The Main Elements of Clinical Learning in Healthcare Education

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2.1 Changing Healthcare Services Also Make Demands on the Education System

Healthcare services are currently undergoing important changes. The ways in which services are delivered has changed; the role of traditional care institutions has declined and that of multiform non-institutional care systems have increased. This can clearly be seen, for example, in elderly care. Healthcare workers increasingly meet clients and patients in their homes. From the viewpoint of professional skills, this means that healthcare workers must be capable of more independent decision-making than, for example, is necessary in a traditional hospital environment, where collegial help is easily obtained. These changes impose new requirements on health-care education; it must produce skilled persons able to act as professional experts—whether as a team member or as a self-reliant worker. There is also a need for continually updating one's professional knowledge; a healthcare worker must be capable for searching for new research-based knowledge and applying it with patients. The lifetime of knowledge can be short in healthcare and working in the field requires a positive attitude to lifelong learning.

Another notable trend in healthcare is rapid increase in information and communication technology (ICT), also known as health informatics. This is especially evident in the documentation of the care process and monitoring of patients' health status. Competence in these areas requires a good general ICT capability. Core competencies comprise the skills, knowledge, attitudes and capabilities necessary to effectively manage electronic patient records and to operationalise other ICT applications needed by healthcare workers in their specific professional field. However, the healthcare service remains a labour-intensive sector—despite the rapid uptake of technological

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M. Saarikoski, C. Strandell-Laine (eds.), *The CLES-Scale: An Evaluation Tool for Healthcare Education,* https://doi.org/10.1007/978-3-319-63649-8_2

innovations. Human resources will always play a central role in healthcare services. It is hard to imagine a robot completely substituting for a home-care worker in elderly care. Some digital distance services (for example, communication and monitoring tools) are valuable but a concrete response to a concrete need—e.g. an elderly person who has fallen at home—requires human services and will continue to do so in the future. Technical tools can make a useful contribution to the healthcare process but do not substitute for a context-sensitive evaluation of a living human being.

2.2 The Clinical Practicum in Healthcare Education

The clinical practicum is an important component of healthcare education programmes. Nowadays, practical training—including skill labs at school and clinical practicums—forms 40–50% of European programmes. The range of 10% in this proportion can be regarded as significant and is explained by historical differences in the development of different countries' education systems. At the beginning of the twentieth century, healthcare education was mainly based on the apprenticeship model and carried out in healthcare organisations, mainly hospitals. Since then, healthcare education has, at different times, regardless of whether the system had its origins in hospital schools or other sites, moved from the service sector to vocational colleges, polytechnics and universities. The term hospital school refers to a school which was a part of a healthcare organisation, albeit often administered by the Ministry of Health (Meerabeau 2001; Lewin 2007). In the Nordic countries, the hospital school system ended in the 1960s whereas in many southern European countries it only ended in the 2000s. If the interval from the hospital school system is short, the education system tends to be more practice orientated, and if the interval is long, the education system tends to be more academic and theory driven. In Greece, Italy and Spain the ratio of the clinical practicum to academic study is approximately 50% whereas in, e.g., Finland it is clearly under 40% (Warne et al. 2010).

Tertiary-level degree programmes in healthcare education are nowadays most often provided in university colleges or in polytechnics. These educational organisations form the HEI system in Europe (Spitzer and Perrenoud 2006; Warne et al. 2010). Clinical practicums have been arranged in social and healthcare service units such as hospitals, homes for the elderly, rehabilitation institutions, outpatient clinics and community nursing teams, which also offer services in clients' homes. The HEIs have total responsibility for the clinical practicum but the supervision and mentoring of students are mainly implemented through clinical placements. This cooperation between the HEIs and service organisations is based on contracts which lay down the requirements set mutually for the quality of clinical learning environments. The person heading cooperation in the HEI is the nurse teacher (NT), who is a responsible stakeholder and clinical teacher. The basic idea is that the clinical practicum supports students' theoretical studies and offers opportunities to apply their theoretical knowledge in practical situations with real-life clients. Working in healthcare services is always team work, and hence the second main objective of the clinical practicum is to provide students with the experience of being a member of a healthcare team.

2.3 Factors of the Clinical Learning Environment (CLE)

The picture of the clinical learning environment and its structures revealed by empirical studies is far from straightforward. Rather, the learning environment is a complex and multidimensional network of social relationships involving a number of crucial elements (Hooven 2014). These elements include psychosocial structures and relations between the personnel in the workplace, the prevailing management culture in the community and the nature of care in the unit. The quality of the cooperative relations between the HEI and healthcare service organisation also affects the quality of the CLE (Saarikoski 2002). These elements can either contribute to the student's professional development or, in an unfavourable situation, add to the risk that the student will drop out and even give up the idea of working in healthcare altogether.

2.3.1 Psychosocial Climate of Work Community

The psychosocial climate of healthcare units is affected by the same group dynamic and psychological laws as any other work community. The working team should be aware of their basic purpose. If the team spirit is free of obstructive and disrupting tensions, the group can devote its energy to implementing its fundamental role. A committed and enthusiastic team also transmits its spirit and motivation to students. A learning experience in a workplace of this kind is an instructive one. In the contrary situation, a student's energy is spent maintaining his or her own psychosocial safety. Research (Pinto et al. 2010; Järvinen 2013) has shown that these elements are dependent on how the team is managed; hence the role of the team leader (known as the ward manager in healthcare units) is crucial in creating a good climate in the unit. In the classic British nurse education research (Orton 1983; Ogier and Barnett 1986), the ward manager (WM) was viewed as the student's most important supervisor. Nowadays, the role of the WM in supervising students is indirect and he or she contributes to the learning environment mainly via management of the unit's climate and its staff's supervisory activities (Fig. 2.1).

There are notable differences between the units in how they perceive their educational profile. British studies carried out in the 1980s (Fretwell 1983; Orton 1983) found two ward types in teaching hospital: highly student-orientated (HSO) wards and low student-orientated (LSO) wards. The difference was explained by the role of WM, who was both the leader of the unit and the supervisor of its students. It is important to note that these studies were carried out in the United Kingdom, where the WM and the student were in a clear hierarchical superior–subordinate relationship. These HSO and LSO terms are still usable in descriptions of typical teaching units.

Nowadays, HSO units have a non-hierarchical structure characterised by teamwork and good communication relations. For example, trained staff encourage students to take part in discussions, e.g. in ward meetings. The leadership style of the WM is democratic; he or she is student orientated and works consciously towards improving the

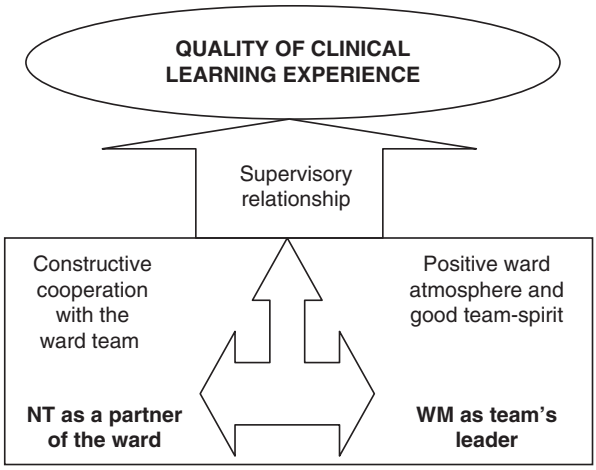

Fig. 2.1 Factors making for a 'good' clinical learning environment

unit's pedagogical atmosphere. In HSO units, the students are primarily learners, not workers. The more informal and open the students experience the unit's climate, the more positively they evaluate the pedagogical principles of the unit (Saarikoski 2002).

2.3.2 Quality of Care and Students' Learning Experiences

High-quality patient care is the most important criterion for meaningful learning experiences. When a student can experience the whole treatment process of a patient, he or she gets more comprehensive picture of the patient's health situation. If the student only sporadically takes part in single phases of the process, the picture remains fragmented (Warne et al. 2010). Holistic planning of care and clear documentation also promote students' comprehensive understanding of the treatment process and provide pedagogically appropriate learning experiences. Thus, the aims of providing high-quality care and a good practical learning experience support each other (Smith 1987; Saarikoski and Leino-Kilpi 1999; Suikkala 2007).

Clinical practicum provides a good vehicle for training students in providing patients with psycho-emotional support. Contacts with patients help students to find professional ways of encountering patients and their unique life situations. Such learning situations in turn promote the integration of conceptual knowledge and empirical experience. In nursing science, learning experiences during clinical situations have increasingly been studied within the framework of caring theories. The concept *caring* includes not only physical care and treatment but also response to patients' psycho-emotional needs. These latter are characterised by empathy, presence, emotional support, human love and sharing of the patient's situation. For students, caring includes many experiential elements associated with the control of emotions. Mentorship studies have shown that similar communicative and psychological elements are also present in the relationship between the student and his or her mentor (Andersson et al. 2015).

2.3.3 Supervisory Relationships in the Unit

Professional socialisation is an interactive process through which a newcomer assumes the values, attitudes, moral conceptions, knowledge and skills of those already established in the target profession. In this process of identification and transition to a new social status, supervisory relationships play a crucial role. Professional socialisation can be viewed as a lifelong process, during which an individual learns new skills and social roles as a member of the reference group. Social integration into the profession can be seen at both the communal level (belonging to the group) and the individual level (socialisation as a prerequisite for individual development). It is an essential condition for successful professional development that the student has the experience of belonging to the target profession. This in turn requires willingness on the part of the student to engage with the assigned working group (Beck 2014; Tomietto 2014).

The model for student supervision has traditionally been group supervision; since the 1990s, however, the emphasis has shifted in favour of an individualised model of supervision (Lewin 2007; Salminen et al. 2010). In healthcare education, individualised supervisory relationships during students' clinical practicums have come to be viewed as crucial for professional development. Confidential supervision sessions have been perceived as important by students because they enable them to talk openly about their experiences and the emotions aroused in caring situations (Saarikoski et al. 2009).

Patient contacts can sometimes be very stressful, if not oppressive, for the student. Situations of these kinds often arise from the emotional shock experienced by patients for whom a serious illness is a holistic phenomenon that influences the patient's existential identity. Patients and their relatives are often in an unstable emotional state. Observing such states can lead to strong emotional reactions in the student. In such situations, mentorship sessions are needed some features of which have been used in clinical supervision. In the English language countries (e.g. USA, UK, Canada, Australia), the concept *clinical supervision* refers to monitoring the quality of professional services to clients. Clinical supervision focuses primarily on the emotional support needed in the human-relation professions in social services and healthcare and in the implementation of different kinds of therapeutic interventions. Clinical supervision helps healthcare workers to manage their emotional reactions, and provides them with opportunities both for finding new ways of learning how to do this and for obtaining professional support, which is particularly important for healthcare staff (Royal College of Nursing 2003; Milne and Watkins 2014).

While from the viewpoint of clinical supervision and counselling the individualised supervisory relationship has a crucial role, it sets some practical conditions. It is important that the cooperation between the student and his or her mentor is clearly specified in their mutual contract and that the mentor named in the contract does not change during the student's placement. Both parties should also have enough time together to properly implement their agreed cooperation. To achieve this objective, the best solution in clinical practice is that, as far as possible, the student works the same shifts as his or her mentor. This procedure enables them to work closely

together, providing possibilities for mini bedside teaching sessions and immediate evaluative feedbacks. From the viewpoint of professional development, weekly supervisory sessions are especially important as they also make it possible to focus on matters which may seem too minor when under the pressure of clinical work.

2.4 The Clinical Practicum as a Vehicle of Professional Development

Supervisory relationships during clinical practicums are the most crucial role factor in the professional development of students. Theoretically, the process is based on role modelling, where a student observes and evaluates models of action by qualified staff. Role modelling is an important factor in educating students in the specific qualities that distinguish 'good' and 'effective' role models from weak or non-desirable ones. In the optimal case, the student's own mentor will act as a 'good' role model and facilitator of learning while also transmitting positive and constructive professional values. Role modelling is also important in the socialisation of students into their future profession (Donaldson and Carter 2005; Larson et al. 2013).

Contacts with patients bring a need for separate supervision sessions that enable students to ponder their clinical experiences. A key issue from the viewpoint of professional development is whether students recognise their emotional reactions and can talk about these with their supervisor. Such psychological introspection is known as *reflection*. Reflection is a generic term that refers to the intellectual and affective activities that individuals engage in when exploring their experiences with the aim of acquiring new understanding. Healthcare students can use reflection during the clinical practicum as a mode of learning to promote their personal and professional growth (Caldwell and Grobbel 2013; Jootun and McGarry 2014).

An individual's professional identity rests on two self-concepts: the *personal self* and the *professional self*. In common discourse, the term self refers to a sense or a feeling that something is 'about me'. Reflecting on oneself is a mental feat that is commonly practiced. Individuals' personal sense of self and self-esteem develop slowly as they mature into adolescents. A stable personal self is an essential feature of the mental health structures of an individual (Oyserman et al. 2012). Professional self-concept has been studied to some extent in nursing science since the 1990s (Arthur and Randle 2007). It is an important concept for academics, administrators and clinicians interested in developing the nursing profession. For nurses, professional self-concept refers to how they feel about themselves as nurses, and is vital in examining current and future nursing practice and education as it affects patient care. The transition from student to professional nurse is an important phase in the individual's professional development and can be significantly promoted by a dialogical mentorship relationship (Kelly and Courts 2007; ten Hoeve et al. 2014).

The development of professional identity, then, is a continuous process that begins with admission to the education programme and evolves throughout the professional career. Education is a key period, as it is during this time that students gain the

knowledge and skills required to become professional healthcare workers. The process involves learning a body of knowledge that forms the basis of healthcare practice; however, knowledge alone is not sufficient. Through educational programmes and learning opportunities, healthcare students come to know and understand the core values and beliefs of the profession as well as what is entailed by professional practice (Johnson et al. 2012; Larson et al. 2013). Professional identity is a logical combination of the concepts of the personal self and the professional self (Fig. 2.2).

It is important to understand the relationship between these two self-concepts, and how far they overlap or 'push' each other apart. Theoretically, they can never be completely separated, as, psychologically, one's personal self is always present in human contacts—whether or not we want this. On the other hand, they cannot overlap completely, as this would create an impossible situation for general professional practice. In patient and client relationships, we can never act solely in accordance with our own personal feelings and wishes. Similarly, acting solely as one's professional self would mean that a nurse, for example, could only be impersonal and affectively neutral or nay cold. The solution to this quandary is the adoption of an appropriate *professional distance* neither wholly personal nor impersonal, which is an important factor in all client and patient relationships in the healthcare services.

Reflection and awareness of one's professional self is the core element of professional development in the healthcare field. Students' direct experiences of contacts with clients and patients further this process. The role of the mentor, in turn, is important, as he or she can help students to find their own style of working in their chosen profession. Although it is a demanding and time-consuming process, it is a necessary condition for a successful career in the healthcare services.

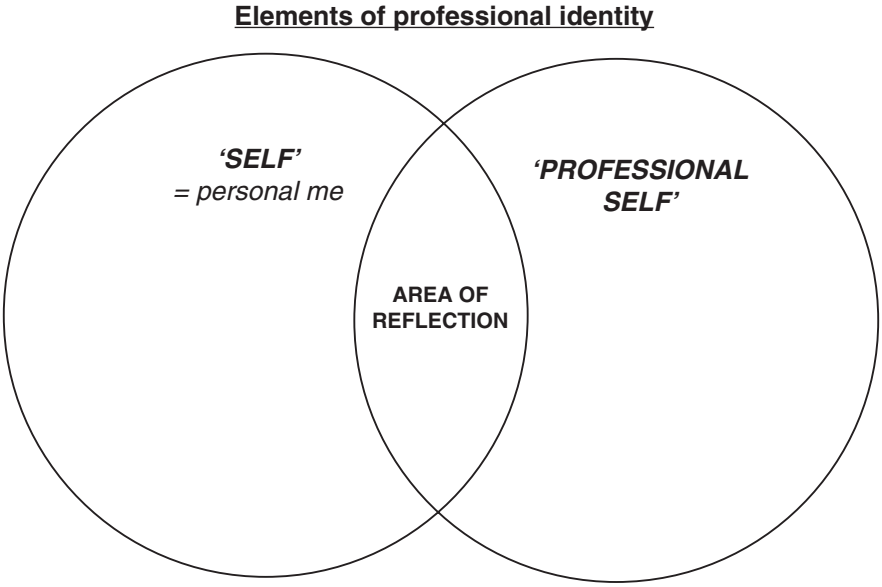

Fig. 2.2 The core context of professional reflection

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