

CHAPTER 2

The Changing Environment of Clinical Nursing Education

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Changes in the characteristics of nursing students, the contexts in which nursing education occurs, the patterns of healthcare delivery, and the healthcare system in general interact to create challenges for the clinical nursing instructor. These same factors present the clinical instructor with opportunities to individualize instruction while encouraging students to think critically and creatively about the care they are providing. A sound theoretical grounding in the sciences that support nursing education and in the subject matter of nursing enables students to better cope with the changes

they will encounter over a lifetime of practice. The pace of that change calls for education that prepares students for practice in an unknown future.

The Nature of Today's Nursing Student

Nursing students today share few characteristics with the nursing classmates of their clinical nursing instructors. Most likely, those classmates were “traditional” students, described as young, most often white, unmarried women entering a nursing program soon after completing high school. Since that time, it is estimated that as many as three-quarters of undergraduate nursing students are considered “nontraditional” (American Association of Colleges of Nursing, 2005). Nontraditional students are defined as having one or more of the following characteristics: age 25 or older, commuting to school, pursuing education part-time, male, member of an ethnic or racial minority group, having English as a second or additional language, the parent (often single) of one or more dependent children, and/or holding a GED or requiring remedial work before entering the nursing course sequence (Bednarz, Schim, & Doorenbos, 2010). The term *nontraditional* often is used interchangeably with the term *diverse*, but students from ethnic or racial minorities form a distinct subset within the larger group of nontraditional students.

The nursing profession has long had the goal of promoting ethnic and racial diversity within its ranks, a goal that has become more compelling in view of the growing diversity of the populations served by nurses. An increasingly diverse student population is not without potential difficulties for the clinical nursing instructor. Members of racial and ethnic minorities from educationally disadvantaged backgrounds may lack the preparation necessary for the rigorous study required in a nursing program. They may not have developed the basic reading, study, and academic writing skills required for success in their nursing studies (Bednarz et al., 2010). The clinical nursing instructor who is alert to these potential issues and detects them early can refer students to remedial and supportive services provided by the educational institution to assist such students. On the other hand, educationally disadvantaged students may excel in the clinical area, where learning moves from the verbal-laden teaching characteristic of texts and the classroom to a practical, hands-on approach to teaching and learning that may be more compatible with these students' dominant learning style.

A major obstacle created by the increased ethnic and racial diversity of the student population (and the patient population) is the impact on communication, the major vehicle by which knowledge is transmitted to students. Communication issues are not confined to verbal communications and their nuances, including slang, acronyms, and medical jargon. Styles of nonverbal communication are heavily influenced by culture and social status and may interfere with the student–teacher relationship as both automatically respond to nonverbal cues that have different meanings for each of them. The same is true of culturally embedded values, practices, and behaviors in relation to the educational process that may differ from the expectations of the instructor (Bednarz et al., 2010).

The clinical nursing instructor and her students are likely to be members of different generations. The members of each distinct generational group have been shaped by the social milieu in which they matured, with effects on language usage, in particular slang, which is used to create and reinforce social identity or group cohesiveness. Values in relation to ethical and moral issues may vary among generational groups. Technology has had a major effect on those born between 1960 and 2000 (Generation X and the Millennials), an impact that influences meaning and fosters a greater comfort with and reliance on technology.

Nontraditional students differ from traditional students in their experiential and educational backgrounds, a difference that can be capitalized upon by the clinical nursing instructor. Career laddering is a commonly used approach to reaching the goal of becoming a professional nurse, and the student may use lower level preparation, for example, as a patient care technician or licensed practical or vocational nurse, to financially support the pursuit of higher education leading to licensure as a registered nurse. Such students have an intimate grasp of the clinical environments in which they function and can be an educational resource for other students in the clinical group. At the same time, working at a lower practice level may reinforce habits of thinking and doing that need to be challenged in the course of professional nursing education.

Nontraditional students may be making a career switch, reentering college after dropping out for any number of reasons, or attending school after a lengthy gap following high school graduation. Such students may need to brush up on the academic skills necessary to succeed in the formal education setting and are likely to be more responsive to educational approaches

based on adult learning principles. Having already operated successfully in the work world, such students have accumulated experiences, knowledge, and skills that can be tapped and transformed for application in the nursing context. They also are likely to be more comfortable in challenging assumptions than are traditional students.

Many of today's nursing students experience competing priorities as multiple responsibilities place demands on their time and energy. They may need to work to pay for their education and to support themselves or family. They may need to care for family members (children, spouse, parents) in addition to attending school. Even for traditional students, the need to fulfill requirements associated with scholarship assistance (e.g., athletics, work on campus) and general participation in campus life may interfere with the time and energy available for the heavy scholastic load characteristic of nursing education.

Most nursing students cite as reasons for entering the nursing field the desire to make a difference in the lives of others (Rhodes, Morris, & Lazenby, 2011), an influential role model (often a family member), or past interactions with the healthcare system due to their own or a family member's illness. Others may be drawn to nursing by the availability of job opportunities, recent increases in compensation for nurses, and the social status represented by a professional career. The student's underlying motivation for pursuing a nursing career may affect her diligence in completing assignments and her attitude in the clinical area.

Implications for Clinical Nursing Education

Clinical nursing instructors are in the unique position of being able to individualize instruction for students in their clinical groups, a process that is much more difficult for the classroom instructor, who must convey information in a compact fashion to a large number of students at one time. Accomplishing individualization of instruction requires the clinical nursing instructor to accurately diagnose barriers a student is experiencing in learning in the clinical area and match the clinical assignment and her teaching style to overcome these barriers, while at the same time maintaining the standards applicable to all students in the group.

Diverse students are "different" and require distinctive approaches to teaching that may or may not be applicable to the traditional student. Yet the effort to span the cultural divide that may affect communication styles,

role expectations, and behavioral norms can tend to heighten the “us” versus “them” dilemma already present in the student–teacher relationship (Bednarz et al., 2010).

Just as the nursing education program seeks to develop cultural competence in students, the nature of today’s nursing student calls for culturally congruent approaches to nursing education that require the clinical nursing instructor to develop personal cultural competence. Developing such competence involves understanding one’s own personal and professional cultural background and beliefs and how these affect one’s perception of and responses to others, considering the variables that may be represented by students in a clinical group without making assumptions or judgments about how these variables may affect learning, and structuring educational interactions with individual students to communicate a respect for observed differences.

The principles of adult learning are uniquely applicable to teaching in the clinical setting and particularly applicable to today’s nursing student. These principles include fostering independence in learning; recognizing life experiences as a valuable source of learning; using educational approaches that are based on developmental needs, often related to lifestyle concerns; respecting the student’s present rather than future orientation; and approaching teaching and learning from a problem-centered rather than subject-centered perspective.

The Educational Context of Nursing Programs

Today’s nursing programs differ from the highly structured programs of the past in three ways that have the potential to affect clinical nursing education. Nursing programs often are characterized by flexibility in program design that did not exist until recently. Clinical experiences take place in multiple healthcare institutions, including the community, often in a variety of timeframes. There is a greater reliance on technology in delivering instruction, accessing information relevant to the care of patients, and communicating with students.

In the not-too-distant past, nursing curricula were structured in ways that made it difficult, if not impossible, for a student to pursue studies part-time or take a break from studies to attend to family, health, or other issues. Failure to complete the sequence of rigidly ordered coursework resulted in

substantial delays in program completion or even barred the student from continuing in the program. While most nursing programs still require that specific foundational courses be completed prior to or concurrently with initial nursing course work, most notably anatomy and physiology, chemistry, psychology, and sociology, other courses, such as microbiology, may be completed later in the program of study. Similarly, while there are some foundational nursing courses that must be completed successfully before moving into advanced clinical coursework, for example, physical assessment and basic nursing skills, there is less attention to the sequencing of the more advanced clinical courses.

Flexibility in program design means that students who might otherwise be barred from the program due to their personal situations have the opportunity to pursue a nursing education. Such flexibility also means that the clinical nursing instructor cannot assume that all students in a clinical group come to the clinical area with a similar knowledge and practice base.

Nursing education's roots in diploma programs that were associated with and heavily subsidized by a hospital used an apprenticeship approach to nursing preparation that emphasized learning by doing. Hospitals with nursing programs grew their own future nursing staff and supplemented staffing with student labor. As nursing education shifted to the collegiate setting, strong ties with one institution continued to be maintained, limiting most clinical experiences to a single setting with some external placements for certain components of the curriculum, such as mental health, rehabilitation, and community health. Today, nursing programs arrange clinical placements in any number of healthcare facilities, and competition for student placements means that students often are scheduled to work outside the traditional day shift, and often for less than a full 8-hour shift.

There is much that is positive in these changes. Students are able to experience a variety of healthcare settings and experience the differences in care delivery based on the institution's philosophy of clinical care as played out through the management style of nursing leadership. While clinical experiences scheduled during the day shift allow exposure to testing procedures and interaction with other healthcare providers, patient care activities are more frequently interrupted. Clinical experiences scheduled during an afternoon or evening shift offer more opportunities for patient teaching and interaction with family members. Student learning in the clinical area need not be reduced to putting in time and repetitive activities but can be focused on patient care experiences tied to objectives that better enable the student

to develop the intellectual, practical, and ethical knowledge necessary to practice successfully in today's healthcare environment (National League for Nursing [NLN], 2008).

Technology has transformed the educational process across academic fields, so it is no surprise that the ubiquitous manikin, Mrs. Chase, has been computerized to provide lifelike simulations that enable students not only to practice skills, but also to make clinical decisions and observe the results of their "interventions." For many years a computerized Resusci Anne has provided feedback on the effectiveness of cardiopulmonary resuscitation efforts, and it is likely that computer modeling of clinical situations will continue to grow in sophistication and applicability across the nursing curriculum. After conducting a meta-analysis of 12 quantitative studies evaluating the effectiveness of simulation-based learning in nursing education, Cant and Cooper (2010) concluded that gains in knowledge, critical thinking, and confidence could result if simulations adhered to best practice guidelines.

Education also has been revolutionized by the increased availability of online courses that support flexibility in pursuing nursing education, especially for licensed professionals who are seeking advanced degrees. The success of online courses depends in large part on the skillful design and sequencing of educational content, with regular feedback from the instructor. Pursuing online education requires that the student be self-disciplined but also comfortable with the technology. The student-student and student-instructor interactions of the classroom may be missing unless the instructor schedules periodic interactive sessions using audiovisual communication technology (e.g., Skype) or other interactive technology.

College and university libraries have shifted from purchasing hard copies of texts and periodicals to offering these resources in an online format. Students are oriented to the use of this technology but will have varying skills in accessing these resources. Textbooks often are available in electronic format, providing a somewhat less expensive and highly portable educational experience for students.

Technology also offers unique means of communicating with students. Instructors are able to use "blast" emails or text messages to inform students of changes in the clinical schedule or other details of the clinical experience. Communications with individual students, for example, anecdotal notes on their performance in clinical, are an effective means of providing timely feedback to students. Instructors can arrange for students to submit papers

and other work electronically, which saves both student and instructor an extra trip to drop off or pick up such assignments. Instructors also can provide feedback to students on these assignments while retaining copies for their files.

The use of cell phones in the clinical setting must be controlled by the instructor. Students are best advised to keep their phones with other personal belongings and to access them only when they are away from the clinical area.

Implications for Clinical Nursing Education

Clinical nursing instructors are frequently cautioned not to use the clinical experience to deliver didactic content. But flexibility in program delivery may mean that some students in the clinical group have yet to be exposed to the content pertinent to the clinical experience or cannot recall relevant facts and theory in ways that connect to the clinical situation. The clinical instructor must develop the ability to provide a snapshot of content that will help these students make sense of the clinical situation. Later, when the content is covered formally in the classroom, students can make the necessary connections based on their clinical experiences, for theory–practice linkages run both ways and can be mutually reinforcing. When students have difficulty recalling content, skilled questioning can open the door for the student to access relevant content, even if coursework was completed some time ago.

The availability of flexibility in negotiating program requirements may cause some students to assume that this flexibility extends to the clinical area. Generally, this is not the case. While an occasional accommodation may be made in terms of the location and timeframe of the clinical experience to fit a student's personal needs, this can occur only if the alternative clinical experience is already available and is a rare occurrence. Similarly, students must be cautioned that the start and stop times for clinical experience are fixed and that there are few opportunities for makeup work in the event of absences.

While the use of multiple venues for students' clinical experiences broadens their perspective on healthcare delivery, students spend time on orientation to each new facility that might otherwise be devoted to patient care experiences. Frequent changes in the settings used for clinical experiences and the limited blocks of time spent in patient care activities mean that students often are unable to experience the continuum of care and changes in patient status over time, a situation that is exacerbated by the shortened

length of stay for most hospitalizations. Immersion in the nursing role in a specific setting, which usually does not occur until a capstone course at the end of the nursing program, would provide an integrative experience that is lacking in most nursing programs today (NLN, 2008).

While some instructors are comfortable with educational technology, others might need to take the time to master this approach to delivering education and learn the best ways to incorporate technology into teaching. This includes careful evaluation of the accuracy of the content and its fit into the clinical component she is teaching. Students' ability to access a wide variety of resources for completing assignments challenges the instructor to evaluate the accuracy and the utility of these resources and the use students make of them.

Patterns of Healthcare Delivery

Dramatic advances in the treatment of acute illness coupled with changes in the populations served by nurses have altered the nature of the recipients of nursing care, the places in which care is delivered, and the methods used to treat illnesses. Additionally, limited resources for healthcare delivery have forced changes in the characteristics of the care environment.

As in the nation generally, the populations served by the healthcare system have grown increasingly diverse. Although immigration to the United States by people from other countries has been characteristic of the country since its inception, there is less pressure on today's immigrants to assimilate into the dominant culture and greater accommodation by healthcare providers that communicates respect for the ethnic and cultural differences of the recipients of care.

A greater proportion of recipients of healthcare services are age 65 or older, reflective of an aging population in general. Chronic rather than acute illnesses predominate in the healthcare system. The chronically ill frequently present with multiple, interacting conditions that complicate care and impede recovery (Institute of Medicine, 2011).

Today's recipients of health care are better informed and increasingly proactive about their healthcare needs. Additionally, patients often are accompanied by family members or friends who serve as advocates and must be included in communications, within the bounds of privacy regulations, particularly if these advocates will be called upon to provide care following discharge.

Advances in surgical interventions, especially less invasive operating techniques and methods of delivering anesthesia that result in few side effects that might delay recovery, have led to limited or no hospital stay for individuals undergoing even complex surgical procedures. Recovery and rehabilitation following surgery are increasingly occurring in rehabilitation facilities or at home. The same is true for acute medical conditions, such as myocardial infarction, stroke, and respiratory illnesses. Shortened episodes of hospital-based care place greater emphasis on the need for discharge teaching for patients and their families, who must provide often complex care at home so that continued recovery is ensured. Individuals with chronic illnesses experience similarly brief episodes of care provided in urgent care centers, emergency departments, and outpatient clinics, with follow up and monitoring of those chronic conditions accomplished in the community, most often in the patients' homes.

The healthcare environment has become characterized by limited resources, time constraints, and distractions, even in secondary and tertiary care facilities. There is greater dependence on unskilled workers, who often are the ones who spend the most time with patients. Treatments and routine observations (blood pressure, pulse, respirations, temperature) that were once the responsibility of the professional nurse are delegated to less skilled workers. The professional nurse now works through others while remaining responsible for monitoring the progress of the larger number of patients in her care. Distractions are inevitable in such an arrangement, continuity of care can be lost, and the potential for errors is high.

Fragmentation of care is a real concern when many workers, including physicians and physician-extenders, are involved in the care of a single patient, a situation that is made worse when a patient has multiple diagnoses. The nurse's role as coordinator of the various strands of care is essential to ensure a positive outcome of care.

Implications for Clinical Nursing Education

Nurses must render care to increasingly diverse, aging, and chronically ill patient populations. Yet the structure of the clinical learning experience, which may involve only a few hours of direct patient care, coupled with the shortened length of stay experienced by many patients, gives nursing students limited time in which to develop relationships with patients and the communication skills and cultural competence necessary to provide

effective care to patients. These factors further interfere with the student's ability to appreciate the anticipated trajectory of illness and recovery that is necessary to evaluate the effectiveness of treatments, anticipate potential complications, and teach patients and their families what to expect as they recuperate and what might need attention by a professional. The episodic nature of nursing students' interactions with patients exacerbates their sense of fragmentation, and students, too, have difficulty putting the pieces of care together in their limited exposure to the clinical setting.

The increased emphasis on the role of the nurse as manager of the care provided by others demands novel approaches to clinical nursing education. Patient care assignments need not always involve total patient care but instead can be geared toward teaching students how to determine what can and should be delegated to others and under what circumstances certain procedures should be performed by the nurse. Students need to understand the nurse's responsibility to evaluate the patient's response to treatments and changes in the patient's status that require intervention, regardless of who is delivering the hands-on care.

The Healthcare System

Economic factors, government regulations, political pressures, and the pace of technological advances have combined to create a healthcare system in the midst of fundamental and dramatic change. The cost of providing healthcare services continues to escalate at the same time that access to these services has been broadened through such government-supported healthcare programs as Medicare and Medicaid, and the anticipated expansion of healthcare services to the uninsured following full implementation of the Affordable Care Act. A discussion of the multiple and interacting forces that have led to what many describe as a chaotic healthcare system is beyond the scope of this text, but the implications for nursing practice and, therefore, for clinical nursing education can be identified by examining the effects of these changes on the provision of healthcare services.

As a service industry, the largest cost of health care is related to employees. Consequently, healthcare institutions have responded to economic and regulatory pressures affecting their bottom lines by reducing staff numbers and changing the mix of staff. Less skilled workers are being hired for jobs once performed by more highly trained professionals. This new mix of healthcare

workers requires reconceptualization of the care to be provided by identifying components that can be safely and effectively delivered by less skilled staff and those components that require a more highly skilled professional, an assessment that may vary with each patient.

There is increased pressure to control costs by shifting from the traditional pay-for-service model, which reimburses providers of health care based on the units of care provided, to a pay-for-outcomes model, which is focused on the most effective and efficient approaches to care. Such a shift can be successful if care is coordinated to avoid delays and redundancies. Nurses are skilled in pulling together the multiple strands of healthcare services provided to individual patients, and so are in an ideal position to assume the role of coordinator of care.

“Length of stay” often is the primary measure of outcomes under the pay-for-outcomes model of reimbursement. A reimbursable length of stay usually is based on the “customary” trajectory of recovery for a specific diagnosis and/or treatment. This “customary” trajectory does not consider patient-specific factors that might influence recovery, such as age and comorbidities, unless these are clearly documented. Careful and complete documentation, then, is essential to ensure that the healthcare provider is properly reimbursed.

As a result of reduced lengths of stay, more patients are being discharged from acute care facilities to rehabilitation facilities or even to home while still in the midst of their recuperation. They are often in the early stages of recovery, when complications are most likely to arise. Discharge teaching must begin earlier in a patient’s stay and must include additional content to address care needs throughout the recuperative process. Early discharge home requires an assessment of the environment to which the patient will return and the availability of the appropriate mix of services needed to support full recovery. Home care may be provided through a visiting nurse organization, but it is often the hospital-based nurse who will need to suggest and advocate for these services.

A major cost driver in health care is the bureaucracy created by third-party payers, including insurance companies and government agencies. Far removed from the recipient of care, workers in these industries determine what services will be covered and how much will be paid. Nurses generally have little interaction with these entities but need to develop an awareness of how much influence they wield in decisions that affect the lives of care recipients.

Similarly, nurses need to contribute to the effort to hold down healthcare costs while at the same time protecting patients from negative impacts of fragmented care and early discharge. They can accomplish this by avoiding waste, coordinating care to reduce duplication of services, documenting patients' responses to their illness and their treatment, and advocating for patients as they negotiate the complex and often baffling healthcare system.

Implications for Clinical Nursing Education

Nursing happens where people need nursing care. The National Council of State Boards of Nursing (2012) defines the practice of nursing as follows:

Nursing is a scientific process founded on a professional body of knowledge; it is a learned profession based on an understanding of the human condition across the lifespan and the relationship of a client with others and within the environment; and it is an art dedicated to caring for others. The practice of nursing means assisting clients to attain or maintain optimal health, implementing a strategy of care to accomplish defined goals within the context of a client centered health care plan and evaluating responses to nursing care and treatment. Nursing is a dynamic discipline that increasingly involves more sophisticated knowledge, technologies and client care activities. (p. 3)

This definition describes nursing practice as patient-centered rather than setting-specific. The rapid changes in the healthcare system suggest that healthcare delivery will occur in a multitude of settings better suited to the needs of care recipients, in particular, the aging and chronically ill, who are not well served by the current system of care delivery. Regardless of where clinical nursing education takes place, the focus of clinical learning activities should emphasize the core of nursing practice in ways that can be transferred to a variety of settings.

The complexity of today's healthcare system demands that graduates of nursing preparation programs enter practice with management and leadership skills. These are not skills that can be developed in a single, capstone clinical experience at the end of the educational program. Rather, the theoretical groundwork in management and leadership needs to be introduced early in the program, and clinical experiences must build on this foundation to provide students with sequential experiences in the management skills of collaboration, coordination, delegation, and resource allocation along with

the leadership skills of setting and communicating goals, motivating others, advocacy, and change agency.

Summary

Clinical nursing instructors will find themselves challenged by the changes in the nature of the nursing student, the educational environment for clinical instruction, and the transformation of the healthcare system and healthcare delivery that affect the instructor's approach to designing clinical experiences that advance students' understanding and practice of nursing and that prepare them for practice in an unknown future. An emphasis on the theoretical bases for nursing actions and clinical decisions provides the foundation on which students can build as they move through the nursing education program and into practice. Thinking through clinical problems from a theoretical perspective enables students to transfer learning to a variety of situations. Students also must be exposed early in the program to the principles and skills of management and leadership in order to function successfully in today's healthcare system.

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