostic; it should not be graded (Nitko & Brookhart, 2007). For example, the clinical teacher or preceptor might observe a student perform wound care and give feedback on changes

to make with the technique. The goal of this assessment is to improve subsequent performance, not to grade how well the student carried out the procedure.

Summative clinical evaluation, however, is designed for determining clinical grades because it summarizes competencies the student has developed in clinical practice. Summative evaluation is done at the end of a period of time—for example, at midterm or at the end of the clinical practicum—to assess the extent to which learners have achieved the clinical outcomes or competencies. Summative evaluation is not diagnostic; it summarizes the performance of students at a particular point in time. For much of clinical practice in a nursing education program, summative evaluation comes too late for students to have an opportunity to improve performance. At the end of a course involving care of mothers and children, for instance, there may be many behaviors the student would not have an opportunity to practice in subsequent courses.

Any protocol for clinical evaluation should include extensive formative evaluation and periodic summative evaluation. Formative evaluation is essential to provide feedback to improve performance while practice experiences are still available.

FAIRNESS IN CLINICAL EVALUATION

Considering that clinical evaluation is not objective, the goal is to establish a *fair* evaluation system. Fairness requires that:

1. The teacher identify his or her own values, attitudes, beliefs, and biases that may influence the evaluation process
2. Clinical evaluation be based on predetermined outcomes or competencies
3. The teacher develop a supportive clinical learning environment

Identify One's Own Values

Teachers need to be aware of their personal values, attitudes, beliefs, and biases that may influence the evaluation process. These can affect both the data collected about students and the inferences made. In addition, students have their own sets of values and attitudes that influence their self-evaluations of performance and their responses to the teacher's evaluations and feedback. Students' acceptance of the teacher's guidance

in clinical practice and information provided to them for improving performance is affected by their past experiences in clinical courses with other faculty members. Students may have had problems in prior clinical courses, receiving only negative feedback and limited support from the teacher, staff members, and others. In situations in which student responses inhibit learning, the teacher may need to intervene to guide students in more self-awareness of their own values and the effect they are having on their learning.

Base Clinical Evaluation on Outcomes or Competencies

Clinical evaluation should be based on preset outcomes, clinical objectives, or competencies that are then used to guide the evaluation process. Without these, neither the teacher nor the student has any basis for evaluating clinical performance. What are the outcomes of the clinical course (or, in some nursing education programs, the clinical objectives) to be met? What clinical competencies should the student develop? These outcomes or competencies provide a framework for faculty members to use in observing performance and for arriving at judgments about achievement in clinical practice. For example, if the competencies relate to developing communication skills, then the learning activities—whether in the patient care setting, as part of a simulation, or in the learning laboratory—should assist students in learning how to communicate. The teacher's observations and subsequent assessment should focus on communication behaviors, not on other competencies unrelated to the learning activities.

Develop a Supportive Learning Environment

It is up to the teacher to develop a supportive learning environment in which students view the teacher as someone who will facilitate their learning and development of clinical competencies. Students need to be comfortable asking faculty and staff members questions and seeking their guidance rather than avoiding them in the clinical setting. A supportive environment is critical for effective assessment, because students need to recognize that the teacher's feedback is intended to help them improve performance.

Many factors influence the development of a supportive learning environment. The clinical setting needs to provide experiences that foster student learning and development. Staff members need to be supportive

of students; work collaboratively with each other, students, and the faculty member; and communicate effectively individually and as a team (Henderson, Twentyman, Heel, & Lloyd, 2006). Most of all, there has to be trust and respect between the teacher and students.

FEEDBACK IN CLINICAL EVALUATION

For clinical evaluation to be effective, the teacher should provide continuous feedback to students about their performance and how they can improve it. Feedback is the communication of information to students, based on the teacher's assessment, that enables students to reflect on their performance, identify continued learning needs, and decide how to meet them (Bonnell, 2008). Feedback may be verbal, by describing observations of performance and explaining what to do differently, or visual, by demonstrating correct performance.

Feedback should be accompanied by further instruction from the teacher or by working with students to identify appropriate learning activities. The ultimate goal is for students to progress to a point at which they can judge their own performance, identify resources for their learning, and use those resources to further develop competencies. Bonnell (2008) emphasized that, for feedback to be useful, students need to reflect on the information communicated to them and take an active role (p. 290).

Students must have an underlying knowledge base and beginning skills to judge their own performance. Nitko and Brookhart (2007) suggested that feedback on performance also identifies the possible causes or reasons why the student has not mastered the learning outcomes. Sometimes the reason is that the student does not have the prerequisite knowledge and skills for developing the new competencies. As such, it is critical for faculty members and preceptors to begin their clinical instruction by assessing whether students have learned the necessary concepts and skills and, if not, to start there.

Principles of Providing Feedback as Part of Clinical Evaluation

There are five principles for providing feedback to students as part of the clinical evaluation process. First, the feedback should be precise and specific. General information about performance, such as, "You need to

work on your assessment” or “You need more practice in the simulation laboratory,” does not indicate what behaviors need improvement or how to develop them. Instead of using general statements, the teacher should indicate what specific areas of knowledge are lacking, where there are problems in critical thinking and clinical judgments, and what particular competencies need more development. Rather than saying to a student, “You need to work on your assessment,” the student would be better served if the teacher identified the specific areas of data collection omitted and the physical examination techniques that need improvement. Specific feedback is more valuable to learners than a general description of their behavior.

Second, for procedures, use of technologies, and any psychomotor skill, the teacher should provide both verbal and visual feedback to students. This means that the teacher should explain first, either orally or in writing, where the errors were made in performance and then demonstrate the correct procedure or skill. This should be followed by student practice of the skill with the teacher guiding performance. By allowing immediate practice, with the teacher available to correct problems, students can more easily use the feedback to further develop their skills.

Third, feedback about performance should be given to students at the time of learning or immediately following it. Giving prompt feedback is one of the seven core principles for effective teaching in undergraduate programs (Chickering & Gamson, 1987, 1999). Providing prompt and rich feedback is equally important when teaching graduate students, nurses, and other learners regardless of their educational level. The longer the period of time between performance and feedback from the teacher, the less effective is the feedback. As time passes, neither student nor teacher may remember specific areas of clinical practice to be improved. This principle holds true whether the performance relates to decision making and critical thinking, a procedure or technical skill, or an attitude or value expressed by the student, among other areas.

Whether working with a group of students in a clinical setting, communicating with preceptors about students, or teaching an online course, the teacher needs to develop a strategy for giving focused and immediate feedback to students and following up with further discussion as needed. Recording short anecdotal notes on paper, in personal digital assistants (PDAs), or on flow sheets for later discussion with individual students helps the teacher remember important points about performance.

Fourth, students need different amounts of feedback and positive reinforcement. In beginning practice and with clinical situations that are

new to learners, most students will need frequent and extensive feedback. As students progress through the program and become more competent, they should be able to assess their own performance and identify personal learning needs. Some students will require more feedback and direction from the teacher than others.

One final principle is that feedback should be diagnostic. After identifying areas in which further learning is needed, the teacher's responsibility is to guide students so that they can improve their performance. The process is cyclical—the teacher observes and assesses performance, gives students feedback about that performance, and then guides their learning and practice so they can become more competent.

RELATIONSHIP OF EVALUATION TO CLINICAL OUTCOMES AND COMPETENCIES

There are different ways of specifying the outcomes to be achieved in clinical practice, which in turn provide the basis for clinical evaluation. These may be stated in the form of outcomes to be met or as competencies to be demonstrated in clinical practice. The faculties of some nursing education programs specify the outcomes in the form of clinical objectives. Regardless of how these are stated, they represent *what* is evaluated in clinical practice.

The outcomes of clinical practice in Exhibit 4.1 can be used for developing specific outcomes or competencies for a clinical course. Not all clinical courses will have outcomes in each of these areas, and, in some courses, there may be other types of competencies unique to practice in that clinical specialty. Some faculties identify common outcomes or competencies that are used for each clinical course in the program and then level those to illustrate their progressive development through the nursing program (Ignatavicus & Caputi, 2004). For example, with this model, each course would have an outcome on communication. In a beginning clinical course, the outcome might be, "Identifies verbal and nonverbal techniques for communicating with patients." In a later course in the curriculum, the communication outcome might focus on the family and working with caregivers—for example, "Develops interpersonal relationships with families and caregivers." Then, in a community health course, the outcome might be, "Collaborates with other health care providers in care of patients in the community and the community as client."

As another approach, some teachers state the outcomes broadly and then indicate specific behaviors students should demonstrate to meet those outcomes in a particular course. For example, the outcome on communication might be stated as, “Communicates effectively with patients and others in the health system.” Examples of behaviors that indicate achievement of this outcome in a course on care of children include, “Uses appropriate verbal and nonverbal communication based on the child’s age, developmental status, and health condition” and “Interacts effectively with parents, caregivers, and others.” Generally, the outcomes or competencies are then used for developing the clinical evaluation tool or form, which is discussed later in the chapter.

Regardless of how the outcomes are stated for a clinical course, they need to be specific enough to guide the evaluation of students in clinical practice. An outcome such as, “Use the nursing process in care of children” is too broad to guide evaluation. More specific outcomes such as, “Carries out a systematic assessment of children reflecting their developmental stage,” “Evaluates the impact of health problems on the child and family,” and “Identifies resources for managing the child’s care at home” make clear to students what is expected of them in clinical practice.

Competencies are the abilities to be demonstrated by the learner in clinical practice. Boland (2009) viewed competencies as the knowledge, skills, and attitudes that students need to develop. For nurses in practice, these competencies reflect the proficiencies for performing a particular task or carrying out their defined role in the health care setting. Competencies for nurses are assessed as part of the initial employment and orientation to the health care setting and on an ongoing basis. Exhibit 16.1 illustrates a competency with related performance criteria. These criteria are important in clinical evaluation, because they illustrate the behaviors or actions as evidence of competency in that area.

Caution should be exercised in developing clinical outcomes and competencies to avoid having too many for evaluation, considering the number of learners for whom the teacher is responsible, types of clinical learning opportunities available, and time allotted for clinical learning activities. In preparing outcomes or competencies for a clinical course, teachers should keep in mind that they need to collect sufficient data about students’ performance of each outcome or competency specified for that course. Too many outcomes make it nearly impossible to collect enough data on the performance of all of the students in the clinical group. The clinical outcomes or competencies need to be realistic and useful for guiding the evaluation.

Exhibit 16.1

SAMPLE COMPETENCY AND PERFORMANCE CRITERIA

Competency: IV Injection of Medication

Performance Criteria

- Checks physician's order.
- Checks medication administration record.
- Adheres to rights of medication administration.
- Assembles appropriate equipment.
- Checks compatibility with existing IV, if present.
- Explains procedure to patient.
- Positions patient appropriately.
- Checks patency of administration port or line.
- Administers medication at proper rate.
- Monitors patient response.
- Flushes tubing as necessary.
- Documents IV medication correctly.

CLINICAL EVALUATION METHODS

There are many evaluation methods for use in nursing education. Some methods, such as journals, are most appropriate for formative evaluation, while others are useful for either formative or summative evaluation.

Selecting Clinical Evaluation Methods

There are several factors to consider when selecting clinical evaluation methods to use in a course. First, the evaluation methods should provide information on student performance of the clinical competencies associated with the course. With the evaluation methods, the teacher collects data on performance to judge whether students are developing the clinical competencies or have achieved them by the end of the course. For many outcomes of a course, different strategies can be used, thereby providing flexibility in choosing methods for evaluation. Most evaluation methods provide data on multiple clinical outcomes. For example, a short written assignment in which students compare two data sets might relate to outcomes on assessment, analysis, and writing. In planning the evaluation for a clinical course, the teacher reviews the outcomes or

competencies to be developed and decides which evaluation methods will be used for assessing them, recognizing that most methods provide information on more than one outcome or competency.

Second, there are many different clinical evaluation strategies that might be used to assess performance. Varying the methods maintains student interest and takes into account learners' individual needs, abilities, and characteristics. Some students may be more proficient in methods that depend on writing, while others prefer strategies such as conferences and other discussions. Using multiple evaluation methods in clinical courses takes into consideration these differences among students. It also avoids relying on one method, such as a rating scale, for determining the entire clinical grade.

Third, the teacher should select evaluation methods that are realistic considering the number of students to be evaluated, available practice or simulation activities, and constraints such as the teacher's or preceptor's time. Planning for an evaluation method that depends on patients with specific health problems or particular clinical situations is not realistic considering the types of experiences with actual or simulated patients available to students. Some methods are not appropriate because of the number of students who would need to use them within the time frame of the course. Others may be too costly or require resources not available in the nursing education program or health care setting.

Fourth, evaluation methods can be used for formative or summative evaluation. In the process of deciding how to evaluate students' clinical performance, the teacher should identify whether the methods will be used to provide feedback to learners (formative) or for grading (summative). With formative clinical evaluation, the focus is on the progression of students in meeting the learning goals (Bonnell, Gomez, Lobodzinski, & West, 2005; Emerson, 2007; Hand, 2006; O'Connor, 2006). At the end of the rotation, course, or semester, summative evaluation establishes whether the student met those goals and is competent (Gallant, MacDonald, & Smith Higuchi, 2006; Scanlan, Care, & Gessler, 2001; Skingley, Arnott, Greaves, & Nabb, 2006). In clinical practice, students should know ahead of time whether the assessment by the teacher is for formative or summative purposes. Some of the methods designed for clinical evaluation provide feedback to students on areas for improvement and should not be graded. Other methods, such as rating scales and written assignments, can be used for summative purposes and therefore can be computed as part of the course or clinical grade.

Fifth, before finalizing the protocol for evaluating clinical performance in a course, the teacher should review the purpose and number required of each assignment completed by students in clinical practice. What are the purposes of these assignments, and how many are needed to demonstrate competency? In some clinical courses, students complete an excessive number of written assignments. Students benefit from continuous feedback from the teacher, not from repetitive assignments that contribute little to their development of clinical knowledge and skills. Instead of daily or weekly care plans or other assignments, which may not even be consistent with current practice, once students develop the competencies, they can progress to other, more relevant learning activities.

Sixth, in deciding how to evaluate clinical performance, the teacher should consider the time needed to complete the evaluation, provide feedback, and grade the assignment. Instead of requiring a series of written assignments in a clinical course, the same outcomes might be met through discussions with students, cases analyzed by students in clinical conferences, group writing activities, and other methods requiring less teacher time and accomplishing the same purposes. Considering the demands on nursing faculty members, it is important to consider one's own time when planning how to evaluate students' performance in clinical practice (Oermann, 2004).

Observation

The main strategy for evaluating clinical performance is observing students in clinical practice, simulation and learning laboratories, and other settings. In a survey of 1,573 faculty members representing all types of prelicensure nursing programs (diploma, 128; associate degree, 866; baccalaureate, 563; and entry-level master's, 8), observation of student performance was the predominant strategy used across programs ($n = 1,289$, 93%) (Oermann, Yarbrough, Ard, Saewert, & Charasika, 2009).

Although observation is widely used, there are threats to its validity and reliability. First, observations of students may be influenced by the teacher's values, attitudes, and biases, as discussed earlier. There also may be overreliance on first impressions, which might change as the teacher or preceptor observes the student over a period of time and in different situations. In any performance assessment, there needs to be a series of observations made before drawing conclusions about performance.

Second, in observing performance, there are many aspects of performance on which the teacher may focus attention. For example, while

observing a student administer an intravenous medication, the teacher may focus mainly on the technique used for its administration, ask limited questions about the purpose of the medication, and make no observations of how the student interacts with the patient. Another teacher observing this same student may focus on other aspects.

Third, the teacher may arrive at incorrect judgments about the observation, such as inferring that a student is inattentive during conference when, in fact, the student is thinking about the comments made by others in the group. It is important to discuss observations with students, obtain their perceptions of their behavior, and be willing to modify one's own inferences when new data are presented. In discussing observations and impressions with students, the teacher can learn about their perceptions of performance; this, in turn, may provide additional information that influences the teacher's judgment about competencies (Oermann, 2008).

Fourth, every observation in the clinical setting reflects only a sampling of the learner's performance during a clinical activity. An observation of the same student at another time may reveal a different level of performance.

Finally, similar to other clinical evaluation methods, the outcomes or competencies guide the teacher on *what* to observe. They help the teacher focus the observations of performance. However, all observed behaviors should be shared with the students.

Anecdotal Notes

It is difficult, if not impossible, to remember the observations made of each student for each clinical activity. For this reason, teachers need a device to help them remember their observations and the context in which the performance occurred. There are several ways of recording observations of students in clinical settings, simulation and learning laboratories, and other settings: anecdotal notes, checklists, and rating scales.

Anecdotal notes are narrative descriptions of observations made of students. Some teachers include only a description of the observations and then, after a series of observations, review the pattern of the performance and draw conclusions about it. Other teachers record their observations and include a judgment about how well the student performed (Case & Oermann, in press). Anecdotal notes should be recorded as close to the time of the observation as possible; otherwise, it is difficult

to remember what was observed and the context (e.g., patient and clinical situation) of that observation. In the clinical setting, notes can be handwritten on flow sheets, on other forms, or as narratives. They also can be recorded in PDAs. Software is available for teachers to keep a running anecdotal record for each student, or they can use the available software on their PDAs. The anecdotal notes can then be exported to a computer for formatting and printing.

White and colleagues (2005) described how they used PDAs for clinical evaluation. The evaluation tool is stored in the PDA, and faculty members add their anecdotal notes. Not only is the PDA valuable for documenting performance related to the course competencies and storing anecdotal notes, but, by the end of the clinical course, there is a completed document on the student's clinical performance (White et al., 2005). Faculty members synchronize this information with their computers and transfer their anecdotal notes into a word-processed document to complete the summative clinical evaluation tool.

Anecdotal notes should be shared with students as frequently as possible; otherwise, they are not effective for feedback. Considering the issues associated with observations of clinical performance, the teacher should discuss observations with the students and be willing to incorporate their own judgments about the performance. Anecdotal notes also are useful in conferences with students—for example, at midterm and at the end of term—for reviewing a pattern of performance over time.

Checklists

A checklist contains specific behaviors or activities to be observed with a place for marking whether they were present during the performance (Nitko & Brookhart, 2007). A checklist often lists the steps to be followed in performing a procedure or demonstrating a skill. Some checklists also include errors in performance that are commonly made. Checklists not only facilitate the teacher's observation of procedures and behaviors performed by students and nurses learning new technologies and procedures, but they also provide a way for learners to assess their own performance. With checklists, learners can review and evaluate their performance prior to assessment by the teacher.

For common procedures and skills, teachers often can find checklists already prepared that can be used for evaluation, and some nursing textbooks have accompanying skills checklists. When these resources are not available, teachers can develop their own checklists but should avoid including every possible step, which makes the checklist too cumbersome.

Instead, the focus should be on critical behaviors and where they fit into the sequence. Exhibit 16.2 provides an example of a checklist developed from the sample competency and performance criteria in Exhibit 16.1.

Rating Scales

Rating scales, also referred to as clinical evaluation tools or instruments, provide a means of recording judgments about the observed performance of students in clinical practice. A rating scale has two parts: (a) a list of outcomes, competencies, or behaviors the student is to demonstrate in clinical practice and (b) a scale for rating their performance of them.

Rating scales are most useful for summative evaluation of performance; after observing students over a period of time, the teacher draws conclusions about performance, rating it according to the scale provided with the instrument. Rating scales also may be used to evaluate specific

Exhibit 16.2

SAMPLE CHECKLIST

Student Name _____

Instructions to teacher/examiner: Observe the student performing the following procedure and check the steps completed properly by the student. Check only those steps that the student performed properly. After completing the checklist, discuss performance with the student, reviewing aspects of the procedure to be improved.

IV Injection of Medication

Checklist

- Checks physician's order.
- Checks medication administration record.
- Adheres to rights of medication administration.
- Assembles appropriate equipment.
- Checks compatibility with existing IV, if present.
- Explains procedure to patient.
- Positions patient appropriately.
- Checks patency of administration port or line.
- Administers medication at proper rate.
- Monitors patient response.
- Flushes tubing as necessary.
- Documents IV medication correctly.

activities that students complete in clinical practice—for example, rating a student’s presentation of a case in clinical conference or the quality of teaching provided to a patient. Other uses of rating scales are to: (a) help students focus their attention on critical behaviors to be performed in clinical practice; (b) give specific feedback to students about their performance; and (c) demonstrate growth in clinical competencies over a designated time period if the same rating scale is used.

The same rating scale can be used for multiple purposes. Exhibit 16.3 shows sample behaviors from a rating scale that is used midway through a course; in Exhibit 16.4, the same behaviors are used for the final evaluation, but the performance is rated as satisfactory or unsatisfactory as a summative rating.

Exhibit 16.3

SAMPLE BEHAVIORS FROM RATING SCALE FOR FORMATIVE EVALUATION

Maternal-Newborn Nursing
Midterm Progress Report

Name _____ Date _____

Objective	Yes	No	Not Obs.
1. Applies the nursing process to the care of mothers and newborns			
A. Assesses the individual needs of mothers and newborns			
B. Plans care to meet the patient’s needs			
C. Implements nursing care plans			
D. Evaluates the effectiveness of nursing care			
E. Includes the family in planning and implementing care for the mother and newborn			
2. Participates in health teaching for maternal-newborn patients and families			
A. Identifies learning needs of mothers and families			
B. Uses opportunities to do health teaching when giving nursing care			

Note: Not Obs. = not observed.

Exhibit 16.4

**SAMPLE BEHAVIORS FROM SAME RATING SCALE
FOR FINAL EVALUATION**Maternal-Newborn Nursing
Clinical Performance Evaluation

Name _____ Date _____

Objective	S	U
1. Applies the nursing process to the care of mothers and newborns		
A. Assesses the individual needs of mothers and newborns		
B. Plans care to meet the patient's needs		
C. Implements nursing care plans		
D. Evaluates the effectiveness of nursing care		
E. Includes the family in planning and implementing care for the mother and newborn		
2. Participates in health teaching for maternal-newborn patients and families		
A. Identifies learning needs of mothers and families		
B. Uses opportunities to do health teaching when giving nursing care		

Note: S = satisfactory, U = unsatisfactory.

Types of Rating Scales

Many types of rating scales are used for evaluating clinical performance. The scales may have multiple levels for rating performance, such as 1 to 5 or exceptional to below average, or have two levels, such as pass-fail. Types of scales with multiple levels for rating performance include:

- Letters: A, B, C, D, E or A, B, C, D, F
- Numbers: 1, 2, 3, 4, 5
- Qualitative labels: excellent, very good, good, fair, poor; exceptional, above average, average, below average
- Frequency labels: always, usually, frequently, sometimes, never

Exhibit 16.5 provides an example of a rating scale for clinical evaluation that has multiple levels for rating performance.

Some instruments have a matrix for rating clinical performance that combines different qualities of the performance. Holaday and Buckley (2008) developed a matrix for their clinical evaluation tool, which rates performance at five levels of competence, from dependent to self-directed. A score is generated from the ratings and can be used to convert to a grade.

Exhibit 16.5

CLINICAL EVALUATION INSTRUMENT WITH MULTIPLE LEVELS FOR RATING PERFORMANCE

Community Health Nursing (RN section) CLINICAL EVALUATION FORM

Total Raw Score: _____ Student Name: _____
 Mean Score: _____ Faculty Name: _____
 Letter Grade: _____ Agency: _____

	4	3	2	1	no
Uses a theoretical framework in care of individuals, families, and groups in the community					
A. Applies concepts and theories in the practice of community health nursing					
B. Examines multicultural concepts of care as they apply to the community					
C. Analyzes family theory as a basis for care of clients in a community setting					
D. Examines relationships of family members in a community setting					
E. Examines the community as a client through ongoing assessment					
F. Evaluates health care delivery systems in a community setting					
Uses the nursing process for care of individuals, families, and groups in the community and the community as client					
A. Adapts assessment skills in the collection of data from individuals, families, and groups in a community setting					

(continued)

	4	3	2	1	no
B. Uses relevant resources in the collection of data in the community					
*C. Analyzes client and community data					
D. Develops nursing diagnoses for individuals, families, and groups in the community and the community as client					
E. Develops measurable outcome criteria and plan of action					
F. Uses outcome criteria for evaluating plans and effectiveness of interventions					
*G. Assumes accountability for own practice in the community					
H. Uses research findings and standards for community-based care					
*I. Accepts differences among clients and communities					
Is responsible for identifying and meeting own learning needs					
*A. Evaluates own development as a professional					
*B. Meets own learning needs in community practice					
Collaborates with others in providing community care					
A. Interacts effectively with clients and others in the community					
B. Effectively uses community resources					
FACULTY-STUDENT NARRATIVE					
Faculty Comments: Signature: _____ Date: _____					
Student Comments: Signature: _____ Date: _____					

Note: 4 = consistently excels in performance of behavior, independent; 3 = is competent in performance, independent; 2 = performs behavior safely, needs assistance; 1 = unable to perform behavior, requires guidance all the time. no = not observed.

*Critical behaviors must be rated at or above 2.0 to pass clinical practicum.

Tool developed by Judith M. Fouladbakhsh. Adapted with permission, 2008.

A short description included with the letters, numbers, and labels for each of the outcomes, competencies, or behaviors rated improves objectivity and consistency (Nitko & Brookhart, 2007). For example, if teachers use a scale of exceptional, above average, average, and below average or a scale based on the numbers 4, 3, 2, and 1, short descriptions of each level in the scale could be written to clarify the performance expected at each level. For the clinical outcome “Collects relevant data from patient,” the descriptors might be:

Exceptional (or 4): Differentiates relevant from irrelevant data, analyzes multiple sources of data, establishes comprehensive data base, identifies data needed for evaluating all possible nursing diagnoses and patient problems.

Above Average (or 3): Collects significant data from patients, uses multiple sources of data as part of assessment, identifies possible nursing diagnoses and patient problems based on the data.

Average (or 2): Collects significant data from patients, uses data to develop main nursing diagnoses and patient problems.

Below Average (or 1): Does not collect significant data and misses important cues in data; unable to explain relevance of data for nursing diagnoses and patient problems.

Rating scales for clinical evaluation also may have two levels such as pass-fail and satisfactory-unsatisfactory. A survey of nursing faculty members from all types of programs indicated that most faculty members ($n = 1,116$, 83%) used pass-fail in their clinical courses (Oermann et al., 2009). This finding is consistent with an earlier survey of 79 nursing programs, randomly selected, that found that 75% ($n = 59$) of the programs had pass-fail rating scales for clinical evaluation (Alfaro-LeFevre, 2004). Exhibit 16.6 is an example of a clinical evaluation tool that has two levels for rating performance: satisfactory-unsatisfactory. Competencies on this form also could be rated as pass-fail.

Issues With Rating Scales

One problem in using rating scales is apparent by a review of the sample scale descriptors. What are the differences between above average and average or between a 2 and a 1? Is there consensus among faculty members using the rating scale about what constitutes different levels

Exhibit 16.6

CLINICAL EVALUATION INSTRUMENT USING SATISFACTORY- UNSATISFACTORY SCALE

Perioperative Nursing
Clinical Performance Evaluation

Name _____ Date _____

Objective	S	U
1. Applies principles of aseptic technique		
A. Demonstrates proper technique in scrubbing, gowning, gloving		
B. Prepares and maintains a sterile field		
C. Recognizes and reports breaks in aseptic technique		
2. Plans and implements nursing care consistent with AORN Recommended Practices for Perioperative Nursing		
A. Collects physiological and psychosocial assessment data preoperatively		
B. Identifies nursing diagnoses for the perioperative period based on assessment data		
C. Develops a plan of care based on identified nursing diagnoses and assessment data		
D. Provides nursing care according to the plan of care		
E. Evaluates the effectiveness of nursing care provided		
F. Accurately documents perioperative nursing care		
3. Provides a safe environment for the patient		
A. Assesses known allergies and previous anesthetic incidents		
B. Adheres to safety and infection control policies and procedures		
C. Prevents patient injury due to positioning, extraneous objects, or chemical, physical, or electrical hazards		
4. Prepares patient and family for discharge to home		
A. Assesses patient's and family's teaching needs		
B. Teaches patient and family using appropriate strategies based on assessed needs		
C. Evaluates the effectiveness of patient and family teaching		
D. Identifies needs for home care referral		
5. Protects the patient's rights during the perioperative period		
A. Provides privacy throughout the perioperative period		
B. Identifies and respects the patient's cultural and spiritual beliefs		

Note: S = satisfactory, U = unsatisfactory.

of performance for each outcome, competency, or behavior evaluated? This problem exists even when descriptions are provided for each level of the rating scale. Teachers may differ in their judgments of whether the student collected *relevant* data, whether *multiple* sources of data were used, whether the data base was *comprehensive*, if *all possible* nursing diagnoses were considered, and so forth.

Scales based on frequency labels are often difficult to implement because of limited experiences for students to practice and demonstrate a level of skill rated as “always, usually, frequently, sometimes, and never.” How should teachers rate students’ performance in situations in which they practiced the skill perhaps once or twice? Even two-dimensional scales such as pass-fail present room for variability among educators.

Nitko and Brookhart (2007) identified eight common errors that can occur with rating scales applicable to rating clinical performance. The first three errors can occur with tools that have multiple points on the scale for rating performance, such as 1 to 5 or below average to exceptional. The other errors can occur with any type of clinical performance rating scale.

1. *Leniency error* results when the teacher tends to rate all students toward the high end of the scale.
2. *Severity error* is the opposite of leniency, tending to rate all students toward the low end of the scale.
3. *Central tendency error* is hesitancy to mark either end of the rating scale and instead use only the midpoint of the scale.
4. *Halo effect* is a judgment based on a general impression of the student. With this error, the teacher lets an overall impression of the student influence the ratings of specific aspects of the student’s performance. This impression affects the teacher’s ability to objectively evaluate and rate specific competencies or behaviors on the tool. The halo may be positive, giving the student a higher rating than is deserved, or negative, letting a general negative impression of the student result in lower ratings of specific aspects of the performance.
5. *Personal bias* occurs when the teacher’s biases influence ratings such as favoring nursing students who do not work while attending school over those who are employed while attending school.
6. *Logical error* results when similar ratings are given for items on the scale that are logically related to one another. This is a problem with rating scales in nursing that are too long and often too detailed. For example, there may be multiple behaviors on

communication skills to be rated. The teacher observes some of these behaviors but not all of them. In completing the clinical evaluation form, the teacher gives the same rating to all communication behaviors on the tool. When this occurs, some of the behaviors on the rating scale often can be combined.

7. *Rater drift* occurs when teachers redefine the performance behaviors to be observed and assessed. Initially in developing a clinical evaluation form, teachers agree on the competencies or behaviors to be rated and the scale to be used. However, over time, educators may interpret them differently, drifting away from the original intent. For this reason, faculty members in a course should discuss as a group each competency or behavior on the clinical evaluation form at the beginning and mid-point in the course. This discussion should include the meaning of the competency or behavior and what a student's performance would look like at each rating level in the tool.
8. *Reliability decay* is a similar issue. Nitko and Brookhart (2007) indicated that, immediately following training on using a rating tool, educators tend to use the tool consistently across students and with each other. As the course continues, though, faculty members may become less consistent in their ratings. Discussion of the clinical evaluation tool among course faculty, as indicated earlier, may improve consistency in the use of the tool. Bourbonnais, Langford, and Giannantonio (2008) suggested that conferences with students about the meaning of the behaviors on the tool encourage students to assess whether they are meeting the clinical outcomes and to reflect on their performance.

Most nursing faculty members use some type of clinical evaluation tool to evaluate students' performance in their courses ($n = 1,534$, 98%) (Oermann et al., 2009). Seventy percent of nursing faculty members ($n = 1,095$) reported in a survey that they used one basic tool for their nursing courses that was adapted for the competencies of each particular course. Exhibit 16.7 provides guidelines for using rating scales for clinical evaluation in nursing.

Simulations for Clinical Evaluation

Simulations are not only effective for instruction in nursing, but they also are useful for clinical evaluation. Students can demonstrate procedures

GUIDELINES FOR USING RATING SCALES FOR CLINICAL EVALUATION

1. Be alert to the possible influence of your own values, attitudes, beliefs, and biases in observing performance and drawing conclusions about it.
2. Use the clinical outcomes, competencies, or behaviors to focus your observations. Give students feedback on other observations made about their performance.
3. Collect sufficient data on students' performance before drawing conclusions about it.
4. Observe the student more than one time before rating performance. Rating scales, when used for clinical evaluation, should represent a *pattern* of the students' performance over time.
5. If possible, observe students' performance in different clinical situations, either in the patient care or simulated setting. When not possible, develop additional strategies for evaluation so that performance is evaluated with different methods and at different times.
6. Do not rely on first impressions; they may not be accurate.
7. Always discuss observations with students, obtain their perceptions of performance, and be willing to modify judgments and ratings when new data are presented.
8. Review the available clinical learning activities and opportunities in the simulation and learning laboratories. Do they provide sufficient data for completing the rating scale? If not, new learning activities may need to be developed, or the behaviors on the tool may need to be modified to be more realistic considering the clinical teaching circumstances.
9. Avoid using rating scales as the only source of data about a student's performance—use multiple evaluation methods for clinical practice.
10. Rate each outcome, competency, or behavior individually based on the observations made of performance and conclusions drawn. If you have insufficient information about achievement of a particular competency, do not rate it—leave it blank.
11. Do not rate all students high, low, or in the middle; similarly, do not let your general impression of the student or personal biases influence the ratings.
12. If the rating form is ineffective for judging student performance, then revise and reevaluate it. Consider these questions: Does the form yield data that can be used to make valid decisions about students' competence? Does the form yield reliable, stable data? Is it easy to use? Is it appropriate considering the types of learning activities that students have in their clinical settings?
13. Discuss as a group (with other educators and preceptors involved in the evaluation) each competency or behavior on the rating scale. Come to agreement about the meaning of the competencies or behaviors and what a student's performance would look like at each rating level in the tool. Share examples of performance, how you would rate them, and your rationale. As a group exercise, observe a video clip or other simulation of a student's performance, rate it with the tool, and come to agreement about the rating. Such exercises and discussions should be held before the course begins and periodically during it to ensure reliability across teachers and settings.

and technologies, conduct assessments, analyze clinical scenarios and make decisions about problems and actions to take, carry out nursing interventions, and evaluate the effects of their decisions. Each of these outcomes can be evaluated for feedback to students or for summative grading.

Different types of simulations can be used for clinical evaluation. Case scenarios that students analyze can be presented in paper-and-pencil format or through multimedia. Many computer simulations are available for use in evaluation. Simulations can be developed with models and manikins for evaluating skills and procedures and for evaluation with standardized patients. With human patient simulators, teachers can identify outcomes and clinical competencies to be assessed, present various clinical events and situations on the simulator for students to analyze and take action on, and evaluate student decision making and performance in these scenarios. In the debriefing session that follows, the students as a group can discuss the case, review findings, and critique their actions and decisions, with faculty members providing feedback (Jeffries, 2007; Schoening, Sittner, & Todd, 2006).

Many nursing education programs have simulation laboratories with human patient simulators, clinically equipped examination rooms, manikins and models for skill practice and assessment, areas for standardized patients, and a wide range of multimedia that facilitate performance evaluations. The rooms can be equipped with two-way mirrors, video cameras, microphones, and other media for observing and rating performance by faculty members and others. Videoconferencing technology can be used to conduct clinical evaluations of students in settings at a distance from the nursing education program, effectively replacing on-site performance evaluations by faculty members.

Incorporating Simulations Into Clinical Evaluation Protocol

The same principles for evaluating student performance in the clinical setting apply to using simulations. The first task is to identify which clinical outcomes will be assessed with a simulation. This decision should be made during the course planning phase as part of the protocol developed for clinical evaluation in the course. It is important to remember when deciding on evaluation methods that assessment can be done for feedback to students and thus remain ungraded, or it can be used for grading purposes.

Once the outcomes or clinical competencies to be evaluated with simulations are identified, the teacher can plan the specifics of the evaluation. Some questions to guide teachers in using simulations for clinical evaluation are:

- What are the specific clinical outcomes or competencies to be evaluated using simulations? These should be designated in the plan or protocol for clinical evaluation in a course.
- What types of simulations are needed to assess the designated outcomes—for example, simulations to demonstrate psychomotor and technological skills; ability to identify problems, treatments, and interventions; and pharmacological management?
- Do the simulations need to be developed by the faculty, or are they already available in the nursing education program?
- If the simulations need to be developed, who will be responsible for their development? Who will manage their implementation?
- Are the simulations for formative evaluation only? If so, how many practice sessions should be planned? What is the extent of faculty and expert guidance needed? Who will provide that supervision and guidance?
- Are the simulations for summative evaluation (i.e., for grading purposes)? If used for summative clinical evaluation, then faculty members need to determine the process for rating performance and how those ratings will be incorporated into the clinical grade, whether pass-fail or another system for grading.
- Who will develop or obtain checklists or other methods for rating performance in the simulations?
- When will the simulations be implemented in the course?
- How will the effectiveness of the simulations be evaluated, and who will be responsible?

These are only a few of the questions for faculty members to consider when planning to use simulations for clinical evaluation.

Standardized Patients

One type of simulation for clinical evaluation uses standardized patients—individuals who have been trained to accurately portray the role of a patient with a specific diagnosis or condition. With simulations using standardized patients, students can be evaluated on a history and

physical examination, related skills and procedures, and communication techniques, among other outcomes. Standardized patients are effective for evaluation, because the actors are trained to re-create the same patient condition and clinical situation each time they are with a student, providing for consistency in the performance evaluation.

When standardized patients are used for formative evaluation, they provide feedback to the students on their performance, an important aid to their learning. Standardized patients are trained to provide both written and oral feedback; they can complete checklists for assessing skills and share those with students and provide immediate one-to-one feedback after the experience (Jenkins & Schaivone, 2007). In a study by Becker and colleagues (2006), undergraduate students viewed their experience with standardized patients as positive. One of the important outcomes was getting written feedback from the standardized patient, which gave them a different perspective of their skills and enabled them to compare their self-assessment with the standardized patient's evaluation. Students also valued the immediacy of the feedback. The opportunity to receive immediate feedback also was identified by graduate nurse practitioner students in a study by Theroux and Pearce (2006).

Objective Structured Clinical Examination

An Objective Structured Clinical Examination (OSCE) provides a means of evaluating performance in a simulation laboratory rather than in the clinical setting. In an OSCE, students rotate through a series of stations; at each station, they complete an activity or perform a task, which is then evaluated. Some stations assess the student's ability to take a patient's history, perform a physical examination, and implement other interventions while being observed by the teacher or an examiner. The student's performance then can be rated using a rating scale or checklist. At other stations, students might be tested on their knowledge and cognitive skills—they might be asked to analyze data, select interventions and treatments, and manage the patient's condition. OSCEs typically are used for summative clinical evaluation; however, they also can be used formatively to assess performance and provide feedback to students.

Newble and Reed (2004) identified three types of stations that can be used in an OSCE. At *clinical stations*, the focus is on clinical competence—for example, taking a history and performing a physical examination, collecting appropriate data, and communicating effectively. Typically, at clinical stations, there is interaction between the

student and a simulated patient (Newble & Reed, 2004). At these stations, the teacher or examiner can evaluate students' understanding of varied patient conditions and management of them and can rate their performance.

At *practical stations*, students perform psychomotor skills, procedures, and technologies, and demonstrate other technical competencies. Performance at these stations is evaluated by the teacher or examiner, usually with checklists. Two challenges in using OSCE are student stress from being observed during performance and issues with validity and reliability (Rushforth, 2007).

At the third type of station, a *static station*, there is no interaction with a simulated or standardized patient (Newble & Reed, 2004). This station facilitates the evaluation of cognitive skills such as interpreting lab results and other data, developing management plans, and making other types of decisions about patient care. At these stations, the teacher or examiner is not present to observe students.

Media Clips

Media clips—short segments of a videotape, a CD, a DVD, a video from YouTube, and other forms of multimedia—may be viewed by students as a basis for discussions in postclinical conferences, on discussion boards, and for other online activities; for small group activities; and for critique and write-up as an assignment. Media clips often are more effective than written descriptions of a scenario, because they allow the student to visualize the patient and clinical situation.

Media clips are appropriate for assessing whether students can apply concepts and content being learned in class to the clinical situation depicted in the media clip, observe and collect data, identify possible problems, identify priority actions and interventions, and evaluate outcomes. Students can answer questions about the media clips as part of a graded learning activity in clinical courses. Media clips also are valuable for formative evaluation, particularly in a group format in which students discuss their ideas and receive feedback from the teacher and peers.

Written Assignments

Written assignments accompanying the clinical experience are effective methods for assessing students' critical thinking and higher-level learning, understanding of content relevant to clinical practice, and ability to

express ideas in writing. Many types of written assignments for clinical courses were described in chapter 15: concept map, concept analysis paper, short written assignments, nursing care plan, case method and study, evidence-based practice papers, teaching plan, journal, group writing, and portfolio. Chapter 10 provided further information about assessing case scenarios. Written assignments can be included as part of the clinical evaluation. Some will be evaluated formatively, such as journals, while others can be graded.

Conferences

The ability to present ideas orally is an important outcome of clinical practice. Sharing information about a patient, leading others in discussions about clinical practice, presenting ideas in a group format, and giving presentations are skills that students need to develop in a nursing program. Working with nursing staff members and health care team members requires the ability to communicate effectively. Conferences provide a method for developing oral communication skills and for evaluating competency in this area. Discussions also lead to problem solving and critical thinking if questions are open ended and geared to those outcomes, as discussed in chapter 11.

Criteria for evaluating conferences include the ability of students to:

- Present ideas clearly and in a logical sequence to the group
- Participate actively in the group discussion
- Offer ideas relevant to the topic
- Demonstrate knowledge of the content discussed in the conference
- Offer different perspectives on the topic, engaging the group in critical thinking
- Assume a leadership role, if relevant, in promoting group discussion and arriving at group decisions

Most conferences are evaluated for formative purposes, with the teacher giving feedback to students as a group or to the individual who led the group discussion. When conferences are evaluated as a portion of the clinical or course grade, the teacher should have specific criteria to guide the evaluation and should use a scoring rubric. Exhibit 16.8 provides a sample form that can be used to evaluate how well a student leads a clinical conference or to assess student participation in a conference.

Exhibit 16.8

EVALUATION OF PARTICIPATION IN CLINICAL CONFERENCE

Student's name _____

Conference topic _____

Date _____

Rate the behaviors listed below by circling the appropriate number. Some behaviors will not be applicable depending on the student's role in the conference; mark those as not applicable (na).

Behaviors	Rating					
	Poor			Excellent		
States goals of conference	1	2	3	4	5	na
Leads group in discussion	1	2	3	4	5	na
Asks thought-provoking questions	1	2	3	4	5	na
Uses strategies that encourage all students to participate	1	2	3	4	5	na
Participates actively in discussion	1	2	3	4	5	na
Includes important content	1	2	3	4	5	na
Includes evidence for practice	1	2	3	4	5	na
Offers new perspectives to group	1	2	3	4	5	na
Considers different points of view	1	2	3	4	5	na
Assists group members in recognizing biases and values	1	2	3	4	5	na
Is enthusiastic about topic	1	2	3	4	5	na
Is well prepared discussion	1	2	3	4	5	na
If leading group, monitors time	1	2	3	4	5	na
Develops quality materials to support discussion	1	2	3	4	5	na
Summarizes at end of conference	1	2	3	4	5	na

Group Projects

Most of the clinical evaluation methods presented in this chapter focus on individual student performance, but group projects also can be assessed as part of the clinical evaluation in a course. Some group work is short term—only for the time it takes to develop a product such as a teaching plan or group presentation. Other groups may be formed for the purpose of cooperative learning with students working in small

groups or teams in clinical practice over a longer period of time. With any of these group formats, both the products developed by the group and the ability of the students to work cooperatively can be assessed.

There are different approaches for grading group projects. The same grade can be given to every student in the group (i.e., a group grade), although this does not take into consideration individual student effort and contribution to the group product. Another approach is for the students to indicate in the finished product the parts they contributed to, providing a way of assigning individual student grades, with or without a group grade. Students also can provide a self-assessment of how much they contributed to the group project, which can then be integrated into their grade. Alternatively, students can prepare both a group and an individual product.

Nitko and Brookhart (2007) emphasized that rubrics should be used for assessing group projects and should be geared specifically to the project. To assess students' participation and collaboration in the group, the rubric also needs to reflect the goals of group work. With small groups, the teacher can observe and rate individual student cooperation and contributions to the group. However, this is often difficult because the teacher is not a member of the group, and the group dynamics change when the teacher is present. As another approach, students can assess the participation and cooperation of their peers. These peer evaluations can be used for the students' own development and shared among peers but not with the teacher, or they can be incorporated by the teacher in the grade for the group project. Students also can be asked to assess their own participation in the group.

Self-Evaluation

Self-evaluation assessment is the ability of students to assess their own clinical competencies and identify where further learning is needed. Self-evaluation begins with the first clinical course and develops throughout the nursing program, continuing into professional practice. Through self-evaluation, students examine their clinical performance and identify both strengths and areas for improvement. Using students' own assessments, teachers can develop plans to assist students in gaining the knowledge and skills they need to meet the outcomes of the course. It is important for teachers to establish a positive climate for learning in the course, or students will not be likely to share an honest self-evaluation with them.

In addition to developing a supportive learning environment, the teacher should hold planned conferences with each student to review performance. In these conferences, the teacher can:

- Give specific feedback on performance
- Obtain the student's perceptions of his or her competencies
- Identify strengths and areas for learning from the teacher's and student's perspectives
- Plan with the student learning activities for improving performance, which is critical if the student is not passing the clinical course
- Enhance communication between teacher and student

Self-evaluation is appropriate only for formative evaluation and should never be graded.

CLINICAL EVALUATION IN DISTANCE EDUCATION

Nursing programs use different strategies for offering the clinical component of distance education courses. Often preceptors in the local area guide student learning in the clinical setting and evaluate performance. If cohorts of students are available in an area, adjunct or part-time faculty members might be hired to teach a small group of students in the clinical setting. In other programs, students independently complete clinical learning activities to gain the clinical knowledge and competencies of a course. Regardless of how the clinical component is structured, the course syllabus, competencies to be developed, rating forms, guidelines for clinical practice, and other materials associated with the clinical course need to be available to whomever is providing the instruction and evaluating student learning. Course management systems facilitate communication among students, preceptors, course faculty, and others involved in the students' clinical activities. Chapter 12 describes the clinical evaluation processes used in one graduate nursing distance education program.

The clinical evaluation methods presented in this chapter can be used for distance education. The critical decision for the teacher is to identify which clinical competencies and skills, if any, need to be observed and the performance rated, because that decision suggests different evaluation methods than if the focus of the evaluation is on the

cognitive outcomes of the clinical course. In programs in which preceptors or adjunct faculty members are available on site, any of the clinical evaluation methods presented in this chapter can be used as long as they are congruent with the outcomes and competencies. There should be consistency, though, in how the evaluation is done across preceptors and clinical settings.

Strategies should be implemented in the course for preceptors and other educators involved in the performance evaluation to discuss as a group the competencies to be rated, what each competency means, and the performance of those competencies at different levels on the rating scale. This is a critical activity to ensure reliability across preceptors and other evaluators. Preceptor development activities of this type should be done before the course begins and at least once during the course to ensure that evaluators are using the tool as intended and are consistent across students and clinical settings.

Even in clinical courses involving preceptors, faculty members may decide to evaluate clinical skills themselves by reviewing videotapes of performance or observing students through videoconferencing and other technology. Videotaping performance is valuable as a strategy for summative evaluation, to assess competencies at the end of a clinical course or another designated point in time, and for review by students for self-assessment and by faculty members to give feedback.

Simulations and standardized patients are other strategies useful in assessing clinical performance in distance education. Performance with standardized patients can be videotaped, and students can submit their patient histories and other written documentation that would commonly be done in practice in that situation. Students also can complete case analyses related to the standardized patient encounter for assessing their knowledge base and rationale for their decisions.

Simulations, analyses of cases, case presentations, written assignments, and other strategies presented in this chapter can be used to evaluate students' decision making and other cognitive skills in distance education courses. Similar to clinical evaluation in general, a combination of approaches is more effective than one method alone.

GRADING CLINICAL PRACTICE

Grading systems for clinical practice are often two-dimensional, such as pass-fail, satisfactory-unsatisfactory, and met or did not meet the clinical

objectives. Some nursing programs add a third category—honors—to acknowledge performance that exceeds the level required. Other grading systems are multidimensional—for example, using letter grades A through F; integers 1 through 5; and percentages. With any of these grading systems, it is not always easy to summarize the multiple types of evaluation data collected about the student's performance into a symbol representing a grade. This is true even in a pass-fail system; it may be difficult to arrive at a judgment to pass or fail based on the evaluation data and the circumstances associated with the student's clinical and simulated practice.

Regardless of the grading system for clinical practice, there are two criteria to be met: (1) the evaluation methods for collecting data about student performance should reflect the clinical competencies and outcomes for which a grade will be assigned, and (2) students must understand how their clinical practice will be evaluated and graded. In planning the course, the teacher needs to decide which of the evaluation methods should be incorporated in the clinical grade. Some of these methods are for summative evaluation, thereby providing a source of information for including in the clinical grade. Other methods, though, are used in clinical practice for feedback only and are not incorporated in the grade.

Categories for grading clinical practice such as pass-fail and satisfactory-unsatisfactory have advantages over a multidimensional system, although there are some disadvantages as well. Pass-fail places greater emphasis on giving feedback to the learner, because only two categories of performance need to be determined. With a pass-fail grading system, faculty members may be more inclined to provide continual feedback to learners, because they do not have to ultimately differentiate performance according to four or five levels of proficiency such as with a multidimensional system. Performance that exceeds the requirements and expectations, though, is not reflected in the grade for clinical practice unless a third category is included—honors-pass-fail. Pass-fail is used most frequently in nursing programs (Alfaro-LeFevre, 2004; Oermann et al., 2009).

A pass-fail system requires only two types of judgment about clinical performance. Do the evaluation data indicate that the student has demonstrated satisfactory performance of the competencies to indicate a pass? Or do the data suggest that the performance of those competencies is not at a satisfactory level? Deciding whether the learner has passed or failed is often easier for the teacher than using the same

evaluation information for deciding on multiple levels of performance. A letter system for grading clinical practice, however, acknowledges the different levels of clinical proficiency students may have demonstrated in their clinical practice.

A disadvantage of pass-fail for grading clinical practice is the inability to include a clinical grade into the course grade. One strategy is to separate nursing courses into two components for grading: one for theory and the second for clinical practice, even though the course is considered a whole. Typically, guidelines for the course indicate that the students must pass the clinical component to pass the course. A second mechanism is to offer two separate courses with the clinical course graded on a pass-fail basis.

Methods for Assigning the Clinical Grade

Once the grading system is determined, there are varied ways of using it to arrive at the clinical grade. The grade can be assigned based on the competencies or outcomes achieved by the student. To use this method, the faculty should consider designating some of the competencies or outcomes as critical for achievement in the course. For example, an A might be assigned if all of the clinical competencies or outcomes were met; a B might be assigned if all of the competencies designated by the faculty as critical behaviors and at least half of the others were met.

For pass-fail grading, the faculty can indicate that all of the competencies or outcomes must be met to pass the course or can designate critical behaviors required for passing the course. For both of these grading systems, the clinical evaluation methods provide the data for determining whether the student's performance reflects achievement of the competencies. These evaluation methods may or may not be graded separately as part of the course grade.

Another way of arriving at the clinical grade is to base it on the evaluation methods. In this system, the clinical evaluation methods become the source of data for the grade. For example,

Paper on analysis of clinical practice issue	10%
Analysis of clinical cases	5%
Conference presentation	10%
Community resource paper	10%
Portfolio	25%
Rating scale (of performance)	40%

In this illustration, the clinical grade is computed according to the evaluation methods. Observation of performance, and the rating on the clinical evaluation tool, is only a portion of the clinical grade. An advantage of this approach is that it incorporates into the grade the summative evaluation methods completed by students.

If pass-fail is used for grading clinical practice, the grade might be computed as follows:

Paper on analysis of clinical practice issue	10%
Analysis of clinical cases	5%
Conference presentation	10%
Community resource paper	10%
Portfolio	25%
Clinical examination, simulations	40%
Rating scale (of performance)	Pass required

This discussion of grading clinical practice suggests a variety of appropriate mechanisms. The teacher must make it clear to students and others how the evaluation and grading will be carried out in clinical practice, through simulations, and in other settings.

FAILING CLINICAL PRACTICE

Teachers will be faced with determining when students have not met the outcomes of the clinical practicum—that is, when students have not demonstrated sufficient competence to pass the clinical course. There are principles that should be followed in evaluating and grading clinical practice, which are critical if a student fails a clinical course or has the potential for failing it. These principles are discussed below.

Communicate Evaluation and Grading Methods in Writing

The evaluation methods used in a clinical course; how each will be graded, if at all; and how the clinical grade will be assigned should be in writing and communicated to the students. The teacher's practices in evaluating and grading clinical performance must reflect this written information. In courses with preceptors, it is critical that preceptors and others involved in teaching and assessing student performance

understand the outcomes of the course, the evaluation methods, how to observe and rate performance, and responsibilities when students are not performing adequately. Luhanga, Yonge, and Myrick (2008) found in a grounded theory study that preceptors passed students in clinical courses who should not have been assigned passing grades.

There is a need for faculty development, especially for new and part-time teachers. As part of this development, teachers should explore their own beliefs and values about grading clinical performance, the meaning of grades, and their views of what constitutes satisfactory performance (Scanlan & Care, 2008).

Identify Effect of Failing Clinical Practicum on Course Grade

If failing clinical practice, whether in a pass-fail or a letter system, means failing the nursing course, this should be stated clearly in the course syllabus and policies. By stating it in the syllabus, which all students receive, they have it in writing before clinical learning activities begin. A sample policy statement for pass-fail clinical grading is:

The clinical component of NUR XXX is evaluated with a pass or fail. A failing grade in the clinical component results in failure of the course even if the theory grade is 75% or higher.

In a letter grade system, the policy should include the letter grade representing a failure in clinical practice—for example, below a C grade. A sample policy statement is:

Students must pass the clinical component of NUR XXX with the grade of C or higher. A grade lower than a C in the clinical component of the course results in failure of the course even if the theory grade is 75% or higher.

Ask Students to Sign Anecdotal Notes, Rating Forms, and Evaluation Summaries

Students should sign any written clinical evaluation documents— anecdotal notes, rating forms (of clinical practicum, clinical examinations, and performance in simulations), narrative comments about the student's performance, and summaries of conferences in which performance was discussed. Their signatures do not mean they agree with the

ratings or comments, only that they have read them. Students should have an opportunity to write in their own comments. These materials are important, because they document the student's performance and indicate that the teacher provided feedback and shared concerns about that performance. This is critical in situations in which students may be failing the clinical course because of performance problems.

Identify Performance Problems Early and Develop Learning Plans

Students need continuous feedback on their clinical performance. Observations made by the teacher, the preceptor, and others and evaluation data from other sources should be shared with the student. Together they should discuss the data. Students may have different perceptions of their performance and, in some cases, may provide new information that influences the teacher's judgment about clinical competencies.

When the teacher or preceptor identifies performance problems and clinical deficiencies that may affect passing the course, conferences should be held with the student to discuss these areas of concern and develop a plan for remediation. In some cases, students need more time and practice to be successful (Gillespie, 2005; McGregor, 2007). It is critical that these conferences focus on problems in performance combined with specific learning activities for addressing them. The conferences should not be the teacher telling the student everything that is wrong with clinical performance; the student needs an opportunity to respond to the teacher's concerns and identify how to address them.

One of the goals of the conference is to develop a plan with learning activities for the student to correct deficiencies and develop competencies further. The plan should include a statement that one good or poor performance will not constitute a pass or fail clinical grade and that sustained improvement is needed (Graveley & Stanley, 1993). The plan also should indicate that completing the remedial learning activities does not guarantee that the student will pass the course and that the student must demonstrate satisfactory performance of the competencies by the end of the course.

Any discussions with students at risk of failing clinical practice should focus on the student's inability to meet the clinical objectives and perform the specified competencies, not on the teacher's perceptions of the

student's intelligence and overall ability. In addition, opinions about the student's ability in general should not be discussed with others.

Conferences should be held in private, and a summary of the discussion should be prepared. The summary should include the date and time of the conference, who participated, areas of concern about clinical performance, and the learning plan with a time frame for completion. The summary should be signed by the teacher, the student, and other participants. Faculty members should review related policies of the nursing education program, because they might specify other requirements.

Identify Support Services

Students who are at risk of failing clinical practice may have other problems affecting their performance. Teachers should refer students to counseling and other support services and not attempt to provide these resources themselves. Attempting to counsel the student and help the student cope with other problems may bias the teacher and influence judgment of the student's clinical performance.

Document Performance

As the clinical course progresses, the teacher should give feedback to the student about performance and continue to guide learning. It is important to document the observations made, other types of evaluation data collected, and the learning activities completed by the student. The documentation should be shared routinely with students, discussions about performance should be summarized, and students should sign these summaries to confirm that they read them.

The teacher cannot observe and document the performance of *only* the student at risk of failing the course. There should be a minimum number of observations and documentation of other students in the clinical group, or the student failing the course might believe that he or she was treated differently than others in the group. One strategy is to plan the number of observations of performance to be made for each student in the clinical group to avoid focusing only on the student with performance problems. However, teachers may observe students who are believed to be at risk for failure more closely and document their observations and conferences with those students more thoroughly and frequently than is necessary for the majority of students. When observations result in

feedback to students that can be used to improve performance, at-risk students usually do not object to this extra attention.

Follow Policy on Unsafe Clinical Performance

There should be a policy in the nursing program about actions to be taken if a student is unsafe in clinical practice. If the practice is safe even though the student is not meeting the outcomes, the student is allowed to continue in the clinical practicum (Graveley & Stanley, 1993). This is because the outcomes and clinical competencies are identified for achievement at the *end* of the course, not during it.

If the student demonstrates performance that is potentially unsafe, however, the teacher can remove the student from the clinical setting, following the policy and procedures of the nursing education program. Specific learning activities outside of the clinical setting need to be offered for students to develop the knowledge and skills they lack; practice with simulators is valuable in these situations. A learning plan should be prepared and implemented as described earlier.

Follow Policy for Failure of a Clinical Course

In all instances, the teacher must follow the policies of the nursing program. If the student fails the clinical course, the student must be notified of the failure and its consequences as indicated in these policies. In some nursing programs, students are allowed to repeat only one clinical course, and there may be other requirements to be met. If the student will be dismissed from the program because of the failure, the student must be informed of this in writing. Generally, there is a specific time frame for each step in the process, which must be adhered to by the faculty, administrators, and students. The specific set of policies and procedures is not as important as the teacher's knowing what they are and following them with all students (Boley & Whitney, 2003).

SUMMARY

Through clinical evaluation, a teacher arrives at judgments about students' performance in clinical practice. The teacher's observations of

performance should focus on the outcomes to be met or competencies to be developed in the clinical course. These provide the framework for learning in clinical practice and the basis for evaluating performance. Although such a framework is essential in clinical evaluation, teachers also need to examine their own beliefs about the evaluation process and purposes it serves in nursing. Clarifying one's own values, beliefs, attitudes, and biases that may affect evaluation is an important first step.

Many clinical evaluation methods are available for assessing student competencies in clinical practice. The teacher should choose evaluation methods that provide information on how well students are performing the clinical competencies. The teacher also decides whether the evaluation method is intended for formative or summative evaluation. Some of the methods designed for clinical evaluation are strictly to provide feedback to students on areas for improvement and are not graded. Other methods, such as rating forms and certain written assignments, may be used for summative purposes.

The predominant method for clinical evaluation is in observing the performance of students in clinical practice. Although observation is widely used, there are threats to its validity and reliability. Observations of students may be influenced by the teacher's or preceptor's values, attitudes, and biases. In observing clinical performance, there are many aspects of that performance on which the teacher may focus attention. Every observation reflects only a sampling of the learner's performance during a clinical learning activity. Such issues point to the need for a series of observations before drawing conclusions about performance. There are several ways of recording observations of students, including anecdotal notes, checklists, and rating scales.

Other methods for clinical evaluation are simulations, standardized patients, OSCEs, written assignments, portfolios, conferences, group projects, and self-evaluation. Some methods are appropriate only for formative evaluation and providing feedback to students. Other methods can be used for both formative and summative evaluation (i.e., graded).

Important guidelines for grading clinical practice and working with students who are at risk for failing a clinical course were discussed in the chapter. These guidelines give direction to teachers in establishing sound grading practices and following them when working with students in clinical practice.

Exhibit 16.9

CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES**3. Use Assessment and Evaluation Strategies**

- A. Provide input for the development of nursing program standards and policies regarding
 - 2. progression
- C. Initiate the development of nursing program standards and policies regarding progression
- D. Enforce nursing program standards related to admission and progression
- E. Use a variety of strategies to assess and evaluate learning in these domains
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- F. Incorporate current research in assessment and evaluation practices
- G. Use existing evaluation tools for assessing clinical practice and educational outcomes
- H. Evaluate available resources for learner assessment and evaluation
- I. Select appropriate assessment instruments
- J. Implement evaluation strategies that are appropriate to the learner and learning outcomes
- K. Analyze assessment and evaluation data
- L. Design tools for assessing clinical practice
- M. Create appropriate assessment instruments to evaluate educational outcomes
- N. Use assessment and evaluation data to enhance the teaching-learning process
- O. Advise learners regarding assessment and evaluation criteria
- P. Provide timely, constructive, and thoughtful feedback to learners

REFERENCES

- Alfaro-LeFevre, R. (2004). Should clinical courses get a letter grade? *The Critical Thinking Indicator*, 1(1), 1–5. Retrieved August 1, 2009, from http://www.alfaroteachsmart.com/clinicalgrade_newsletter.pdf
- Becker, K., Rose, L., Berg, J., Park, H., & Shatzer, J. (2006). The teaching effectiveness of standardized patients. *Journal of Nursing Education*, 45, 103–111.
- Boland, D. L. (2009). Developing curriculum frameworks, outcomes, and competencies. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (3rd ed., pp. 137–153). St. Louis, MO: Saunders.
- Boley, P., & Whitney, K. (2003). Grade disputes: Considerations for nursing faculty. *Journal of Nursing Education*, 42, 198–203.

- Bonnel, W. (2008). Improving feedback to students in online courses. *Nursing Education Perspectives*, 29, 290–294.
- Bonnel, W., Gomez, D. A., Lobodzinski, S., & West, C.D.H. (2005). Clinical performance evaluation. In D. M. Billings & J. A. Halstead (Eds.), *Teaching in nursing: A guide for faculty* (2nd ed., pp. 521–542). St. Louis, MO: Elsevier.
- Bourbonnais, F., Langford, S., & Giannantonio, L. (2008). Development of a clinical evaluation tool for baccalaureate nursing students. *Nurse Education in Practice*, 8(1), 62–71.
- Case, B., & Oermann, M. H. (in press). Clinical teaching and evaluation. In L. Caputi (Ed.), *Teaching nursing: The art and science*. Glen Ellyn, IL: College of DuPage Press.
- Chickering, A. W., & Gamson, Z. F. (1987). Seven principles for good practice in undergraduate education. *AAHE Bulletin*, 39(7), 3–7.
- Chickering, A. W., & Gamson, Z. F. (1999). Development and adaptations of the seven principles for good practice in undergraduate education. *New Directions in Teaching and Learning*, 80, 75–81.
- Emerson, R. J. (2007). Assessing student learning outcomes: Evaluation and grading. In *Nursing education in the clinical setting* (pp. 271–291). St. Louis, MO: Mosby.
- Gallant, M., MacDonald, J., & Smith Higuchi, K. A. (2006). A remediation process for nursing students at risk of clinical failure. *Nurse Educator*, 35, 223–227.
- Gillespie, M. (2005). Student-teacher connection: A place of possibility. *Journal of Advanced Nursing*, 52, 211–219.
- Graveley, E. A., & Stanley, M. (1993). A clinical failure: What the courts tell us. *Journal of Nursing Education*, 32, 135–137.
- Hand, H. (2006). Assessment of learning in clinical practice. *Nursing Standard*, 21, 48–56.
- Henderson, A., Twentyman, M., Heel, A., & Lloyd, B. (2006). Students' perception of the psycho-social clinical learning environment: An evaluation of placement models. *Nurse Education Today*, 26, 564–571.
- Holaday, S. D., & Buckley, K. M. (2008). A standardized clinical evaluation tool-kit: Improving nursing education and practice. In M. H. Oermann (Ed.), *Annual review of nursing education* (Vol. 6, pp. 123–149). New York: Springer Publishing.
- Ignatavicus, D., & Caputi, L. (2004). Evaluating students in the clinical setting. In L. Caputi & L. Engelmann (Eds.), *Teaching nursing: The art and science* (Vol. 1, pp. 178–195). Glen Ellyn, IL: College of DuPage Press.
- Jeffries, P. (2007). *Simulation in nursing: From conceptualization to evaluation*. New York: National League for Nursing.
- Jenkins, L. S., & Schaivone, K. (2007). Standardized patients in nursing education. In M. H. Oermann & K. Heinrich (Eds.), *Annual review of nursing education* (Vol. 5, pp. 3–23). New York: Springer Publishing.
- Luhanga, F., Yonge, O. J., & Myrick, F. (2008). "Failure to assign failing grades": Issues with grading the unsafe student. *International Journal of Nursing Education Scholarship*, 5(1), article 8. doi: 10.2202/1548-923X.1366
- McGregor, A. (2007). Academic success, clinical failure: Struggling practices of a failing student. *Journal of Nursing Education*, 46, 504–511.
- Newble, D., & Reed, M. (2004). *Developing and running an Objective Structured Clinical Examination (OSCE)*. Retrieved January 25, 2005, from <http://www.shf.ac.uk/~dme/oscehandbook.doc>

- Nitko, A. J., & Brookhart, S. M. (2007). *Educational assessment of students* (5th ed.). Upper Saddle River, NJ: Pearson Education.
- O'Connor, A. B. (2006). *Clinical instruction and evaluation: A teaching resource* (2nd ed.). Sudbury, MA: Jones and Bartlett.
- Oermann, M. H. (2004). Reflections on undergraduate nursing education: A look to the future. *International Journal of Nursing Education Scholarship*, 1(1), article 1. doi: 10.2202/1548-923X.1001
- Oermann, M. H. (2008). Clinical evaluation. In B. Penn (Ed.), *Mastering the teaching role: A guide for nurse educators* (pp. 299–313). Philadelphia: F. A. Davis.
- Oermann, M. H., Yarbrough, S. S., Ard, N., Saewert, K. J., & Charasika, M. (2009). Clinical evaluation and grading practices in schools of nursing: National Survey Findings Part II. *Nursing Education Perspectives*, 30, 274–279.
- Rushforth, H. (2007). Objective structured clinical examination (OSCE): Review of literature and implications for nursing education. *Nurse Education Today*, 27, 481–490.
- Scanlan, J. M., & Care, W. D. (2008). Issues with grading and grade inflation in nursing education. In M. H. Oermann, (Ed.), *Annual review of nursing education* (Vol. 6, pp. 173–188). New York: Springer Publishing.
- Scanlan, J. M., Care, W. D., & Gessler, S. (2001). Dealing with the unsafe student in clinical practice. *Nurse Educator*, 26, 23–27.
- Schoening, A., Sittner, B., & Todd, M. (2006). Simulated clinical experience: Nursing students' perceptions and the educators' role. *Nurse Educator*, 31, 253–258.
- Skingley, A., Arnott, J., Greaves, J., & Nabb, J. (2006). Supporting practice teachers to identify failing students. *British Journal of Community Nursing*, 12(1), 28–32.
- Theroux, R., & Pearce, C. (2006). Graduate students' experiences with standardized patients as adjuncts for teaching pelvic examinations. *Journal of the American Academy of Nurse Practitioners*, 18, 429–435.
- White, A., Allen, P., Goodwin, L., Breckinridge, D., Dowell, J., & Garvy, R. (2005). Infusing PDA technology into nursing education. *Nurse Educator*, 30, 150–154.

Appendix: Certified Nurse Educator (CNE^{CM}) Examination Detailed Test Blueprint*

1. Facilitate Learning – 25%

- A. Implement a variety of teaching strategies appropriate to
 - 1. content setting
 - 2. learner needs
 - 3. learning style
 - 4. desired learner outcomes
- B. Use teaching strategies based on
 - 1. educational theory
 - 2. evidence-based practices related to education
- C. Modify teaching strategies and learning experiences based on consideration of learners'
 - 1. cultural background
 - 2. past clinical experiences
 - 3. past educational and life experiences
- D. Use information technologies to support the teaching-learning process
- E. Practice skilled oral and written (including electronic) communication that reflects an awareness of self and relationships with learners (e.g., evaluation, mentorship, and supervision)
- F. Communicate effectively orally and in writing with an ability to convey ideas in a variety of contexts
- G. Model reflective thinking practices
- H. Model critical thinking

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- I. Create opportunities for learners to develop their own critical thinking skills
- J. Create a positive learning environment that fosters a free exchange of ideas
- K. Show enthusiasm for teaching, learning, and the nursing profession that inspires and motivates students
- L. Demonstrate personal attributes that facilitate learning (e.g., caring, confidence, patience, integrity, respect, and flexibility)
- M. Respond effectively to unexpected events that affect clinical and/or classroom instruction
- N. Develop collegial working relationships with clinical agency personnel to promote positive learning environments
- O. Use knowledge of evidence-based practice to instruct learners
- P. Demonstrates ability to teach clinical skills
- Q. Act as a role model in practice settings

2. Facilitate Learner Development and Socialization – 11%

- A. Identify individual learning styles and unique learning needs of learners with these characteristics
 - 1. culturally diverse (including international)
 - 2. traditional vs. non-traditional
 - 3. at-risk (e.g., educationally disadvantaged, learning and/or physically challenged, social, and economic issues)
- B. Provide resources for diverse learners to meet their individual learning needs
- C. Advise learners in ways that help them meet their professional goals
- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse
- E. Foster the development of learners in these areas
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- F. Adapt teaching styles and interpersonal interactions to facilitate learner behaviors

- G. Assist learners to engage in thoughtful and constructive self and peer evaluation
- H. Encourage professional development of learners

3. Use Assessment and Evaluation Strategies – 15%

- A. Provide input for the development of nursing program standards and policies regarding
 - 1. admission
 - 2. progression
 - 3. graduation
- B. Initiate the development of nursing program standards and policies regarding admission
- C. Initiate the development of nursing program standards and policies regarding progression
- D. Enforce nursing program standards related to admission and progression
- E. Use a variety of strategies to assess and evaluate learning in these domains
 - 1. cognitive
 - 2. psychomotor
 - 3. affective
- F. Incorporate current research in assessment and evaluation practices
- G. Use existing evaluation tools for assessing clinical practice and educational outcomes
- H. Evaluate available resources for learner assessment and evaluation
 - I. Select appropriate assessment instruments
 - J. Implement evaluation strategies that are appropriate to the learner and learning outcomes
 - K. Analyze assessment and evaluation data
 - L. Design tools for assessing clinical practice
- M. Create appropriate assessment instruments to evaluate educational outcomes
- N. Use assessment and evaluation data to enhance the teaching-learning process

- O. Advise learners regarding assessment and evaluation criteria
- P. Provide timely, constructive, and thoughtful feedback to learners

4. Participate in Curriculum Design and Evaluation of Program Outcomes – 19%

- A. Lead in the development of designing a curriculum
- B. Actively participate in the design of the curriculum to reflect
 - 1. institutional philosophy and mission
 - 2. current nursing and health care trends
 - 3. community and societal needs
 - 4. educational principles, theory, and research
 - 5. use of technology
- C. Demonstrate knowledge of curriculum development including
 - 1. identifying program outcomes
 - 2. developing competency statements
 - 3. writing course objectives
 - 4. selecting appropriate learning activities
 - 5. selecting appropriate clinical experiences
 - 6. selecting appropriate evaluation strategies
- D. Revise the curriculum based on evaluation of
 - 1. program outcomes
 - 2. learner needs
 - 3. societal and health care trends
 - 4. stakeholder feedback (e.g., from learners, agency personnel, accrediting agencies)
- E. Implement curricular revisions using appropriate change theories and strategies
- F. Update courses to reflect the philosophical and theoretical framework of the curriculum
- G. Design courses to reflect the philosophical and theoretical framework of the curriculum
- H. Maintain community and clinical partnerships that support the educational goals
- I. Create community and clinical partnerships that support the educational goals
- J. Evaluate educational goal attainment through community and clinical partnerships

- K. Implement program assessment models
- L. Analyze results of program evaluation and initiates curricular change
- M. Critique the program evaluation methods and plan

5. Pursue Continuous Quality Improvement in the Academic Nurse Educator Role – 12%

- A. Engage in activities that promote one's socialization to the role
- B. Maintain membership in professional organizations
- C. Participate actively in professional organizations through committee work and/or leadership roles
- D. Demonstrate a commitment to life-long learning
- E. Participate in professional development opportunities that increase one's effectiveness in the role
- F. Select professional development activities to continue to grow and evolve in the role
- G. Balance the teaching, scholarship, and service demands inherent in the role of the educator and as influenced by the requirements of the institutional setting
- H. Use feedback gained from self, peer, learner, and administrative evaluation to improve role effectiveness
- I. Acquire knowledge of legal and ethical issues relevant to higher education and nursing education
- J. Mentor and support faculty colleagues in the role of an academic nurse educator
- K. Engage in self-reflection and continued learning to improve teaching practices

6. Engage in Scholarship, Service, and Leadership

- A. Function as a Change Agent and Leader – 8%
 - 1. Model cultural sensitivity when advocating for change
 - 2. Integrate a long term, innovative, and creative perspective into the academic nurse educator role
 - 3. Evaluate organizational effectiveness in nursing education

4. Enhance the visibility of nursing and its contributions by providing leadership in the
 - a. nursing program
 - b. parent institution
 - c. community
 5. Participate in interdisciplinary efforts to address health care and educational needs
 - a. within the institution
 - b. locally
 6. Implement strategies for change within the
 - a. nursing program
 - b. institution
 7. Create a culture for change within the nursing program
 8. Promote innovative practices in educational environments
 9. Develop leadership skills in others to shape and implement change
 10. Use legal and ethical principles to influence, design, and implement policies and procedures related to learners, faculty, and the educational environment
 11. Adapt to changes created by external factors
 12. Support changes as an early adopter
- B. Engage in Scholarship of Teaching – 5%**
1. Exhibit a spirit of inquiry about teaching and learning, student development, and evaluation methods
 2. Use evidence-based resources to improve and support teaching
 3. Develop an area of expertise in the academic nurse educator role
 4. Share teaching expertise with colleagues and others
 5. Demonstrate integrity as a scholar
- C. Function Effectively within the Institutional Environment and the Academic Community – 5%**
1. Identify how social, economic, political, and institutional forces influence nursing and higher education
 2. Network, collaborate, and partner with other disciplines to enhance nursing's influence within the academic community

- 3.** Determine professional goals within the context of academic nursing and the mission of the nursing program and parent institution
- 4.** Integrate the values of respect, collegiality, professionalism, and caring to build an organizational climate that fosters the development of learners and colleagues
- 5.** Consider the goals of the nursing program and the mission of the parent institution when proposing change or managing issues
- 6.** Participate on institutional and departmental committees
- 7.** Assume a leadership role in various levels of institutional governance

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