Incorporating theory and practice to achieve competency nursing essay

" Dewey (1938) stated that all genuine education comes through experience. Certainly, in practice-based professions such as the health care professions, clinical experience should be the basis for learning. To extract learning from experience, we need to create meaning from our experiences as we interact with and react to, them. We cannot allow any experience to be taken for granted; once we do so, actions become routine and habitual, we stop noticing and enter into a rut" (Stuart 2007).

Critically discuss this quotation by focusing on the complexity of learning in practice, the complexity of supervisory process and the end goal of creating a competent practitioner.

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Introduction

John Dewey, one of the paramount philosophers and educational theorists of this century, wrote the book Experience and Education, more than 70 years ago, toward the end of his career. The book is based on the principle that all genuine education comes about through experience. Are his ideas relevant to nursing education in this day and age? Can we develop a theory for learning in our workplace? Are all experiences educative? Should clinical experience be the basic of learning? The following assignment shall use these questions as the basis of critical discussion about the complexity of learning and supervising and the formation of competent practitioners.

The Maltese Code of Ethics for Nurses and Midwives (1997) seeks to promote the highest level of care delivered by nurses and midwives to their patients. This goal can only be achieved in the nursing profession, by the confluence

of the two segments of health care; science and art. It was Florence Nightingale who created the ' art and science' model of professional nursing practice and entrusted it to future generations. Nursing as a science and a profession is characterized by a close relationship between theory and practice (Papastavrou, Lambrinau, Tsangari, Saarikoski, & Lieno-Kilpi, 2010), which involves the technological and research aspect of patient care. Conversely, the art of nursing is a more holistic view and takes into account all the patients' mental, physical and spiritual needs. Hence, competent professional practice requires educational theoretical knowledge, as well as knowledge gained through hands on experience.

Clinical experience and learning in practice

Dewey (1998) argued that all genuine education comes about through experience. If Dewey's statement is accurate, then why is the number of students attending universities increasing year after year? Why youths do not find employment instead of going to universities if the essential education can be gained directly through work experience? Is it feasible to allocate students in a ward, without any background knowledge about nursing? It is a fact that the knowledge base of nursing can be found in books, journals, and media and in handbooks of practice. On the other hand, Handal and Lauvas (1983) argued that a different component of practical theories is the transmitted knowledge and understanding communicated by others. This is because we pick up others' knowledge and understanding together with our own experiences. Bonwell & James (1991) stated that research consistently has shown that traditional lecture methods, in which lecturers talk and students listen, dominate university classrooms. Rolfe

(1998) added that although this kind of knowledge forms the foundation of the science in nursing, nurses also need to have knowledge about themselves, their own clinical practice and their individual patients, if ever nursing has to become holistic and patient centered rather than disease focused.

YourDictionory. com (2010) defines experience as an " activity that includes training, observation of practice, and personal participation". Therefore, experience offers opportunities to the student to live through alternative ways of approaching the practice setting. However, nursing procedures, which may initially be taught in university clinical skills laboratories, require more varied and complex skills than can be taught in classrooms. It is not sufficient for a student to learn, for example, aseptic techniques, by reading a book, attending a lecture, or performing a skill in the lab where the environment and role model are perfectly controlled. Although knowledge learnt in the lecture rooms is essential as basic information, performing the skill in real life is something different altogether. For instance, when considering aseptic technique, a student on the wards can actually observe the wound, any odour or exudates, and assess pain whilst answering patient questions. Moreover, Polanyi (1967) argued that much of the knowledge which inheres in human skill is tacit, and can only be learnt by observation. Thus clinical practice is a combination of practice of skills, the use of tacit knowledge, the use of knowledge about the skill and the use of knowledge of the field of practice (Jarvis, 1992). Besides, Nightingale (1893) as cited by Alliggod and Marrier-Tommey (2006) believed that nursing education should be a combination of both clinical and classroom experience. She states that "

Neither can it (nursing) be taught in lectures or by books (alone) although these are valuable accessories, if used as such: otherwise what is in the book stays in the book" (p. 24).

In addition, Dewey (1998) further argued that experience alone, even educative is not enough. To a certain extent, it is the meaning that one perceives in and then constructs from an experience that gives the experience value. Consequently, this leads to the role of reflection, where its function is to make meaning out of our experiences. Loughran (2002) acknowledged that reflection is continually emerging as a suggested way of helping practitioners better understand what they know and do, as they develop their knowledge of practice through reassessing what they learn in practice. Moreover, Schon (1983) emphasis that reflection is a way in which professionals can bridge the theory practice gap, based on the potential of reflection to encourage knowledge in and on action. Since reflection facilitates discussion, it promotes the concept of shared learning. Furthermore, Schon (1987) acknowledged that when clinicians are trained to make their knowing in action clear, they can inevitably use this awareness to enliven and change their practice. However, one can argue that reflection is not a natural state or known without someone introducing it, but as Schon stated these systematic processes need to be guided experiences so that practitioners can derive the best possible outcomes from them. On the other hand, Crathern (2001) asserts that once reflective skill is mastered it will not leave the person. Thus clinical supervisors should help and guide students to develop and engage in the process of reflection as a means of deriving knowledge from their clinical experience.

The complexity of learning in practice

Antonacopoulou (2006) declared that learning is a process as well as a product, a cause, a consequence and context in which life and work patterns are achieved, and in turn organise learning. People have been trying to understand learning for over 2000 years. However, everyone has a different suggestion how to approach learning. Some might argue that learning is an increase in knowledge, that it is memorizing, or that it is acquiring facts or procedures that are to be used. Others may say that learning is making sense or understanding the reality. On the other hand, learning theorists have provided us with a set of ideas about how people learn, to facilitate practical implications for teaching (Darling-Hammond, Rosso, Austin, Orcutt, & Martin, 2001). Yet, one must keep in mind that students' practice experience is one of the most important aspects of their preparation for registration.

Bransford (2000) affirmed that research has found that the brain plays a role in learning. Thus we cannot assume that all students learn in the same way. One must keep in mind that different students have different needs, and the concept that one size fits all is inaccurate. Additionally, if teaching methods do not match a student's strength or learning style this may affect learning and behaviour. Mentors should primarily assist students to integrate into the practice setting while continuously providing ongoing support. Through observation, interaction and discovering a student's interests, mentors can determine which learning styles would best facilitate the learning process. Novice students require an approach that is supportive, facilitative and structured, where careful monitoring, observation, demonstration and

teaching are essential (Benner 1987). Alternatively, more advanced students need to be empowered to provide reflective holistic care. However, communication and an effective working relationship is the key to success (Chan, 2002; Papp, Markkanen, & von Bonsdroff, 2003; Saarikoski & Leino-Kilpi, 2002; Berggren, Barbosa da Silva, & Severinsson, 2005).

Learning is also based on the associations or connections we make. According to the learning theorist Jean Piaget accessing prior knowledge is how we make sense of the world. We attempt to take new information and fit it into existing knowledge in order to create a schema, or mental map that fits into a specific category. This makes the information more accessible because it is more memorable. On the other hand, workplace learning is of central importance and a crucially important site for learning. Nevertheless, students need to have theoretical background knowledge before working in a ward in order to be more motivated. Additionally, Burns and Peterson (2005) acknowledged that having a good role model is beneficial for the students. However, researchers found that sometimes mentors act as poor role models, where students alleged that they have observed malpractice practice in the clinical area (Rungapadichy, Mandill, & Gough, 2004). Consequently, the key to successful practice learning lies in the level of support and guidance that students receive from mentors (Block, Claffey, Korow, & McCaffrey, 2005 & Jones, Walters, & Akehurst, 2001) and other healthcare professionals. Gone are the days where students only require friendly or emotional support in practice settings. Besides, they also demand and deserve good quality, appropriately delivered practice learning that

challenges the professionals delivering it and develops practice based on theoretical principles (Andrews, 2007).

One of Jarvis' points is that professionals also learn in situations with routine actions, because they are able to ask questions both about their actions and the attitudes behind them. Along these lines, they are able to regenerate disjuncture (Jarvis, 1999). Yet, can ritualism deteriorate into alienation, where skills will be performed without meaning? Thus it is important to discuss with the students what they want to learn and express their decisions in the form of learning objectives. The sequence of learning tasks should be moved from simple to complex and adequate guidelines and feedback (Darling 1985, Elliott & Higgs, 2005) should be incorporated, so that the key points of learning are reinforced.

Hammnond, Austin, Orcutt, & Rosso, (2001) observed that the different ways' people think and feel about their own learning affects their development as learners. Glasersfeld, (1989) argued that responsibility of learning should reside increasingly with the learner. Thus social constructivism is important so that students will be actively involved in the learning process, unlike previous educational viewpoints where the responsibility rested with the lecturer to teach and where students played only a passive role. Therefore, students should be encouraged to develop critical thinking skills and not just emulate the practices they observe. Motivation is another crucial assumption where some might give all the responsibility to learn to the students' confidence in their potential for learning. However, one must keep in mind that other underlying problems might be the cause, such as personal problems or stress during clinical

placement. Building a good relationship with the mentee can solve such problems, because when students confide their problems, mentors can address them appropriately. This would be supported by Darling's (1984) work, where in her study, after she interviewed 50 nurses, 20 physicians and a number of healthcare executives about their experiences with mentors, she identified that there were three vital ingredients for a mentoring relationship: attraction (admiration for the other person), action (invests time and energy to the relationship) and affect (positive feelings toward the other person). In addition, Prawat and Floden (1994) believed that feelings of competence and beliefs to solve new problems are derived from firsthand experience of mastery problems in the past and are much more powerful than any external acknowledgment and motivation. Consequently, the importance of being good role models is once more being stressed where with appropriate behaviour and attitudes, and with interaction together, the mentee will be helped to achieve the state of a competent practitioner.

Strengths, problems, and challenges of learning in practice

The clinical environment is a strong provider of learning (Cope, Cuthbertson, & Stoddart, 2000). In fact, it is the only setting in which the skills of history taking, skills practicing, clinical reasoning, decision making, empathy, and professionalism can be taught and learnt as an integrated whole. However, common problems with clinical teaching exist such as lack of clear objectives and expectations, focusing on factual recall rather than on development of problem solving skills and attitudes, passive observation instead of active participation from the student, lack of reflection, discussion, and feedback and at times teaching by humiliation. These problems may arise due to time

pressure, competing demands (especially when needs of patients and students conflict) and last but not least due to the increasing number of students and lack of mentors.

Complexity of supervisory process

Ever since research reports appeared to suggest that a theory-practice gap existed in nursing (Alexander 1983), a search has been in progress for new roles for nurses in clinical practice and in nurse education. These roles might ensure that what is taught in the theoretical component of nurse education corresponds, at least to some degree, with what happens in clinical practice. Evidently, the key to progressing from novice to an expert is the key to excellent mentor support (Watson, 2000), otherwise the nursing student may make defective assumptions based on inadequate personal reflections.

It is useless having a state of the art hospital learning environment, without having enough supportive mentors who are really interested in mentoring. Such learning environment gives students the opportunity to get the most out of their learning processes and to achieve the objectives of clinical placements. On the other hand, failure to meet students' expectations can cause disappointment to students during their clinical placement, where they can proclaim that their experience was unfruitful since for learning to take place, there is the need to create meaning from the experience (1998). Thus, one can question if all mentors are enthusiastic and committed to mentoring. Alternatively, mentorship may be supported, by developing workshops (Howatson-Jones, 2003) and other tools to teach, in order to remind mentors how to optimize their skills and to promote mentors and mentorship. Some authors argue, that the choice of the mentor is crucial to a meaningful

supervisory relationship, and that this relationship is integral to the whole supervision process in relation to uptake and effectiveness (Jones A., 2001a; Spence, Cantrell, Christie, & Sammet, 2002). However, mentorship in Malta is still in its infancy, and there are not enough mentors to accommodate all the students in the faculty, let alone choosing their mentors. Consequently, the need for more responsible mentors arises. Llyod-Jones, Walters, & Akehurst, (2001) in their study of 81 pre-registered students found that those students who did not work with a mentor, were usually not supported by any other trained staff, leading to auxiliary nurse work being delegated to the student. Nevertheless, the system in Malta overcame this problem by giving the opportunity to every student to be mentored by different mentors according to the clinical placement, in most of their clinical placements.

The environment itself is a valued characteristic for students to learn, mostly characterised by co-operation among staff, and an atmosphere in which they are treated as colleagues not as an extra pair of hands. The impact of a good ward cannot be overstated, where the philosophy of nursing team affects the ward atmosphere. Pearsy and Elliot (2004) declared that if students observe mentors acting as poor role models it affects the students learning negatively. Thus the supervisor role is to assist the supervisee to apply theoretical knowledge, appropriate attitudes and therapeutic communication into practice. This can only be done through the medium of supervisory relationship, since it is through others that we develop into ourselves (Vygotsky 1981). Mentoring is founded upon relationships between people and, like all relationships, is affected by what each participant brings to the relationship. Openness, self-awareness, and a belief in the value of

mentoring are important qualities for both mentors and mentees to possess. Competency to mentor is built on a balance of individual cognitive, emotional and relationship abilities; personal virtues or characteristics, such as integrity and empathy, and competencies both within one's field of practice and related to mentorship itself (Epstin & Hundert, 2002).

The success of clinical supervision depends mainly on the supervisee (Dewar & Walker, 1999), and it can be useful if they look at their responsibilities in the role. It is important that students are treated with respect as an equal partner. The primary responsibility of the mentors is for their own development and willingness to learn and change, irrelevant to the extent of experience. Yet mentors serve a variety of roles, including being a professional parent, teacher, guide, counsellor, motivator, sponsor, coach, advisor, role model, referral agent, and door opener. Hence a successful mentor must be capable of blending these roles with other important characteristics such as being patient, available, approachable, respected, people oriented, knowledgeable, and secure in their position, in order to help students in the process of competency.

Creating competent practitioners

Ensuring competence to effectively and safely practice should be the aim of mentoring, and a critical task for the educators. Kane (1992) defines competence as the degree to which the individual can use the knowledge, skills and judgment associated with the profession, to perform effectively, in the domain of possible encounters, defining the scope of professional practice. On the other hand, domains of competence can be assessed to some degree via direct observation because it provides the opportunity to

make multiple assessments over time and across different clinical circumstances. Yet, this is not always possible due to time constrains with the student. Thus the faculty must find another approach how to combine lectures and clinical practice in order to give ample time for the student to work with the mentor.

Moreover, another question might arise regarding the system sufficiency in providing competent and safe practitioners. The introduction of mentorship was the first step aiming to provide better competent practitioners. However, there are strategies that both mentors and mentees can employ to ensure that they get the most out of a mentoring relationship. Yet, are there policies in place that support the selection of competent, appropriate mentors? Equally important, is the method of students' assessment acceptable? Burns & Peterson (2005) declared that the assessment must be on going, where the mentor provides formative assessment in line with outcomes and competencies they are expected to achieve. Thus, locally, the final four hour role play, (where students can be motivated purely by the process of assessment to adapt to what they perceive as the requirements of the assessor rather than moving towards achievement of goals such as independent thinking, problem solving and originality) should not contain too much weight in determining students' competence. Hence supervision methods will be more effective if used within the context of a healthy supervisory relationship. Asadoorian & Batt (2005) acknowledged that self assessment should be the first step in self directed learning. However, self-assessment should only complement and not replace another means of assessment. Portfolios, on the other hand, can address a wide range of

competencies because it provides a reflective insight into mentees' abilities to self assess and learn from experiences.

Conclusion

Although experience is extremely important as a means of education, theoretical knowledge must be the basic to prepare students for the clinical practice. On the other hand, the need for nurses to be able to integrate theory and practice effectively has long been recognised. Thus, competent mentors are required to help students in minimizing the theory practice gap. The gap can be bridged through reflection and critical thinking so that experience can be transformed into learning. A good relationship between mentor and mentee is important for learning. Mentees appreciate a learning environment where they have the opportunity to learn, to act professionally and to learn about the values and norms on the ward. Moreover, since nursing is a practical profession, there is a need to ensure that practical assessment systems are able to discern the true knowledge base of students. Alternatively, the key to success is to monitor both student and mentor feedback on the learning practice environment.