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Preface

The focus of Volume 6 of the Annual Review of Nursing Education is on clinical nursing education. The chapters in this volume describe new partnership models, innovative clinical experiences for nursing students, the ways schools of nursing in a region collaborate to select clinical sites, approaches to evaluating students’ clinical performance, and grade inflation. The Annual Review would not be complete without new teaching strategies and reflections on the development of nursing faculty, which also are included in Volume 6. In a special chapter (14), Peggy L. Chinn reflects on her career and experiences as a nurse educator and now on her active retirement. If you need new ideas for your clinical courses, chapters in this volume will meet that need.

Part I of this year’s Annual Review focuses on innovative partnerships between schools of nursing and clinical agencies. In Chapter 1, Gayle Preheim describes the development and implementation of the clinical scholar model within a caring, competency-based curriculum as an exemplar for clinical nursing education. The clinical scholar model is an innovative partnership with health care providers to improve the clinical learning experience of students in prelicensure nursing courses. Central to the model is the clinical expert nurse, who collaborates with faculty to coordinate clinical placements, facilitate student learning, and evaluate student performance and the learning experience in the clinical setting.

As Betsy Frank explains in Chapter 2, partnerships between health care service institutions and nursing education are not new. What has spurred this renewed interest in partnerships? In a rapidly changing health care system characterized by personnel shortages, heightened patient acuity in inpatient settings, and a move to deliver health care away from the hospital, service personnel and nurse educators have discovered that effective partnerships can benefit both students and the agencies where clinical experiences take place. Read this chapter
to understand the development of various forms of academic–service partnerships in nursing education and to think about ways you can form partnerships in your own environments.

Chapter 3 builds on Betsy Frank’s review and presents two innovative partnership models that address the need for clinical faculty and bridge the gap between education and practice. In this chapter Susan E. Campbell and Debra A. Filer present their clinical partner model and the home room mentoring model used at their school of nursing. As clinical instructors, they have experienced the rewards and challenges of working with both models, which they describe in this chapter. The authors emphasize the importance of establishing partnerships to meet the goals of education and practice, describe ways of sustaining these partnership relationships, and offer suggestions for implementing the models in a nursing program and health care agency.

Kathleen M. White and Jo M. Walrath, in Chapter 4, describe their Fuld Leadership Fellows in Clinical Nursing Program, an innovative partnership between the School of Nursing and Johns Hopkins Medicine. The Fuld Fellowship is a vehicle for developing the professional and leadership skills of undergraduate nursing students. Each nursing student selected as a fellow works with a hospital-based nurse mentor on a project aimed at improving the safety and quality of inpatient care. The program has provided students with meaningful opportunities to develop their critical thinking skills, conduct important clinical nursing research, and apply evidence-based practice in real-world settings.

Nursing faculty spend much time planning clinical activities for students and guiding their learning in the clinical setting. How do students perceive these activities and their clinical experiences? In Chapter 5, Leonie L. Sutherland and Virginia Gilbert present their research findings on how students respond to clinical assignments. Their analysis showed that embedded within the educational requirements of the clinical practicum was a set of rules guiding the work of nursing students. Students classified patients as “good” or “bad” based on how well the patient’s nursing care needs met the students’ perceived faculty requirements. Students came to view patients as objects to forward the educational requirements of the practicum and experienced tension and conflict in translating classroom learning to care of their patients.
As nursing education programs struggle to meet the demand for more nurses, one limiting factor is insufficient clinical sites for student learning experiences. With schools of nursing increasing their student enrollments, there is more competition for clinical sites. Kay Setter Kline, Janice Hodges, Marilyn Schmidt, Daniel Wezeman, and Jan Coye, in Chapter 6, describe the collaborative process they use to negotiate and obtain clinical sites for their nursing program. In their Clinical Placement Consortium, nursing programs and service settings work together, using software and technology, to place all students in appropriate clinical sites. This is a true collaborative partnership between education and service.

Evaluation of students’ clinical performance is often a difficult process for faculty. Chapters in Part II of the *Annual Review* guide faculty in evaluating and grading students in clinical practice, including evaluating professionalism among nursing students. Other chapters examine how students assess their own learning and development of clinical competencies, and explore issues of grading and grade inflation. The final chapter in Part II describes a study on providing feedback to students in an online course.

In Chapter 7, Stephanie D. Holaday and Kathleen M. Buckley present a framework for clinical evaluation and an innovative tool-kit to assess, evaluate, and measure student performance and growth across clinical settings and at all levels of a nursing program. The tool-kit includes consensus-based clinical outcomes and competencies against which to base judgments for evaluation, a five-point rating scale for measuring the quality of clinical performance, and conversion scales for grading the achievement of the clinical outcomes. The framework of the tool-kit provides a lens to view clinical education and performance and a benchmark for assessing and measuring student, course, and accreditation outcomes.

For many decades nursing students worldwide have measured their education and attributed the quality of their nursing education directly to their clinical experiences. Moreover, continuous quality improvement in educational experiences is directly linked to hearing, reflecting, and responding to the thoughts and beliefs of all stakeholders, including students. In Chapter 8, Nel Glass and Lou Ward bring to the forefront the value of innovative student assessment. This assessment is
focused on a group of stakeholders, namely, nursing students, and their reflections on achieving teacher-derived clinical competencies in one clinical environment, that of a mental health setting in Australia. The authors contend that student reflections on their clinical experiences are an important educational and clinical consideration integral to the advancement of clinical nursing education.

Grade inflation is an increase in the grade point average without an increase in the student’s ability; grade inflation devalues what an A truly means. In Chapter 9, Judith M. Scanlan and W. Dean Care examine the issue of grade inflation in nursing. This issue is a sensitive matter for faculty, who are often unwilling to believe that they contribute to grade inflation in nursing courses. The authors explore whether grade inflation is real or perceived, discuss causes of grade inflation, and suggest strategies that nurse educators can use to ameliorate the problem of grade inflation in schools of nursing. They believe that nurse educators need to address the problems related to grade inflation in clinical courses.

Faculty often struggle with defining and evaluating clinical behaviors related to professionalism in nursing students. The authors of Chapter 10, Karen Rizk and Rebecca Bofinger, found this to be true with both attendance and dress code issues. In an attempt to simplify clinical evaluation of professionalism, the authors developed an objective tool based on a point system to monitor Absenteeism, Punctuality, and Adherence to Dress code (APAD). This easy-to-use tool provides a way of evaluating professionalism. This chapter is a good source of information about developing professionalism in nursing students and how to evaluate those behaviors in the clinical setting.

The growth of online courses in nursing is continuing at a rapid pace, but there is limited evidence as to the best teaching strategies to promote students’ learning in these courses. Chapter 11 continues with the theme of evaluation but shifts to the type and extent of feedback that faculty should give to students in their online nursing courses. Although best practices in online education acknowledge that prompt feedback is important, guidelines as to what this means are lacking. Wanda Bonnel, Charlene Ludwig, and Janice Smith address this issue as they report on their survey to better understand the concept of online course feedback from the students’ perspectives. From this study,
the authors gained an understanding of what students expected in an online course and what feedback was important to their learning. The authors present many implications for nurse educators and provide examples of how to integrate good feedback into online courses.

Part III of the Annual Review begins with Chapter 12 by Janice J. Hoffman on teaching strategies for critical thinking. Critical thinking is considered essential to the provision of safe, effective care to patients in a variety of settings. Hoffman explains that the importance of critical thinking is directly related to the complexity of the current health care environment and expanding technologies. Her chapter presents several practical teaching strategies that can be used to facilitate critical thinking, including reading assessment and activities, case studies, and questioning. These strategies can be used in clinical courses, in the classroom, and in online environments.

In Chapter 13, Nola A. Schmidt discusses the need for integrating evidence-based practice (EBP) in our nursing curricula. She explores how to develop a curriculum with EBP as its core. After providing a brief overview of EBP, she discusses student outcomes, curricular changes, and teaching strategies for incorporating EBP content in a nursing curriculum. She concludes with suggestions for developing expertise for teaching EBP in nursing.

The contributions that Peggy L. Chinn has made to nursing and nursing education are apparent in our everyday work as teachers—in how we interact with students, how we think about our role as educators, and how we carry out the teaching process with students in clinical practice, in the classroom, and in online environments. Chinn’s work has guided our practices for many years. She has been on the advisory board of the Annual Review since its inception and has written chapters for the Review: “Teaching Creativity Online” (Volume 1) and “A Praxis for Grading” (Volume 2). She also coauthored the chapter “Peace and Power” as a critical, feminist framework for nursing education. In Chapter 14 of this volume she shares her reflections on retirement, her 30-year career in nursing education, and what she has found to be important in making the transition to retirement. Her reflections will inspire you to bring some “retirement” into your own active careers as educators. This chapter is a very special contribution to Volume 6.
Leaders in nursing education have a vision of the future, know how to get there, and can lead others toward that vision. Although leaders in nursing education are essential to move the profession forward, there is little evidence to guide their development. In the last chapter (15) of this volume, Diane Whitehead, Maria Fletcher, and Jean Davis address this lack of evidence. They report on their study to determine what nursing faculty leadership entails and how nurse educators become leaders. Critical reflection, a certain leadership style, communication skills, and networking ability are essential; however, it is even more important to have passion for what you do and what you want to accomplish.

The goal of the Annual Review of Nursing Education is to keep you updated on innovations and new ideas in nursing education. We hope you will agree that Volume 6 meets that goal. A special acknowledgment is extended to Sally J. Barhydt, Executive Editor at Springer Publishing Company, for her guidance and assistance. And a thank-you to all the authors who so generously shared their innovations for the benefit of educators everywhere.

*Marilyn H. Oermann, Editor*
Part I

Educating Students in Clinical Practice: Through Partnerships and Innovative Learning Experiences
The conceptualization, implementation, and expansion of the clinical scholar model (CSM) at the University of Colorado at Denver and Health Sciences Center (UCDHSC) School of Nursing demonstrate value-driven and outcome-oriented excellence in clinical nursing education. The CSM is a prototype of academia partnering with health care providers to improve the experience of clinical placements and education in prelicensure nursing courses. Central to the model is the clinical expert nurse, who collaborates with faculty to coordinate clinical placements, facilitate student learning, and evaluate student performance and the learning experience in the clinical setting.

The CSM was created in 1984 within an educative-caring paradigm (Bevis & Watson, 1989; Watson, 1979, 1985, 1988a, 1988b). The model evolved over 2 decades to emphasize competency development in preparation for contemporary professional nursing practice (Lenburg, 1979, 1999a, 1999b). Originating with one school and one hospital, the CSM thrives today at UCDHSC School of Nursing in 14 acute care, ambulatory, and community-based clinical settings with 22 clinical scholars.

The model addresses calls for nursing education reform (American Association of Colleges of Nursing [AACN], 2006a; National League for Nursing [NLN], 2003, 2005b) and mandates to prepare nurses for
competent practice in today’s complex and rapidly changing health care environments (AACN, 1998, 2006a; American Nurses Association, 2002; American Organization of Nurse Executives [AONE], 2004a; NLN, 2000, 2005b; Tresolini & Pew-Fetzer Task Force, 1994). Hallmarks of the CSM with sustaining power are the following:

• meaningful education–practice partnerships
• valuing of the clinical nurse expertise
• a relationship-centered, caring curriculum
• competency-based, outcomes-oriented performance in practice

In this chapter, I describe the development and implementation of the CSM within a caring, competency-based curriculum as an exemplar for clinical nursing education. I discuss attributes of the CSM compared to the traditional clinical instruction models, as well as guides for implementation. The CSM is used to illustrate the coexistence of a caring (Bevis & Watson, 1989) and competency-based (Lenburg, 1999a, 1999b) curriculum for modeling caring and professionalism and building initial competencies of baccalaureate nursing students. I summarize the benefits realized by the student, the affiliating clinical agency, and the educational program to provide evidence of an effective and enduring model for clinical nursing education.

Confronting Threats During Challenging Times

Numbers are prominent in discussions regarding nursing education and practice today. A dominant focus on quantity is evidenced by the plethora of reports and literature tracking increasing enrollments, nursing faculty shortages, scarcity of clinical placements, and dwindling funding for education (AACN, 2006b, 2006c, 2006d; NLN, 2005a). The critical need for professional nurses and the potential impact on access, quality, and cost of health care are compelling. However, the quantification of professional nursing education and practice poses threats to the integrity and potentially undermines values and beliefs foundational to excellence in nursing education and quality patient care. Numbers become irrelevant if curricular frameworks and practice environments do not support caring or promote competency.
Reform in nursing education requires transition from traditional and behavioralist pedagogies to an educative-caring philosophy of education (Bevis & Watson, 1989; Diekelmann, 1988; Noddings, 1984; Tanner, 1990). Progress toward transformation, however, is thwarted when change efforts encounter resistance, uncertainty, and competition for limited resources. Although an array of initiatives is necessary to transform clinical education (Tanner, 2006), caution must be exerted to ensure that excellence in clinical education is enhanced. The AONE (2004b) and the National Council of State Boards of Nursing (2005) confirm the essential value of strong, structured, and well-supervised clinical instruction in prelicensure programs. The merit of any clinical placement and education strategy should ultimately be determined by whether the quality of preparation for professional practice is enhanced, as well as whether management of the quantity of student placements and education needs has improved. Solutions to complex problems must be theory guided, values driven, and outcomes oriented.

Early Beginnings of the Clinical Scholar Model

The CSM evolved from a conceptual framework that values collaboration, clarifies roles and responsibilities, and specifies outcomes. Embedded within an educative-caring philosophy and a competency-based model of assessment, the CSM supports learning and teaching environments to prepare increased numbers of nurses today for the highly challenging realities of practice tomorrow. Baccalaureate enrollments at the UCDHSC School of Nursing have quadrupled in the last decade, while simultaneously experiencing curriculum revisions, the nursing faculty shortage, scarcity of clinical placements, and constrained resources. The CSM endured in turbulent times, evolving and expanding to accommodate increasing enrollments with assurance of quality clinical placements and education.

Participation by a health care organization in the education of future nurses affects the daily workflow and relationships within the organization. Cronenwett and Redman (2003) described the value of affiliation to the clinical agency as (a) negative drain with no value; (b) essentially meaningless with no drain or no value; (c) a valued
partnership, primarily as a recruitment opportunity for graduate nurses as future employees; and (d) a greatly valued active partnership whereby more is accomplished together than either could accomplish alone. Whether the affiliation is negative or positive depends on contextual factors. Economic, societal, and political trends influence the ability or willingness of health care organizations and educational programs to collaborate.

A review of the cultures in education and practice in the early 1980s reflects a disconnection and provides a perspective for the early beginnings and inception of the Clinical Teaching Associate (CTA) model, a precursor to the CSM. Team nursing was the typical care delivery model. The longevity of staff nursing experience contributed to the stability of service organizations. Agency, pool, or traveling nurses had minimal impact on staffing and patient care. Nursing units were organized into distinct services, and managers often supervised a single unit. Directors exercised a span of control over a limited number of clinical areas and employees, allowing for close supervision. Patient acuity tended to be lower, and intensive care units were reserved for the critically ill. Length of stay accommodated assessment, provision of care, teaching, and discharge planning over time. Quality indicators focused on basic patient satisfaction and safety. During the 1980s the payer mix began to change, and managed care influenced delivery and cost of care.

Individual schools routinely arranged clinical placements with agencies without centralized communication or processes. Typically, faculty from the School of Nursing accompanied a group of nursing students to instruct and supervise the clinical rotation. Students often lacked adequate orientation to the unit or clinical expectations. Patient care protocols and policies of the clinical unit were not well understood by faculty, and specific clinical objectives were largely unknown to staff. Staff nurse involvement was variable and depended on individual interest or the faculty’s ability to perform in the clinical setting. Little consideration was given to the level or scope of learning activities, as students were assigned nursing tasks as they became available. Individual student learning needs or interests were addressed serendipitously, if at all. A disconnect between academia and service existed, and clinical nursing education was inconsistent and chaotic.
Development of the Clinical Teaching Associate Model

The foundation for collaboration and an enduring education–practice partnership began in 1984 with a joint initiative between UCDHSC School of Nursing and the University of Colorado Hospital in Denver. Recognizing staff nurses’ clinical expertise and teaching ability, the Clinical Teaching Associate (CTA) was designated as a resource to improve the clinical education experience for both students and staff. Practicing nurses, employed by hospitals, participated formally in clinical education in collaboration with lead teachers from the schools. The CTAs skillfully planned learning experiences and implemented problem-solving approaches to enhance the student’s ability to plan, implement, and evaluate care. As role models and mentors to individual students, CTAs also significantly influenced socialization into nursing (Benner, 1984). The CTA model expanded to additional schools of nursing and hospitals and stimulated the development of reciprocal policies related to student practice guidelines and clinical placement policies (Phillips & Kaempfer, 1987). The CTA model was useful in building links between faculty and clinicians, encouraging meaningful presence of faculty in service and clinicians in education, and enhancing the clinical relevance of education through collaborative planning (DeVoogd & Salbenblatt, 1989; Phillips & Kaempfer, 1987).

Evolution of the Clinical Scholar Model

The CTA model demonstrated beginning success but proved to be insufficient in clarifying roles and expectations. Students continued to lack adequate orientation, preparation, and readiness to engage actively with the CTA in providing patient care. Clinical instruction continued to be inconsistent and dependent on CTA and lead teacher experience with the student level or specific course competencies (DeVoogd & Salbenblatt, 1989).

As problems with the CTA model surfaced, education and health care provider environments were changing significantly with mounting economic, regulatory, and accrediting pressures. Shifting payer models, increasing acuity, and decreasing length of stay overshadowed
commitment to clinical education. The nursing staff mix changed to include more temporary agency and traveler nurses with potentially less familiarity of specific clinical agency protocol and reduced investment in students as prospective employees. Service began to convey the need for remuneration for providing clinical experiences. Simultaneously, demands for faculty productivity in scholarship and research increased, encroaching on teaching time. Collaboration in curriculum development or practice initiatives was minimal. Clinical education affiliations became less mutually satisfying. The focus reverted to managing student numbers and clinical schedules. Again, the gap between education and practice began to widen.

An Enduring Model for Excellence in Clinical Nursing Education

In the early 1990s, nursing leaders determined the CTA model needed restructuring to improve the clinical education experience for academia and service. Mutual concerns and expectations centered on strengthening clinical experiences and facilitating professional role behaviors and practice competencies within positive learning and work environments for students and staff.

The Clinical Scholar Model

The components, implementation, and benefits of the CSM for clinical supervision of nursing students are described by Preheim, Casey, and Krugman (2006). Assumptions underlying the model guided initial design and implementation.

Underlying Assumptions

- Actively involving the nurse expert in clinical education in collaboration with faculty maximizes development of professional role behaviors and practice competencies.
- Demonstrating caring and clinical expertise is crucial in serving as a role model and mentor for enculturation into the nursing profession.
• Coordinating clinical placements, schedules, and orientation prior to the clinical experience is essential for smooth integration into the clinical setting.
• Understanding the School of Nursing’s unique philosophy of nursing and education, as well as curricular framework, is important to role modeling and facilitating individual student professional growth and clinical performance within the context of the course.
• Planning learning activities consistent with the student level and expected course-related outcome competencies facilitates individual student professional role and competency development.
• Clarifying roles and responsibilities of faculty and the clinical scholar is key to meaningful student–clinical scholar–faculty interactions and consistent education and evaluation.
• Consistently assessing students’ performance according to expected outcome competencies ensures progression and preparation for safe entry into practice.
• Participating in the evaluation of the clinical experience is necessary to ensure emphasis on contemporary practice priorities and program quality improvement.

Attributes and Qualifications

The clinical scholar is

• A caring, expert nurse who exemplifies professionalism in nursing practice and conveys passion for learning and teaching in the clinical setting.
• An employee of the clinical agency, with time dedicated for coordinating, educating, and evaluating student clinical experiences.
• Master’s prepared in nursing with a specialty focus in the area of teaching responsibility in the baccalaureate program.
• Experienced in nursing practice, with a minimum of 5 years’ experience in the specialty and a minimum of 2 years of employment within the hospital or clinical agency.
• Recommended and recruited within the clinical agency, based on extensive experience in practice and as a preceptor.
• A role model who values and demonstrates relationship-centered caring with patients, families, the health care team, students, and faculty.
• Interactive in caring, learner-focused relationships with students and faculty.
• Jointly interviewed and selected for hire by the clinical agency and the School of Nursing.

Clinical Scholar Roles and Responsibilities. An essential characteristic of the CSM is the incorporation of a master’s-prepared practicing expert nurse who is employed by a hospital or clinical agency and also holds a clinical adjunct appointment in the School of Nursing. The responsibilities include collaborating with school faculty and agency staff to plan and coordinate student experiences and learning activities to meet expected competency outcomes. The clinical scholar, student, and faculty form a triad to facilitate the student’s acquisition of clinical competencies. Roles of the clinical scholar include responsibilities for coordination, clinical education, and evaluation (Table 1.1).

Clinical Scholar Model Components for Implementation. To establish and maintain effective working relationships, education and practice partners implement several key components of the CSM (Preheim et al., 2006). These components include establishing contracts with clinical

<table>
<thead>
<tr>
<th>TABLE 1.1 Roles and Responsibilities of the Clinical Scholar</th>
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<tbody>
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<td>Roles</td>
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<td>1. Coordination</td>
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<tr>
<th>Roles</th>
<th>Description of Responsibilities</th>
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<tr>
<td>2. Clinical education</td>
<td>• Role models professional behaviors to facilitate socialization as a member of the health care team and nursing profession</td>
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<td>• Clarifies expectations and roles using effective communication and conflict management skills to guide the learning experience</td>
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<td>• Assesses critical thinking and clinical skills, and determines knowledge and application of the nursing process specific to the patient assignment</td>
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<td>• Interacts with individual student to model, dialogue, and provide feedback on performance</td>
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<td>• Provides oversight education to ensure the clinical course outcomes are met</td>
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<td>• Conducts clinical conferences to provide an opportunity to reflect on care provided and aspects of professional nursing roles and responsibilities</td>
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<td>• Fosters a trusting and caring relationship, key in developing student’s skills; confidence in performance; and socialization into professional nursing roles</td>
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<td>3. Evaluation of student performance</td>
<td>• Assesses readiness for engagement in clinical practice</td>
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<td>• Serves as a liaison to preceptor and faculty to ensure practice opportunities and skill development according to critical elements for competent practice</td>
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<td>• Consistently evaluates student’s clinical performance using standardized Competency Performance Examination (CPE) tools and procedures</td>
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<td></td>
<td>• Prepares recommendations for further development and/or revisions of the clinical experience or teaching/learning tools</td>
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<td></td>
<td>• Facilitates development and implementation of joint research and scholarly activities</td>
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agencies, conducting advisory meetings, developing communication and problem-solving protocols, and collaborating in course planning and evaluation.

**Clinical Affiliation Contractual Agreements.** Clinical agency and School of Nursing obligations are documented in the Clinical Affiliation Agreement. Agencies agree to recommend nurse experts for the role, provide benefits and professional liability insurance coverage and invoice for payment, and specify responsibilities of the clinical scholar. The school agrees to terms of payment, provision of student professional liability coverage, and enforcement of academic and disciplinary policies. An addendum outlines specific payment for clinical scholar services for confirmed clinical hours, including dates, hourly salary, and benefit data. The contractual agreement is between the School of Nursing and the clinical agency, with the school paying the agency.

**Clinical Scholar Advisory Meetings.** The School of Nursing hosts quarterly meetings for clinical scholars and faculty to address current issues and review relevant policies. Dialogue is facilitated by faculty or the clinical scholar on contemporary, evidence-based topics, such as the art of questioning, working with students at risk or with special needs, and effective relationships with multigenerational groups of students and staff. Dialogue may result in teaching and learning tools for use in the clinical setting. Networking builds comradeship and an awareness of current issues and trends across education and practice.

**Communication and Problem-Solving Protocols.** The CSM builds a strong education–practice link to clinical education by encouraging meaningful presence of practicing nurses in education and faculty in the clinical agencies. The clinical learning experience is improved, and the potential negative impact of students on a clinical unit is reduced when a credible and responsive clinical scholar is available to the staff to assist when questions or concerns arise. The clinical scholar frequently consults with the course faculty, who are knowledgeable about the specific course syllabus as a teaching and learning guide for expected performance and associated School of Nursing policies related to student progression.

The clinical scholar is in a pivotal position to interact frequently with staff and students to identify strengths or areas of concern. The expectation for early and frequent communication with student and
faculty is emphasized, especially when concerns about student performance relate to patient safety, or if a student may be at risk for satisfactory performance in meeting expected course outcomes. Approaches to support student learning and professional accountability and to ensure safety in care provision are developed in partnership with the student. Faculty is involved to provide clarification of expectations, jointly assess, or collaborate on a plan of action. The clinical agency’s goal for safe, quality patient care in a positive working environment and the school’s responsibility for consistent education and evaluation in a positive learning environment are achieved when open communication and collaborative problem solving occur routinely.

Collaborative Course Planning, Implementation, and Evaluation. The clinical scholar and the faculty course coordinator deliberate prior, during, and following the clinical experience to maximize strengths and address concerns or areas previously identified as needing improvement. Faculty is responsible for orienting the clinical scholar to the overall learning outcomes of the course, the design and implementation of teaching and learning principles recommended, and the processes and criteria used in student competency performance evaluation. The clinical scholar is invited to the first didactic class session to meet with the clinical group to establish an initial relationship, relay expectations, and exchange contact and logistical information for the first day of clinical. Clinical scholars and faculty plan regularly scheduled clinical site visits by faculty to meet with clinical scholars, students, and preceptors. Frequency and purpose of site visits are based on the need to ensure quality learning and teaching experiences, support and referral for individual learning needs, and guidance of clinical scholars.

Outcomes of collaboration include intake assessment guides, grading rubrics, and revised learning and competency assessment tools. A variety of approaches are used for improving student preparation, engaging students in practice activities, and interacting professionally with members of the health care team. The clinical readiness self-assessment is a tool used to assist the clinical scholar in determining individual student learning needs (Table 1.2). Clinical learning activities are planned to address the student’s individual interests and changing learning needs.
# TABLE 1.2 UCDHSC School of Nursing Clinical Readiness Self-Assessment

<table>
<thead>
<tr>
<th>Name: ____________________________________ Date: ____________</th>
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</thead>
<tbody>
<tr>
<td>Course Name: ___________________________________</td>
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</table>

The quality of your clinical experience depends on adequate student preparation and appropriate preceptor/instructor supervision style and structure. The purpose of this self-assessment is to identify your learning needs and readiness for clinical. This self-assessment process should be helpful in determining preparation needed for clinical care and is also helpful to your preceptor and clinical scholar in planning and evaluating your learning experiences. Please complete and bring with you to your agency orientation.

1. What previous clinical rotations have you completed to date?
   - ___ Nursing Care of Adults & Older Adults
   - ___ Nursing Leadership & Management
   - ___ Nursing Care of Childbearing Families
   - ___ Public Health Nursing
   - ___ Nursing Care of Children & Adolescents
   - ___ Clients with Complex Disease Entities
   - ___ Psychiatric/Mental Health Nursing
   - ___ Summer Externship, specify site and clinical setting ________________
   - ___ Clinical Elective, specify course/site ___________________________

2. What areas of needed improvement are you aware of from other clinical experiences?

3. Have you been/are you employed in health care? If so, where, for how long, and what type of role/responsibilities?

4. Do you have a previous college degree? If so, in what field of study?

5. Generally, do you learn and perform most successfully with:
   - ___ very close supervision
   - ___ moderate supervision, initiated by the preceptor for yourself
   - ___ available supervision, requested by you as needed.

6. What population or care setting are you most interested in, possibly as your entry into nursing practice? (i.e., adults, pediatrics, geriatrics, medical, surgical, obstetrics, etc.)

(continued)
**TABLE 1.2 (continued)**

7. What aspects of care delivery or care coordination are you particularly interested in? (i.e. assessment, interdisciplinary care coordination, delegation to unlicensed assistive personnel, patient education, discharge planning, clinical guidelines or care planning, technology, preventive care, quality improvement, cost containment initiatives)?

8. Within the context of the course competency outcomes (performance expected at the completion of the course), what would make this an outstanding clinical experience in your mind?

9. What is your greatest concern for this clinical?

10. During this clinical rotation, what learning opportunities do you specifically want to seek?

11. In one year from now, what do you plan to be doing?

12. Optional: Do you have additional learning needs or anything else you want your preceptor to know about you?

13. **Personal Learning Objectives:** Please identify three measurable learning objectives related to this clinical rotation.

   A.

   B.

   C.

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**Benefits of the Clinical Scholar Model**

**Benefits to the Students.** Students benefit from the continuity provided by the clinical scholar, who links theory with practice and increases the relevance of the clinical experience. The clinical learning environment is positively evaluated by students, largely due to the clinical scholar’s influence, communication, and conflict management with staff. A higher standard of student performance is upheld when the clinical scholar understands expected course outcomes, students’ ability levels, and important curricular concepts. Students’ positive evaluations support the importance of prompt and
constructive feedback, student engagement to demonstrate critical thinking skills, and competency and caring in practice.

Benefits to the Clinical Agency. Consistency of clinical faculty within the facility results in less disruption and better integration of students into unit and staff activities. Preceptors feel supported in interactions with students when the clinical scholar is an accessible colleague. Practice partners identify issues and recommend changes to faculty to increase the relevancy of the clinical experience consistent with contemporary practice. A positive clinical experience enhances potential recruitment of new graduate nurse employees. The clinical agency is able to retain experienced nurses by enriching their roles with teaching and scholarship opportunities.

Benefits to the School of Nursing. The CSM serves as a relationship and solution-building model between the school and the clinical agency. Long-term planning is less fragmented and more flexible, facilitating the placement of a significantly increased number of students. Fewer temporary clinical instructors need to be hired and oriented due to the consistent affiliation with the CSM. Academic standards and policies are uniformly upheld. Student performance is reliably evaluated, contributing to appropriate progression or remediation. The clinical scholar facilitates preparation for entry into practice and professional roles, further supporting meaningful relationships with clinical agencies (Preheim et al., 2006).

Comparison of the Clinical Scholar Model and Traditional Models of Clinical Instruction

Assumptions underlying excellence in clinical education, attributes and qualifications of the clinical scholar, and specific roles and responsibilities guide the implementation of the CSM and distinguish the CSM from traditional models of clinical instruction (Table 1.3). In addition to specifying instruction and supervision roles, the CSM creates a framework for facilitating competency and professional development through caring, learner-focused relationships.


<table>
<thead>
<tr>
<th>Clinical Scholar Model</th>
<th>Traditional Clinical Instructor Model</th>
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<tbody>
<tr>
<td>• Clinical scholar employed and paid by clinical agency, with the school providing payment to the clinical agency for time dedicated to the Clinical Scholar role</td>
<td>• Clinical instructor employed and paid directly by the school of nursing</td>
</tr>
<tr>
<td>• School of nursing simultaneously negotiates clinical placements and clinical supervision needs with the clinical agency</td>
<td>• School of nursing negotiates clinical placements with the agency independent of clinical supervision</td>
</tr>
<tr>
<td>• Clinical scholar coordinates clinical experience, identifying and preparing the unit and preceptors for student’s arrival and learning needs</td>
<td>• Clinical instructor interacts with the clinical agency nurse manager or educator to confirm student’s assignment to a clinical unit</td>
</tr>
<tr>
<td>• Clinical scholar uses assigned preceptor and direct teaching for individualized student learning and evaluation and provides oversight supervision and evaluation</td>
<td>• Clinical instructor provides direct teaching and evaluation of groups of students with or without unit staff acting as preceptors</td>
</tr>
<tr>
<td>• Clinical scholar promotes development of critical thinking and integration of knowledge and skills across courses and curriculum</td>
<td>• Clinical instructor facilitates critical thinking and achievement of goals and objectives specific to the course</td>
</tr>
<tr>
<td>• Clinical scholar collaborates as a liaison with the school of nursing course faculty and program director for course and curriculum planning and revisions, and evaluation of clinical experiences at the clinical agency</td>
<td>• Clinical instructor interacts with the school of nursing course faculty to evaluate individual student performance</td>
</tr>
</tbody>
</table>

Historically, the prominent approach in nursing education has been a traditional, behavioral pedagogy with structured and paternalistic learning environments. The curriculum determines the plan for learning, outlining learning experiences to achieve goals and objectives. Even critics of behavioral approaches acknowledge the effectiveness and efficiency of traditional strategies in increasing the amount of content learned.

However, inherent limitations of behavioral approaches are evident. Nurse theorists and educators protest the traditional model of undergraduate education that has been used for decades. Diekelmann (1988) referred to behavioral pedagogy as linear, mechanistic, and focused on content acquisition. Faculty assumes authoritarian roles, controlling content knowledge and student activities. Students become passive consumers of information. Learning, defined as retention of facts, emphasizes behavioral objectives to prepare for the job rather than a life as a professional (Aydelotte, 1992) and may impede the understanding that practice rules are guides to be interpreted with experience and within context. The potential exists for the neglect of values, ethics, and morality in socialization of students (Bevis & Watson, 1989). Tanner (1990) cautioned, “The rational technical model of education may no longer serve us well for educating caring and critically thinking nurses. There is a growing sense of malfunction with the continued use of the behavioral model of education in nursing” (p. 296).

Em Bevis in her book with Jean Watson (1989), Toward a Caring Curriculum: A New Pedagogy for Nursing, declares that nursing education must seek the kind of nurse who accepts the ambiguities and uncertainties of complex practice and social environments. “The nurse we seek is one who can act and reflect, and who has the nature of a compassionate scholar with a mind that never ceases to inquire, quest, or expand” (Bevis & Watson, 1989, p. 68). Teaching and learning strategies must promote critical thinking, personal accountability, and self-direction. The CSM is an exemplar of educative-caring philosophy in nursing education, existing within a competency-based curriculum (Lenburg, 1979). The components of a philosophy of caring

Clinical Scholar Model: Competency Development Within a Caring Curriculum
education (Nodding, 1984) can be applied to student–clinical scholar interactions and learning experiences. The components are modeling, dialogue, practice in caring, and confirmation.

**Modeling**

In a caring curriculum, the clinical scholar demonstrates caring behaviors with patients, families, coworkers, and students. The CSM may be viewed as a mentorship or caring and cognitive apprenticeship (Brown, Collins, & Duguid, 1989). Clinical learning is experiential, and students seek to emulate patterns of performance that exemplify the nursing roles to which they aspire. As an expert nurse, the clinical scholar personifies caring and practice competencies. Consideration is given to how the clinical scholar demonstrates these valued behaviors and what feedback encourages these behaviors in student performance. The reasoning underlying the values is explored through the student–clinical scholar relationship to enhance understanding and integration into practice (Connor, 2001).

**Dialogue**

Frequent student–clinical scholar interactions and the use of caring, teaching moments are critical to motivate students. Personal stories illustrate values, relationships, and clinical reasoning. Talking about how professional nurses think and act assists students to access and construct knowledge. Intellectual commitment is encouraged when the student knows the clinical scholar well. Skillful listening encourages reflection on experiences and learning goals. Trusting and respectful relationships provide context for questioning, critiquing, and assisting each other.

**Practice in Caring**

A caring relationship between the student and the clinical scholar is central to clinical learning (Evans, 2000). The clinical scholar develops col-
laborative and collegial relationships, interacting with the student and the health care team to make his or her presence and influence known. Students are supported and challenged toward growth through a variety of teaching and learning strategies, including honoring previous life experience and providing freedom to be learners who sometimes make mistakes (Evans, 2000). The clinical scholar demonstrates the use of praxis, theory, and practice informing each other as a framework for planning and providing quality care.

**Confirmation**

By acknowledging the current level of performance and affirming the best in all, the clinical scholar demonstrates belief and trust in the student. Feedback, questioning, and seeking opinions in a supportive learning environment promote confidence (Brown et al., 2003) and help move the student toward an expected level of mastery.

Within a caring curriculum, a conceptual framework for competency development and assessment can coexist. Rather than a model that is traditionally teacher focused or course-objective driven, an outcomes-oriented framework consistent with contemporary practice competencies is foundational for the CSM. The UCDHSC School of Nursing integrated the competency outcomes performance assessment model (Lenburg, 1979) into a revised curriculum that emphasizes reflective nursing practice, relationship-centered caring, social justice and responsibility, and diversity and cultural competencies (Hinton-Walker & Redman, 1999). Faculty, in collaboration with clinical scholars, determines “the essential competencies and outcomes for contemporary practice” (Lenburg, 1999a, p. 3).

In the competency outcomes performance assessment model, practice-based competency outcomes are clustered in eight core practice competencies (assessment and intervention, communication, critical thinking, human caring and relationship, management, leadership, teaching, and knowledge integration skills). Each practice competency is further defined by specific subskills for diverse populations and practice settings and guides competency outcome performance assessment. Indicators that define the competency, the most effective way to learn
the competency, and the most effective way to document achievement complete the organizing framework.

The competency outcomes performance assessment model, implemented within the caring curriculum, provides a useful framework for faculty and clinical scholars in planning and implementing clinical experiences appropriate to the student’s learning level and specific course outcome competency requirements. Critical elements of performance are described in the competency performance evaluation. The indicators define essential competencies and are used by students and clinical scholars throughout the clinical experience to guide practice and learning opportunities and to assess student performance.

Conclusions: Value of the Clinical Scholar Model

Accountability in professional nursing education requires value-driven, learner-focused, practice-based, and outcome-oriented approaches to prepare the nursing workforce for the future. The CSM is an education–practice partnership, proven successful in establishing and maintaining excellence in clinical nursing education. As a partnership, the CSM facilitates mutual understanding of values and goals in caring practice. Built on strengths of an educative-caring pedagogy and a framework for assessing competency performance outcomes, clinical education for prelicensure students is provided through shared responsibilities and resources. The expert clinical nurse is a vital link, contributing to caring and competent practice, crucial to excellence in clinical education. Collaboration between partners facilitates continuous improvement and opportunities for scholarship related to evidence-based education and practice.

REFERENCES


American Association of Colleges of Nursing. (2006a). *Hallmarks of quality patient safety: Recommended baccalaureate competencies and curricular guidelines to assure...*


