CHAPTER 6

ORGANIZING AND MANAGING INSTRUCTION IN THE CLINICAL PRACTICE SETTING

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The clinical practice setting provides students with opportunities to develop the knowledge, skills, and attitudes of a nurse within the realistic work settings in which they will eventually practice. Although the structure and process of clinical nursing education has changed over time, the critical role of the clinical setting in preparing students for the challenges of practice has remained a central component of nursing curricula. The original apprenticeship model, in which students’ work in the hospital was supplemented by occasional classes and the processes involved in delivering nursing care were passed on to students by graduate nurses, was abandoned decades ago for a more structured and organized approach to guiding the transfer of theoretical knowledge to the practice setting.

To succeed in the clinical practice setting, the clinical nursing instructor needs to be well grounded in the clinical specialty in which she is teaching and comfortable in the clinical environment in which she will be providing instruction. A thorough understanding of the systems and procedures adopted by unit personnel for the management of patient care allows the instructional process to proceed with a minimal disruption of the routines that characterize the unit’s operations. A rapport with staff members that fosters trust in the instructor and her approaches to teaching students creates a positive learning environment for everyone. The clinical instructor paves the way for students’ clinical learning experiences. The relationships she forges with staff—on the basis of her clinical know-how, her willingness to adapt to the culture and flow of the unit, and her enthusiasm for and delight in the work of nursing—result in an atmosphere of collegiality that enhances the students’ experience.

Having spent sufficient time on the unit to learn its routines, the clinical instructor is in a good position to orient students to the unit when they arrive for their first clinical day. Sensitivity to fostering collaboration with staff may lead her to ask the nurse manager to perform this task. Such a request consolidates the alliance with staff that the instructor seeks to establish, and makes students feel a part of—rather than apart from—the life of the clinical unit.
For the most part, the initial clinical day is spent in establishing expectations for the clinical experience and for student behaviors in relation to that experience, reviewing routines and procedures used on the unit, and providing students with the opportunity to develop some familiarity with the layout of the unit. This initial day should include a discussion of the types of patient problems that usually are encountered on the unit, the level of acuity involved, and the customary focus of nursing interventions. If appropriate to the setting, nursing rounds may be conducted to enable students to have some initial connection with the patients and the setting in which they are receiving care. Students may be encouraged to review nursing care plans and related orders or read patient charts, if this will not be disruptive for staff, to gain a sense of how these documents are organized and where information they will need in preparing for future assignments is located. More advanced students who have some familiarity with the clinical setting may be given a patient assignment in coordination with a staff nurse as a means of introducing students to the clinical environment and its rhythms.

Expectations, Hopes, and Fears

Students and instructor both approach the clinical learning situation with numerous expectations, hopes, and fears. The ultimate aim of teaching is to skillfully select and apply strategies and techniques that will enable students and instructor to find common ground that will foster learning. Once they have found that common ground, students and instructor are able to develop collaborative approaches to teaching, learning, and providing nursing care that are the essence of a nursing education.

One purpose of Wilson’s (1994) qualitative study of baccalaureate nursing students in a senior-level clinical course was to identify goals for the clinical practice experience as perceived by the student. Six major goals emerged from the analysis:

- to cause no harm to a patient;
- to help patients;
- to integrate theory-based knowledge from lecture and reading into clinical practice;
- to learn nursing clinical practice skills;
- to look good as a student; and
- to look good as a nurse. (p. 83)
An exploration of the dimensions underlying each of these identified goals is a useful means of uncovering the expectations, hopes, and fears carried to the clinical learning situation by students and instructors.

**Causing No Harm to the Patient**

Students in Wilson's study identified their responsibility for patient care assignments as quite different from their responsibility for learning. As learners, they expected to make mistakes as part of the process of learning, and to use trial and error approaches in mastering a learning task. This approach was viewed as unacceptable when learning carried with it the responsibility for another person's well-being. Because “doing no harm” was superordinate to other goals for the clinical experience, students were highly motivated to prepare adequately for clinical assignments. They identified any lack of knowledge and/or skills related to patient needs as inherently dangerous to patients in their care, and became anxious when they felt their knowledge and/or skills were insufficiently developed to meet the demands of the assignment.

In reality, however, a student cannot make progress if increasingly difficult assignments, which by their nature contain demands for knowledge and/or skill the student has not yet mastered, do not challenge her. If the learning experience is well designed and the instructor is taking full advantage of the clinical material available in the setting, it is very likely that even the best-prepared students will encounter situations that appear to be beyond their ability. The challenge to the instructor is to make learning safe for the student, while ensuring that no harm comes to the patient because, of course, the instructor shares the students' fear of harming patients. This fear often is the driving force behind the instructor's vigorous quizzing of students prior to their providing care and close supervision as they perform various procedures. Such practices tend to increase students' distrust of the instructor as well as increasing their anxiety. Distrust causes students to avoid interactions with the instructor, particularly those that might reveal any lack of certainty regarding how to proceed with the clinical assignment. This behavior further jeopardizes patient safety.

Practicing nurses are able to tolerate the “messiness” of the clinical area, where it’s “okay” not to know immediately what is going on with a patient, as long as the nurse knows enough to know what might be going on, what to look for, and what the patient needs from the nurse in the meantime. Is it
possible to transfer this tolerance for uncertainty to clinical teaching, to enable students to achieve the goal of doing no harm while also engaging in learning that might result in mistakes? Making mistakes, and overcoming their consequences, has great educational value, and should not be avoided at all costs. Further, in the rapidly changing situations that occur in most clinical settings, things quickly can move beyond the student’s ability to manage, and this does not necessarily mean that the student is inadequate or at fault.

The key to accomplishing this involves three steps. First, the instructor must verify with students the level of knowledge and skills they are bringing to each clinical experience, to reinforce the need for adequate preparation for assignments, and to fill in gaps in knowledge when these occur. Second, the instructor must develop a climate of trust with students so that students recognize that perfection is an unrealistic expectation, are able to ask questions freely, and feel that they can acknowledge mistakes when these occur without fear of embarrassment or reprimand. Third, the instructor must be prepared to calmly step in to correct mistakes and address their consequences without distressing the patient or undermining the student’s confidence.

Helping Patients

Students in Wilson’s study viewed the help they were able to provide for patients as somehow compensating for their “use” of these patients for learning. The instructor can take advantage of this desire to help patients by reinforcing the positive benefits for patients of having students care for them, and encouraging the student to plan care activities so as to maximize the benefits received by the patient. By helping the student to consider what “value added” she might be able to provide for the patient during the clinical experience, the instructor encourages the student to look beyond her own learning needs to consider the larger context of patient care needs. For example, the patient’s daily care may be rushed or fragmented when staffing is short; the student is able to provide care calmly and with minimal interruption, if she plans and manages her time properly.

The time constraints associated with clinical learning often impede the student’s ability to fully help patients. The student’s position in the system makes it difficult for her to follow up on issues that might arise as she cares for a patient, and her sporadic presence on the unit (often only once a
week) is disruptive to any continuity of care that might be provided, excepting in long-term care and community health settings. This reality also must be addressed by the instructor, who needs to set boundaries on students' activities with patients once the students have left the clinical learning situation while still providing the mechanisms necessary to ensure that issues identified during the students' work with the patients are addressed by staff after the students depart. The frustration the student feels at not being able to complete the work she has begun in helping the patient can be channeled into equally important lessons concerning the role of teamwork and communication in ensuring continuity of care.

Integrating Theory into Clinical Practice

For some students in Wilson's study, observing or practicing the clinical application of content presented in class provided the means by which they could understand the material. Others found clinical practice experiences to reinforce learning, and so aid their retention of material. For many instructors, such integration is serendipitous, since the clinical situation rarely matches classroom content with a great deal of fidelity. Students are able to identify fragments of the clinical experience that provide the illustration for a theoretical concept (perhaps because they are searching for such connections) and become quite adept at pointing these out to their fellow students and the instructor. It is important for the instructor to validate such integration, and elaborate on the example by distinguishing the theoretical ideal from the observed reality in the clinical setting. It is equally important for the instructor to identify flaws in integration, as when the student misreads the clinical situation as illustrating a theoretical concept or erroneously applies theory in practice. Correcting these errors by explaining the distinctions between the student's application of theory and the correct application in this situation helps the student to fine-tune her understanding of theory through the use of clinical examples.

Learning Clinical Practice Skills

Students in Wilson's study tended to equate learning with the first-time performance or mastery of a growing list of psychomotor skills. Instructors ignore this student goal at their peril, because students seem unable to concentrate on the larger patient care situation until they feel comfortable with the hands-on care they are providing. This focus on skilled clinical
performance in accomplishing patient care procedures is likely to be related to the goal of looking good as a nurse. The instructor can accelerate the students’ shift in perspective to include larger goals for patient care by identifying those technical skills that are likely to be encountered in providing care in the particular clinical setting, providing opportunities early in the clinical experience for each student to perform these skills, and tracking each student’s accomplishments with respect to skill development and mastery. By focusing on a limited list of skills appropriate to the setting, the instructor can satisfy the strong need students have to develop clinical expertise through technical skill performance while limiting the amount of attention and effort expended on technical skill mastery to the detriment of the development of other nursing skills.

Looking Good as a Nurse and as a Student

For the students in Wilson’s study, looking good as a nurse involved achieving the goal of helping patients, as affirmed by the patient and his family members as well as by staff members (the instructor’s comments on student performance with patients are evaluated differently by students, who judge these in terms of how they affirm or disaffirm looking good as a student); mastering new aspects of nursing care; being organized; and feeling confident and competent in performing nursing care. A different set of behaviors was identified for looking good as a student. Looking good as a student involved answering all questions correctly, performing all skills flawlessly, being involved in clinical learning activities at all times that the instructor is present, and having the right answers in instructor–student interactions. Because such perfection is an impossible feat, students modified their interactions with the instructor based on the confidence they felt in their knowledge and/or skill base. While the instructor struggles to create “teachable moments,” in which student learning can be maximized through skilled questioning by the instructor, students view these moments as an examination that will make or break their careers as nursing students. They stop relating to the clinical situation as a learning opportunity and retreat into their classroom response style. Similarly, students generally avoid asking questions of the instructor (relying instead on fellow students and staff) in order to avoid looking bad as a student.

Despite the instructor’s assurance that evaluation is not the central goal of all instructor–student interactions, students remain unconvinced. Consequently, the instructor must structure such interactions to look as little
like an examination as possible. In her provocative discussion of thinking in nursing education, Ironside (1999) describes one instructor's approach to stimulating students to think about the process of patient care by sharing her own thinking about the presenting situation and engaging the student in a dialogue about the meanings embedded in the situation as well as the various possibilities for nursing response. Sharing one's own thinking provides the student with insights as to how nurses view and analyze situations; it also reveals the constant interplay of observations, selection of what is relevant in the situation, hypothesis generation, and hypothesis testing—all with the clear potential for "error"—that characterizes nursing in action. Students' usual response in interactions with instructors—to provide the right answers—reinforces a too-rapid closure on a single solution to a problem, forestalling consideration of alternatives or confounding issues. Nursing's particular art is in tolerating a certain lack of closure on problems or answers without losing track of the patient's situational response and corresponding needs for care. Teaching in the clinical setting requires an approach that prevents such premature closure and the resulting simplistic, incomplete responses to the complexities being presented by clinical material.

Selecting Clinical Learning Experiences

The clinical setting is both a stimulus environment for the application of learning and an environment rich in its own opportunities for learning. It is the instructor's job to select the most appropriate "stimuli" for students' application of theoretical knowledge and to capitalize on additional learning opportunities. It is the instructor's use of and response to the complex interplay of educational goals, learner abilities and needs, and the clinical environment that determines the success of the clinical experience. (Box 6-1 provides a systematic approach to planning students' clinical assignments.)

Fothergill-Bourbonnais and Higuchi (1995) identify four factors that should be considered in selecting clinical learning experiences: curricular goals as determined by the nursing program, the learning environments that have been identified as the places where these goals will be pursued, the clinical expertise of the instructor, and characteristics of the students.
### Box 6–1: How to Select Clinical Assignments

1. **Assess available clinical material**
   - What experiences are available in the clinical setting?
   - What potential learning opportunities are presented in relation to specialty-specific theoretical content, skills development, overriding curricular content (e.g., interpersonal communication, patient teaching, advocacy, life span development, etc.)?
   - What anticipated patient events (e.g., absence from the unit for prolonged testing, imminent discharge) might interrupt or interfere with student learning?
   - Have staff voiced concerns or cautions regarding specific patient care assignments?

2. **What are the curricular goals and related clinical objectives for this experience?**
   - What is the primary focus of learning for this clinical experience?
   - Can that focus be described as a larger concept of which the specific patient case at hand is an example?
   - What other learning can be extracted from the situation? Scan curricular goals and clinical objectives to identify 2 or 3 other objectives that might be addressed in the experience.
   - Does the student have sufficient background knowledge, either from previous courses or experiences or from the concurrent theoretical class, to deal with the situation? If not, can sufficient theory be provided to permit the student to function safely and effectively in an otherwise excellent learning situation?

3. **What is the overall environment for learning?**
   - Can connections be made between the proposed assignment and the previous experiences of the student that will help to integrate the experiences?
   - What lessons might be drawn from the specific clinical setting that can be carried over into another setting (e.g., what information from the patient setting would be helpful to the nurse?)
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Box 6–1  Continued

providing care for the patient in the community setting or to the nurse providing care for a nursing home resident admitted to the hospital for an episodic illness)?

• What staffing issues need to be considered in making the assignment (e.g., short staffing because of illness, planned meetings) that may impact the learning experienced?

4. What do you, as the instructor, feel comfortable in managing?

• Where do you anticipate needing to spend the most time in relation to specific students and/or specific patient care assignments?
  • Does the overall assignment shortchange any students or create safety issues?
  • What patient events can or might happen in the course of the clinical day? If one or more of these events were to occur, would this be manageable given the assignments planned for all students in the group?

5. What are the characteristics of the learner group and individual students?

• What previous experiences have the students had that can be drawn on in managing the proposed clinical assignment?
• What is the performance level of individual students? Is each student capable of managing the proposed assignment?
• Has each student had opportunities to progress toward achieving clinical objectives?
• What level of independent functioning has each student achieved? Will one or more students require more attention than others?
• What learning needs have individual students expressed? Are these addressed in the assignment?
• Have students voiced any specific needs or desires in relation to clinical assignments? Can these be accommodated?
• What is the level of student confidence? Anxiety?
Curricular Goals

Curricular goals are expressed in the objectives that have been developed for each course in the program. These objectives flow from a set of outcomes desired for graduates of the program, and expectations for progressive student growth in knowledge, skill, and attitudes in relation to professional values as they pursue these outcomes throughout their educational experience. Commonly identified curricular goals include the development of

1. clinical judgment through critical thinking in the use of problem-solving and decision-making skills;
2. technical expertise in the delivery of nursing care, based on scientific rationales;
3. communication skills in interactions with patients, their families, and other health care providers;
4. caring behaviors in the provision of nursing care;

Selecting Clinical Learning Experiences

- Can each student function safely? If not, what precautions must be taken as the student proceeds through the clinical day?
- Are there any special needs of patients that can be matched to a student’s special abilities?
- What backup plans are available?
  - Can students be paired in providing care without diluting the experience?
  - Can students be assigned multiple patients to provide opportunities to practice planning and priority setting when challenging clinical situations are not available?
  - Are there any off-unit experiences available that address clinical objectives?
  - Can students focus on a single skill set with multiple patients?
  - Can case studies and “what if” scenarios be developed to effectively use “down time”?

Box 6–1 Continued

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5. the full professional nursing role through such activities as advocacy, initiation and response to change, and clinical leadership;
6. operational familiarity with the organizational contexts in which health care is delivered;
7. autonomy in decision making and accountability for actions; and
8. the ability to identify learning needs and plan approaches to meet them.

Course objectives reflect one stage in the sequence that students follow in pursuing program outcomes. Course objectives may apply to both classroom and clinical learning in the course, or a parallel set of objectives may be developed for each area. In some programs, objectives for each clinical experience are created; in others, the approach to be used in addressing the overall objectives for the course is left to each clinical instructor. (Sample course objectives appear in Appendix A.)

From one perspective, any separation of classroom and clinical objectives makes no sense, since all theoretical knowledge should eventually be applicable in the clinical area. From another, the level of learning represented in “ knowing that” is different than that involved in “ knowing how,” justifying the creation of two sets of objectives. The instructor must provide experiences for students that enable them to reach the objectives and hence move toward achieving the curricular goals; but she has considerable latitude in how to accomplish this. It is entirely appropriate to broadly interpret the objectives provided for the experience so that the richness of the clinical setting can be exploited for student learning. The instructor must, however, be aware of what has been covered in the classroom, so she can provide the relevant theoretical background for the activities in which students are engaged in the clinical setting. Eventually, the two will merge into a synthesized whole, particularly if the instructor is consistent in guiding such integration. Contributing author Mimi Wright Maher characterizes this as “ planting seeds now, with the flowers coming later.”

Learning Environment

The clinical environments in which students learn nursing vary enormously in such characteristics as

- acuity versus chronicity;
- pace of unit operations;
- nature of the patient;
• trajectory of a usual episode of illness;
• nature of the patient’s needs for nursing;
• level of nursing intervention required (prevention, rehabilitation, etc.);
• length of stay;
• applications of technology;
• intensity of staffing, both nursing and other health care providers;
• relative autonomy and independence afforded the nurse in determining the course of care; and
• impact of financial constraints on the quantity and quality of patient care.

These varied environments expose students to numerous perspectives on the phenomenon of nursing, human responses to illnesses and their treatment, and the processes involved in nursing care. As a result of these multiple exposures, students gain much more than a series of snapshots of nursing in action. They begin to recognize the full impact of an episode of illness and the cycle involved in restoring health or promoting optimal functioning or comfort in the face of ongoing chronic illness or death, as well as the nurse’s role in assisting the patient through that cycle. In the course of these experiences, students also master an array of technical skills associated with the nursing needs of the patients for whom they care.

With time, students’ caring for patients involves the selective application of appropriate technical skills, rather than a focus on the skills themselves. Caring for a variety of patients increases students’ sensitivity to the different ways in which people respond to illness and its treatment, enabling them to begin to develop the “skilled clinical knowledge” and “perceptual awareness” that marks the expert nurse (Benner & Wrubel, 1982). Learning about a disease process, treatment, or drug therapy in the classroom becomes enriched by the depth and variety of knowledge that is developed in interaction with patients. In comparing and contrasting the human responses they witness, students begin to integrate the theoretical with the practical. This only can occur if the clinical instructor recognizes these nuances and the subtle distinctions presented in clinical situations chosen for student learning and deliberately selects assignments to develop this awareness in students. This means that the instructor approaches the clinical setting as a learning environment that presents multiple opportunities for students to observe postoperative healing, with less concern about whether each student has been exposed to a patient who has undergone major abdominal surgery.
As unit staff observe the types of patient situations the instructor selects for student learning, they add to the mix their own perspective on what is significant in the particular clinical setting in which learning is occurring. When the instructor has established positive relationships with staff, they support the instructor's efforts by making suggestions regarding patient situations that would provide good (or negative) learning experiences for students. This collaboration further refines the instructor's ability to capitalize on the richness of the clinical learning environment.

Instructor Expertise

While the instructor must be an excellent role model of professional nursing, the expertise required for clinical teaching, especially with respect to selecting learning experiences, is different and far more complex than that required for bedside nursing. Three areas of knowledge essential for clinical teaching are subject matter content, the teaching–learning process, and the curriculum content (Shulman, 1986, cited by Fothergill-Bourbonnais & Higuchi, 1995).

Expertise in the specialty area represented by the learning environment is essential in order for the instructor to recognize the educational potential that exists within the available patient situations and to guide the student learning that should be taking place. Additionally, the instructor must be able to predict the likely course for each patient being cared for by students, so they are not overwhelmed (or too minimally challenged) by the assignment. While any patient can crash—or be unexpectedly discharged—this will occur infrequently if the instructor has a well developed sense of typical trajectories of response to illness and treatment in her specialty. The instructor must also feel confident in managing multiple patient variables without becoming ruffled or confused. When more advanced students are assigned to care for two or three patients, the instructor's responsibility multiplies to as many as 24 patients whose care must be tracked and safety assured. In acute care areas, even expert instructors will vary assignments by having some students care for the most complex patients on one clinical day, while others have a lighter assignment, and then reversing this on a subsequent clinical day (Fothergill-Bourbonnais & Higuchi, 1995).

Pedagogical expertise is necessary to enable the instructor to help students to make the intellectual connections between classroom theory and the clinical material that comprises their learning experience. The instructor...
also needs to understand the progressive nature of learning and be able to track the individual learning needs of students as they develop the necessary knowledge and skills involved in achieving course objectives. The instructor must be as adept at diagnosing and responding to educational needs of students as she is at diagnosing and responding to nursing needs of patients, because each is likely to progress at a different rate.

Curricular knowledge is necessary to understand where in the “vertical curriculum” the course is positioned—what content and experiences have preceded the course and which will follow the course. This way, the instructor won’t expect too much or too little from her students. (It is entirely possible that some students in a course will have had a prior course in, for example, maternal–child nursing while others will have this course next. This creates a real challenge for the instructor who would like to draw on this content, for example, in a community nursing experience, but must vary assignments based on individual students’ actual experiences in the curriculum.) Placement of content in another course does not mean that the instructor cannot include an experience if it arises, but that she will recognize the student’s need for background information to maximize the learning potential of the experience. At the same time, much content in the curriculum—the management of the diabetic patient, acid-base balance, and the like—merits repetition in successive courses. The instructor also must be familiar with the “lateral curriculum,” the theoretical content of courses that are being taught simultaneously with the clinical component in which she is teaching. For example, courses in microbiology and nutrition often are taken concurrently with an initial clinical course. General concepts taught in such courses can be reinforced with clinical examples. This is necessary so that students can experience the necessary clinical examples of the theoretical as a means of integrating and reinforcing theory and practice (Shulman, 1986, cited by Fothergill-Bourbonnais & Higuchi, 1995). This is particularly important in associate degree and practical nursing programs, where students do clinical work concurrently with foundational courses in anatomy and physiology, psychology, sociology, and the like.

The instructor also must be skilled in human relations, not only with students and staff, but also with patients and their families. It is the instructor who introduces patient and student and, in the process, helps to build the patient’s confidence in being cared for by the student. This introduction assures the patient that there is an expert guiding the student and that the patient has recourse to the instructor.
Learner Characteristics

The clinical instructor must consider the individual abilities of the students in the clinical group and select learning experiences accordingly. While all students are expected to achieve course objectives by the end of the semester, each will achieve these at different rates and levels of competence. The instructor must tailor assignments to allow each student to progress steadily and comfortably toward the final goal. By sharing with each student her rationale for making specific assignments, the instructor enables the student to focus on the key learning opportunities the assignment presents.

Advanced awareness of each student’s academic progress as well as her performance in previous clinical experiences gives the instructor some basic information upon which to base initial assignments while she completes her own initial assessment of each student’s strengths and weaknesses. In using this information, the instructor must be careful not to allow grades or another instructor’s comments on a student’s performance to unduly bias her own judgments. Many students whose academic performance has been mediocre excel in the clinical arena and should be given the opportunity to demonstrate their unique abilities.

“A sequence of experiences that has both continuity and connection is important” (Fothergill-Bourbonnais & Higuchi, 1995, p. 40). The design of successive assignments should build on each student’s progress in:

- technical skill development;
- ability to manage increasingly complex care demands;
- responsiveness to an increasing number of patient variables;
- ability to recognize typical, then atypical patterns of response;
- ability to organize and manage a complex assignment; and
- achieving independence in making decisions and clinical judgments.

The instructor must tap into the student’s knowledge base as it expands, so that the student is continuously challenged to access and utilize prior learning.

The student’s level of anxiety or confidence must be considered in selecting learning experiences. The anxious student will need a patient assignment that will enable her to have a positive experience and so reduce some of the anxiety she is experiencing in the clinical area. Often, one or two satisfying experiences are sufficient to enhance the student’s level of confidence and lower dysfunctional anxiety. The overconfident student...
must also be managed carefully, because the student's bravado may mask high anxiety.

The student's ability to function safely in providing care is a major concern in selecting learning experiences. The instructor will not want to "dumb down" an assignment for the student who may pose a safety problem, but she will want to consider her own ability to provide adequate supervision for this student while still attending to the learning needs of others in the group. This is a situation in which the instructor's rapport with staff, who can provide the necessary backup either for the problem student or the remaining student group, is a major contributor to the success of the experience.

The instructor will want to capitalize on a student's unique abilities—for example, language skills in caring for a patient who speaks no English—but not at the expense of the student's exposure to a variety of experiences.

The instructor will need to keep track of various aspects of each student's assignments to ensure that the learning opportunities experienced by each student are relatively equivalent. It's important to track the student's array of psychomotor skills and other, nontechnical skills, such as patient teaching, preparing the patient for a procedure, and conducting an admission interview and assessment. Students also should have equivalent exposure to the typical patient problems encountered in the specialty area and to managing the care of more than one patient.

Student requests for specific experiences should be honored to the extent that this is possible. Students develop a good sense of their own needs for learning, and this awareness should be reinforced.

Other Considerations

Contingency planning is essential in the rapidly changing environment of health care delivery. A well-conceived assignment can evaporate when a patient is transferred or discharged. A unique experience may be missed because the student who was given the assignment has called in sick, or a magnificent experience may arise just as the students are leaving the unit. A usually busy unit may have a fallow period, with only a few extremely routine patient care situations available for students. Educationally sound backup plans are essential to ensure that each clinical experience offers each student the opportunity to continue her progressive development of knowledge and skills. When the acuity level of patients is unusually high,
students can be paired in completing assignments. When acuity is unu-
sually low, students might be given a multiple patient assignment to develop 
their organizational and time management skills. Case studies can be de-
veloped for review to reinforce the application of theory to practice. “Worst 
case scenarios” can be imagined for stable patients, with students identi-
ifying various problems that could develop given the patient’s underlying 
illness, and the appropriate response to each of these. Off-unit experi-
ences, such as observing major diagnostic procedures or becoming in-
volved in outpatient clinic routines, are a good alternative activity if 
planned in advance.

Needs particular to the clinical setting in which students practice also 
should be considered in planning learning activities. Assisting with unit 
routines—such as feeding residents in the long-term care setting—rein-
forces the concept of teamwork in addition to providing opportunities to 
witness the problems that may be encountered by the elderly and dis-
able in managing utensils, or swallowing and chewing food. Any activity 
can be transformed into a learning opportunity by the clinical instructor 
who recognizes students’ need for socialization into the role of the nurse, 
which involves more than providing patient care. Indeed, Hill (1993) notes, 
“it is impossible to provide nursing care without processing knowledge in 
some way” (p. 133).

Alternative Approaches

One scheme for selecting clinical learning experiences is to break the rou-
tine practice of assigning each student to care for one or two patients and, 
instead, have some students engage in a different pattern. Assessment 
skills can be fine-tuned by having two or three students make “lung” 
rounds, to listen to the breathing patterns of a variety of patients and de-
velop a sense of the distinctions that are encountered in the clinical set-
ing. It is not necessary for each student to provide all care for a patient for 
whom a procedure is required in which students need practice; a succes-
sion of students can perform the procedure with one patient if the patient 
is consulted first and agrees to this.

Heims and Boyd (1990) advocate the use of concept-based learning ac-
tivities as a substitute for traditional clinical assignments that give stu-
dents responsibility for total patient care. In this approach students receive guidelines developed for each major concept to be addressed in 
the course. The student’s task is to analyze the concept as it plays out in
the clinical area. Heims and Boyd assert that this approach enables stu-
dents to pursue nursing care planning creatively and frees them from
repetitive care activities. Missing, however, is the accountability inherent
in accepting a total care assignment, as well as the opportunity for the stu-
dent to develop in the full role of the nurse through clinical activities and
to learn through repetition.

Techniques to Help Students Prepare for Clinical Learning Experiences

Students need some guidance in organizing for the clinical day, although
the nature and degree of assistance needed will change as students
progress through the nursing program. More advanced students will be
able to prepare adequately for an assignment in the period just prior to
embarking upon it, much as does a graduate nurse. Beginning students
need more time to prepare and usually are given the clinical assignment
the day before the clinical experience to provide the opportunity for ade-
quate preparation.

Structured assignments can be used to guide the student in accessing
prior knowledge and identifying gaps that need to be filled before engag-
ing in the clinical experience. Such assignments create an “anticipatory
set,” or readiness to learn, by helping students to identify important ele-
ments of the situation and to do any necessary reading, review, or thinking
related to completing the assignment successfully. In making such assign-
ments, however, the instructor must be clear as to how she expects the as-
signment to contribute to student learning.

Teacher-Created Data Collection Forms

These forms attempt to guide the student’s identification and organiza-
tion of data relevant to patient care. (Sample forms can be found in Ap-
pendix F.) The student abstracts data from the patient’s chart and inserts
the information into the appropriate categories on the form. Then the stu-
dent consults her class notes and textbooks to review information perti-
nent to data elements—for example, the normal range of laboratory
values given the laboratory test results for this patient; the indications,
actions, and side effects of the drugs the patient is receiving; and so forth.
As the student proceeds with patient care activities, she may consult the form for information rather than returning to the chart to retrieve it, or she may consult the form to answer the instructor's questions. Rarely is the student asked to verify the data she has collected through her own assessment of the patient, or to add to the patient's database as she works with the patient.

Teacher-created forms have the advantage of providing a format or framework for data collection that ensures that the student's preparation is comprehensive. However, it is difficult for the instructor to thoroughly evaluate each student's preparation in a timely manner in order to guide the student's use of the data or point to areas in which data are missing or incomplete.

A major problem with this approach to preparing for clinical is that the form does not direct the student to what is most relevant in the situation from either a patient care or a learning perspective. Rather, the student is faced with an overwhelming amount of data with no real notion of what matters and what doesn't. The data from the clinical situation initiate the quest for the related theoretical components, but there is no mechanism for reflection of this theory back into practice. The student dutifully records the patient's lab data and notes the normal range for these values but is not challenged to take the next step to compare the two and identify what might be going on to create abnormal lab findings or, more significantly, the consequences for patient care that might accompany this. While it is possible to include a list of focus questions that prompt the student to take this next step, such questions are unlikely to be specific to the situation.

**Daily Nursing Care Plans**

The student may be required to prepare a plan for the care of the assigned patient based on data drawn from the patient's chart, the existing nursing care plan, and other sources. Such plans are intended to guide the student's intellectual preparation for the clinical experience by encouraging review of relevant theoretical information and procedural guidelines. The student's "planning" takes place apart from the patient, and so does not incorporate much that is relevant to actually implementing the plan.

The format for the care plan usually follows the nursing process but includes a space in which the student is expected to provide rationales for planned activities. This approach attempts to connect theory to practice in
the student's preparation by requiring her to think through the reasons for various actions that she plans to take. As students search for appropriate rationales for planned actions, however, they tend to copy textbook explanations and rarely consider their applicability to the actual situation or how the theory might guide their interventions with the patient.

As with teacher-created data collection forms, daily nursing care plans are time-consuming to correct, and such correction usually takes place after the day's clinical experience is completed and the plan no longer is a relevant source of learning for the student.

**The “Verbal Connection”**

Emerson and Groth (1996) describe an alternative to teacher-made forms and daily nursing care plans that is intended to assist the student in analyzing and synthesizing clinical data rather than merely collecting and recording facts and associated theory. The student is encouraged to gather data using a format that works for her. Guidelines that identify what the student needs to know in the specific clinical setting assist the student in her preparation. These guidelines help to direct the student's attention to relevant areas of inquiry (e.g., demographics, diagnostic information, prior history, or concomitant health conditions) and a beginning synthesis of information (e.g., by asking questions about the interrelationships among laboratory trends and dietary and fluid status). The student is free to record as much or as little information as she chooses in preparing for the clinical assignment. This is intended to free the student from a focus on paperwork while stimulating a focus on mind work. The approach certainly frees the instructor from the need to review and correct students' written preparation for the clinical.

At the start of the clinical experience, the student and instructor discuss the student's plan of care; this is the “verbal connection.” At this time, the instructor is able to verify the adequacy of the student's preparation, the student is able to ask questions, and the instructor is able to guide the integration of complex information gleaned from the student's preparation.

Beginning students may need some guidance in developing a format for seeking and recording data, beyond the structure provided by the familiar nursing process. The concepts identified in the nursing program's conceptual framework are a useful device for ensuring that students consider the full array of nursing issues that are likely to emerge in providing care for the assigned patient.
Clinical Focus Guidelines

Clinical focus guidelines are another approach to both streamlining and focusing students’ preparation for clinical assignments (Blainey, 1991). The guidelines are developed for each clinical experience in the semester and are tied to course objectives. They state expected learning outcomes, the activities in which the student should engage (observations, assessments, interventions, written assignments) in order to achieve outcomes, as well as the criteria that will be used in evaluating learning at the end of the semester. Suggestions for how the student might evaluate her own progress toward learning outcomes also are contained in the guidelines. Students receive all of the guidelines for the semester at one time, so they’re able to capitalize on a full array of learning experiences in meeting objectives and completing assignments. The guidelines also assist in communicating with staff nurses who may be called upon to facilitate student learning.

Clinical focus guidelines appear to have the benefit of orienting the student to the content of clinical learning and providing the means to probe and work with that content on an appropriate level, because the guidelines evolve from course objectives. However, the guidelines may so tightly focus the student’s attention that she will seek the “fit” between the guidelines and the clinical material and miss much that is present in the clinical situation because it has not been explained in the written guidelines or is not a stated focus for learning. If the clinical instructor is aware of this drawback to the use of clinical focus guidelines and makes continual efforts to encourage students to look—and see—beyond the demands of the guidelines, this approach to preparing for clinical learning experiences can be very fruitful and certainly promotes a degree of independence and flexibility in learning.

Clinical Concept Mapping

Concept mapping is a “hierarchical graphic organizer” that illustrates students’ understanding of the relationships among concepts. In the clinical context, concept mapping demonstrates the linkages that exist between a patient’s health conditions, their clinical manifestations, the therapeutic interventions prescribed for each, and any interrelationships that might exist among these (for example, the contraindication of a drug used to treat one of the conditions when another of the conditions is present).
Baugh and Mellott (1998) describe the use of clinical concept mapping with advanced medical-surgical students, who can be presumed to have mastered many of the subconcepts to be dealt with in completing concept maps. Practice in constructing concept maps is provided in the classroom setting using case studies. Figure 6–1 illustrates the construction of a concept map for a patient with multisystem involvement. First, the student identifies the patient’s relevant conditions, with an emphasis on the presenting condition. (Medical terminology is used in this illustration, but nursing diagnoses can easily be substituted.) Then the student clusters the clinical manifestations related to each condition. She adds therapeutic interventions to the map. Finally, the student links the clusters of conditions, manifestations, and interventions as these interact, and explains any relationships among them. Although Figure 6–1 reflects complex interactions, simple maps of single concepts can be developed as a teaching-learning approach to linking theory and practice with beginning students.

Once they have become familiar with the process, students develop one concept map each week for their assigned patients. In order to construct the map, students must review the pertinent data from the patient’s chart as well as the relevant theoretical information to support proposed linkages. As the student interacts with the patient in the clinical area, the map is revised and updated. This process enables the student to reflect theoretical knowledge back into practice, and vice versa, as she deepens her personal understanding of the connections among the clinical elements that are pertinent for the patient for whom she is providing care.

King and Shell (2002) suggest that students focus on the reason the patient is seeking care as a beginning point in constructing a concept map. Assessment data, both objective and subjective, are related to the patient’s need for care, with the goal of enabling the student to synthesize relevant data for analysis. This becomes the source for planning and prioritizing interventions and the search for additional information. Wheeler and Collins (2003) maintain that the active processing of concepts promotes critical thinking by moving the student away from the linear model used in the nursing process toward the recognition of, search for, and synthesis of more complex interrelationships among conceptual elements.

One advantage of clinical concept mapping is that it provides a very accessible means through which the instructor can evaluate student preparation and detect any gaps in her knowledge base or logical flaws in her
Chapter 6: Organizing and Managing Instruction in the Clinical Practice Setting

Figure 6-1  Clinical Concept Map Development
reasoning concerning clinical connections. Another advantage of clinical concept mapping is that, while focused on a single concept chosen by the student, the map will inevitably encompass more holistic concerns, given the interacting nature of physiological (as well as psychological) processes, their manifestations, and their treatment.

The Clinical Preconference

The tradition of preconferences and postconferences as a component of clinical learning experiences persists despite little documentation as to their effectiveness (Packer, 1994). The preconference is intended to prepare both students and instructor for the clinical experience by providing anticipatory guidance for the day. Students are oriented to the objectives or focus for clinical activities, as well as any noteworthy situations or events of which they should be aware. The instructor may use the preconference to check on each student’s preparation, and to articulate the building nature of successive clinical experiences and the progress that the student group is making.

Each instructor must determine for herself the utility of the preconference in the setting in which she is teaching. Some instructors find that having students attend the change-of-shift report serves as a worthwhile substitute for the preconference. In addition to providing information...
about the status of the patients for whom students will be providing care, the shift report introduces students to the communications strategies used by nurses to relate complex information clearly and succinctly to one another. Students begin to develop sensitivity to what needs to be communicated to ensure continuity of care (Yurkovich & Smyer, 1998). However, the format and timing of the shift report, or physical limitations of the setting, may make student participation impossible. Many instructors elect to attend report prior to students’ arrival on the unit and then use the preconference time to deliver a modified shift report on students’ patients. Others attempt to preserve the positive professional socialization inherent in nurse-to-nurse reporting by having students receive report on their patients from the nurse who will be responsible for the patient that day. Regardless of the approach used, students will need to have the most up-to-date information on their assigned patient(s) prior to beginning care activities, and the instructor must build the means to gain this into her plans.

Many instructors find preconference quizzing of students on their preparation to be tedious and time-consuming, because the group usually “tunes out” while their classmate is on the firing line. The anticipation of being grilled by the instructor (and possibly embarrassed in front of peers) probably magnifies the normal anxiety students bring to the clinical setting. An alternative approach to verifying that each student is adequately prepared for the clinical day is to conduct a form of rounds, visiting each student–patient pair and discussing with the student her plans for the day. Spot checks on essential information (“Are you aware that Mr. D’s antibiotic was discontinued? Do you know why?”) and the student’s familiarity with procedures that must be performed in conjunction with providing care (“When do you plan to check Mrs. P’s blood sugar? Do you know where the equipment is?”) provide a sense of the student’s level of preparation, and also give the student a chance to ask questions about aspects of care to be provided. The instructor also can use this opportunity to remind a student to call for the instructor when she is ready to perform a new skill that the instructor wishes to observe.

The instructor may find preconferences useful at the beginning of a clinical experience and with inexperienced students, and then may discontinue their use as the semester progresses. As long as there is a mechanism for verifying student preparation for the experience and awareness of the goals for learning, it is unimportant what format or approach is used in getting students off to a good start in the clinical setting.
Guiding Student Learning in the Clinical Setting

The clinical setting presents students with experiential, practical learning opportunities that involve different processes than the depository–repository approach (so named because the instructor “deposits” knowledge in the students’ brains, where it “reposes” until accessed by the student) common to classroom teaching and learning.

First, the clinical setting demands interaction with content. Diekelmann’s (1993) study of the lived experiences of baccalaureate nursing students and their teachers uncovered a pattern that she labeled “learning-as-cognitive-gain.” This pattern, which emerged in the analysis of stories respondents told about a situation that captured for them what it means to be a student or teacher in nursing, contained two themes: “applying content as thinking” and “content as neutral, unproblematic, and consensual.” Diekelmann comments,

> The danger in the view of ‘learning-as-cognitive-gain’ is that what matters, which is thinking in particular situations, becomes lost as students are schooled to enter practice with a correspondence view of applying content (rules) to practice. (p. 247)

The content of the clinical setting is more subtle, and more embedded within the complexity of the patient’s situation, than that presented in the classroom. Unless the student interacts with this content, she will have no means of developing a working knowledge of the rules she has learned in the classroom.

Second, the clinical setting is dynamic, with much of the content out of the direct control of the instructor. Clinical content is not organized in sequential packages that match the classroom syllabus, nor can the classroom syllabus be rearranged to adapt to the clinical reality. Like a map, classroom content will have given the student a general sense of the terrain to be traveled in the clinical area, but the student is still apt to get lost in the woods and have to work her way around fallen trees.

Third, the clinical setting invites independence in learning. Because the instructor cannot be everywhere, students are challenged to step into the unknown, assess their need for assistance, and seek assistance when it is needed. To accomplish this, they need broad guidelines for determining when they need help and in identifying whom to turn to if the instructor is
The instructor also is challenged: to accurately assess each student’s readiness to function independently; to accurately forecast her own expectations regarding both student performance and patient responses, so as to anticipate the need for her timely presence or intervention; to adapt to rapidly changing circumstances with respect to student learning needs and patient responses; and to learn to let go.

Finally, while the clinical setting does not preclude reflection on learning, it doesn’t invite this without the instructor’s assistance. Students who are truly engaged in clinical learning tend to disengage (at least temporarily) from thinking about learning. While the student may mull over a point made during a lecture, or reread a passage in her textbook, similar reflections on the meanings embedded in the practice situation with which she is engaged are not automatic. Rather, the instructor must devise approaches that encourage reflection on practice, both during and after the clinical experience.

Teaching–Learning Principles Underlying Instruction

Several general principles are central to effective instruction in any setting. These concern students’ readiness to learn, variety in instructional content and technique, repetition of content and experiences, promotion of transfer of learning to new situations, and making learning meaningful.

Readiness to Learn. While readiness to learn involves being motivated to learn as well as demonstrating prior mastery of the necessary knowledge and skills upon which clinical objectives are predicated, it also involves being “fully present” in the clinical setting, focused on achieving the goals for learning and for patient care. Ideally, students’ attention should not be diverted by concerns about an upcoming examination, family issues, or social affairs while they are in the clinical setting. Yet the reality is that everyone comes to work, educational, and other activities burdened with personal concerns that tend to divert attention from the task at hand. To deal with this reality, the instructor must be prepared to create an “anticipatory set” that invites students to become interested in the content and eager to participate in mastering it (Rowles & Brigham, 1998, p. 253).

Preconferences, preliminary nursing rounds, and listening to reports are commonly used approaches to bringing students’ attention into focus as they begin the clinical experience. Regardless of the approach used, the instructor must establish an anticipatory set by clearly identifying the
goals and objectives for the day’s activities; bringing into the students’ awareness the prior knowledge they have that will be needed to achieve the objectives; and identifying the specific content areas that will be the focus of the assignment. In identifying goals and objectives for the clinical day, the instructor should not ignore the students’ own goals for the experience. The tendency to focus on the assigned patients’ needs, while appropriate, should be balanced with equal attention to what the student hopes to gain from the experience. This helps to further engage the student in the assignment and the possibilities for learning that it presents. Another aspect of identifying goals involves sharing with students the instructor’s rationale in making specific assignments. By revealing what she has identified as the “content” inherent in the assignment, and the related learning opportunities to be realized in engaging in the assignment, the instructor makes explicit aspects of the assignment that may have eluded the student.

During the clinical experience, the instructor needs to remain aware of the periodic need to reengage students in learning. Wagner and Ash (1998) describe approaches to create “the teachable moment,” when the student will be “receptive to new understandings” (p. 278). As the clinical experience proceeds, the instructor seeks opportunities to interact with the student around the student’s immediate concerns or a readily recognizable situation that is clearly important to the student. Student concerns are elicited through open-ended questions (“How is the day going for you?”), sharing of observations (“You seemed to be perplexed when Mr. G. asked about his prognosis”), an invitation to share a professional concern (“Has Mrs. L’s early discharge raised any concerns for you?”), recognizing a student accomplishment (“Baby G seemed less fussy during his feeding today; how did you manage that?”), or when the student discloses a concern. In her dialogue with the student, the instructor structures her teaching to focus first on any expressed student concern. Realizing that her issues have been recognized and validated by the instructor captures the attention of the student and creates the “teachable moment” that signals readiness to learn.

**Variety.** Students (and instructors) easily can become bored with learning experiences that become predictable in their pattern. By introducing a change of pace occasionally, the instructor reengages students in the learning. For example, planned rotations off the assigned unit, to participate in alternative experiences (e.g., a rotation through a step-down unit
for students in an acute care setting), observational experiences (as of a surgical intervention or invasive diagnostic test or the opportunity to shadow a nurse manager or clinical specialist), and attending a conference can provide variety that broadens the students’ perspective on a clinical specialty. Alternative instructional approaches, such as the use of gaming, case studies, nursing rounds, or other ways of interacting with content, can lend the variety that stimulates learning.

Variety in the ways in which concepts are explained or procedures taught also is necessary to promote learning. A change in the vocabulary of instruction may be the single element that enables a student to grasp a concept. Drawing a picture rather than persisting in a verbal explanation may do the trick. Offering students alternative approaches to performing procedures, while maintaining a focus on the critical elements that remain the same, may enable the seemingly inept student to master a technique. While students become skilled at manipulating content to satisfy their own styles of learning, the ability of the instructor to offer alternative presentations of concepts increases the chances that learning will occur.

For many instructors, variety in clinical teaching means ensuring that students are exposed to patients of different ages, ethnic and social backgrounds, as well as to multiple disease processes. Students should have experiences involving the major health problems encountered in each specialty area, as well as the opportunity to work with diverse patient populations. However, variety involves more than attention to the patient and diagnosis variables. Because skilled nursing knowledge only can be developed through multiple exposures to multiple instances of a concept, students also need to experience variety in clinical assignments that appear to be redundant. While closely related to the principle of repetition, this application of the principle of variety seeks to broaden the student’s perspective on a phenomenon through the planning of clinical assignments to include elements that have been encountered by the student before, but in a somewhat different context, so the student can begin to appreciate the differences in patients’ responses to similar health conditions and treatments. The instructor may need to point this out to the student. For example, the student’s attention might be drawn to the factors that may be contributing to different recuperative trajectories for two patients with similar diagnoses.

**Repetition.** Few people are able to master concepts without revisiting them several times and in different contexts. In order for a student to “own”
content, she must be able to revisit it frequently, testing out her understanding. While it is easy to interpret a student’s repetitious questions as mental laziness, it is unrealistic to expect that each student will retain every scrap of content and word of wisdom the instructor has imparted. Anticipating that students will repeat their questions is less frustrating for the instructor, who might use the occasion to rephrase the answer or provide additional information. Of course, at times a student’s repeated queries covering the same issues does represent mental laziness, requiring a response that both invites and facilitates the student’s recall of the information. Students need encouragement to trust their memories and their brains rather than continually rely on the instructor’s input when they are puzzled. Providing prompts, such as, “Do you remember what you did with Mrs. O last week?”, helps the student to recognize that she has encountered—and solved—this issue before and has the requisite knowledge to do so again.

Multiple exposures to situations involving the same concepts are an example of using repetition to both reinforce and enhance learning. Recognition of the commonalities and the differences among patients with the same condition is an essential element of developing clinical judgment and expertise.

Students also need repeated opportunities to perform technical skills. As with the development of proficiency in athletic or artistic endeavors, repetition of skills gives the student the body sense that helps to reinforce performance. With each successive performance, the skill is accomplished with greater fluidity and ease, moving the student to a higher level of psychomotor learning.

Transfer of Learning. Despite faculty’s careful efforts to create a progressive learning experience that builds upon previously acquired knowledge, students tend to approach each new clinical situation as a unique and isolated event. They have difficulty in recognizing the cues that signal the need to apply information or skills mastered in previous courses or during earlier clinical experiences. This may be because they are unable to distinguish those aspects of a presenting situation that are truly novel, and those that resemble or replicate conditions that have been encountered before. Or, the student may be unable to isolate the aspects of the situation that signal the need for specific information from the student’s repository of knowledge.

The instructor can facilitate the transfer of learning in the clinical setting by guiding the student to the appropriate area of knowledge that must be
accessed in order to understand the situation, and then allowing her to identify and apply the specific information that is needed. For example, many clinical situations require the application of concepts learned in basic anatomy and physiology classes. By asking the student what she knows about the normal function of the system involved in the presenting situation, the instructor stimulates consideration of the applicable anatomy and physiology related to the case, setting the student on the appropriate path to begin to access and use what she knows to understand the situation. Asking a progressive series of questions—while perhaps tedious to the instructor—enables the student to begin building a model for accessing and using her store of knowledge.

“And what happens when function is interrupted?”
“How might function have been interrupted in this case?”
“How will that affect other organs or systems?”
“How might that be manifested in the patient’s signs and symptoms?”

This is a process of verbal content mapping, which might be made explicit in written assignments completed by students. Similarly, students may need prompts to recognize commonalities among clinical cases.

It is least helpful to students for the instructor to say, “Look it up!” when they have questions while in the midst of a clinical experience. Students who have prepared adequately for clinical already have reviewed those areas of information they believe will be needed to address the clinical problems they have identified in their assignments. If they have failed in this preparation, it is because they were unable to identify what they needed to know. Being told to look it up during the clinical experience does not help them to locate the information they need. If the clinical problem has arisen unexpectedly, the student will need guidance in thinking through the situation rather than running away from the bedside to read the textbook explanation, which she will have difficulty in applying anyway. It is more helpful to assist the student in reasoning through the problem in the present and then suggesting further review after she leaves the clinical setting so that she can acquire a better understanding of the phenomenon she has observed, as a means to link theory with practice. The student who is truly unprepared for the clinical should be sent to the library to fully prepare for the clinical assignment.

Transfer of knowledge also can be facilitated by assisting students’ understanding of a concept as one example of a broader class of concepts to
which knowledge can be generalized. Consider, for example, the clinical
management of tubes. By their nature, tubes are susceptible to problems
with patency, regardless of whether the tube is an intravenous device, a
suction catheter, urinary drainage apparatus, a nasogastric tube, or a tra-
cheotomy tube. While the management of a clogged tube will vary with its
type and placement, the potential for a patency problem to develop is
common to all of them, and this knowledge can be transferred to broaden
the student's understanding of management problems concerning a large
variety of similar devices.

Making Learning Meaningful. Learning becomes meaningful when stu-
dents feel they are making progress toward achieving goals. Those goals
include the planned outcomes of the learning experience as well as stu-
dents' personal goals for the clinical experience. Student goals are related
to what they hope to accomplish for the patient or patients for whom they
are assigned to provide care as well as what they hope to accomplish in
terms of their own learning. Both are legitimate. While research findings
and the nursing education literature suggest the potential expectations
and goals that students have for clinical learning experiences, it is impera-
tive for the instructor to validate those goals with each student. A review of
each student's goals enables the instructor to identify the student whose
expectations for her own performance are either too high or too low, and
then contribute to revising those expectations. Such a review also helps
the instructor to shape the learning experience to assist students in meet-
ing their personal goals. The instructor's reference to students' personal
goals—and their progress in achieving them—makes meaningful the
learning that is occurring in the clinical setting.

Knowledge of the students' goals for the clinical learning experience can
inform the instructor's selection of specific assignments, as well as her
communications with students concerning the rationale for assignments.
For example, the instructor can remind a student that she had expressed
an interest in working with a patient with a specific health concern, and that
the day's assignment has been made to provide for that opportunity. This
validates the legitimacy of the student's goal, the concern the instructor
has that the student have the opportunity to achieve that goal, and also di-
 rects the student's attention to the primary content of the assignment. In-
teractions with students during the clinical day also can be structured
around goals, by asking whether the student feels she is making progress
in achieving a specific goal for the patient or for her own learning. The
sense of movement toward goal achievement makes the continued engagement with the content of clinical learning inherently meaningful and exciting for students.

**Modeling the Professional Nursing Role**

Because clinical learning is experiential in nature, students search for patterns of performance that exemplify the professional nursing role to which they aspire. Once these models are identified, the student attempts to emulate them as she engages in her clinical assignment.

Citing several authors, Wiseman (1994) asserts, "In nursing education, the faculty member serves as the primary role-model initiating the student into the profession" (p. 405). Is this assertion true? If it is, what are the consequences for instructor behavior, in particular, the balancing of the multiple facets of the instructional role? If the instructor must focus on patient care in order to adequately role-model nurse behaviors, does she do this at the expense of the instructional, supervisory, and evaluative components of her role? If it is not the instructor who serves as the primary role model for students, who does? And how can the instructor guide students' selection of role models?

In reality, students draw from a broad variety of persons in their efforts to identify appropriate role models. If the instructor is an active participant in nursing care, working with students (what Kiger [1993] calls “mucking in”) rather than standing at the sidelines observing (from the students' perspective, evaluating), she will be among the role models selected by students. Staff who appear to be knowledgeable and effective in providing care, regardless of their status, are equally likely to be selected as role models. The instructor can guide the selection of role models by pointing out to students those among the staff who most consistently demonstrate expertise and professionalism, and suggesting that these nurses be observed and emulated.

In her study of role model behaviors, Wiseman found a high degree of agreement among junior and senior baccalaureate nursing students as to the importance of various role model behaviors, but a perceived inconsistency as to the degree to which students were rewarded for emulating these behaviors. This suggests that instructors must carefully consider what professional behaviors are important, how these behaviors can be demonstrated to students, and then consistently provide positive feedback when
students in the clinical setting evidence the behaviors. In developing a picture of the “ideal” professional role model, the instructor should consider how such important behaviors as caring, advocacy, leadership, and collaboration might be modeled in interactions with students, patients and their families, staff, and physicians. She also should consider how best to articulate the reasoning behind the behaviors that students observe and seek to emulate. For example, students observe the results of the nurse’s thought process but cannot be privy to that intellectual work unless the nurse reveals her process of thinking as well as her conclusions. Similarly, values that are demonstrated in action may need to be made explicit for students in terms of the analytical process of dealing with value conflicts, reaching decisions that result in value choices, and then determining how best to act in accord with those choices.

The role model behaviors identified in Wiseman’s study (p. 407) can be organized into four clusters: technical know-how, interpersonal effectiveness, critical thinking, and professional role behaviors (see Table 6–1). Many of these behaviors (those related to interpersonal interactions with students) can be readily incorporated into the instructional role; others can be demonstrated while assisting students with care activities (demonstrating the ability to care for patients’ needs). Other behaviors might be better modeled by staff (those related to demonstrating nursing care procedures and the use of equipment), who are able to communicate “tricks of the trade” developed in their daily practice. Negative role modeling is also an important source of learning for students. The instructor should not hesitate to point out such negative examples and explain why they fail to conform to the expected behaviors of the professional nurse.

Managing Off-Unit Experiences

Assignments away from the clinical unit are commonly used to augment the student’s perspective on the clinical specialty that is the focus of learning. For example, students whose regular clinical assignment is on a surgical unit may experience rotations through the one-day surgical unit, the operating room, and the recovery room; some may also have an experience in a clinic setting, where preoperative instruction is given and postoperative recovery is assessed. These off-unit experiences help the student to integrate the various components of the surgical cycle (or
Table 6–1 ROLE MODEL BEHAVIORS IN THE CLINICAL SETTING

Technical Know-How
- Demonstrates the use of equipment unique to the clinical setting.
- Demonstrates nursing care procedures.
- Demonstrates up-to-date nursing practices.
- Demonstrates ability to care for patients’ needs.
- “Pitches in” when needed to assist students.

Interpersonal Effectiveness
- Uses therapeutic communication skills with each patient.
- Interacts with physicians in a confident manner.
- Displays a sense of humor in appropriate context.
- Demonstrates a caring attitude toward patients.
- Demonstrates a caring attitude toward students.
- Appears to have respect of the agency personnel.
- Provides a positive atmosphere for students to learn.
- Listens to students’ point of view.
- Gives positive feedback.
- Gives negative feedback in a constructive manner.

Critical Thinking
- Listens to change of shift reports.
- Asks questions regarding patient’s condition.
- Demonstrates problem-solving ability in the clinical setting.

Professional Role Behaviors
- Reports clinical data to staff personnel in a timely fashion.
- Identifies self to patients when first meeting them.
- Is neat and clean in personal appearance.
- Keeps confidential information to self.
- Is organized in the clinical setting.
- Is flexible when the situation requires different approach.
- Respects the patients’ integrity.
- Encourages discussion of ethical dilemmas.
- Demonstrates accountability for own actions.
- Demonstrates an enthusiastic attitude toward nursing.

whatever specialty is being addressed) in a way that makes the direct care she is providing for patients in the immediate postoperative phase more meaningful. Further, her own observations of patients during various phases of that cycle enable her to communicate confidently with hospitalized patients concerning their experiences and anticipated recovery trajectories.

Off-unit experiences may be tightly linked to the primary clinical setting, as with the example of observations of various aspects of the surgical cycle, or they may involve more “offbeat” experiences. Students have few, if any, experiences with “normal” people, other than their peer-partners in a physical examination lab. Consequently, they have not developed skilled observation of normal function in a variety of people. A trip to the mall or other place of activity can help students to tune in to “normal” patterns of gait, respiration, and so forth as a basis for the often difficult to discern subtle signs of decompensation that they eventually will witness in their patients.

By their very nature, off-unit experiences are largely outside the control of the clinical instructor, who must find ways to make these learning experiences meaningful for the students who are involved in them, enabling them to integrate what has been learned with their learning experiences on the unit. Specific objectives that are closely tied to the course or clinical objectives should be developed for all off-unit experiences. Guidelines and assignments should provide a mechanism for students to demonstrate their achievement of these objectives and link the learning that occurs during the off-unit experience with classroom theory and the care being provided in the associated clinical setting. (Sample guidelines for off-unit experiences are shown in Appendix G.)

Guidelines for the off-unit experience should indicate where and when the student should report and who will be her contact and guide. Students should be briefed about what they can expect to observe during the experience, and what their role is likely to be. For example, most nursing programs have students scrub and garb for an observational experience in the operating suite, but do not involve them in direct care activities. In the recovery room, where the focus is on monitoring the patient’s emergence from anesthesia, and the potential rapidly changing situation this presents, the student may be recruited to participate in taking vital signs, checking mental status, and monitoring wound drainage. In a clinic setting, the student may be responsible for conducting an intake interview and
providing preoperative instruction for a patient who will be undergoing a procedure with which the student is familiar.

When the experience is entirely observational, students will need guidelines that direct them to specific phenomena to be noted during the experience. For example, an experience involving the observation of preschool children should direct the student to identify pertinent aspects of growth and development and evaluate whether the children being observed are within or outside the guidelines for their age group. Asking students to provide examples to support their conclusions helps the instructor to verify whether learning actually has occurred. When the experience involves participant observation, which might also occur if students were sent to a preschool to observe and interact with well children, similar guidelines would be needed, as well as encouragement to become involved with preschool activities rather than simply stand to the side and observe. This might be encouraged by requiring students to select one of the children for a focused interaction, with a report to include how the interaction proceeded and what conclusions about the socialization skills of the preschooler might be drawn from the experience.

Provision must be made for the student to report on her experiences in off-unit activities. Such a report may be in writing, as in completing an observational guide that asks the student pertinent questions that relate observed activities to events in the primary clinical setting, or it may be an oral presentation made to other members of the clinical group. While either the written or oral report format enables the instructor to verify the student’s participation in the planned activity and her achievement of established objectives, oral reports become a common pool of information that can be used by the group as they proceed with patient care activities on the primary clinical unit. Such reports also have the potential to enhance the off-unit experiences of students who have not yet had them.

The instructor should make every effort to refer frequently to off-unit experiences when they relate to events in the clinical setting. A discussion of these experiences “fills in the gaps” in the picture presented by patients in the clinical setting, even for those students in the group who have not yet participated in the off-unit activity. The continuous reference to these experiences as sources of information applicable to the immediate clinical situation encourages students to maximize their participation in these experiences and to value the knowledge that can be acquired through simple observations and interactions that do not necessarily involve the delivery of hands-on nursing care.
Taking Advantage of Serendipitous Opportunities

In the classic article titled, “Serendipity and Objectivity,” Styles (1975) bemoans nursing’s focus on behavioral objectives as a means of structuring and guiding learning experiences. Styles believes that this focus has limited the use of learning experiences that arise in the clinical setting but cannot be linked to one of the objectives established for the course. As is true of neophyte nurses, it is easy for neophyte instructors to become so focused on ensuring that students are provided with opportunities to achieve course objectives that they miss some of the richest opportunities for teaching and learning that exist in the clinical practice setting. When unusual, one-of-a-kind experiences become available, the instructor should feel free to take advantage of them. By the same token, when a clinical situation occurs that provides an excellent opportunity for teaching some concept, demonstrating some technique, or discussing some ethical issue, this opportunity should be seized without concern about how it “fits” with the day’s clinical objectives or even the overall course objectives. The clinical instructor also should remain alert to those events that provide insight into and opportunities to learn more about aspects of the role of the nurse within the organizational context of health care, such as interprofessional interactions, resource management, advocacy, and the like. If the situation is pertinent to nursing practice, it will serve the purpose of fostering learning in the clinical setting.

One approach to taking advantage of serendipitous opportunities is to consider the universalities that are present in every clinical situation, which usually can be drawn from a clear understanding of the program’s conceptual framework, and, hence, its conceptual elements, and how these are represented in learning objectives. These universalities are generally threaded through the curriculum and usually address such topics as therapeutic communication, growth and development, loss and grieving, autonomy, patient dignity, comfort, and the like. These overarching concepts help the instructor to draw upon the potential in any clinical situation.

The Clinical Postconference

Like the preconference, the clinical postconference is a traditional approach to the synthesis of clinical learning that has not been subjected to
empirical testing of its effectiveness in enhancing student learning. The postconference has become an integral component of the clinical experience that is intended to accomplish numerous worthy outcomes such as

1. providing a time for both students and instructor to pause and reflect on the day’s events, their meaning, and the relation between what has been observed and experienced and what was taught in the classroom or discussed in assigned readings;
2. contributing to the achievement of course and clinical objectives by making explicit the connections between clinical activities and the goals for learning;
3. examining commonalities and differences in patient responses to illness and its treatment within the clinical specialty;
4. permitting students to vicariously share in their peers’ experiences, broadening their exposure to the clinical situations they might encounter in practice;
5. promoting affective learning through debriefing that allows students to express feelings and attitudes about the experiences they encountered during the day’s activities; and
6. providing students with experience in the effective use of the group process.

Several problems typically encountered in conducting postconferences can limit the usefulness of this teaching–learning strategy in enabling students to achieve these goals. Problems arise when the instructor dominates the conference, limiting (or eliminating) student contributions to the discussion. This can occur when the instructor uses the conference as an occasion for the evaluation of student learning rather than an opportunity to promote learning. Alternatively, the instructor may elect to use conference time to teach content that was not covered in the classroom. While such instruction occasionally is necessary, as when the clinical situation has not been dealt with in class but presents an excellent opportunity for connecting theory and practice, presentation of didactic content should be kept to a minimum and tightly connected to clinical events. When the conference involves sequential individual presentations rather than group involvement in a discussion, students often “tune out” until it is their turn to present. This is especially true if students are not encouraged to ask questions of their peers, or to offer suggestions for alternative approaches to the clinical issues being discussed. When content and questions remain at lower cognitive levels, conferences can become trivial or boring. While it
takes effort and planning to move questioning to a level that stimulates students’ higher cognitive functions, this is essential to an effective post-conference session (Wink, 1993). Finally, low energy levels of both students and instructor after a day of nonstop activity are likely to affect student participation in the conference. This challenges the instructor to identify novel and stimulating approaches to introducing conference topics and keep the discussion lively.

Letizia’s (1998) descriptive study of the strategies used in clinical post-conferences revealed that most such conferences last for 50–60 minutes, and most involve a discussion of clinical experiences or a presentation by students of case studies involving the clinical assignment. Other approaches used included role play, quizzes, tours of other units, nursing rounds, and guest speakers. Ethical issues arising in practice was a frequent source of content for conferences, as was the coverage of theoretical content.

In planning the clinical postconference, the instructor must identify a focus for discussion and an approach to stimulating students’ active participation in the discussion. The focus of discussion might be a significant event that occurred during the clinical day, the clinical objective or focus that had been identified for the session, or commonalities encountered by several students during the experience. The selected content must be converted to one or more questions that the instructor can pose to the group or to identified students to get the discussion going. The questions must be open-ended and nonthreatening, requesting the student to share an observation or an experience with the group. The instructor must prepare for the ensuing discussion by knowing where she wants it to go—what she hopes students will learn through the discussion. Usually the goal of the discussion is the synthesis of learning and the evaluation of events and interventions during the clinical experience. Therefore, the instructor must identify just what theory strands are connected to the practice situation that will be the focus of discussion, and how these strands can be interwoven with the practice reality to promote learning.

In addition to planning the discussion, the instructor must create a climate that stimulates both questioning and thinking. Stokes (1998) lists the following actions instructors can take to facilitate conferences:

- support the sharing of information;
- keep the discussion focused and moving in a meaningful way while remaining flexible and open to alternative paths for learning;
- encourage active involvement of each student by raising questions, proposing ideas, providing cues, and offering leading statements;
provide nonthreatening feedback;
• assist students to identify relationships, patterns, and trends that span their individual experiences; and
• facilitate the group process by encouraging the participation of each member of the group.

Ideally, the clinical postconference can become a means of shifting much of the control of the learning experience to the students. Wagner and Ash (1998) note that when discussions are based in the clinical experiences of the students, as is the usual approach in postconferences, the discussion becomes rich in possibilities. To accomplish this, the conference cannot be allowed to revert to a classroom session. Second, postconference discussions provide opportunities to affirm students’ growth as evolving practitioners of nursing. Finally, the postconference engages students with the instructor as partners in learning, as they use their personal knowledge to inform the situation as well as their own learning (p. 280).

Summary

The instructor’s organization and management of instruction in the clinical practice setting brings the student into meaningful interaction with the richness of clinical learning opportunities. Through these activities, the instructor orchestrates an experience in which students’ activities become the source of their learning and where the goals of both the students and the instructor for the experience can be realized. A well-designed clinical experience frees the instructor to be selective in her work with those students who need individual attention and instruction. It also frees the students to learn.

References


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