

PART ONE

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 Client and Staff Education
- The Education Process Defined
- The Contemporary Role of the Nurse as Educator
 - *Nursing Education Transformation*
 - *Patient Engagement*
- *Quality and Safety Education in Nursing*
- *The Institute of Medicine Report: The Future of Nursing*
- Barriers to Teaching and Obstacles to Learning
 - *Factors Affecting the Ability to Teach*
 - *Factors Affecting the Ability to Learn*
- Questions to Be Asked About Teaching and Learning
- State of the Evidence

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KEY TERMS

education process
teaching/instruction
learning
patient education

staff education
barriers to teaching
obstacles to learning

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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 client and staff/student education.
4. Compare the education process to the nursing process.
5. Define the terms *education process*, *teaching*, and *learning*.
6. Identify reasons why client and staff/student 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 educator should ask about the teaching–learning process.

Education in health care today—both patient education and nursing staff/student education—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. Also, 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, or to which staff nurses and nursing students have acquired the up-to-date knowledge and skills needed to competently and confidently render care to the consumer in a variety of settings.

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. 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 educators 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 and the nurse’s role as teacher. 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. Also, this chapter addresses the continuing education efforts necessary to ensure ongoing practice competencies of nursing personnel.

In addition, this chapter clarifies the broad purposes, goals, and benefits of the teaching–learning process; focuses on the philosophy of the nurse–client partnership in teaching and learning; compares the education process to the nursing process; identifies barriers to teaching and obstacles to learning; and highlights the status of research in the field of patient education as well as in the education of nursing staff and students. The focus is on the overall role of the nurse in teaching and learning, no matter who the audience of learners might be. Nurses must have a basic prerequisite 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 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 support of maternal and child health in the United States, the Division of Child Hygiene was established in New York City in 1908 (Bartlett, 1986). Under the auspices of this organization, public health nurses

provided instruction to mothers of newborns in the lower East Side on how to keep their infants healthy.

The period from 1930 through 1960 is described as a time of relative quiet for patient education. Patient teaching continued to occur as part of clinical encounters, but it was overshadowed by the increasingly more technological orientation of health care (Bartlett, 1986). The first references in the literature to patient education began to appear in the early 1950s (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 entity 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 the early 1960s, voluntary agencies and the U.S. Public Health Service funded several patient and family education projects dealing with congestive heart failure, stroke, cancer, and renal dialysis, and hospitals in a variety of states became involved in various education programs and projects (Public Health Service, 1971).

Concerned that patient education was being provided only occasionally and that patients were not routinely being given information that would allow them to participate in their own health care, the American Public Health Association formed a multidisciplinary Committee on Educational Tasks in Chronic Illness in 1968 that recommended a more formal approach to patient education (Public Health Service, 1971). One of the committee’s seven basic premises was an

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educational prescription that would base teaching on individual patient needs and be included as part of the patient's record. This recommendation represented one of the first times that the documentation of patient education was mentioned (Falvo, 2004). The committee ultimately developed a model that defined the educational processes necessary for patient and family education that could be used with any illness by any member of the healthcare team (Health Services and Mental Health Administration, 1972).

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. Through these health education programs, hospitals could contribute to important healthcare goals such as improved quality of patient care, reduced healthcare costs, shorter lengths of stay, fewer admissions and readmissions to inpatient facilities, and better utilization

of outpatient services (AHA, 1976). Also, the healthcare system began to pay more attention to patient rights and protections involving informed consent (Roter, Stashefsky-Margalit, & Rudd, 2001).

Patient education was a significant part of the AHA's *A Patient's Bill of Rights*, affirmed in 1972 and then formally published in 1973 (AHA, 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. The *Patient's Bill of Rights* also guarantees a patient's right to respectful and considerate care. The adoption of this bill of rights promoted additional growth in the concept of patient education, which came to be seen as a "patient right" as well as an obligation and legal responsibility of health professionals. In addition, patient education was recognized as a condition of quality care and as a factor that could affect the efficiency of the healthcare system (Falvo, 2004). Furthermore, during the 1970s, insurance companies began to deal with issues surrounding patient education, because they saw how patient education could positively influence the costs of health care (Bartlett, 1986).

Further support for and validation of patient education as a right and expectation of quality health care came as a result of the 1976 edition of the *Accreditation Manual for Hospitals* published by the Joint Commission on Accreditation of Healthcare Organizations, now known as The Joint Commission (Falvo, 2004). This manual broadened the scope of patient education to include both outpatient and inpatient services and specified that criteria for patient education should be established. Patients had to receive information about their medical problem, prognosis, and treatment, and evidence had to be provided that patients understood the information they were given (Joint Commission on Accreditation of Healthcare Organizations, 1976).

In the 1980s, national health education programs once again came into vogue as health-care trends focused on disease prevention and health promotion. This evolution represented a logical response to the cost-containment efforts occurring in health care at that time. The U.S. Department of Health and Human Services' *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, issued in 1990 and building on the U.S. Surgeon General's *Healthy People* report of 1979, established important goals for national health promotion and disease prevention in 22 areas (U.S. Department of Health and Human Services [USDHHS] Office of Disease Prevention and Health Promotion, 2000). Establishing educational and community-based programs was one of the priority areas identified in this document. Following on the heels of *Healthy People 2000*, *Healthy People 2010* built on the previous two initiatives and provided an expanded framework for health prevention for the nation (USDHHS, 2000). Specific goals and objectives included the development of effective health education programs to assist individuals to recognize and change risk behaviors, to adopt or maintain healthy practices, and to make appropriate use of available services for health care (USDHHS, 2010). The latest iteration of the *Healthy People* initiative, *Healthy People 2020* is the product of an extensive evaluation process by stakeholders. Its 40 topic areas support four overarching goals: attaining high-quality and longer lives; achieving health equity and eliminating disparities; creating social and physical environments that promote good health for all; and promoting quality of life, healthy development, and behaviors across the entire life span (USDHHS, 2012). Patient education is a fundamental component of these far-reaching national initiatives.

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. These standards, known as mandates, describe the type and level of care, treatment, and services that agencies or organizations must provide to receive accreditation. Required accreditation standards have provided the impetus for nursing service managers to emphasize unit-based clinical staff education activities for the improvement of nursing care interventions to achieve expected client outcomes (JCAHO, 2001). Nurses are 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 the provision of 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).

In the mid-1990s, the Pew Health Professions Commission (1995), influenced by the dramatic changes surrounding health care, published a broad set of competencies it believed would mark the success of the health professions in the 21st century. Shortly thereafter, the commission released a fourth report as a follow-up on health professional practice in the new millennium (Pew Health Professions Commission, 1998). This report offered recommendations pertinent to the scope and training of all health professional groups, as well as a new set of competencies for the 21st century. Many of the competencies deal with the teaching role of health professionals, including nurses. These competencies for the practice of health care include the need for all health professionals to do the following:

- Embrace a personal ethic of social responsibility and service
- Provide evidence-based, clinically competent care

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- Incorporate the multiple determinants of health in clinical care
- Rigorously practice preventive health care
- Improve access to health care for those with unmet health needs
- Practice relationship-centered care with individuals and families
- Provide culturally sensitive care to a diverse society
- Use communication and information technology effectively and appropriately
- Continue to learn and help others learn

In 2006, the Institute for Healthcare Improvement announced the 5 Million Lives campaign. This campaign's objective was to reduce the 15 million incidents of medical harm that occur in U.S. hospitals each year. Such an ambitious campaign has major implications for teaching patients and their families as well as staff and students the ways they can improve care to reduce injuries, save lives, and decrease costs of health care (Berwick, 2006).

Another recent initiative was the formation of the Sullivan Alliance to recruit and educate health professionals, including nurses, to deliver culturally competent care to the public they serve. Effective health care and health education of patients and their families depend on a sound scientific base and cultural awareness in an increasingly diverse society. This organization's goal is to increase the racial and cultural mix of health professional faculty, students, and staff, who are sensitive to the needs of clients of diverse backgrounds (Sullivan & Bristow, 2007).

Accomplishing the goals and meeting the expectations of these various organizations have necessitated a redirection of education efforts. 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).

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, as well as educating other nurses for professional practice.

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 of 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).

For decades, then, patient teaching has been recognized as an independent nursing function. Nurses have always educated others—patients, families, and colleagues. 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). By 1950, the NLNE had identified course content in nursing school curricula to prepare nurses to assume the role. Most recently, the NLN (2006) developed the first certified nurse educator (CNE) exam to raise “the visibility and status of the academic nurse educator role as an advanced professional practice discipline with a defined practice setting” (Klestzick, 2005, p. 1).

In similar fashion, the American Nurses Association (ANA, 2010) 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 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 as well as other healthcare personnel, 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).

In addition to providing patient education, professional nurses are responsible for educating their colleagues. Another role of today’s nurse educator is one of training the trainer—that is, preparing nursing staff through continuing education, in-service programs, and staff development to maintain and improve their clinical skills and teaching abilities. Nurses must be prepared to effectively perform teaching services that meet the needs of many individuals and groups in different circumstances across a variety of practice settings. The key to the success of our profession is for nurses to teach other nurses. We are the primary educators of our fellow colleagues and other healthcare staff personnel (Donner, Levonian, & Slutsky, 2005). In addition, the demand for educators of nursing students is at an all-time high.

Another very important role of the nurse as educator is serving as a clinical instructor for

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students in the practice setting. Many staff nurses function as clinical preceptors and mentors to ensure that nursing students meet their expected learning outcomes. However, evidence indicates that nurses in the clinical and academic settings feel inadequate as preceptors and mentors as a result of poor preparation for their role as teachers. This challenge of relating theory learned in the classroom setting to the practice environment requires nurses not only to keep up-to-date with clinical skills and innovations in practice, but also to possess knowledge and skills related to the principles of teaching and learning. Knowing the practice field is not the same thing as knowing how to teach the field. The role of the clinical educator is a dynamic one that requires the teacher to actively engage students to become competent and caring professionals (Gillespie & McFetridge, 2006).

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 client and staff 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; DeSilets, 1995; Glanville, 2000; Lea, Skirton, Read, & Williams, 2011; USDHHS, 2000; 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. Nurses, as the largest group of health professionals, play an important role in making a real difference by teaching clients to attain and maintain healthy lifestyles.

- 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 clients.
- Health providers are recognizing the economic and social values of reaching out to communities, schools, and workplaces to provide education for disease prevention and health promotion.
- Politicians and healthcare administrators alike recognize the importance of health education to accomplish the economic goal of reducing the high costs of health services. Political emphasis is on productivity, competitiveness in the marketplace, and cost-containment measures to restrain health service expenses.
- Health professionals are becoming increasingly concerned about malpractice claims and disciplinary action for incompetence. Continuing education, either by legislative mandate or as a requirement of the employing institution, has come to the forefront in response to the challenge of ensuring the competency of practitioners. It is a means to transmit new knowledge and skills as well as to reinforce or refresh previously acquired knowledge and abilities for the continuing growth of staff.
- Nurses continue to define their professional role, body of knowledge, scope of practice, and expertise, with

client education as central to the practice of nursing.

- 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 intensify. The quest for consumer rights and responsibilities, which began in the 1990s, continues into the 21st century.
- 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 cohort deals with degenerative illnesses and other effects of the aging process.
- Among the major causes of morbidity and mortality are those diseases now recognized as being lifestyle related and preventable through educational intervention. In addition, millions of incidents of medical harm occur every year in U.S. hospitals. Clearly, it is imperative that clients, nursing staff, and nursing students be educated about preventive measures to reduce these incidents.
- 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 client health literacy as an essential skill to improve health outcomes nationwide. Nurses must attend to the education needs of their patients or clients to be sure that they adequately understand the information required for independence in self-care activities that promote, maintain, and restore their health.
- Many healthcare providers believe—and this belief is supported by research—that client education improves compliance and, hence, health and well-being. Better understanding by clients and their families of the recommended treatment plans can lead to increased cooperation, decision making, satisfaction, and independence with therapeutic regimens. Health education enables patients to solve problems they encounter outside the protected care environments of hospitals, thereby increasing their independence.
- 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.
- The use of online technologies in nursing education programs is increasing. Nurses are expected to have the critical thinking skills needed to identify problems, conduct research on problems encountered, and apply new knowledge to address these problems. Also, nurses are expected to have familiarity with computerized charting and electronic health information records. Nursing informatics is becoming

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highly important in the paperless world of patient care, and nurse educators are beginning to address the gap in skills with respect to electronic data collection and analysis that nursing students and staff face in the practice settings.

- The fields of genetics and genomics, as included in the holistic approach of nursing practice, are providing patients with more options to consider for screenings, procedures, and therapies to obtain optimal health. The United States and Europe have established core competencies in genetics and genomics for nurses to support the development of skills, knowledge, and attitudes in the delivery of safe comprehensive care.

Nurses recognize the need to develop their expertise in teaching to keep pace with the demands of patient and staff 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 educators. Nurses have many opportunities to carry out health education. They are the healthcare providers who have the most continuous contact with clients, 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 (Mason, 2001; McCafferty, 2002; Saad, 2006).

PURPOSES, GOALS, AND BENEFITS OF CLIENT AND STAFF 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 clients

for self-care. This can be achieved by supporting patients 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 clients with opportunities to explore and expand their self-care abilities (Cipriano, 2007).

The single most important action of nurses as educators 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 client 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 client 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 clients 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 clients 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, clients 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 are that they were not adequately informed (Reising, 2007).

Just as the need exists for teaching patients to become participants and informed consumers to achieve independence in self-care, so the need also exists for staff nurses to be exposed to up-to-date information with the ultimate goal of enhancing their practice. The purpose of staff and student education is to increase the competence and confidence of nurses to function independently in providing care to the consumer. The goal of education efforts is to improve the quality of care delivered by nurses. Nurses play a key role in improving the nation's health, and they recognize the importance of lifelong learning to keep their knowledge and skills current (DeSilets, 1995).

In turn, the benefits to nurses in their role as educators include increased job satisfaction when they recognize that their teaching actions have the potential to forge therapeutic relationships with clients, enhanced patient–nurse autonomy, increased accountability in practice, and the opportunity to create change that really makes a difference in the lives of others.

The primary aims of nurse educators, then, should be to nourish clients, mentor staff, and serve as teachers and clinical instructors for nursing students. They must value their role in educating others and make it a priority for their patients, fellow colleagues, and the future members of the profession.

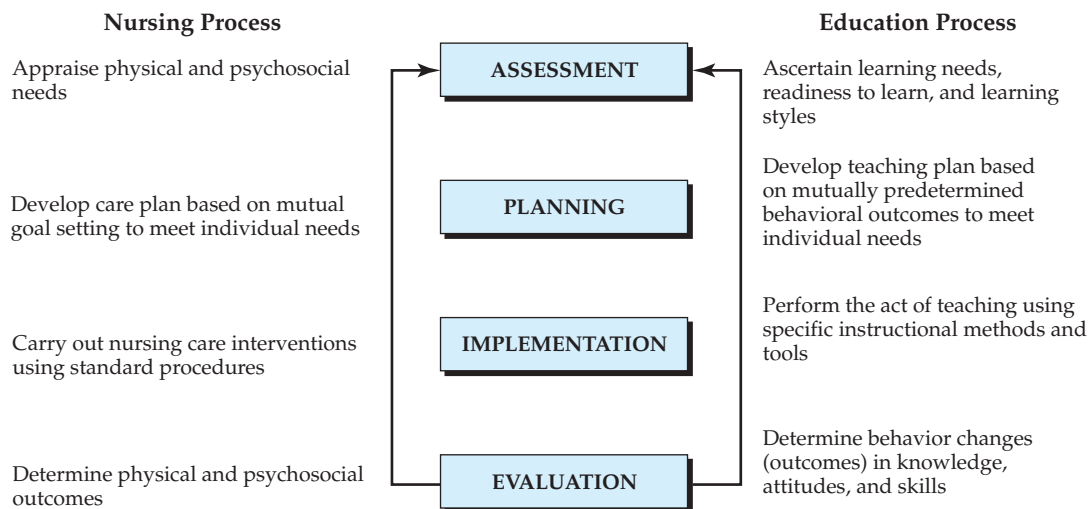
THE EDUCATION PROCESS DEFINED

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).

The education process is similar across the practice of many of the health professions. In fact, it can be compared to the nursing process because the steps of each process run parallel to the steps of the other ([Figure 1–1](#)). The education process, like the nursing process, 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, 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, then 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

14 **Chapter 1:** Overview of Education in Health Care**FIGURE 1-1** Education process parallels nursing process.

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, both one and the same, are often formal, structured, organized activities prepared days in advance, but they can be performed informally on the spur of the moment during conversations and incidental encounters with the learner. Whether formal or informal, planned well in advance or spontaneous, teaching and instruction are nevertheless deliberate and conscious acts with the objective of producing learning (Carpenter & Bell, 2002).

The fact that teaching and instruction are intentional does not necessarily mean that they must be lengthy and complex tasks, but it does mean that they comprise conscious actions on the part of the teacher in responding to an individual's need to learn. 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, motivated, and adequately informed (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 educator's endeavors in teaching is measured not by how much content the nurse imparts, 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. *Staff education*, by contrast, is the process of influencing the behavior of nurses by producing changes in their knowledge, attitudes, and skills to help them maintain and improve their competencies for the delivery of quality care to the consumer. Both patient and staff education involve forging a relationship between the learner and the educator so that the learner's information needs (cognitive, affective, and psychomotor) can be met through the process of education.

The ASSURE model is a useful paradigm originally developed to assist nurses to organize and carry out the education process (Rega, 1993). This model is appropriate for all health professional educators. 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 ROLE OF THE NURSE AS EDUCATOR

Over the years, organizations governing and influencing nurses in practice have identified teaching as an important responsibility. For nurses to fulfill the role of educator, no matter whether their audience consists of patients, family members, nursing students, nursing staff, or other agency personnel, 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 educator role of the nurse an integral part of high-quality care to be delivered by all

registered nurses licensed in the United States, regardless of their level of nursing school preparation. Given this fact, it is imperative to examine the present teaching role expectations of nurses, irrespective of their preparatory background. The role of educator is not primarily to teach, but rather to promote learning and provide for an environment conducive to learning—that is, to create the teachable moment rather than just waiting for it to happen (Lawson & Flocke, 2009; Wagner & Ash, 1998). Also, the role of the nurse as teacher of patients and families, nursing staff, and students certainly should stem from a partnership philosophy. A learner cannot be made to learn, but an effective approach in educating others is to actively involve learners in the education process (Bodenheimer et al., 2002).

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 et al., 2005). Obviously, a nurse needs a great deal of knowledge and skill to carry out the role as educator 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). Consider the following questions:

- Is every nurse adequately prepared to assess for learning needs, readiness to learn, and learning styles?
- Can every nurse determine whether the information given is actually received and understood? Are all nurses capable of taking appropriate action to revise the approach to educating the patient if the patient does not comprehend the information provided through the initial approach?
- Do nurses realize that they need to transition their role as educator from being a content transmitter to being a process manager, from controlling the

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learner to releasing the learner, and from being a teacher to becoming a facilitator (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, the role of the educator 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 educators 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)

Nursing Education Transformation

New evidence also supports a transformation of the process of how nurses are educated, which influences the role of the nurse as educator. Benner, Sutphen, Leonard, and Day (2010) completed a study of the national trends causing the nursing shortage and the increased complexity of demands on nursing practice. These trends have led to a significant gap between nursing education and practice. The results of Benner et al.’s (2010) study include 26 recommendations in six key areas, including entrance into nursing education, pathways for nursing education, student population characteristics, student experiences, teaching in nursing, transition into practice, and professional oversights of nursing education and practice.

Patient Engagement

In 2010, the Nursing Alliance for Quality Care (NAQC)—a partnership of the United States’ leading health and nursing organizations—proposed a strategic policy to advocate for the highest quality consumer-centered care. This policy aims to work with patients, nurses, and policy-makers to encourage and promote the optimum health care to consumers. The NAQC (2010) established four goals addressing key areas to support excellence in the delivery of health care:

1. *Consumer-centered health care:* Establish nursing health and safety goals to achieve safe, effective, timely, efficient, and equal patient-centered care.
2. *Performance measurement and public reporting:* Advocate for the development, implementation, and public reporting of performance measures that reflect nursing’s contribution to patient care.

3. *Advocacy*: Establish policy reform focused on evidence-based nursing practice to improve patient care.
4. *Leadership*: Promote nursing's capability to serve in leadership roles that advance patient care standards.

In 2012, the NAQC issued another initiative as part of its drive to address care coordination and to promote patient engagement during care. In this announcement, nine core principles were released to encourage nurses and other healthcare providers to improve the quality and safety of the care they deliver. The focus is on developing policies that will lead to the integration of patients and their families in the decisions of their care. According to the NAQC (2012), the following principles should be at the core of professional nursing practice:

1. Quality care is based on a dynamic partnership between healthcare providers, patients, and their families. There must be a mutual respect of privacy, decision making, and ethical behaviors.
2. The relationship must be established on confidentiality, and the patient has the right to make his or her own decisions.
3. There are mutual responsibilities and accountabilities that must be observed by all parties to be effective. Healthcare providers must understand to what extent the patient can engage in his or her own care, and advocate for those patients who are not able to fully participate.
4. All interactions with the patient and family must respect the boundaries that protect the patient as well as healthcare providers. Patient advocacy is a representation of a functioning dynamic partnership.
5. The patient–provider relationship is centered on respect for the patient's rights, which includes mutuality.

6. Mutual decision making is based on the sharing of information.
7. Healthcare providers must be aware of the health literacy level and appreciate the diversity of cultural backgrounds of their patients and families to allow for full patient engagement.

Quality and Safety Education in Nursing

In 2005, the Robert Wood Johnson Foundation (RWJF) funded a national study, the Quality and Safety Education in Nursing (QSEN) project, to educate nursing students on patient safety and healthcare quality. The goal of this three-phase study was to address the challenges in preparing nursing students with the knowledge, skills, and attitudes to improve the safety and quality of healthcare delivery (QSEN, 2012). During the first phase, 17 national leaders in nursing education were asked to outline the necessary competencies that should be mastered by prelicensure nursing students. Six competencies were developed in Phase I (QSEN, 2012):

1. *Patient-centered care*: The patient has control of and is a full partner in the provision of holistic, compassionate, and comprehensive care based on the patient's values, needs, and preferences.
2. *Teamwork and collaboration*: Nurses and other health professionals must collaborate effectively with open communication, respect, and mutual decision making to achieve quality care.
3. *Evidence-based practice*: Current evidence must be integrated to support clinical expertise in providing optimal health care.
4. *Quality improvement*: Measure data and monitor patient outcomes to develop changes in methods so as to continuously

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improve the quality and safety in healthcare delivery.

5. *Informatics*: Use information technology to effectively communicate, manage knowledge, eliminate error, and support collaborative decision making.
6. *Safety*: Minimize the risk of harm to patients and healthcare providers through self- and system evaluation.

In 2007, the RWJF funded Phase II of the QSEN project, which included launching a website (www.QSEN.org) dedicated to teaching strategies and resources. A second goal of this phase was to collaborate with organizations that represent advanced practice nurses in developing competencies for graduate education. Also, 15 schools served as pilot sites committed to a curriculum revision that included the QSEN competencies.

In 2009, the American Association of Colleges of Nursing (AACN) also received funding to complete Phase III of the QSEN project. The goal of this phase was to develop the faculty expertise needed to teach the competencies, incorporate the competencies in textbooks, implement innovative teaching strategies, and assist in the licensure and accreditation processes (QSEN, 2012). In February 2012, the RWJF supported the AACN in the development of a new project to establish national QSEN competencies for graduate education. Expert consultants and stakeholders achieved four primary goals (QSEN, 2012):

1. Develop a consensus on the competencies in quality and safety that must be mastered in a graduate nursing program.
2. Create learning resources and interactive materials to help prepare graduate students to deliver quality and safe care.
3. Host workshops to train faculty to facilitate implementation of competencies into curriculum.
4. Develop an online collaborative of education materials for use by graduate-level faculty and clinical partners.

In September 2012, the AACN issued graduate-level QSEN competencies that focus on the knowledge, skills, and attitudes required for advanced practice nurses to effectively improve safety and quality in healthcare delivery.

The Institute of Medicine Report: The Future of Nursing

In 2011, the Robert Wood Johnson Foundation and the Institute of Medicine (IOM) partnered to establish recommendations designed to enhance the role of nurses in the delivery of health care. In 2010, the U.S. Congress passed and President Barack Obama signed into law the Affordable Care Act, a comprehensive healthcare reform legislation. The Affordable Care Act 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. In response to this transformation of U.S. health care, four key messages were developed by a multidisciplinary committee whose membership represented a variety of healthcare professionals, educators, researchers, policymakers, consumers, advocacy groups, and healthcare institutions (IOM, 2011):

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training.
3. Nurses should be full partners with health professionals in redesigning health care.
4. Effective workforce planning and policy making require better data collection.

Based on these four key messages, the report made eight recommendations to achieve a transformation in nursing education and practice (IOM, 2011):

1. Remove scope of practice barriers (addressing key message #1)
2. Expand opportunities for nurses to lead in collaborative improvement efforts (addressing key message #3)
3. Implement nurse residency programs (addressing key message #1)
4. Increase the proportion of nurses with baccalaureate degrees to 80% by 2020 (addressing key message #2)
5. Double the number of nurses with a doctorate by 2020 (addressing key message #2)
6. Ensure that nurses engage in lifelong learning (addressing key message #2)
7. Prepare and enable nurses to lead change to advance health (addressing key message #3)
8. Build an infrastructure for the collection and analysis of data (addressing key message #4)

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 clients in their efforts to achieve the goal of optimal health (Donovan & Ward, 2001). They also can assist their

colleagues in gaining knowledge and skills necessary for the delivery of professional nursing care.

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 educator 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 these teachable moments are not necessarily unplanned or that a coordinated set of circumstances will always lead to positive health change. Instead, it is the interaction between learner and teacher that is central to the development of a teachable moment, regardless of the obstacles or barriers that may be encountered (Lawson & Flocke, 2008).

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 may interfere with the ability of nurses to carry out their roles as educators

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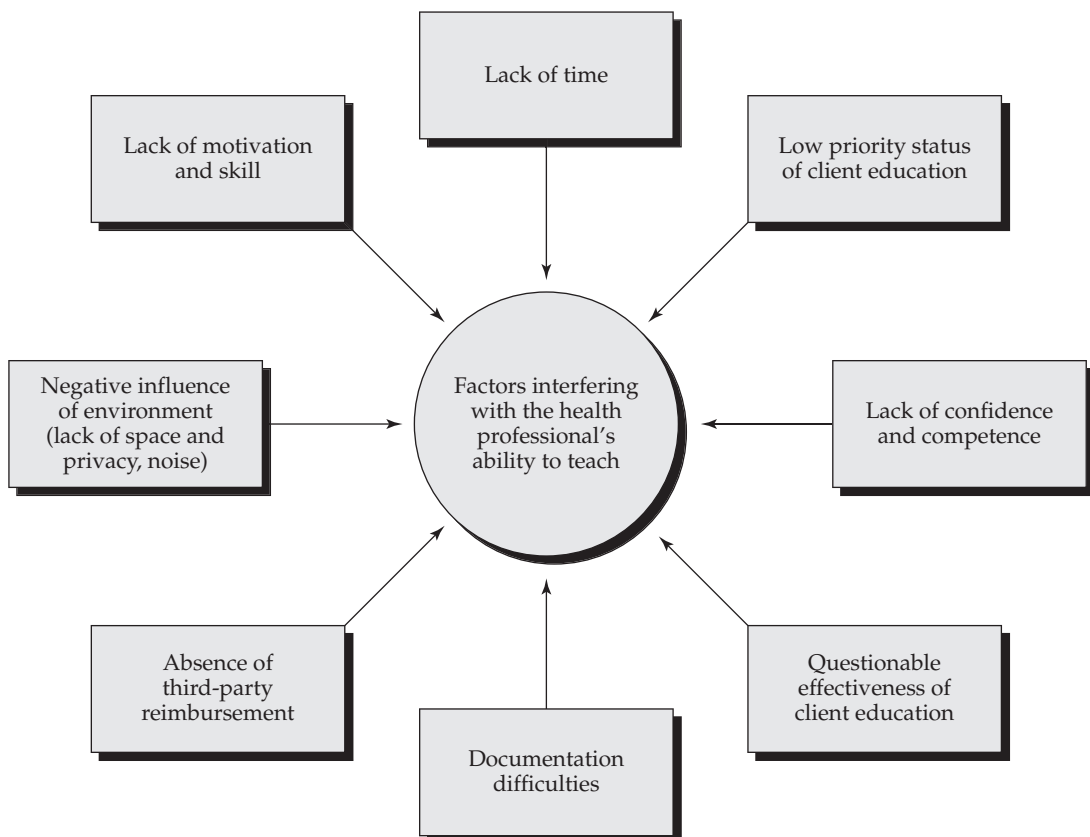
(Carpenter & Bell, 2002; Casey, 1995; Chachkes & Christ, 1996; Duffy, 1998; Glanville, 2000; Honan, Krsnak, Petersen, & Torkelson, 1988)

(Figure 1-2):

1. Lack of time to teach is cited by nurses as the greatest barrier to being able to carry out their educator role effectively. Early discharge from inpatient and outpatient settings often results in nurses and clients 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 The Joint Commission, 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 client and staff

FIGURE 1-2 Barriers to teaching.



education first by adequately assessing the learner and then by using appropriate instructional 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. Pohl (1965) compiled some interesting statistics regarding nursing, long considered one of the first health professions to have a strong teaching role. As early as the mid-1960s, Pohl 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 client and staff 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. Few additional studies have been forthcoming on nurses' perceptions of their educator role (Trocino, Byers, & Peach, 1997). Today, the role of the nurse as educator still needs to be strengthened

in undergraduate nursing education, but fortunately an upswing in interest and attention to the educator role has been gaining significant momentum in graduate nursing programs across the country.

3. Personal characteristics of the nurse educator 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 and staff education. With the strong emphasis of The Joint Commission mandates, the level of attention paid to the educational needs of both consumers and healthcare personnel 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 client 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

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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 in the American Medical Association's Common Procedural Terminology (CPT) codes, 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).

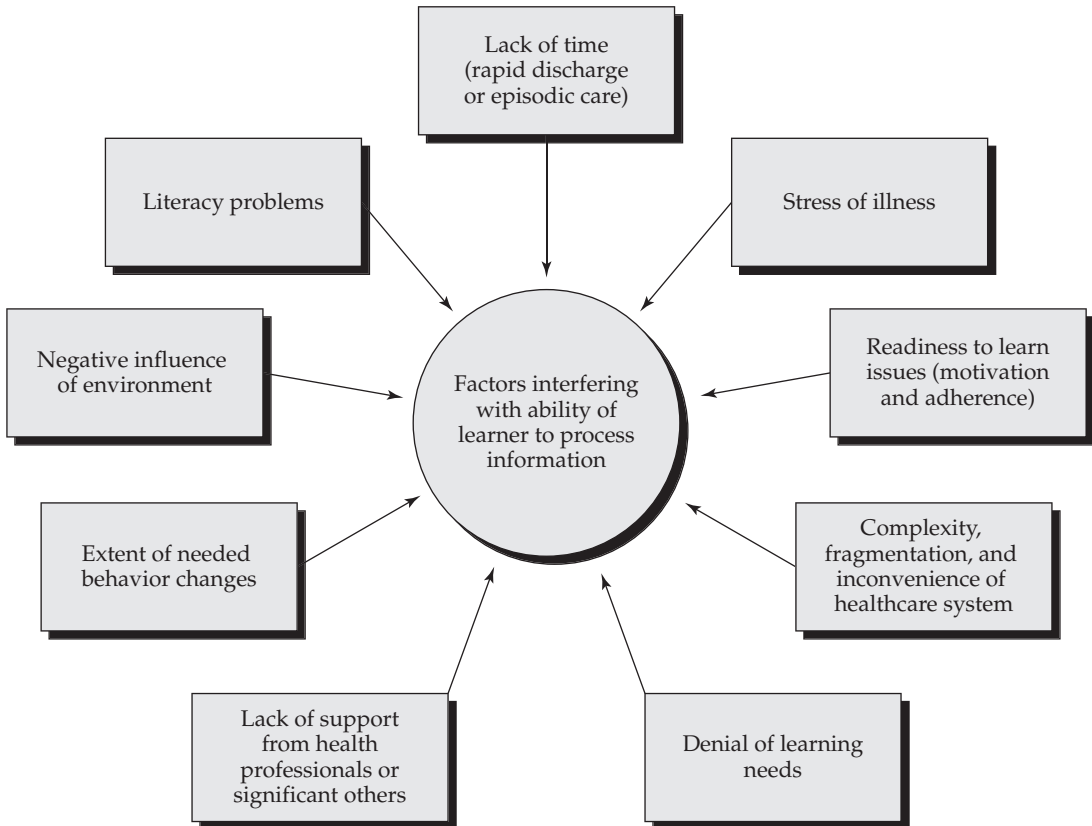
7. Some nurses and physicians question whether patient education is effective as a means to improve health outcomes. They view patients as impediments to teaching when patients do not display an interest in changing behavior, when they demonstrate an unwillingness to learn, or when their ability to learn 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. Unless all healthcare members buy into the utility of patient education (that is, they believe it can lead to significant behavioral changes and increased compliance to therapeutic regimens), then some professionals may continue to feel absolved of their responsibility to provide adequate and appropriate patient education.
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 may interfere with a learner's ability to attend to and process information (Beagley, 2011; Glanville, 2000; Weiss, 2003) (**Figure 1-3**):

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 clients 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

FIGURE 1-3 Obstacles to learning.

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

6. The extent of behavioral changes needed, both in number and in complexity, can overwhelm learners and dissuade them from attending to and accomplishing learning objectives and goals.
7. Lack of support and lack of ongoing positive reinforcement from the nurse

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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, staff, and student education, the nurse must examine the elements of the education process and the role of the nurse as educator. 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 work together more effectively to coordinate educational efforts?
- What are the ethical, legal, and economic issues involved in patient and staff 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 educators 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?

- What can be done about the inequities (in quantity and quality) in the delivery of education services?
- Which elements must the nurse as educator take into account when developing and implementing teaching plans?
- Which instructional methods and materials are available to support teaching efforts?
- Under which conditions should nurses use certain teaching methods and materials?
- 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?

STATE OF THE EVIDENCE

The literature on patient and staff education, from both a research- and non-research-based perspective, is particularly extensive in nursing. The non-research-based literature on patient education is prescriptive in nature and tends to offer anecdotal tips on how to take individualized approaches to teaching and learning. A computer literature search, for example, reveals literally thousands of nursing and allied health articles and books on teaching and learning that are available, ranging from the general to the specific.

Although many research-based studies are being conducted on teaching specific population groups about a variety of topics, only recently has the field focused its attention on how to most effectively teach persons with long-term chronic illnesses. Nurses as educators must conduct much more research on the benefits of patient education as it relates to the potential for increasing quality of life, enabling patients to lead a disability-free life and manage themselves independently at home, and decreasing the costs of health care through anticipatory teaching approaches.

Studies from acute-care settings tend to focus on preparing a patient for a procedure, with emphasis on the benefits of information in alleviating anxiety and promoting psychological coping. The evidence does suggest that patients cope much more effectively when taught exactly what to expect (Donovan & Ward, 2001; Duffy, 1998; Mason, 2001; Wong, Chan, & Chair, 2010).

More research is definitely needed on the benefits of teaching methods and instructional tools that use the technologies of computer-assisted instruction, online and other distance-learning modalities, cable television, podcasts, and Internet access to health information for both patient and staff education. These new approaches to information dissemination require a role change for the educator, from being a teacher to becoming a resource facilitator, as well as a shift in the role of the learner, from being a passive partner to becoming an active recipient. The rapid advances in technology for teaching and learning also require educators to have a better understanding of generational orientations and experiences of the learner (Billings & Kowalski, 2004). Also, the effectiveness of videotapes and audiotapes with different learners and in different situations must be further explored (Kessels, 2003). Given the significant incidence of low literacy rates among patients and their family members, much more investigation needs to be done on the impact of printed versus audiovisual materials as well as written versus verbal instruction on learner comprehension (Weiss, 2003).

Gender issues, the influence of socioeconomics on learning, and the strategies of teaching cultural groups and populations with disabilities need further exploration as well. Unfortunately, the findings from interdisciplinary research on the influence of gender on learning remain inconclusive.

Nevertheless, nurses are expected to teach diverse populations with complex needs and a range of abilities in both traditional settings and nontraditional, unstructured settings. For more than 30 years, nurse researchers have been

studying how best to teach patients, but much more research is required (Mason, 2001). Also, relatively few studies have examined nurses' perceptions about their role as educators in the practice setting (Friberg et al., 2012). We need to establish a stronger theoretical basis for intervening with clients throughout "all phases of the learning continuum, from information acquisition to behavioral change" (Donovan & Ward, 2001, p. 211). Also, emphasis needs to be given to research in nursing education to ensure that the nursing workforce is prepared for "a challenging and uncertain future" in health care (Stevens & Valiga, 1999, p. 278).

In addition, nurses as educators should further investigate the cost-effectiveness of educational efforts in reducing hospital stays, decreasing readmissions, improving the personal quality of life, and minimizing complications of illness and therapies. Furthermore, given the number of variables that can potentially interfere with the teaching-learning process, additional studies must be conducted to examine the effects of environmental stimuli, the factors involved in readiness to learn, and the influences of learning styles on learner motivation, compliance, comprehension, and the ability to apply knowledge and skills once they are acquired. One particular void is the lack of information in the research database on how to assess motivation. The *Compliance, Motivation, and Health Behaviors of the Learner* chapter proposes parameters to assess motivation but notes the paucity of information specifically addressing this issue.

More than 20 years ago, Oberst (1989) delineated the major issues in patient education studies related to the evaluation of the existing research base and the design of future studies. The four broad problem categories that she identified remain pertinent today:

1. Selection and measurement of appropriate dependent variables (educational outcomes)
2. Design and control of independent variables (educational interventions)

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3. Control of mediating and intervening variables
4. Development and refinement of the theoretical basis for education

SUMMARY

Nurses can be considered information brokers—educators who can make a significant difference in how patients and families cope with their illnesses and disabilities, how the public benefits from education directed at prevention of disease and promotion of health, and how staff and student nurses gain competency and confidence in practice through education activities that are directed at continuous, lifelong learning. As the United States moves forward in the 21st century, many challenges and opportunities lie ahead for nurse educators 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 client, staff, and student 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 the audiences they serve.

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 the role of educator.

REVIEW QUESTIONS



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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, TJC, and PEW Commission influenced the role and responsibilities of the nurse as educator?
6. What is the current focus and orientation of patient education?
7. Which social, economic, and political trends today make it imperative that patients and nursing staff 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?
11. What is the current status of research- and non-research-based evidence pertaining to education?

CASE STUDY

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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 and staff education efforts. When you solicit feedback from your professional nursing staff regarding their feelings 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 all the boring, mandated continuing education programs we are required to complete." Finally, Jaipaul comments, "I have no idea how I am supposed to fit education in with all the other tasks I am supposed to complete." Because the staff obviously has some strong feelings about the department's education efforts, you feel a SWOT (strengths, weaknesses, opportunities, threats) analysis is a good place to begin to gather information from your colleagues.

1. As a prelude to the SWOT analysis, identify the goals of patient and staff education.
2. 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 and five potential obstacles to learning that your staff might identify.
3. Provide possible solutions to the issues you identified as barriers and obstacles that would serve to enhance patient and staff education.

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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 Association of Colleges of Nurses (AACN). (2012). *Graduate-level QSEN competencies: Knowledge, skills, and attitudes*. Retrieved from <http://www.aacn.nche.edu/faculty/qsen/competencies.pdf>
- 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). (2010). *Scope and standards of practice* (2nd 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.

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- Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.
- 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.ihl.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.
- DeSilets, L. D. (1995). Assessing registered nurses' reasons for participating in continuing education. *Journal of Continuing Education in Nursing*, 26(5), 202–208.
- Donner, C. L., Levonian, C., & Slutsky, P. (2005). Move to the head of the class: Developing staff nurses as teachers. *Journal of 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.
- 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.
- 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.
- Health Services and Mental Health Administration, Committee on Educational Tasks in Chronic Illness. (1972). *A model for planning patient education; An essential component of health care*. DHEW publication no. (HSM) 72-4023. Rockville, MD: American Public Health Association.
- 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. (1976). *Accreditation manual for hospitals*. Chicago, IL: Author.
- Joint Commission on Accreditation of Healthcare Organizations. (2001). *Patient and family education: The compliance guide to the JCAHO standards* (2nd ed.). Retrieved from <http://www accredinfo.com/news/index.cfm?artid=2011>
- Kessels, R. P. C. (2003). Patients' memory for medical information. *Journal of the Royal Society of Medicine*, 96, 219–222.
- Klestzick, K. R. (2005). *Results from landmark nurse educator certification examination*. Retrieved from <http://www.nln.org/news>
- 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.
- 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.
- Mason, D. (2001). Promoting health literacy: Patient teaching is a vital nursing function. *American Journal of Nursing*, 101(2), 7.
- 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.
- National League for Nursing (NLN). (2006). *Certified nurse educator (CNE) 2006 candidate handbook*. Retrieved from <http://www.nln.org/facultycertification/index.htm>
- Nursing Alliance for Quality Care (NAQC). (2010). *Strategic policy and advocacy roadmap, 2010*. Retrieved from <http://www.gwumc.edu/healthsci/departments/nursing/naqc/documents/Roadmap.pdf>
- Nursing Alliance for Quality Care (NAQC). (2012). *Nursing experts release guiding principles for patient engagement*. Retrieved from http://www.gwumc.edu/healthsci/departments/nursing/naqc/documents/Patient_Engagement_Principles.pdf
- Nyswander, D. V. (1980). Public health education: Sources, growth and educational philosophy. *International Quarterly of Community Health Education*, 1, 5–18.
- Oberst, M. T. (1989). Perspectives on research in patient teaching. *Nursing Clinics of North America*, 24(2), 621–627.
- Orr, R. (1990). Illness as an educational opportunity. *Patient Education and Counseling*, 15, 47–48.
- Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions for the twenty-first century: The third report of the Pew Health Professions Commission*. San Francisco, CA: University of California.
- Pew Health Professions Commission. (1998). *Recreating health professional practice for a new century: The fourth report of the Pew Health Professions Commission, Center for the Health Professions*. San Francisco, CA: University of California.
- Pohl, M. L. (1965). Teaching activities of the nursing practitioner. *Nursing Research*, 14(1), 4–11.
- Public Health Service. (1971). Public health then and now. *American Journal of Public Health*, 61(7), 1277–1279.
- Quality and Safety Education in Nursing (QSEN). (2012). *Project overview*. Retrieved from <http://www.qsen.org/overview.php>
- 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.
- 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>
- Stevens, K. R., & Valiga, T. M. (1999). The national agenda for nursing education research. *Nursing and Health Care Perspectives*, 20(5), 278.
- 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>
- Sullivan, L. W., & Bristow, L. R. (2007, March 13). *Summary proceedings of the national leadership symposium on increasing diversity in the health professions*. Washington, DC: Sullivan Alliance.
- Trocino, L., Byers, J. F., & Peach, A. G. (1997). Nurses' attitudes toward patient and family education: Implications for clinical nurse specialists. *Clinical Nurse Specialist: A Journal for Advanced Nursing Practice*, 11(2), 77–84.

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- U.S. Department of Health and Human Services (USDHHS). (2000). *Healthy people 2010: Objectives for improving health* (Vol. II). Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services (USDHHS), Office of Disease Prevention and Health Promotion. (2000). *Healthy people 2000*. Retrieved from <http://odphp.osophs.dhhs.gov/pubs/hp2000/>
- U.S. Department of Health and Human Services (USDHHS), Office of Disease Prevention and Health Promotion. (2010). *Healthy people 2010*. Retrieved from <http://www.healthypeople.gov/>
- U.S. Department of Health and Human Services (USDHHS), Office of Disease Prevention and Health Promotion. (2012). *Healthy people 2020*. Retrieved from <http://www.healthypeople.gov/>
- 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 Monograph*, 1, 11–19.
- Weiss, B. D. (2003). *Health literacy: A manual for clinicians*. Chicago: American Medical Association & American Medical Association Foundation.
- Wong, E. M. L., Chan, S. W. C., & Chair, S. Y. (2010). Effectiveness of an educational intervention on levels of pain, anxiety and self-efficacy for patients with musculoskeletal trauma. *Journal of Advanced Nursing*, 66(5), 1120–1131.
- 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.