CHAPTER 1

Goals of Clinical Nursing Education

The ultimate goal of nursing education is to prepare the student to think critically, communicate accurately, and perform indicated therapeutic nursing interventions in patient care situations; exhibit the caring behaviors inherent in nursing actions; apply an ethical perspective in clinical decision making; and function effectively as a team member within the

organizational structures surrounding the delivery of patient care. The clinical laboratory is the place where much of this learning occurs.

The goals of clinical nursing education are to enable the student to:

1. Apply theoretical learning to patient care situations through the use of critical thinking skills to recognize and resolve patient care problems and the use of the nursing process to design therapeutic nursing interventions and evaluate their effectiveness
2. Develop communication skills in working with patients, their families, and other healthcare providers
3. Demonstrate skill in the safe use of therapeutic nursing interventions in providing care to patients
4. Evaluate and utilize evidence-based practices and research findings in designing patient care
5. Evidence caring behaviors in nursing actions
6. Recognize and respect the varied beliefs, values, and customs of individual patients inherent in an increasingly diverse population
7. Consider the ethical implications of clinical decisions and nursing actions
8. Gain a perspective on the contextual environment of healthcare delivery
9. Develop a beginning mastery of technology as it is utilized in patient care settings
10. Experience the various roles of the nurse within the healthcare delivery system
11. Develop the skills necessary to continuously update knowledge in the practice of nursing

Applying Theoretical Learning to Patient Care Situations

Clinical nursing education enables students to move from theoretical learning about nursing, based on textbook and classroom explanations of human responses to illness and its treatment, to practical learning in making the observations and performing the interventions necessary to manage those responses in real-life situations. Theory becomes reality as students begin to make connections between the generic "usual" case presented in the classroom and the specific "actual" case with which they are involved.

The clinical laboratory is the place where the theoretical begins to make sense, and a great deal of integration of theoretical with practical knowledge becomes possible as students search out explanations for the phenomena they are witnessing in the clinical situations to which they are exposed. Abandoning the safety of "book learning" for the real world of patient care is frightening. Students enter this aspect of their education with eager trepidation. The clinical instructor must be skilled in assessing the degree of anxiety presented by each student and able to channel unfocused functional anxiety to maximize learning and defuse dysfunctional anxiety to permit safe performance.

Students see how the theoretical "ideal" plays out in the clinical "real" as they embark on the critical thinking process of problem identification, sorting through theoretical and experiential knowledge to determine what is relevant in the present situation, and applying this knowledge to the design of interventions. Exposure to an array of clinical situations is essential to fine-tune the student's observational skills, recall and application abilities, and problem solving skills, and such exposure is impossible in the relatively brief time allotted to clinical learning. Therefore, the clinical instructor must devise approaches to enhance critical thinking, for example, through conferencing, where students compare and contrast their individual experiences; journaling, where students reflect on the clinical experience and begin to make the intellectual connections that might have eluded them during the experience; structured questioning that presents "what if" situations, where students are encouraged to explore alternative scenarios that might occur; and "war stories" that recount the instructor's experiences with similar situations.

The nursing process makes it easier to understand the intellectual connections that are necessary to apply theory in practice. When the nursing process is used as a guide to critical thinking that emphasizes the connections between making observations and assessments, analyzing these to formulate tentative diagnoses, selecting approaches to address the problems identified through the diagnostic process, implementing interventions, and evaluating the effectiveness of interventions and the accuracy of initial diagnoses, students can embrace it as a useful tool for clinical decision making. The clinical instructor can facilitate this use of the nursing process by articulating her own thinking through of clinical problems.

Written care plans, usually based on a nursing process format, require the student to make explicit the intellectual connections she has (or has

not) made, and force the integration of theoretical learning in the case being addressed. Such assignments are a useful adjunct to clinical learning and are a check of the degree to which each student is successfully connecting theory to practice. However, when the nursing process is reduced to a framework for the written care plan rather than an active approach to thinking about clinical situations, students may devalue the critical thinking that is an inherent aspect of developing clinical knowledge.

Developing Communication Skills

Transitioning from a predominantly social style of communication to the situationally determined communication styles required in nursing practice is an essential component of clinical learning. No amount of classroom or college laboratory practice can prepare the student for this communication challenge.

The development of therapeutic communication skills is the primary focus of theoretical learning about communication in nursing education programs. The student must be guided to recognize the full repertoire of communication strategies and to become skilled in selecting and using appropriate strategies in specific situations. In addition to therapeutic communications, nurses must be adept at interviewing, counseling, and teaching patients; documenting observations and interventions, both orally and in writing, including the skilled use of information technology; and delegating up and down the chain of healthcare workers. Each of these strategies requires attentiveness to the objective of the interaction, the best means of structuring the interaction, and the applicable language to use.

Unlike social communications, professional communications are goal directed. Students need help in identifying the objective of their communication strategies and the information necessary to achieve that objective. Initial interactions need to be as carefully planned and mentally rehearsed as administering an intramuscular injection or changing a dressing.

Students also need to be skilled in listening to and observing their communication partners, hearing and absorbing what is said, interpreting what is said, and then crafting a response. Too often, students are so anxious to deliver a message that they fail to listen to the responses that would improve that message. Clinical instructors can assist the student to listen better by encouraging her to slow down to allow silence to provide the time and space needed for both partners to think before talking.

Nurses tend to use "common language" with patients and their families, readily translating medical jargon into terms that patients can understand. In using common language, nurses make adjustments based on the patient's age, educational level, culture, native language, and existing communication problems—such as hearing deficits or an inability to speak around an endotracheal tube—as well as the patient's level of anxiety or alertness. Nurses also make full use of nonverbal communication, such as touch, facial expressions, and reassuring vocalizations. By observing the interactions of staff and the clinical instructor with patients, students learn the nuances of skilled communication with patients. When the clinical instructor points out an especially effective approach, or one that is less than successful, and articulates the critical elements of the interaction, students are better able to grasp the full dynamic of the episode.

Nurses use "nurse-talk" with one another, particularly coworkers. Nurse-talk is an abbreviated communication style loaded with acronyms and terms specific to the clinical environment. Such talk suits the rapidly changing clinical situation and the limited time that nurses have to brief one another. For students, nurse-talk can be both baffling and intimidating. Unable to decipher the language and afraid to display ignorance by requesting a translation, students may muddle through a clinical experience with little understanding of what is going on. This problem is exacerbated if some students in the clinical group, who have had work experiences in an environment similar to the clinical area in which they are learning, use their mastery of nurse-talk to feign clinical expertise. The clinical instructor must serve as translator, accepting students' inability to negotiate nurse-talk at this stage of their professional development and interpreting the nurse-talk for them. Providing translation presents an excellent opportunity to reinforce theoretical content. For example, when a staff nurse refers to "the cabbage in Room 304," the clinical instructor can explain that "cabbage" refers to the acronym "CABG," which stands for "coronary artery bypass graft," and then provide a brief overview of indications for the procedure, what the procedure accomplishes, and practice pointers such as the need to monitor both the primary and donor operative sites. This also would be an opportune time to reinforce the concept that patients are people, not medical diagnoses or procedures. Nurse-talk also uses humor, often macabre, to diffuse tension. Such nurse-talk may strike students as uncaring but serves as a coping mechanism for nurses who deal with the emotional demands of caring for patients with especially devastating illness.

"Delegation-talk" is another type of communication to be mastered by students. Delegation occurs "down" when an aspect of nursing care is to be provided by another; delegation occurs "up" when the nurse is requesting an intervention by a physician or supervisor. Delegation-talk uses explicit language to communicate to the delegatee what needs to be done and why, when it needs to be done, how it should be done, and expectations for response or report back to the delegator. Delegation-talk must clearly identify "who" is to perform the delegated task; stating, "someone ought to . . ." is unlikely to accomplish the objective of delegation-talk. Students are uncomfortable delegating to individuals who are more knowledgeable and/ or skilled than they are, which can interfere with communication. Shared responsibility for healthcare delivery demands delegation, and students must become skilled in and comfortable with the use of delegation-talk. Practicing with one another can help master this language.

They must also learn the "professional tongue." The professional tongue uses medical and nursing terminology to provide a precise description or explanation of a situation. It is used to communicate with those who are partners in providing care but are less familiar with the existing situation, as in completing written documentation on a patient's status, giving an end-of-shift report, discussing a patient's condition during "rounds," or in teaching other professionals. The development of the professional tongue can be enhanced by insisting on its use in student reports to staff members at the conclusion of the clinical day or in conference presentations.

While it is impossible for the clinical instructor to witness each episode of communication in order to provide students with practical pointers on fine-tuning communication skills, this aspect of clinical education must become part of the curriculum. Process recordings are a useful device for helping students to focus on their communication skills and need not be confined to therapeutic interactions.

Demonstrating Skill in the Use of Therapeutic Nursing Interventions

The clinical area is the place where students learn their technical skills. Opportunities to learn and practice specific skills in the controlled college laboratory setting, while valuable, are not a substitute for using these skills with patients. Hands-on care propels the student toward the goal of becoming a nurse; progress is measured by an ever-lengthening list of

technical skills that have been performed—if not mastered—in the clinical area.

Doing transcends thinking or communicating, especially in early clinical experiences. Doing enables the student to feel useful and is generally accompanied by a sense of accomplishment. Access to the patient is facilitated when the student has a purpose for entering the patient's domain, and so the need to provide physical care or render a treatment makes approaching the patient less intimidating. A patient assignment that does not involve the use of technical skills feels like a waste of time and energy to most students, who tend not to seek out or respond to other patient needs, such as teaching or counseling.

For the clinical instructor who knows that technical skills are only a small component of the professional nursing role, this focus on doing can be distressing. Students' focus on technical skills, however, mirrors patients' valuing of physical care over nursing actions that seek to promote comfort and a trusting relationship (Patistea & Siamanta, 1999). Students enter nursing education programs sharing many perceptions with patients; these perceptions change as students incorporate the values of the profession into their view of nursing.

Despite its centrality for students, the goal of developing the technical skills of practice is a source of intense anxiety. Students are afraid to make an error and harm—or even kill—the patient. They worry that the patient will find them inept, will feel like a guinea pig, or will insist that the student be replaced by a "real nurse." The urge to "care" competes with the real need to learn through practice; the two motives feel incompatible.

Developing skills to deliver therapeutic nursing interventions involves more than technical expertise. It requires the simultaneous performance of caring behaviors, technical skills, and the intellectual manipulations of critical thinking, which can only be achieved when technique—the "how to" of the skill component—is so well mastered that it no longer requires conscious mental attention for successful performance. It is at this point that the nursing student—or, more likely, graduate nurse—is able to focus on the "whole picture" and respond to the patient who is receiving the intervention. The clinical instructor can advance skill development by attending to the details the student is unable to see when performing a technical task, especially for the first time. For example, the instructor can explain the procedure to the patient, provide comfort—such as holding the patient's hand—and observe the patient's response to the intervention. In this way,

the instructor can complement the student's activities to model the "whole" performance. Assuming a complementary role also helps the instructor to refrain from taking over for the student in the midst of a procedure.

For the clinical instructor, safety is a primary concern when students are learning technical skills in the clinical setting. Like the students, the instructor is concerned that errors will occur and patients will be harmed, a concern that is multiplied by the number of students being supervised in the clinical area. Knowing that she cannot be with every student at all times, the clinical instructor must allocate time fairly to provide all students with relatively equivalent opportunities to learn the technical skills required. Keeping track of levels of experience and competence achieved by each student in each skill, coupled with the instructor's overriding concern with safety, can create the impression that students are correct: technical skill mastery is what clinical learning is all about. The instructor's skillful use of questioning and verbal rehearsals of care activities can create opportunities for teaching the "why" behind the "how" and alert students to the clinical issues associated with interventions.

Incorporating Evidence-Based Practices and Research Findings into the Design of Nursing Interventions

Evidence-based practice is the delivery of nursing care based on information about what works. It involves the critical analysis of primarily randomized controlled quantitative research studies and the integration of the best evidence from these studies into the clinical situation based on the nurse's clinical expertise, patient preferences, and available resources (DiCenso & Cullum, 1998).

The ability to fully incorporate evidence-based practices and research findings into the delivery of nursing care is dependent on the student's ability to analyze and critique research studies to evaluate their usefulness in practice. These are skills that are introduced in baccalaureate-level preparatory programs, often after students have completed several clinical experiences. Their full development can only be accomplished over time, after the student has graduated, and only if the employing institution values and encourages evidence-based practice and provides the support, time, and resources necessary to accomplish it.

Still, the clinical nursing instructor can develop in students a "spirit of inquiry" regardless of the level of preparatory program in which she is

teaching and regardless of whether students have been exposed to a research course. A spirit of inquiry is one of four competency clusters identified by the National League for Nursing (2010) as desirable outcomes for programs at the practical/vocational, associate degree and diploma, and baccalaureate levels of nursing education. Such a spirit of inquiry questions the basis of various nursing practices, many of which are rooted in tradition rather than science. It calls for a challenge to assumptions and the status quo, and a search for evidence that supports established nursing practices, including the generation of new insights that may improve patient care.

Students can be challenged to formulate questions about the actions they are taking in the delivery of specific components of care to patients and then search the available literature regarding best practices that might be applicable to the practice in question. The analysis and synthesis of available empirical support have been completed for many nursing practices across many nursing specialties. Such evidence need not be rediscovered by the student. Instead, students can be guided to thoughtfully consider whether the information provided in support of a suggested "best practice" appears to be sufficient and whether the "best practice" is an appropriate approach to caring for the assigned patient. Such use of established best practices is an effective means of introducing any level of student to the concept of evidence-based nursing practice.

Evidencing Caring Behaviors in Nursing Actions

It is a rare student who fails to express the desire to "care for others" as a primary reason for becoming a nurse (Rhodes, Morris, & Lazenby, 2011). Students usually cannot articulate what they mean by "caring," but we can assume that it involves relief of suffering, providing comfort, and a general "connectedness" with the patient.

Students' focus on technical skill development corresponds with their tendency to equate activities that do something for the patient with caring for the patient. Caring expressed by "doing for" needs to be replaced with caring that is enabling and empowering—a caring "about" the person of the patient who is struggling to cope with illness and its treatment or to incorporate a necessary change into his lifestyle (Almon, 1999). Yet "doing for" is highly valued by students for many reasons, and it is difficult to shift their emphasis toward a conception of caring as providing the patient with the support necessary to achieve and maintain wellness.

Students are typically unable to see the "big picture." They do not view the patient as a functioning whole, as a member of a family system or a community. They do not consider the situation from which the patient enters the healthcare system and to which he will return. This tunnel vision is not due to lack of data on these larger issues; indeed, the student may have collected all the relevant data herself. The student's focus is on the immediate situation and is more self-absorbed than other-directed as the student struggles with the tasks and issues presented by the clinical assignment. Students are likely to monitor intravenous (IV) drip rates without checking to see that the IV site and tubing are intact; they are likely to watch a cardiac monitor display of an arrhythmia without checking the patient's response to the arrhythmia.

Students are able to recognize caring when they see it, however. Therefore, role-modeling the caring component of nursing care delivery is an essential part of the clinical instructor's role. Complimenting students when the instructor has observed caring actions signals to students their capacity to develop this aspect of their profession and reinforces caring behaviors, underlining their importance.

Students are also able to recognize the failure to care in other staff members and often are verbal about this. Channeling their outrage into a discussion of why the observed episode was "uncaring," what might have contributed to staff behavior, and what actions might have been taken to transform the interaction into a caring one helps students to understand caring as reflected in actions and in general attitudes of concern and compassion.

Exhibiting Cultural Competence in the Care of Patients

Students may be overwhelmed by the diversity they encounter during their clinical experiences and will need guidance in recognizing the individual manifestations of cultural differences in the patients they care for and in developing culturally sensitive approaches to working with them. The generalized information concerning culturally based health beliefs, values, and practices obtained through classroom instruction and reading must be fine-tuned for application in the unique situation of the individual patient.

Cultural competence is "the ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the

cultural context of the client (individual, family, community)" (Campinha-Bacota, 1998, p. 181). While nursing education programs have long recognized the ways in which the health beliefs and values held by members of various cultures can influence short- and long-term health outcomes, there has been a gradual but steady shift in the approach to communicating the importance of cultural awareness to nursing students as they provide care for increasingly diverse patient populations during their clinical experiences.

Early approaches to sensitizing students to cultural differences centered on stereotypical beliefs, values, and practices of a handful of distinctive ethnic and racial groups without acknowledging that the very process of acculturation may have altered these beliefs, values, and practices for individual members of such groups. With a shift in perspective on cultural influences on healthcare practices came the recognition that distinctive cultures exist not only in relation to ethnicity and race, but also based on age, gender, sexual orientation, educational background, socioeconomic status, employment, disability, and so forth.

Leininger's (1995) pioneering work on transcultural nursing stressed the importance of what she termed "culturally congruent" care designed to align with the cultural values, beliefs, and practices of individuals and groups. She advocated three alternative approaches to delivering care to members of a culturally distinctive group based on a thorough assessment of the individual's beliefs and practices. For those beliefs and practices that are efficacious, Leininger's model calls for care that preserves and maintains the existing practice. This requires the nurse to look beyond the specific approach being used to evaluate its effects, recognizing that there are multiple ways to achieve a desired outcome. This is particularly difficult for beginning students, who tend to be focused on the "right" way to accomplish a treatment, or even for more advanced students, who are striving to incorporate best practices in their approach to patient care. For those beliefs and practices that have no discernible negative effect on health outcomes, care involves accommodating the individual's approach to health care while negotiating for the inclusion of effective health practices as an addition to rather than substitute for existing practices. In the case of beliefs and practices that are likely to have a negative effect on healthcare outcomes, the nurse must work with the patient to restructure the approach to care to eliminate elements that are harmful or inhibit recovery. The beginning student, in particular, may be intimidated by the prospect of challenging the established practices of a patient from a different culture than her own.

While Leininger's (1995) model calls for the nurse to manipulate the approach to providing care based on an analysis of the effects of cultural beliefs and practices on health outcomes, Campinha-Bacota's (1998) model of care focuses more on the nurse's own response to the cultural differences she encounters in practice. Campinha-Bacota describes five components of the process of developing cultural competence. Cultural awareness involves self-examination of personal biases, prejudices, and assumptions about others who are different. Such awareness opens the door to potential acceptance of others' beliefs, values, and practices. The development of cultural knowledge necessitates the search for general information about a culture and its health-related beliefs and values and the recognition of and appreciation for the individual's unique expression of his culture as altered by life experiences and the process of acculturation to other cultures. Accurate physical and cultural assessment is the essence of cultural skill, while cultural encounters reveal linguistic barriers that must be surmounted to enhance communication. Finally, cultural desire describes wanting to provide culturally responsive care rather than feeling compelled to do so.

By emphasizing the uniqueness of each individual, the clinical instructor can guide students in gaining the cultural awareness that is the critical first step in developing cultural competence through a lifetime of practice, one major manifestation of a caring approach to patient care.

Considering the Ethical Implications of Clinical Decisions and Nursing Actions

Ethical considerations in nursing care delivery also are intimately entwined with caring. Ethical action involves "doing what is right" in situations that involve alternative possibilities for action. In responding to a situation ethically, the nurse does not substitute her judgment for that of the patient, but, rather, considers which clinical decisions and nursing actions best reflect the patient's expressed wishes and underlying values. While ethical considerations encompass such major issues as the right to self-determination, the right to privacy, and the right to be treated with dignity, ethics also entails the consideration of clinical decisions and nursing actions reflecting the "best good" in the situation from the patient's perspective.

Despite their general tendency toward caring in their interactions with patients, nursing students are often self- rather than other-centered. In an

effort to perform competently, the student focuses on the performance more than on the recipient of the care being performed. Actual or perceived expectations of the instructor also divert the student's attention away from the patient and toward the tasks to be completed.

Translating a code of ethics presented in the classroom into action in individual patient situations is beyond the ability of most nursing students. The student's clinical knowledge base is still developing. The student has not yet encountered a sufficient number of practice situations to enable her to recognize the ethical issues in day-to-day practice, identify acceptable alternatives for action, and set priorities that exemplify patient-centered care. The student cannot yet perceive the subtleties of a given situation that suggest the need for a discretionary response. The student is unaware of the parameters within which discretion can be exercised.

The nursing student is unable to fully evaluate the patient's situation, with all its distinctiveness, as a basis for considering alternatives that would represent an ethical response. For example, the nursing student is unlikely to consider deferring morning care until later in the day if the patient has had a difficult night, or to take time to allow the patient to elaborate on concerns when a routine blood pressure reading is scheduled, or to encourage the patient to participate in physical therapy despite complaints of assorted aches and pains.

The clinical instructor can use conference time to review each student's plan of care for the day, pointing out specific situations that might call for a change in the routine approach for a given patient. Focused questioning of what constitutes the "best good" for this patient at this time can help the student to consider the ethical implications of the clinical situation and the alternative approaches available to achieve an optimal outcome.

Ethical behavior also entails taking responsibility for one's actions. Students often bring a classroom morality to the clinical setting. That morality includes guessing when unsure of an answer, avoiding asking for assistance, ignoring problem situations in the hope that no one will notice, and, unfortunately, cheating. Such behaviors are obviously incompatible with safe patient care, and the clinical instructor must establish standards of clinical morality at the outset of the clinical experience. This involves encouraging questions, consulting with others, looking up answers, verifying activities before performing them, and admitting to errors. Students need to learn that it is okay to make mistakes while learning, but wrong to

cover them up. Consistency in managing student errors, while maintaining patient safety, is essential in promoting clinical morality.

Gaining a Perspective on the Contextual Environment

Clinical nursing education takes students through a series of experiences with patients of all ages receiving health care for a full array of conditions in a variety of settings. Experiences focus on health maintenance and health promotion, acute illness, and chronic conditions that occur in institutional and community settings. Each of these experiences has a unique contextual environment. Although they are affected by the characteristics of the environments in which clinical learning occurs, students often are unaware of the effects of this environment on patient care.

Each clinical setting varies in the pace of activities that occur there. Pace is reflected in the urgency of time constraints and in the rapidity of changes in patient condition. Even the most slow-paced environment, as in the skilled nursing facility, contains time pressures for beginning nursing students. As skilled performance of routine care activities evolves, this environment may begin to feel sluggish. As students progress to more acute situations, they must learn to keep pace with rapidly evolving environments. Priorities for care activities must shift in accordance with changes in patient condition, and the student must become attuned and responsive to these changes. The orientation to the clinical setting provided by the clinical instructor should include pace and time constraints as factors affecting patient care.

Related to pace is the amount of noise in the clinical environment. Background sounds can soothe or energize, and their effects are felt not only by patients, but also by healthcare workers. Acute care environments are notoriously noisy, and this noise can increase student anxiety and even interfere with their ability to think through clinical situations. Students need to be told to control noise whenever possible, for example, by turning down a TV set when attempting to interview a patient or by learning to alter their natural response to contextual noise by ignoring the noise when it interferes with performance. The clinical instructor also needs to be aware of the effect of contextual noise on her own behaviors, especially when several students are competing for attention and asking questions simultaneously. A "time-out" to reorganize the situation, or to move to a quieter venue, may be the answer when the instructor becomes frazzled due to noise overload.

Institutional environments also contain many workers who affect the atmosphere of the setting and often compete with one another for access to the patient. The clinical instructor's assistance in identifying the roles and functions of all the workers in the healthcare facility helps students to cope with this variable. Students often feel subordinate to all other workers and need the instructor's support in asserting their rightful position as care providers and patient advocates.

The clinical instructor needs to alert students to the governing rules and operational realities of a given clinical setting. Documentation procedures vary from setting to setting. Priority tasks to which other activities are subordinate may characterize a clinical area, such as on a surgical unit where preoperative preparation of patients scheduled for surgery is the dominant morning activity. Staff practices may be diametrically opposed to those taught to students, as in managing used linen, which staff routinely tosses onto the floor. In the institutional setting, supervision and consultation are readily available; community settings—in particular, the homecare environment—lack these backup supports. Recognition of the great variety of rules and realities in clinical situations helps students to ask rather than assume when they move from setting to setting.

In addition to institution-specific rules, students must be cognizant of the regulatory environment of health care, particularly as it relates to patients receiving care funded through Medicaid and Medicare. Faulty documentation practices, for example, can inadvertently disqualify a patient from continuing to receive such assistance.

In today's healthcare system, economics affects the care environment. Waste of materials—inevitable when students are learning—may be viewed as a minor catastrophe by staff. Small economies may be practiced, such as changing linens on alternate days if they are not soiled. Charges for supplies must be accurately allocated. Clear documentation of nursing care provided to patients must support charges so that these are reimbursed to the institution through government programs or private insurance. Early discharge of patients, often unexpected, disrupts the rhythm of the day and compresses the time available for teaching.

Staffing may be adjusted because students are scheduled to be on the unit, despite contractual stipulations that students will not substitute as staff. In the past, healthcare institutions have been willing to absorb the costs associated with serving as a clinical setting for nursing education.

More recently, these same institutions have attempted to charge a fee to the educational institution for the use of the facility. Few programs can afford this, leading to competition for clinical settings, which may influence scheduling of student activities on specific units. Sensitizing students to economic realities while maintaining an environment that is supportive of learning and that maintains standards of care is a vital yet difficult task for the clinical instructor.

The various clinical settings that students traverse in the course of their education have contextual differences that they must recognize and respond to if they are to learn and function successfully in each setting. Providing an orientation to the contextual variables that are likely to be encountered enables students to better "read" the environments in which they are learning and make the necessary adjustments to support success.

Utilizing Technological Advances and Information Systems in Clinical Care

Rapid advances in pharmacological interventions and in technological approaches to assessing patients and delivering care have transformed healthcare delivery through the control or eradication of once life-threatening illnesses and the dramatic shortening of recovery from surgery and critical illness. The continued pace of these advances means that students must be prepared to practice in an uncertain future. While the majority of today's students will enter their nursing education with a degree of technical savvy, the clinical instructor cannot assume that all students will feel comfortable with utilizing technology and information systems in clinical care.

The amount of technical equipment and the degree to which healthcare providers rely on technology in monitoring patients' conditions varies with each setting. Each machine encountered by the student presents a challenge apart from the person connected to it. Greater reliance on technology tends to result in a degree of depersonalization. This tendency toward depersonalization is further exacerbated by the student's tendency toward self-absorption and focus on tasks, now represented by the technology. Care is provided to the machine rather than to the patient. The clinical instructor can help to overcome the depersonalization that occurs with increased technology, while at the same time teaching students how to utilize equipment, by focusing on how the equipment is being used in the specific patient

situation and what observations of the patient are necessary to support the technology. Because the type of equipment used for specific purposes varies from institution to institution and is likely to change in the future, the instructor also needs to familiarize students with the underlying mechanism of the technology so that they can readily transfer this knowledge to new situations. Knowing the how and why of equipment operation enables the student to master technology and stay connected to the patient. Students' understanding of the theory that underpins the use of technology enables them to accurately interpret the information a given technology is providing about a patient's status and evaluate the effectiveness of treatments delivered through technological means. Such a theoretical underpinning enhances the student's future flexibility to work with emerging technologies and to work in settings where there is minimal dependence on technology.

Information systems supporting patient care, most notably the electronic health record, are another aspect of technology to be mastered by students, yet a descriptive study of 350 recent graduates of nursing programs in Nevada indicated that these graduates felt inadequately prepared in the use of patient electronic health records (Candela & Bowles, 2008). Although government mandates require that every patient have an electronic health record, a recent survey of acute care hospitals indicated that few (1.5%) utilized a comprehensive electronic records system in all clinical units, with an additional 7.6% having a basic system involving at least one clinical unit. The use of the electronic health record for entry of medication orders and administration was reported by 17% of respondents. Larger hospitals, those in urban settings, and teaching hospitals were more likely than others to use electronic records (Jha et al., 2009).

The presence of some form of electronic records and students' ability to access and contribute to these records varies from setting to setting. In some settings, such as mental health, students may have no access to the electronic record, if one exists; in others, access may be through the instructor. Entries into the medication administration record are most commonly accomplished through the instructor. Consequently, students experience varying levels of exposure to utilizing the electronic health record in gathering information concerning a patient's status and plan of care and to documenting the care that they provide and patients' response to that care. This leads to a sense of inadequacy in utilizing this technology. Inconsistencies in the utilization of electronic health records in patient care settings and policies that

serve to limit students' access to these records stymie students' development of this critical skill and challenge the clinical instructor to devise means to overcome these limitations.

Experiencing the Variety of Nursing Roles

In most clinical learning situations, students are charged with providing full care to one or more patients, except for treatments they have not yet learned. The experience of providing full patient care helps students sort out what to delegate and what to do themselves, and to anticipate outcomes and cues that signal deviation from a normal or expected clinical course. The clinical instructor can assist the student in developing such insights. Yet, the reality of the clinical practice setting is that the nurse rarely, if ever, provides full care to patients. The nurse accomplishes patient care goals by delegating and by managing a multiworker/multitask approach to patient care. Students cannot master the critical role of coordinating care unless they have a structured clinical experience that allows them to practice delegation and the necessary oversight that accompanies it. The role of coordinating care provided by a team of healthcare workers is particularly vital when patients present with multiple and complex problems that are being treated by a variety of specialists. The nurse often is the key individual who can ensure that care is not fragmented, that the impact of a treatment for one disorder does not negatively affect the treatment of the whole patient, and that the patient and his family understand the approach to care that is being used. This requires the nurse to act as a team leader in advocating for the patient, a role that students must learn to embrace.

During their early clinical experiences, students execute a care plan created by others. Students need help to recognize that this is not a delegated role, but rather a collaborative role, because many nurses will use the plan in their work with patients. As students work with existing care plans, they should be encouraged to critique the plans based on their own observations of patient responses to the care being provided. The notion that the care plan is a dynamic instrument for moving the patient toward desired outcomes helps students to better grasp the concept of continuity in care and can be used to help them trace patient progress. Consciously incorporating the evaluation component of the nursing process to assess progress of the patient toward goal achievement "closes the loop" and reinforces the utility of the nursing process in planning and implementing patient care.

Leadership involves articulating a goal that can be embraced by others and motivating performance toward goal achievement. Nursing leadership can be demonstrated in direct patient care, such as when the nurse works with a patient to identify goals and the means to achieve them and then motivates the patient to achieve those goals. Nursing leadership is also demonstrated in the mobilization of the patient care team to resolve issues in patient care delivery. Change agency and advocacy are nursing roles generally considered to be components of leadership and are inherent in students' clinical experiences.

While the leadership role of the nurse is often conceptualized as the management of nursing care delivery, in reality the management role is more focused on resource allocation and coordination. In an increasingly fragmented healthcare delivery system, the nurse's ability to coordinate care often is the only means by which continuity of care can be ensured. Highlighting these roles, for example, in postconference activities, increases students' awareness of the multifaceted profession they are about to enter.

Developing the Skills of Lifelong Learning

It is impossible to expose students in any meaningful way to the variety of settings and specialties in which nurses can practice. Instead, clinical nursing education must focus on the foundational knowledge and skills pertinent to the patient population and setting represented in the clinical assignment. Such a foundation is the base on which students will build an evolving expertise in caring for patients, families, and communities regardless of the health conditions they encounter, patients' lifestyles, the settings in which care is provided, and available resources. Flexibility in the application of foundational knowledge and skills must be supplemented and supported by the ability to search for, evaluate, and apply new information. The development and use of this ability are essential to the lifelong learning necessary to sustain a successful career.

The multiple goals of clinical nursing education are achieved, in part, through the written assignments that students complete in conjunction with their clinical work. Although students may characterize these assignments as "busy work," the intellectual effort invested in such work, in addition to their growing awareness of and familiarity with information resources, supports the thoughtful and safe delivery of nursing care. Written assignments enable the student to:

- Make connections between theory and practice
- Engage in the critical thinking necessary to the design, implementation, and evaluation of nursing interventions
- Search for the most effective approaches to the care of individual patients
- Obtain the information required to deliver safe patient care
- Reflect on practice experiences to refine and improve their work with patients

Students' search for evidence to support actions and conclusions and to explain the phenomena with which they are dealing in a particular patient care assignment begins the development of the critical skills of lifelong learning: self-assessment of learning needs, search for information and/or experiences to satisfy these needs, application of the acquired information and/or skill in practice, and evaluation of outcomes.

Summary

The overall goal of clinical nursing education is to prepare students for future practice through current learning experiences. Because of the rapid changes occurring in health care, understanding is more important than doing, and rationale more important than technique. The clinical instructor must maintain a focus on the essential knowledge to be mastered through clinical learning, while orchestrating students' care activities in a way that ensures patient safety, provides opportunities for students to perform successfully in the clinical area, and communicates the fullness of the nursing role.

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