PART 1

Perspectives on Teaching and Learning

CHAPTER 1

Overview of Education in Health Care

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Chapter Highlights

- Historical Foundations for Patient Education in Health Care
- The Evolution of the Teaching Role of Nurses
- Social, Economic, and Political Trends Affecting Health Care
- Purposes, Goals, and Benefits of Patient Education
- The Education Process Defined
- The Contemporary Teaching Role of the Nurse
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  - *Factors Affecting the Ability to Teach*
  - *Factors Affecting the Ability to Learn*
- Questions to Be Asked About Teaching and Learning

Key Terms

barriers to teaching
education process
learning
obstacles to learning
patient education
teaching/instruction

Objectives

After completing this chapter, the reader will be able to

1. Discuss the evolution of patient education in health care and the teaching role of nurses.
2. Recognize trends affecting the healthcare system in general and nursing practice in particular.
3. Identify the purposes, goals, and benefits of patient education.
4. Compare the education process to the nursing process.
5. Define the terms *education process*, *teaching*, *learning*, and *patient education*.
6. Identify reasons why patient education is an important duty for nurses.
7. Discuss the barriers to teaching and the obstacles to learning.
8. Formulate questions that nurses in the role of patient teachers should ask about the teaching–learning process.

Patient education in health care today is a topic of utmost interest to nurses in every setting in which they practice. Teaching is an important aspect of the nurse's professional role (Friberg, Granum, & Bergh, 2012). The current trends in health care are making it essential that clients be prepared to assume responsibility for self-care management. These trends make it imperative that nurses in the workplace be accountable for the delivery of high-quality care. The focus of modern health care is on outcomes that demonstrate the extent to which patients and their significant others have learned essential knowledge and skills for independent care.

According to Friberg and colleagues (2012), patient education is an issue in nursing practice and will continue to be a significant focus in the healthcare environment. The term **patient education** is defined as "any set of planned educational activities, using a combination of methods (teaching, counseling, and behavior modification), that is designed to improve patients' knowledge and health behaviors" (Friedman, Cosby, Boyko, Hatton-Bauer, & Turnbull, 2011). Because so many changes are occurring in the healthcare system, nurses are increasingly finding themselves in challenging, constantly changing, and highly complex positions (Gillespie & McFetridge, 2006). Nurses in the role of patient teachers must understand the forces, both historical and present day, that have influenced and continue to influence their responsibilities in practice.

One purpose of this chapter is to shed light on the historical evolution of patient education in health care. Another purpose is to offer a perspective on the current trends in health care that make the teaching of clients a highly visible and required function of nursing care delivery. In addition, this chapter clarifies the broad purposes, goals, and benefits of the teaching–learning process; presents the philosophy of the nurse–patient partnership in teaching and learning; compares the education process to the nursing process; and identifies barriers to teaching and obstacles to learning. The focus is on the overall role of the nurse in teaching and learning, with the patient as the audience. Nurses must have a basic understanding of the principles and processes of teaching and learning to carry out their professional practice responsibilities with efficiency and effectiveness.

Historical Foundations for Patient Education in Health Care

"Patient education has been a part of health care since the first healer gave the first patient advice about treating his (or her) ailments" (May, 1999, p. 3). Although the term *patient education* was not specifically used, considerable efforts by the earliest healers to inform, encourage, and caution patients to follow appropriate hygienic and therapeutic measures occurred even in prehistoric times (Bartlett, 1986). Because these early healers—physicians, herbalists, midwives, and shamans—did not have a lot of effective diagnostic and treatment interventions, it is likely that education was, in fact, one of the most common interventions (Bartlett, 1986).

From the mid-1800s through the turn of the 20th century, described as the formative period by Bartlett (1986), several key factors influenced the growth of patient education.

The emergence of nursing and other health professions, technological developments, the emphasis on the patient–caregiver relationship, the spread of tuberculosis and other communicable diseases, and the growing interest in the welfare of mothers and children all had an impact on patient education (Bartlett, 1986). In nursing, Florence Nightingale emerged as a resolute advocate of the educational responsibilities of district public health nurses and authored *Health Teaching in Towns and Villages*, which advocated for school teaching of health rules as well as health teaching in the home (Monterio, 1985).

In the first few decades of the 20th century, patient teaching continued to be delivered by nurses as part of their clinical practice, but this responsibility was overshadowed by the increasing technology that was being introduced into health care (Bartlett, 1986). Then in the early 1950s, the first references in the literature to patient education began to appear (Falvo, 2004). In 1953, Veterans Administration (VA) hospitals issued a technical bulletin titled *Patient Education and the Hospital Program*. This bulletin identified the nature and scope of patient education and provided guidance to all hospital services involved in patient education (Veterans Administration, 1953).

In the 1960s and 1970s, patient education began to be seen as a specific task where emphasis was placed on educating individual patients rather than providing general public health education. Developments during this time, such as the civil rights movement, the women's movement, and the consumer and self-help movement, all affected patient education (Bartlett, 1986; Nyswander, 1980; Rosen, 1977). In 1971, two significant events occurred: (1) A publication from the Department of Health, Education, and Welfare, titled *The Need for Patient Education,* emphasized a concept of patient education that provided information about disease and treatment as well as teaching patients how to stay healthy, and (2) President Richard Nixon issued a message to Congress using the term *health education* (Falvo, 2004). Nixon later appointed the President's Committee on Health Education, which recommended that hospitals offer health education to families of patients (Bartlett, 1986; Weingarten, 1974). Although the terms *health education* and *patient education* were used interchangeably, this recommendation had a great impact on the future of patient education because a health education focal point was established in what was then the Department of Education and Welfare (Falvo, 2004).

As a result of this committee's recommendations, the American Hospital Association (AHA) appointed a special committee on health education (Falvo, 2004). The AHA committee suggested that it was a responsibility of hospitals as well as other healthcare institutions to provide educational programs for patients and that all health professionals were to be included in patient education (AHA, 1976). Also, the healthcare system began to pay more attention to patient rights and protections involving informed consent (Roter, Stashefsky-Margalit, & Rudd, 2001). Also in the early 1970s, patient education was a significant part of the AHA's *Statement on a Patient's Bill of Rights* (1973). This document outlines patients' rights to receive current information about their diagnosis, treatment, and prognosis in understandable terms as well as information that enables them to make informed decisions about their health care.

In the 1980s, national health education programs once again became popular as healthcare trends focused on disease prevention and health promotion. The U.S. Department of

Health and Human Services' *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (USDHHS, 1990), followed by *Healthy People 2010* (USDHHS, 2000) and *Healthy People 2020* (USDHHS, 2010), established specific and important goals and objectives for the public health of the nation. Patient education is a fundamental component of these far-reaching national initiatives.

Also, in recognition of the importance of patient education by nurses, The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), established nursing standards for patient education as early as 1993 (JCAHO, 2001). These standards required nurses to achieve positive outcomes of patient care through teaching activities that must be patient centered and family oriented. More recently, TJC expanded its expectations to include an interdisciplinary team approach in providing patient education as well as evidence that patients and their significant others participate in care and decision making and understand what they have been taught. This requirement means that all healthcare providers must consider the literacy level, educational background, language skills, and culture of every client during the education process (Cipriano, 2007; Davidhizar & Brownson, 1999; JCAHO, 2001).

The Evolution of the Teaching Role of Nurses

Nursing is unique among the health professions in that patient education has long been considered a major component of standard care given by nurses. Since the mid-1800s, when nursing was first acknowledged as a unique discipline, the responsibility for teaching has been recognized as an important role of nurses as caregivers. The focus of nurses' teaching efforts is on the care of the sick and promotion of the health of the well public.

Florence Nightingale, the founder of modern nursing, was the ultimate educator. Not only did she develop the first school of nursing, but she also devoted a large portion of her career to teaching nurses, physicians, and health officials about the importance of proper conditions in hospitals and homes to improve the health of people. Nightingale also emphasized the importance of teaching patients the need for adequate nutrition, fresh air, exercise, and personal hygiene to improve their well-being. By the early 1900s, public health nurses in the United States clearly understood the significance of the role of the nurse as teacher in preventing disease and in maintaining the health of society (Chachkes & Christ, 1996). It is from these roots that nurses have expanded their practice to include the broader concepts of health and illness (Glanville, 2000).

As early as 1918, the National League of Nursing Education (NLNE) in the United States (now the National League for Nursing [NLN]) observed the importance of health teaching as a function within the scope of nursing practice. Two decades later, this organization recognized nurses as agents for the promotion of health and the prevention of illness in all settings in which they practiced (NLNE, 1937). In similar fashion, the American Nurses Association (ANA, 2015) has for years issued statements on the functions, standards, and qualifications for nursing practice, of which patient teaching is a key element. In addition, the International Council of Nurses (ICN, 2012)

has long endorsed the nurse's role as patient educator to be an essential component of nursing care delivery.

Today, all state nurse practice acts (NPAs) include teaching within the scope of nursing practice responsibilities. Nurses, by legal mandate of their NPAs, are expected to provide instruction to consumers to assist them to maintain optimal levels of wellness and manage illness. Nursing career ladders often incorporate teaching effectiveness as a measure of excellence in practice (Rifas, Morris, & Grady, 1994). By teaching patients and families, nurses can achieve the professional goal of providing cost-effective, safe, and high-quality care.

A variety of other health professions also identify their commitment to patient education in their professional documents (Falvo, 2004). Standards of practice, practice frameworks, accreditation standards, guides to practice, and practice acts of many health professions delineate the educational responsibilities of their members. In addition, professional workshops and continuing education programs routinely address the skills needed for quality patient and staff education. Although specific roles vary according to profession, directives related to contemporary patient education clearly echo Bartlett's (1986) assertion that it "must be viewed as a fundamentally multidisciplinary enterprise" (p. 146).

Since the 1980s, the role of the nurse as educator has undergone a paradigm shift, evolving from what once was a disease-oriented approach to a more prevention-oriented approach. In other words, the focus is on teaching for the promotion and maintenance of health (Roter et al., 2001). Education, which was once done as part of discharge planning at the end of hospitalization, has expanded to become part of a comprehensive plan of care that occurs across the continuum of the healthcare delivery process (Davidhizar & Brownson, 1999).

As described by Grueninger (1995), this transition toward wellness entails a progression "from disease-oriented patient education (DOPE) to prevention-oriented patient education (POPE) to ultimately become health-oriented patient education (HOPE)" (p. 53). Instead of the traditional aim of simply imparting information, the emphasis is now on empowering patients to use their potential, abilities, and resources to the fullest (Glanville, 2000). Along with supporting patient empowerment, nurses must be mindful to continue to ensure the protection of "patient voice" and the therapeutic relationship in patient education against the backdrop of ever-increasing productivity expectations and time constraints (Roter et al., 2001).

Social, Economic, and Political Trends Affecting Health Care

In addition to the professional and legal standards various organizations and agencies have put forth, many social, economic, and political trends nationwide that affect the public's health have focused attention on the role of the nurse as teacher and the importance of patient education. The following are some of the significant forces influencing nursing practice in particular and healthcare practice in general (Ainsley & Brown, 2009;

Berwick, 2006; Birchenall, 2000; Bodenheimer, Lorig, Holman, & Grumbach, 2002; Cipriano, 2007; Glanville, 2000; IOM, 2011; Lea, Skirton, Read, & Williams, 2011; Osborne, 2005; USDHHS, 2010; Zikmund-Fisher, Sarr, Fagerlin, & Ubel, 2006):

- The federal government, as discussed earlier, published *Healthy People 2020,* a document that set forth national health goals and objectives for the next decade. Achieving these national priorities would dramatically cut the costs of health care, prevent the premature onset of disease and disability, and help all Americans lead healthier and more productive lives. Among the major causes of morbidity and mortality are those diseases now recognized as being lifestyle related and preventable through educational intervention. Nurses, as the largest group of health professionals, play an important role in making a real difference by teaching patients to attain and maintain healthy lifestyles.
- The Institute of Medicine (IOM, 2011) established recommendations designed to enhance the role of nurses in the delivery of health care. This includes nurses functioning to the fullest extent of their education and scope of practice. Patient and family education is a key component of the nurse's role.
- The U.S. Congress passed into law in 2010 the Affordable Care Act (ACA), a comprehensive healthcare reform legislation. The ACA is designed to provide cost-effective, accessible, equitable, quality health care to all Americans with the intent of improving their health outcomes. Universal accessibility to health care has the potential to transform the healthcare system, and nurses will play a major role in meeting the demands and complexities of this increasing population of patients.
- The growth of managed care has resulted in shifts in reimbursement for healthcare services. Greater emphasis is placed on outcome measures, many of which can be achieved primarily through the health education of patients.
- Health providers are recognizing the economic and social values of reaching out to communities, schools, and workplaces, all settings where nurses practice, to provide public education for disease prevention and health promotion.
- Consumers are demanding increased knowledge and skills about how to care for themselves and how to prevent disease. As people are becoming more aware of their needs and desire a greater understanding of treatments and goals, the demand for health information is expected to grow. The quest for consumer rights and responsibilities, which began in the 1990s, continues into the 21st century.
- An increasing number of self-help groups exist to support clients in meeting their physical and psychosocial needs. The success of these support groups and behavioral change programs depends on the nurse's role as teacher and advocate.
- Demographic trends, particularly the aging of the population, require nurses to emphasize self-reliance and maintenance of a healthy status over an extended life span. As the percentage of the U.S. population older than age 65 years climbs dramatically in the next 20 to 30 years, the healthcare needs of the baby-boom generation of the post–World War II era will increase as this vast group of people deals with degenerative illnesses and other effects of the aging process.

- The increased prevalence of chronic and incurable conditions requires that individuals and families become informed participants to manage their own illnesses. Patient teaching can facilitate an individual's adaptive responses to illness and disability.
- Advanced technology increases the complexity of care and treatment in home and community-based settings. More rapid hospital discharge and more procedures done on an outpatient basis force patients to be more self-reliant in managing their own health. Patient education assists them in following through with self-management activities independently.
- Healthcare providers increasingly recognize patient health literacy as an essential skill to improve health outcomes nationwide. Nurses must attend to the education needs of their patients to be sure that they adequately understand the information to promote, maintain, and restore their health. Better understanding by patients and their families of the recommended treatment plans can lead to increased cooperation, decision making, satisfaction, and independence with therapeutic regimens.

Nurses recognize the need to develop their expertise in teaching to keep pace with the demands for patient education. As they continue to define their role, body of knowledge, scope of practice, and professional expertise, they are realizing, more than ever before, the significance of their role as teachers. Nurses have many opportunities to carry out health education. They are the healthcare providers who have the most continuous contact with patients and their families, are usually the most accessible source of information for the consumer, and are the most highly trusted of all health professionals. In Gallup polls conducted since 1999, nurses continue to be ranked number 1 in honesty and ethics among 45 occupations (McCafferty, 2002; Riffkin, 2014; Saad, 2008).

Purposes, Goals, and Benefits of Patient Education

The purpose of patient education is to increase the competence and confidence of clients for self-management. The ultimate goal is to increase the responsibility and independence of patients and their families for self-care. This can be achieved by supporting them through the transition from being dependent on others to being self-sustaining in managing their own care and from being passive listeners to active learners. An interactive, partnership education approach provides them with opportunities to explore and expand their self-care abilities (Cipriano, 2007).

The single most important action of nurses as teachers is to prepare patients for self-care. If patients cannot independently maintain or improve their health status when on their own, nurses have failed to help them reach their potential (Glanville, 2000). The benefits of patient education are many. For example, effective teaching by the nurse can do the following:

- Increase consumer satisfaction
- Improve quality of life
- Ensure continuity of care
- Decrease patient anxiety

- Effectively reduce the complications of illness and the incidence of disease
- Promote adherence to treatment plans
- Maximize independence in the performance of activities of daily living
- Energize and empower consumers to become actively involved in the planning of their care

Because patients and their families must handle many health needs and problems at home, people must be educated on how to care for themselves—that is, both to get well and to stay well. Illness is a natural life process, but so is humankind's ability to learn. Along with the ability to learn comes a natural curiosity that allows people to view new and difficult situations as challenges rather than as defeats. As Orr (1990) observes, "Illness can become an educational opportunity . . . a 'teachable moment' when ill health suddenly encourages [patients] to take a more active role in their care" (p. 47). This observation remains relevant today.

Numerous studies have documented the fact that informed patients are more likely to comply with medical treatment plans, more likely to find innovative ways to cope with illness, and less likely to experience complications. Overall, they are more satisfied with care when they receive adequate information about how to manage for themselves. One of the most frequently cited complaints by patients in litigation cases is that they were not adequately informed (Reising, 2007).

The Education Process Defined

The **education process** is a systematic, sequential, logical, scientifically based, planned course of action consisting of two major interdependent operations: teaching and learning. This process forms a continuous cycle that also involves two interdependent players: the teacher and the learner. Together, they jointly perform teaching and learning activities, the outcome of which leads to mutually desired behavior changes. These changes foster growth in the learner and, it should be acknowledged, growth in the teacher as well. Thus the education process is a framework for a participatory, shared approach to teaching and learning (Carpenter & Bell, 2002). This process is similar across the practice of many of the health professions.

The education process can be compared to the nursing process because the steps of each process run parallel to the steps of the other (Figure 1–1). Like the nursing process, it consists of the basic elements of assessment, planning, implementation, and evaluation. The two are different in that the nursing process focuses on the planning and implementation of care based on the assessment and diagnosis of the physical and psychosocial needs of the patient. The education process, in contrast, focuses on the planning and implementation of teaching based on an assessment and prioritization of the client's learning needs, readiness to learn, and learning styles (Carpenter & Bell, 2002).

The outcomes of the nursing process are achieved when the physical and psychosocial needs of the client are met. The outcomes of the education process are achieved when changes in knowledge, attitudes, and skills occur. Both processes are ongoing,

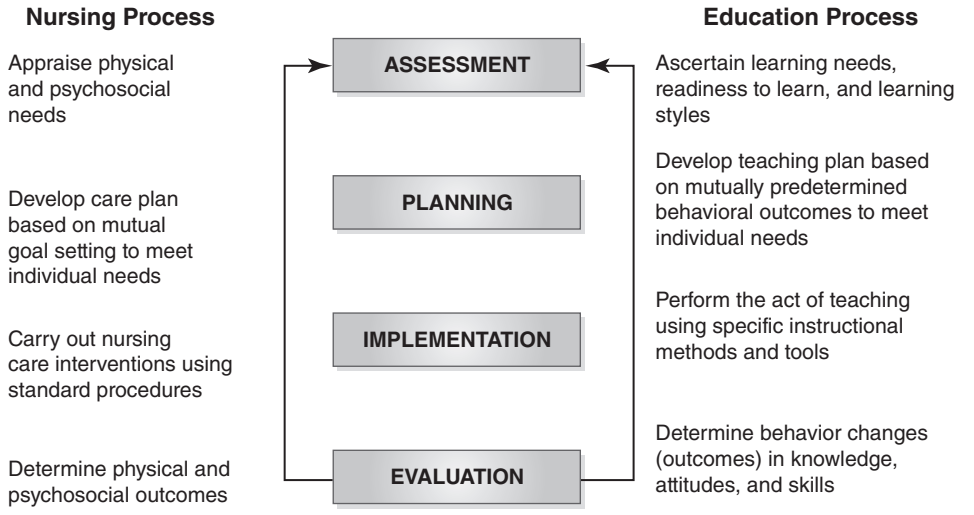

Figure 1–1 Education process parallels nursing process

with assessment and evaluation perpetually redirecting the planning and implementation phases. If mutually agreed-on outcomes in either process are not achieved, as determined by evaluation, the process can and should begin again through reassessment, replanning, and reimplementation.

Note that the actual act of **teaching** or **instruction** is merely one component of the education process. Teaching and instruction—terms that are often used interchangeably—are deliberate interventions that involve sharing information and experiences to meet intended learner outcomes in the cognitive, affective, and psychomotor domains according to an education plan. Teaching and instruction are often thought of as formal, structured, organized activities, but they also can be informal, spur-of-the-moment education sessions that occur during conversations and incidental encounters with the learner. The cues that someone has a need to learn can be communicated in the form of a verbal request, a question, a puzzled or confused look, a blank stare, or a gesture of defeat or frustration. In the broadest sense, then, teaching is a highly versatile strategy that can be applied in preventing, promoting, maintaining, or modifying a wide variety of behaviors in a learner who is receptive and motivated (Duffy, 1998).

Learning is defined as a change in behavior (knowledge, attitudes, and/or skills) that can be observed or measured and that occurs at any time or in any place as a result of exposure to environmental stimuli. Learning is an action by which knowledge, skills, and attitudes are consciously or unconsciously acquired such that behavior is altered in some way. The success of the nurse's endeavors in teaching is measured not by how much content is shared, but rather by how much the person learns (Musinski, 1999).

Specifically, patient education is a process of assisting people to learn health-related behaviors that they can incorporate into everyday life with the goal of achieving optimal health and independence in self-care. The ASSURE model is a useful paradigm

originally developed to help nurses to organize and carry out the education process (Rega, 1993). This model is appropriate for use by all health professionals who teach. The acronym stands for

Analyze the learner
State the objectives
Select the instructional methods and materials
Use the instructional methods and materials
Require learner performance
Evaluate the teaching plan and revise as necessary

The Contemporary Teaching Role of the Nurse

Over the years, organizations governing and influencing nurses in practice have identified teaching as an important responsibility. For nurses to fulfill the role of patient teacher, they must have a solid foundation in the principles of teaching and learning.

Legal and accreditation mandates as well as professional nursing standards of practice have made the teaching role of the nurse an essential part of high-quality care to be delivered by all registered nurses, regardless of their level of nursing school preparation. Given this fact, it is imperative to examine the present teaching role expectations of nurses (Gleasman-DeSimone, 2012). The role of the nurse as teacher of patients and families should stem from a partnership philosophy. A learner cannot be made to learn, but an effective approach in educating others is to create the teachable moment, rather than just waiting for it to happen, and to actively involve learners in the education process (Bodenheimer et al., 2002; Lawson & Flocke, 2009; Tobiano, Bucknell, Marshall, Guinane, & Chaboyer, 2015; Wagner & Ash, 1998).

Although all nurses are expected to teach as part of their licensing criteria, many lack formal preparation in the principles of teaching and learning (Donner, Levonian, & Slutsky, 2005). Obviously, a nurse needs a great deal of knowledge and skill to carry out the teaching role with efficiency and effectiveness. Although all nurses are able to function as givers of information, they need to acquire the skills of being a facilitator of the learning process (Musinski, 1999).

A growing body of evidence suggests that effective education and learner participation go hand in hand. The nurse should act as a facilitator, creating an environment conducive to learning that motivates individuals to want to learn and makes it possible for them to learn (Musinski, 1999). Both the educator and the learner should participate in the assessment of learning needs, the design of a teaching plan, the implementation of instructional methods and materials, and the evaluation of teaching and learning. Thus the emphasis should be on the facilitation of learning from a nondirective rather than a didactic teaching approach (Donner et al., 2005; Knowles, Holton, & Swanson, 1998; Mangena & Chabeli, 2005; Musinski, 1999).

No longer should teachers see themselves as simply transmitters of content. Indeed, their role has shifted from the traditional position of being the giver of information to that of a process designer and coordinator. This role alteration from the traditional teacher-centered perspective to a learner-centered approach is a paradigm shift that

requires nurses to possess skill in needs assessment as well as the ability to involve learners in planning, link learners to learning resources, and encourage learner initiative (Knowles et al., 1998; Mangena & Chabeli, 2005).

Instead of the teacher teaching, the new educational paradigm focuses on the learner learning. That is, the teacher becomes the guide on the side, assisting the learner in his or her effort to determine objectives and goals for learning, with both parties being active partners in decision making throughout the learning process. To increase comprehension, recall, and application of information, clients must be actively involved in the learning experience (Kessels, 2003; London, 1995). Glanville (2000) describes this move toward assisting learners to use their own abilities and resources as "a pivotal transfer of power" (p. 58).

Certainly, patient education requires a collaborative effort among healthcare team members, all of whom play more or less important roles in teaching. However, physicians are first and foremost prepared "to treat, not to teach" (Gilroth, 1990, p. 30). Nurses, by comparison, are prepared to provide a holistic approach to care delivery. The teaching role is a unique part of nursing's professional domain. Because consumers have always respected and trusted nurses to be their advocates, nurses are in an ideal position to clarify confusing information and make sense out of nonsense. Amidst a fragmented healthcare delivery system involving many providers, the nurse serves as coordinator of care. By ensuring consistency of information, nurses can support patients and their families in efforts to achieve the goal of optimal health (Donovan & Ward, 2001).

Barriers to Teaching and Obstacles to Learning

It has been said by many educators that adult learning takes place not by the teacher initiating and motivating the learning process, but rather by the teacher removing or reducing obstacles to learning and enhancing the process after it has begun. The nurse as teacher should not limit learning to the information that is intended, but rather should clearly make possible the potential for informal, unintended learning that can occur each and every day with each and every teacher–learner encounter (Carpenter & Bell, 2002). The evidence supports that interactions between learner and teacher are central to the development of teachable moments, regardless of the obstacles or barriers that may be encountered (Lawson & Flocke, 2009).

Unfortunately, nurses must confront many barriers in carrying out their responsibilities for educating others. Also, learners face a variety of potential obstacles that can interfere with their learning. For the purposes of this text, **barriers to teaching** are defined as those factors that impede the nurse's ability to deliver educational services. **Obstacles to learning** are defined as those factors that negatively affect the ability of the learner to pay attention to and process information.

Factors Affecting the Ability to Teach

The following barriers (Figure 1–2) may interfere with the ability of nurses to carry out their roles as educators (Carpenter & Bell, 2002; Casey, 1995; Chachkes & Christ, 1996;

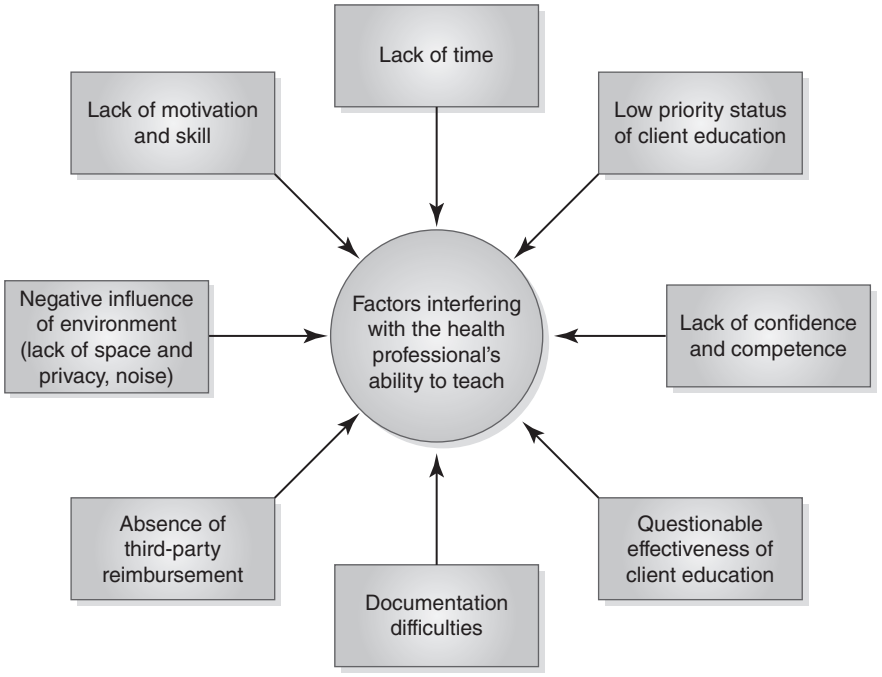

Figure 1–2 Barriers to teaching

Donovan & Ward, 2001; Duffy, 1998; Friberg et al., 2012; Glanville, 2000; Honan, Krsnak, Petersen, & Torkelson, 1988; Tobiano et al., 2015):

1. Lack of time to teach is cited by nurses as the greatest barrier to being able to carry out their role effectively. Early discharge from inpatient and outpatient settings often results in nurses and patients having fleeting contact with each other. In addition, the schedules and responsibilities of nurses are very demanding. Finding time to allocate to teaching is very challenging in light of other work demands and expectations. In one survey by TJC, 28% of nurses claimed that they were not able to provide patients and their families with the necessary instruction because of lack of time during their shifts at work (Stolberg, 2002). Nurses must know how to adopt an abbreviated, efficient, and effective approach to patient education, first by adequately assessing the learner and then by using appropriate teaching methods and instructional tools at their disposal. Discharge planning is playing an ever more important role in ensuring continuity of care across settings.
2. Many nurses and other healthcare personnel admit that they do not feel competent or confident with their teaching skills. As stated previously, although nurses are expected to teach, few have ever taken a specific course on the principles of teaching and learning. The concepts of patient education are often integrated throughout nursing curricula rather than being offered as a specific course of

study. As early as the 1960s, Pohl (1965) found that one third of 1500 nurses, when questioned, reported that they had no preparation for the teaching they were doing, while only one fifth felt they had adequate preparation. Almost 30 years later, Kruger (1991) surveyed 1230 nurses in staff, administrative, and education positions regarding their perceptions of the extent of nurses' responsibility for and level of achievement of patient education. Although all three groups strongly believed that patient education is a primary responsibility of nurses, the vast majority of respondents rated their ability to perform educator role activities as unsatisfactory. Many of the other health professions share similar views. Only a few additional studies have been forthcoming on nurses' perceptions of their teaching role (Friberg et al., 2012; Kelo, Martikainen, & Eriksson, 2013; Lahl, Modic, & Siedlecki, 2013; Trocino, Byers, & Peach, 1997). Today, preparation for the role of the nurse as educator still needs to be strengthened in undergraduate nursing education.

3. Personal characteristics of the nurse play an important role in determining the outcome of a teaching–learning interaction. Motivation to teach and skill in teaching are prime factors in determining the success of any educational endeavor.
4. Until recently, administration and supervisory personnel assigned a low priority to patient teaching. With the strong emphasis of TJC mandates, the level of attention paid to the education needs of consumers has changed significantly. However, budget allocations for educational programs remain tight and can interfere with the adoption of innovative and time-saving teaching strategies and techniques.
5. The environment in the various settings where nurses are expected to teach is not always conducive to carrying out the teaching–learning process. Lack of space, lack of privacy, noise, and frequent interferences caused by patient treatment schedules and staff work demands are just some of the factors that may negatively affect the nurse's ability to concentrate and effectively interact with learners.
6. An absence of third-party reimbursement to support patient education relegates teaching and learning to less than high-priority status. Nursing services within healthcare facilities are subsumed under hospital room costs and, therefore, are not often specifically reimbursed by insurance payers. In fact, patient education in some settings, such as home care, often cannot be incorporated as a legitimate aspect of routine nursing care delivery unless specifically ordered by a physician. Because there are no separate billing codes for patient education, it is difficult to make this process an area of focus; instead, it must be integrated into a therapeutic intervention for many health professionals (Hack, 1999).
7. Some nurses and physicians question whether patient education is effective as a means to improve health outcomes. They view patients as impediments to teaching when patients do not display an interest in changing behavior, when they demonstrate an unwillingness to learn, or when their ability to learn is in

question. Concerns about coercion and violation of free choice, based on the belief that patients have a right to choose and that they cannot be forced to comply, explain why some professionals feel frustrated in their efforts to teach. It is essential that all healthcare members buy into the utility of patient education (that is, they believe it can lead to significant behavioral changes and increased compliance with therapeutic regimens).

8. The type of documentation system used by healthcare agencies has an effect on the quality and quantity of patient teaching. Both formal and informal teaching are often done (Carpenter & Bell, 2002) but not written down because of insufficient time, inattention to detail, and inadequate forms on which to record the extent of teaching activities. Many of the hard-copy forms or computer software used for documentation of teaching are designed to simply check off the areas addressed rather than allowing for elaboration of what was actually accomplished. In addition, most nurses do not recognize the scope and depth of teaching that they perform on a daily basis. Communication among healthcare providers regarding what has been taught needs to be coordinated and appropriately delegated so that teaching can proceed in a timely, smooth, organized, and thorough fashion.

Factors Affecting the Ability to Learn

The following obstacles (Figure 1–3) may interfere with a learner's ability to attend to and process information (Beagley, 2011; Billings & Kowalski, 2004; Glanville, 2000; Kessels, 2003; Weiss, 2003):

1. Lack of time to learn resulting from rapid patient discharge from care and the amount of information a client is expected to learn can discourage and frustrate the learner, impeding his or her ability and willingness to learn.
2. The stress of acute and chronic illness, anxiety, and sensory deficits in patients are just a few problems that can diminish learner motivation and interfere with the process of learning. However, illness alone seldom acts as an impediment to learning. Rather, illness is often the impetus for patients to attend to learning, make contact with the healthcare professional, and take positive action to improve their health status.
3. Low literacy and functional health illiteracy have been found to be significant factors in the ability of patients to make use of the written and verbal instructions given to them by providers. Almost half of the American population reads and comprehends at or below the eighth-grade level, and an even higher percentage suffers from health illiteracy.
4. The negative influence of the hospital environment itself, which results in loss of control, lack of privacy, and social isolation, can interfere with a patient's active role in health decision making and involvement in the teaching–learning process.
5. Personal characteristics of the learner have major effects on the degree to which behavioral outcomes are achieved. Readiness to learn, motivation and

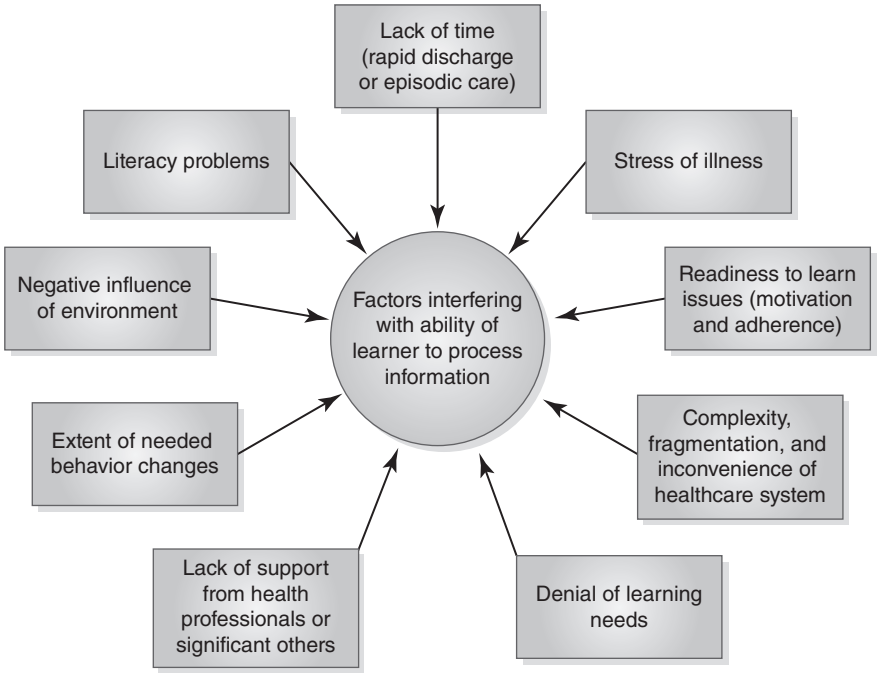

Figure 1–3 Obstacles to learning

compliance, developmental-stage characteristics, and learning styles are some of the prime factors influencing the success of education efforts.

6. The extent of behavioral changes needed, both in number and in complexity, can overwhelm learners and discourage them from attending to and accomplishing learning objectives and goals.
7. Lack of support and lack of ongoing positive reinforcement from the nurse and significant others serve to block the potential for learning.
8. Denial of learning needs, resentment of authority, and lack of willingness to take responsibility (locus of control) are some psychological obstacles to accomplishing behavioral change.
9. The inconvenience, complexity, inaccessibility, fragmentation, and dehumanization of the healthcare system often result in frustration and abandonment of efforts by the learner to participate in and comply with the goals and objectives for learning.

Questions to Be Asked About Teaching and Learning

To maximize the effectiveness of patient education, the nurse must examine the elements of the education process and the role of the nurse as teacher. Many questions

arise related to the principles of teaching and learning. The following are some of the important questions that this text addresses:

- How can members of the healthcare team more effectively work together to coordinate educational efforts?
- What are the ethical, legal, and economic issues involved in patient education?
- Which theories and principles support the education process, and how can they be applied to change the behaviors of learners?
- Which assessment methods and tools can nurses as teachers use to determine learning needs, readiness to learn, and learning styles?
- Which learner attributes negatively and positively affect an individual's ability and willingness to learn?
- Which elements must the nurse take into account when developing and implementing teaching plans?
- What teaching methods and instructional materials are available to support teaching efforts?
- How can teaching be tailored to meet the needs of specific populations of learners?
- Which common mistakes do nurses make when teaching others?
- How can teaching and learning be best evaluated?

Summary

Nurses can be considered information brokers—teachers who can make a significant difference in how patients and families cope with their illnesses and disabilities as well as how the public benefits from education directed at prevention of disease and promotion of health. As the United States moves forward in the 21st century, many challenges and opportunities lie ahead for nurses in the role of teachers in the delivery of health care.

The teaching role is becoming even more important and more visible as nurses respond to the social, economic, and political trends affecting health care today. The foremost challenge for nurses is to be able to demonstrate, through research and action, that definite links exist between education and positive behavioral outcomes of the learner. In this era of cost containment, government regulations, and healthcare reform, the benefits of patient education must be made clear to the public, to healthcare employers, to healthcare providers, and to payers of healthcare benefits. To be effective and efficient, nurses must be willing and able to work collaboratively with one another to provide consistently high-quality education to patients and their families.

Nurses can demonstrate responsibility and accountability for the delivery of care to the consumer in part through education based on solid principles of teaching and learning. The key to effective education of the varied audiences of learners is the nurse's understanding of and ongoing commitment to his or her role in patient education.

Review Questions

1. Which key factors influenced the growth of patient education during its formative years?
2. How far back in history has teaching been a part of the nurse's role?
3. Which nursing organization was the first to recognize health teaching as an important function within the scope of nursing practice?
4. Which legal mandate universally includes teaching as a responsibility of nurses?
5. How have the ANA, NLN, ICN, AHA, and TJC influenced the role and responsibilities of the nurse for patient education?
6. What is the current focus and orientation of patient education?
7. Which social, economic, and political trends today make it imperative that patients be adequately educated?
8. What are the similarities and differences between the education process and the nursing process?
9. What are three major barriers to teaching and three major obstacles to learning?
10. Which factor serves as both a barrier to education and an obstacle to learning?

Case Study

As part of Lackney General Hospital's continuous quality improvement plan, and in preparation for the next Joint Commission accreditation visit, all departments in the hospital are in the process of assessing the quality and effectiveness of their patient education efforts. When the professional nursing staff on your unit are asked about their opinions on this topic, you are surprised at the frustration they express. Liz states, "Although I am incredibly frustrated by the lack of administrative support for patient education, I do believe that patient education makes a difference." Jeremiah jumps in and says, "I am sick of continuously being interrupted when trying to educate my patients." Finally, Johaun comments, "I have no idea how I am supposed to fit education in with all the other tasks I need to complete, especially when the patient is clearly not willing to learn." Because the nursing staff obviously have some strong feelings about the department's education efforts, your manager feels that a SWOT (strengths, weaknesses, opportunities, threats) analysis is a good place to begin to gather information about the issues and problems.

1. Use the section titled "Barriers to Teaching and Obstacles to Learning" as a beginning framework for the weaknesses and threats section of the SWOT analysis, and then describe five potential barriers to teaching on your unit that the nurses might identify.
2. Use the section titled "Barriers to Teaching and Obstacles to Learning" as another framework for the weaknesses and threats section of the SWOT analysis, and then describe five potential obstacles to learning on your unit that the nurses might identify.
3. Provide possible solutions to the barriers and obstacles identified that would serve to enhance patient education.

References

Ainsley, B., & Brown, A. (2009). The impact of informatics on nursing education: A review of the literature. *Journal of Continuing Education, 40*(5), 228–232.

American Hospital Association (AHA). (1973). Statement on a patient's bill of rights. *Hospitals*, *47*(4), 41.

American Hospital Association (AHA). (1976). Statement on the role and responsibilities of hospitals and other health care institutions in personal and community health education. *Health Education*, *7*(4), 23.

American Nurses Association (ANA). (2015). *Scope and standards of practice* (3rd ed.). Silver Spring, MD: Nursebooks.org.

Bartlett, E. E. (1986). Historical glimpses of patient education in the United States. *Patient Education and Counseling*, *8*, 135–149.

Beagley, L. (2011). Educating patients: Understanding barriers, teaching styles, and learning techniques. *Journal of PeriAnesthesia Nursing, 26*(5), 331–337.

Berwick, D. (2006, December 12). *IHI launches national campaign to reduce medical harm in U.S. hospitals: Building on its landmark 100,000 lives campaign*. Retrieved from http://www.ihi.org

Billings, D., & Kowalski, K. (2004). Teaching learners from varied generations. *Journal of Continuing Education in Nursing*, *35*(3), 104–105.

Birchenall, P. (2000). Nurse education in the year 2000: Reflection, speculation and challenge. *Nurse Education Today*, *20*, 1–2.

Bodenheimer, T., Lorig, K., Holman, H., & Grumbach, K. (2002). Patient self-management of chronic disease in primary care. *Journal of the American Medical Association*, *288*(19), 2469–2475.

Carpenter, J. A., & Bell, S. K. (2002). What do nurses know about teaching patients? *Journal for Nurses in Staff Development*, *18*(3), 157–161.

Casey, F. S. (1995). Documenting patient education: A literature review. *Journal of Continuing Education in Nursing*, *26*(6), 257–260.

Chachkes, E., & Christ, G. (1996). Cross cultural issues in patient education. *Patient Education and Counseling*, *27*, 13–21.

Cipriano, P. F. (2007). Stop, look, and listen to your patients and their families. *American Nurse Today*, *2*(6), 10.

Davidhizar, R. E., & Brownson, K. (1999). Literacy, cultural diversity, and client education. *Health Care Manager*, *18*(1), 39–47.

Donner, C. L., Levonian, C., & Slutsky, P. (2005). Move to the head of the class: Developing staff nurses as teachers. *Journal for Nurses in Staff Development*, *21*(6), 277–283.

Donovan, H. S., & Ward, S. (2001, third quarter). A representational approach to patient education. *Journal of Nursing Scholarship*, 211–216.

Duffy, B. (1998). Get ready—Get set—Go teach. *Home Healthcare Nurse*, *16*(9), 596–602.

Falvo, D. F. (2004). *Effective patient education: A guide to increased compliance* (3rd ed.). Sudbury, MA: Jones and Bartlett.

Friberg, F., Granum, V., & Bergh, A. L. (2012). Nurses' patient-education work: Conditional factors: An integrative review. *Journal of Nursing Management, 20*(2), 170–186.

Friedman, A. J., Cosby, R., Boyko, S., Hatton-Bauer, J., & Turnbull, G. (2011). Effective teaching strategies and methods of delivery for patient education: A systematic review and practice guideline recommendations. *Journal of Cancer Education, 26*, 12–21.

Gillespie, M., & McFetridge, B. (2006). Nursing education: The role of the nurse teacher. *Journal of Clinical Nursing*, *15*, 639–644.

Gilroth, B. E. (1990). Promoting patient involvement: Educational, organizational, and environmental strategies. *Patient Education and Counseling, 15,* 29–38.

Glanville, I. K. (2000). Moving towards health oriented patient education (HOPE). *Holistic Nursing Practice*, *14*(2), 57–66.

Gleasman-DeSimone, S. (2012). *How nurse practitioners educate their adult patients about healthy behaviors: A mixed method study* (Unpublished dissertation in partial fulfillment of requirements for the degree of Doctor of Philosophy). Capella University, Minneapolis, MN.

Grueninger, U. J. (1995). Arterial hypertension: Lessons from patient education. *Patient Education and Counseling*, *26*, 37–55.

Hack, L. M. (1999). Health policy implications for patient education in physical therapy. *Journal of Physical Therapy Education*, *13*(3), 57–61.

Honan, S., Krsnak, G., Petersen, D., & Torkelson, R. (1988). The nurse as patient educator: Perceived responsibilities and factors enhancing role development. *Journal of Continuing Education in Nursing*, *19*(1), 33–37.

Institute of Medicine (IOM). (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.

International Council of Nurses (ICN). (2012). *International Council of Nurses fact sheet*. Retrieved from http://www.icn.ch/about-icn/about-icn/

Joint Commission on Accreditation of Healthcare Organizations. (2001). *Patient and family education: The compliance guide to the JCAHO standards* (2nd ed.). Retrieved from http://catalog.hathitrust.org/Record/003169433

Kelo, M., Martikainen, M., & Eriksson, E. (2013). Patient education of children and their families: Nurses' experiences. *Pediatric Nursing, 39*(2), 71–79.

Kessels, R. P. C. (2003). Patients' memory for medical information. *Journal of the Royal Society of Medicine*, *96*, 219–222.

Knowles, M. S., Holton, E. F., & Swanson, R. A. (1998). *The adult learner: The definitive classic in adult education and human resource development* (5th ed., pp. 198–201). Houston, TX: Gulf Publishing.

Kruger, S. (1991). The patient educator role in nursing. *Applied Nursing Research*, *4*(1), 19–24.

Lahl, M., Modic, M. B., & Siedlecki, S. (2013, July–August). Perceived knowledge and self-confidence of pediatric nurses as patient educators. *Clinical Nurse Specialist Journal*, 188–193.

Lawson, P. J., & Flocke, S. A. (2009). Teachable moments for health behavior change: A concept analysis. *Patient Education and Counseling*, *76*, 25–39.

Lea, D. H., Skirton, H., Read, C. Y., & Williams, J. K. (2011). Implications for educating the next generation of nurses on genetics and genomics in the 21st century. *Journal of Nursing Scholarship, 43*(1), 3–12.

London, F. (1995). Teach your patients faster and better. *Nursing*, *95*(68), 70.

Mangena, A., & Chabeli, M. M. (2005). Strategies to overcome obstacles in the facilitation of critical thinking in nursing education. *Nurse Education Today*, *25*, 291–298.

May, B. J. (1999). Patient education: Past and present. *Journal of Physical Therapy Education*, *13*(3), 3–7.

McCafferty, L. A. E. (2002, January 7). Year of the nurse: More than four out of five Americans trust nurses. *Advance for Nurses*, 5.

Monterio, L. A. (1985). Florence Nightingale on public health nursing. *American Journal of Public Health*, *75*, 181–186.

Musinski, B. (1999). The educator as facilitator: A new kind of leadership. *Nursing Forum*, *34*(1), 23–29.

National League of Nursing Education (NLNE). (1937). *A curriculum guide for schools of nursing*. New York, NY: Author.

Nyswander, D. V. (1980). Public health education: Sources, growth and educational philosophy. *International Quarterly of Community Health Education*, *1*, 5–18.

Orr, R. (1990). Illness as an educational opportunity. *Patient Education and Counseling*, *15*, 47–48.

Osborne, H. (2005). *Health literacy A to Z: Practical ways to communicate your health message.* Sudbury, MA: Jones and Bartlett.

Pohl, M. L. (1965). Teaching activities of the nursing practitioner. *Nursing Research*, *14*(1), 4–11.

Rega, M. D. (1993). A model approach for patient education. *MEDSURG Nursing*, *2*(6), 477–479, 495.

Reising, D. L. (2007, February). Protecting yourself from malpractice claims. *American Nurse Today, 39,* 44.

Rifas, E., Morris, R., & Grady, R. (1994). Innovative approach to patient education. *Nursing Outlook, 42*(5), 214–216.

Riffkin, R. (2014, December 18). Americans rate nurses highest on honesty, ethical standards. Retrieved from http://gallup.com/p011/180260/americans-rate-nurses-highest-honesty-ethical-standards.aspx

Rosen, G. (1977). *Preventive medicine in the United States, 1900–1995*. New York, NY: Prodist.

Roter, D. L., Stashefsky-Margalit, R., & Rudd, R. (2001). Current perspectives on patient education in the U.S. *Patient Education and Counseling*, *44*, 79–86.

Saad, L. (2008, November 24). *Nurses shine, bankers slump in ethics ratings. Gallup Poll*. Retrieved from http://www.gallup.com

Stolberg, S. G. (2002, August 8). Patient deaths tied to lack of nurses. *New York Times*. Retrieved from http://www.nytimes.com/2002/08/08/health/08NURS.html?pagewanted=1

Tobiano, G., Bucknell, T., Marshall, A., Guinane, J., & Chaboyer, W. (2015, June 21). Nurses' view of patient participation in nursing care. *Journal of Advanced Nursing,* 1–12.

Trocino, L., Byers, J. F., & Peach, A. G. (1997). Nurses' attitudes toward patient and family education: Implications for clinical nurse specialists. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, *11*(2), 77–84.

U.S. Department of Health and Human Services (USDHHS), Office of Disease Prevention and Health Promotion. (1990). *Healthy People 2000*. Retrieved from http://www.cdc.gov/nchs/healthy_people/hp2000.htm

U.S. Department of Health and Human Services (USDHHS), Office of Disease Prevention and Health Promotion. (2000). *Healthy People 2010*. Retrieved from http://www.cdc.gov/nchs/healthy_people/hp2010.htm

U.S. Department of Health and Human Services (USDHHS), Office of Disease Prevention and Health Promotion. (2010). *Healthy People 2020*. Retrieved from http://www.cdc.gov/nchs/healthy_people/hp2020.htm

Veterans Administration. (1953). *Patient education and the hospital program* (TB 10–88). Washington, DC: Author.

Wagner, S. P., & Ash, K. L. (1998). Creating the teachable moment. *Journal of Nursing Education*, *37*(6), 278–280.

Weingarten, V. (1974). Report of the findings and recommendations of the President's Committee on Health Education. *Health Education Monographs*, *1*, 11–19.

Weiss, B. D. (2003). *Health literacy: A manual for clinicians*. Chicago, IL: American Medical Association & American Medical Association Foundation.

Zikmund-Fisher, B. J., Sarr, B., Fagerlin, S., & Ubel, P. A. (2006). A matter of perspective: Choosing for others differs from choosing for yourself in making treatment decisions. *Journal of General Internal Medicine*, *21*, 618–622.