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CLINICAL PRACTICE OF NURSING:
IDENTIFICATION, DEVELOPMENT AND EVALUATION

Report on a WHO Meeting

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1. Introduction

The Working Group, convened by the WHO Regional Office for Europe at the invitation of the Federal Republic of Germany and in collaboration with the authorities of the City of Ulm, was held from 2 to 5 November 1982.

The purposes of the meeting were to:

- (a) review the current acceptable principles governing the educational expectations of students during clinical practice;
- (b) examine the developments and current status of nursing and nursing research as basic decision-making tools for clinical practice;
- (c) review the present European Region situation regarding the effects of current enabling or constraining factors affecting the relative use of the above tools and/or methods;
- (d) examine the existing data available concerning approaches which have potential for improving the cost-effectiveness of clinical teaching;
- (e) formulate recommendations and strategies for short-term and long-term planning of the medium-term programme in nursing/midwifery in Europe in regard to:
 - further activities to communicate recommendations to relevant persons, institutions and bodies;
 - methods which could be used to ensure and enhance the incorporation of the contemporary approaches examined and the reorientation to primary health care into curricula.

The Working Group included 20 temporary advisers (18 nurses, one physician and one economist) from 13 countries and by two members of the Regional Office staff (see Annex 2). The Regional Director, Dr Leo A. Kaprio, was represented by Dr M. Farrell, Regional Officer for Nursing.

Miss I. Hamelin was Chairman and Miss M. Storey Rapporteur.

In her opening address, Dr Farrell said that the Working Group was considered significant by WHO in relation to others convened as part of the medium-term programme in nursing and midwifery. Working documents and background material (see Annex 1) covered pertinent issues.

The Regional Office's medium-term programme in nursing/midwifery in Europe was then discussed and the Working Group was considered in relation to the overall activities of the WHO medium-term programme and other working groups.

2. Principles governing the educational expectations of the student: enabling and constraining factors

Participants set a framework for discussion by designing an organizational chart depicting:

- (a) who pays for nursing services;
- (b) who pays for nursing education;
- (c) who is responsible to whom for nursing care;
- (d) who is responsible to whom for nursing education;

and to list:

- (e) the enabling and constraining factors allied to the structure; and
- (f) the associated risk factors.

The exercise highlighted the complexity of issues facing nurse managers/teachers, who must examine each of these factors when planning nursing curricula. Further, it was held to be easier to devise a future structure than to chart what currently exists in some situations. The need to re-examine the provision and financing of nursing education was seen as necessary in order to formulate acceptable principles to govern learning experience and to meet the educational expectations of the student.

The current systems of divided responsibility hinder communication between the faculty^a and service agencies. Clinical practitioners may not always recognize their responsibility to the students' educational programme and may find it difficult to identify with faculty objectives, and the faculty does not always interpret the objectives in a way that practitioners can understand.

The position of the clinical practitioner as a role model is important to students placed within that sphere of authority. Because of her prime concern in patient care, the teaching aspect of the clinician's role unavoidably takes second place. However, where students are placed in clinical learning situations, it is not only inevitable but desirable for the practitioner to maintain and be prepared for a clearly defined teaching role. Support by staff must be available, along with resources to enable the practitioner to fulfil her teaching role when patient care must be her priority concern.

It was felt important to clearly define "who pays" and where accountability lies. It was considered less important as to whether the system chosen was centralized or decentralized, e.g.:

Centralization

Decentralization

Decision-making flows from above

Advice/consultation comes from all levels (may be more chaotic, but everyone involved in decision)

Gives greater feeling of security, but

Need to accept that the decision comes from one person

Commitment to decision is high

than that control and accountability should be clearly defined.

Participants agreed that nursing education should, in the first instance, be the responsibility of nurse educators who were prepared for their role as professional nursing teachers and who were intimately familiar with the learning needs of their students. Having thus agreed, however, it was acknowledged that, in exercising control, the "consumer" of care or education must play an important part in determination of the content of nursing education and in the formulation of curricula.

The "consumer" was identified as both the student and the patient/client. Because the patient/client pays for health services through insurance and/or taxation, he/she has a legitimate say in the kind and extent of health services rendered. In turn, the patient/client, as consumer, has an interest in ensuring that nursing education programmes are contemporaneous with his/her needs.

The student, because he/she may be paying directly for education, both in financial terms and in time, has also the right to be involved in determination of the educational programme.

It was agreed that, in general, by involving the consumer in the curricular process, the chances of ensuring his/her support will be greatly enhanced - that is, the more opportunities there will be to identify with the problems and to participate actively in the formulation of solutions.

3. Decision-making - a major approach to patient care

Miss Pat Ashworth, Research Programme Manager, University of Manchester, reminded the Group of the important focus within the medium-term programme placed upon the nursing process. The process offered, at present, more effective individualized patient/client care, more documented evidence

^a The term "faculty" for the purpose of this report means university, college or school of nursing.

The current state of the art of information systems in nursing practice, it was noted, is in an exciting state of development where efforts are currently under way to quantify nursing outcomes in the evaluation of nursing care. The evaluation of clinical nursing practice would perhaps come nearer to reality ensuing from the use of the nursing process, the documentation of nursing action and research evaluation of the process itself.

Despite these initial moves being made in the right direction, reinforcement was given to the nature of nursing care as being only one part of total health care. Nurses can only make and benefit from decisions taken as long as these are in concert with other disciplines. Changes in the system of nursing care, e.g. the introduction of the nursing process, must be in collaboration with others.

It was noted, however, that in some places multidisciplinary work in nursing curricula was just beginning and efforts to work on such teams has been initiated in selected settings. The skills of working in a collegiate way must be an essential part of the curricula and must be incorporated into plans to educate nurses.

To further the topic of student expectations related to the need for multidisciplinary activity in the health care system, a simulated role play was enacted. A situation was depicted which highlighted the student as a "consumer" having rights within the setting of her educational programme. The "actors" played out the conflict where team members illustrated the realistic interests presented which depended upon individual motivations.

The Group saw it as inevitable that a student placed in such a position of conflict would cease to be motivated and would leave the system. Although most members believed that the role play exaggerated the situation in reality, nevertheless, most could relate to the principles depicted. These included:

- (a) the necessity to ensure that patients receive care;
- (b) the clear mandate for experienced practitioners to teach and supervise students;
- (c) the need to move away from the view of the student as a "pair of hands" (to the detriment of her education) towards one of student as learner only;
- (d) the need for an explicit contractual arrangement in respect of defining students' expectations and needs, patients' legitimate right to safe nursing care, level and accountability of supervision;
- (e) the need for total team participation to work in a collegiate manner in order to identify, examine and solve the issues related to the conflict.

It was considered that, if the philosophy of the service agencies in respect of extending health care to the patient/client in a holistic manner is reflected in the philosophy followed by the faculty, the same philosophy extends into the areas where students gain experience.

A common goal, well communicated, would serve to reduce or eliminate conflict of the type depicted and discussed. The ideology taught in the theoretical environment should not be such as to ignore the reality of practice in those areas responsible for giving care.

4. Economic views on clinical practice issues

Mr Alistair Gray, economist on the staff of the Health Economics Research Unit, University of Aberdeen, Scotland, presented some important economic views relating to clinical practice. In introducing the subject, Mr Gray reminded the Group that, in all industrial countries, the health care sector is labour-intensive, and commonly 60-70% of the total expenditure on health care is devoted to salaries and wages. Within this labour force, the largest single occupational group is "nursing", which accounts for approximately one third of the expenditure. Economically, therefore, a major concern is to ensure that education, recruitment, deployment and management of the nursing labour force is conducted as efficiently as possible.

- Producing an output can be done with different combinations of inputs. In health care, nursing is often just one of these inputs. Therefore, nurses cannot consider the issues in isolation.
- Some substitution possibilities exist between different occupational groups. It is best to plan and be aware of these.

All these concepts and methods apply not only to nurses, but to everyone else. Accepting them involves taking some risks, but carries more opportunities.

Discussion

Considerable emphasis was placed by participants on belief in the nursing process as a method of improving nursing care, meeting patients' needs, decision-making/problem-solving, developing professional identity and quantifying care in order to analyse the relative costs of nursing services.

Additionally, introduction of the process had produced a framework for change and, where implemented, had required commitment of the whole institution and, therefore, influenced the whole.

It was considered important that nursing practice should be performed in the most cost-effective manner, which would require quantification of nursing care outputs.

Three main principles were seen to govern economic issues surrounding nursing care:

- (a) any change in the system also changes other parts of the system, and the secondary changes evoked must be taken into economic consideration when decisions are made;
- (b) to be effective, any change requires collaboration and input from others;
- (c) if nurses are to undertake cost-effectiveness studies in relation to their work, then there is a need for a change in the nurses' knowledge base; thus, educational changes in the preparation of the nurse are basically required.

Economic decision-making is unlikely to come within a situation of unlimited resources. Therefore, nursing must develop data in order to justify demands for changes in the service or the level of service given.

There is a need for logical thinking and a requirement to prepare a strategy for goal achievement in attempting to reach conclusions and recommendations in the light of previous discussion and background information given, and the Working Group addressed themselves to the following questions.

- A. Considering the following factors, what should constitute the principles in determining the content of clinical practice for students:
 - economic issues?
 - nursing as a practice discipline?
 - nursing as a profession?
 - nursing practice as a basic clinical tool?
 - the learner as a consumer?
 - the length of the total learning time?
- B. Considering the above factors, what are the conditions under which clinical experience should take place? For example:
 - who is responsible for student actions?
 - what legal protections must exist to protect teacher, student, patient?
 - what is the faculty's responsibility for the learner during clinical experience?
 - what is the faculty member's responsibility for the learner?
 - what kinds of policy must exist to ensure the implementation of the curriculum?
 - what is the extent and intensity of faculty supervision required for safe learning to fulfil curriculum objectives?
 - what is the composition of other staff to complete student learning?

(9) The practising nurse or teacher is accountable for his/her own actions. Students must be taught the implications of professional accountability at both student and practising nurse levels. Although accountability varies from setting to setting, responsibility for student behaviour may flow to the head nurse or to other qualified nursing staff in practice. The degree or level of responsibility and accountability must be defined in written, contractual terms as they relate to the student, the faculty, and any other persons involved in the clinical teaching or learning process.

(10) Patients have a legal right to a form of care that is safe and in accord with legitimate expectations of the context within which it is provided. Thus, patients have a right to know if their care is being provided by a student nurse.

(11) The curriculum should include consideration of the legal aspects of practice. This knowledge should be imparted to the student prior to placement for practical experience.

(12) It should be the responsibility of the faculty to ensure that the student's experience is growth-producing and meets the learner's needs. The philosophy of the curriculum should identify the health care needs of the community in which the programme is located as well as the needs of the student. If the student, in the process of meeting the health needs of a community, is likely to be exposed to an experience involving risk, the initial contract with the student must make the position clear as to known risks and potential risk factors. Alternative clinical experiences must be available so that the student may make a choice when faced with a high-risk situation and/or with one that conflicts with genuine ethical or religious beliefs.

(13) The faculty should be responsible for the selection of the clinical areas for student placement according to agreed criteria.

(14) The faculty should be responsible for providing adequate supervision either directly or by mutually agreed delegation to other qualified staff.

(15) Adequate monitoring, both of the process and the outcome of education, should include:

- well-defined examination/assessment procedures;
- faculty self-evaluation;
- student evaluation of the programme;
- evaluation of the newly qualified nurse by employers; and
- nursing assessment of the impact of the presence of students on a clinical setting.

(16) Explicit contractual arrangements between faculty, students and service agencies should be written down and accepted prior to the initiation of a clinical experience. These contracts should spell out the expected conditions and hours of work in a given setting. The details defined by the agency will include the number of students involved, the current level of competence of the students concerned, the degree of supervision available, the hours of work, holiday time and other procedural issues

(17) The extent of supervision by faculty and staff should be determined by the student's level of competence and learning needs and the safety/risk factors of the student and the patient/client.

(18) The number and quality of supervisory staff should be adequate to provide the desired learning experience and the ideal learning environment in the setting concerned. In certain placements, supervision may be provided by staff of other disciplines who understand clearly the non-nursing elements of teaching they are expected to contribute.

Annex 2

LIST OF PARTICIPANTS

TEMPORARY ADVISERS

- Miss P. Ashworth
Research Programme Manager, Department of Nursing, University of Manchester, United Kingdom
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^a Participation expenses not paid by WHO.