Coaching Model + Clinical Playbook = Transformative Learning

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Health care employers demand that workers be skilled in clinical reasoning, able to work within complex interprofessional teams to provide safe, quality patient-centered care in a complex evolving system. To this end, there have been calls for radical transformation of nursing education including the development of a baccalaureate generalist nurse. Based on recommendations from the American Association of Colleges of Nursing, faculty concluded that clinical education must change moving beyond direct patient care by applying the concepts associated with designer, manager, and coordinator of care and being a member of a profession. To accomplish this, the faculty utilized a system of focused learning assignments (FLAs) that present transformative learning opportunities that expose students to "disorienting dilemmas," alternative perspectives, and repeated opportunities to reflect and challenge their own beliefs. The FLAs collected in a "Playbook" were scaffolded to build the student's competencies over the course of the clinical experience. The FLAs were centered on the 6 Quality and Safety Education for Nurses competencies, with 2 additional concepts of professionalism and systems-based practice. The FLAs were competency-based exercises that students performed when not assigned to direct patient care or had free clinical time. Each FLA had a lesson plan that allowed the student and faculty member to see the competency addressed by the lesson, resources, time on task, student instructions, guide for reflection, grading rubric, and recommendations for clinical instructor. The major advantages of the model included (a) consistent implementation of structured learning experiences by a diverse teaching staff using a coaching model of instruction; (b) more systematic approach to present learning activities that build upon each other; (c) increased time for faculty to interact with students providing direct patient care; (d) guaranteed capture of selected transformative learning experiences; (e) increased student reflection to promote transformative learning; and (f) provided avenues for timely feedback to students. (Index words: Coaching; Clinical competencies; Transformative learning; Clinical affiliate faculty) J Prof Nurs 32:121–129, 2016.

THE CARNEGIE FOUNDATION for the Advancement of Teaching, Joint Commission on Accreditation of Hospitals, and the National Council of State Boards of Nursing have all issued reports concluding that nurses entering the workforce are not prepared for the practice challenges of today and certainly not for the future (Benner, Sutphen, & Day, 2010; Joint Commission on Accreditation of Healthcare Organizations, 2002; National Council of State Boards of Nursing, 2004). These findings were congruent with a large national survey of hospital and academic leaders concerning new graduate preparation (Berkow, Virkstis, Stewart, & Conway, 2008). Of the 5,700 leaders who responded, only 10% of acute care nurse executives were satisfied with new graduates' skills. Most new graduate nurses (84%) are employed in acute care positions (Tanner, 2010), and new nurses typically make up 10% of a hospital's workforce (Berkow et al., 2008). Based on these statistics, one could conclude that new nurses who are inadequately prepared could pose risks to patient safety. In 2007, hospitals across the country reportedly budgeted

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$150,000 to $1,000,000 annually to cover new graduate orientation (Greene, 2010). Now as hospital reimbursements are contingent upon patient outcomes, gaps in nursing workforce abilities also have the potential to further damage the financial bottom line through decreased reimbursements. The gap between academic preparation and the needs and expectations of health care agencies presents problems in terms of extensive and expensive orientations, lost nursing hours for preceptors, efficiency, and threats to patient safety (Jeffries & Battin, 2012).

Many nurse educators were taught to be nurses within curricula guided by the Tyler model (National League of Nursing, 2003). This framework prescribed needed curricular components and tended to focus on "what" should be taught rather than "how" one should teach. This approach has resulted in highly structured, content-driven curricula that have become increasingly burdensome as knowledge of health, illness, and associated treatments grow (Jones, 2009). Despite dramatic changes, both in the health care system and in what is known about pedagogy, educators seem to find it difficult to abandon the ways they were taught in the interest of contemporary, evidence-based pedagogy.

In the traditional clinical teaching model, students are assigned to faculty, and then, faculty assign each student a patient in a clinical agency. The student provides total care to the patient according to the agency protocol for the entirety of the learning experience. In this model, learning opportunities are limited by available patients and tend to be driven by patient diagnosis rather than student learning needs (LeFlore, Anderson, Michael, Engle, & Anderson, 2007). In addition, this model presents operational challenges. Shortened lengths of stay and more complex patients make assignment and monitoring processes particularly burdensome for faculty (Niederhauser, Schoessler, Gubrud-Howe, Magnussen, & Codier, 2012). Patient safety is threatened when students are placed in positions of responsibility that are not congruent with their knowledge and skills. In many schools, faculty are responsible for supervising 6 to 10 students, and it is difficult for faculty to provide direct supervision to groups of this size. In addition, faculty have the added responsibility of maintaining currency with the agency protocols and scientific advances (Decker, Sportsman, Puetz, & Billings, 2008).

Preceptors and faculty are obligated to directly supervise students with a primary emphasis on keeping patients safe. Most patients are quite complex and require multifaceted care, it is challenging for students to manage such care, especially for those who are just beginning clinical experiences. Consequently, faculty spend much of their time reviewing patient safety issues, and little time is available to help students to achieve deeper understanding. Clinical learning environments become task-oriented settings in which it is impossible for students to focus on single aspects of care in a way that fosters clinical judgment (Lasater & Nielsen, 2009). Students spend most of their day in task-oriented care or observing (Ironside, McNelis, & Ebright, 2014; Tanner, 1998).

Agencies are increasingly responsible for providing safe and high-quality care, and this drives very high expectations of caregivers. Patients have high expectations as well. Although quality care and patient satisfaction have always been important, changes in health care finance have made quality and safety a single top priority for hospital administrators. The public has easy access to hospital performance data, and the newly implemented pay-for-performance standards will impact the bottom line (U.S. Department of Health & Human Services, 2012). In the interest of quality and safety, hospital administrators may begin limiting clinical placement opportunities, and that would be devastating for schools that currently have insufficient clinical sites (Barnett et al., 2008).

The Institutes of Medicine recommended that all health care providers must be skilled in clinical reasoning/critical thinking and be able to work within complex interprofessional teams to provide safe, patient-centered care (Committee on the Health Professions Education Summit, 2003). Beyond delivering quality care, nurses must understand, participate in, and often lead quality improvement (QI) projects and be informaticians and care coordinators. Institutes of Medicine (2010) describes nurses as spending only 20% of their time in direct patient care (DPC) with a greater majority spent in more expanded roles. Nursing education has not kept pace with practice demands. A survey study corroborated this when the authors found that prelicensure nursing students felt that QI, teamwork, and collaboration were addressed least in their educational program (Sullivan, Hirst, & Cronenwett, 2009). The traditional teaching strategies fail to fully prepare students for the complexity of today's health care systems and can potentially place patients and students at risk.

Time for Clinical Innovation

Benner et al. (2010) recognized that it was important to train nurses to be lifelong expert learners and reflective practitioners because they are entering a practice that will only become more complex with time. As faculty reflect on their charge of preparing a nursing workforce for the 21st century, they must realize that they, too, need to embrace the same principles of lifelong learning. They must challenge the status quo; specifically, there is a need to transform the established frame of reference for clinical teaching with adult learners.

The faculty of the University of Kansas School of Nursing (SON) realized that the traditional clinical curricula left much of the student's development to chance and only prepared nurses to provide DPC—not the expanded roles needed in today's health care system. Could it be that our current way of teaching was no longer a fit for the fast paced, complicated, and challenging clinical environment? Faculty agreed that a clinical teaching model that was purposefully driven was necessary to change the status quo and better prepare the graduates to meet the challenges they would face. Through dialog and reflection, individual faculty began to examine their own habits of mind and to be open to