Introduction

The growing professionalization of nursing and midwifery has led to the development of pre-registration diploma and degree courses in the United Kingdom that have moved away from an apprentice style system of training where students were included in the ward numbers and seen as an ‘extra a pair of hands’ for practice areas, to a curriculum that focuses on academic achievement and student status. Practice areas require competent, confident professionals able to undertake a range of nursing interventions. The belief was that this new curriculum would create flexible, knowledgeable nurses able to operate in a range of practice areas, including the community (UKCC 1986).

Arguably this change has led to a growing gap between higher education and health care services (Castledine 2000). The perception is that nurse education has become increasingly isolated from practice and the values of practice placements, where there is a dichotomy between the educated nurse and the skilled practice nurse, who are seen as two different individuals (Williams 2000).

Recent nursing strategies have emphasized the importance of clinical learning for students and the role of lecturers in supporting them (Department of Health [DoH] 1999, UKCC 1999, English National Board [ENB] and DoH 2001a & b). There is therefore a need to re-establish close and meaningful links between education and practice settings. This requires a commitment from both the higher education and service sectors to ensure that the student experience is positive and successful. In addition, there are quality

Enhancing your clinical links and credibility: the role of nurse lecturers and teachers in clinical practice

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In addition to teaching and research, nurse lecturers are expected to maintain clinical credibility and competence by spending at least 20% of their time in practice; this requirement is included in many nurse lecturer/teacher employment contracts. The aim of this paper is to suggest a number of realistic, pragmatic approaches that can be used to enhance clinical credibility and competence, which in turn should result in teaching which is up-to-date and grounded in the realities of clinical practice. The approaches discussed include working clinically, developing the learning environment, getting involved in practice development, developing links with the local trust, involving clinicians in teaching, running a learning set, doing some clinically orientated research, and running a staff support group. The argument that runs throughout this paper is that nurse lecturers need to develop an individualized practice-based role that enables them to keep in touch with current clinical developments. © 2001 Harcourt Publishers Ltd
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assurance issues connected with the Quality Assurance Agency (QAA) subject review process and the requirements of the English National Board (ENB 1998; QAA 1999).

Clinically competent and credible lecturers are seen as essential by clinical staff and regulators (UKCC 1994, 1998, 1999). The English National Board for Nursing, Midwifery and Health Visiting advocates that nurse lecturers spend 20% of their time in practice (ENB 1995, 1997). Although many nurse lecturers may find this difficult to achieve because of the competing demands of classroom teaching, administration and research it may also reflect uncertainty around the most appropriate means of maintaining clinical credibility and competence. Camiah (1998), for example, argues that following the move into higher education and the demise of the clinical teacher, an effective model for nurse lecturers in practice no longer exists.

There is little doubt that nurse lecturers need to negotiate a role for themselves in practice (Forrest et al. 1996, Day et al. 1998). In our experience, however, a universal model for the role of the lecturer in practice is neither feasible nor desirable. Individual nurse lecturers need to consider their current knowledge, skills, and expertise to develop an individualized practise-based role that enables them to keep in touch with current clinical developments. The aim of this paper is to suggest a number of realistic, pragmatic approaches that nurse lecturers can use to enhance both clinical competence and credibility, and to ensure that their teaching is up-to-date and grounded in the realities of clinical practice. The approaches discussed include working clinically, developing the learning environment, getting involved in practice development, developing links with the local trust, involving clinicians in teaching, running a learning set, doing some clinically orientated research, and running a staff support group.

Working clinically

Experienced lecturers who have maintained their clinical competence can often negotiate honorary clinical contracts with their local trusts. This contract enables lecturers to practise within their area of expertise on a negotiated basis and thus keep up-to-date with current developments. This model is particularly appropriate for lecturers with a clearly defined clinical expertise that can be utilized on a sessional basis.

Arguably this model is less suitable for lecturers who have not worked clinically for many years. Such lecturers may find it difficult to negotiate appropriate placements, and their resultant role in practice may be very limited. In addition it is important to acknowledge that lack of up-to-date experience and skills may place both patients and other staff at risk. We would suggest that nurse lecturers in this position consider some of the alternative approaches to maintaining clinical credibility advocated in this paper.

The appeal of clinically competent lecturers has fuelled a growing debate on clinical academic careers for nurses, midwives and health visitors (Council of Deans & Heads 1999, Kenkre & Foxcroft 2000). As a result, the number of lecturer/practitioner posts has increased. The vision underpinning the development of such roles is laudable and provides an opportunity for such staff to practice clinically, teach and carry out research. Whilst some studies have demonstrated that such roles can be successful (Lathlean 1997, Salvoni 2001), others have highlighted difficulties such as the tensions arising from endeavouring to fulfil the expectations of both service and academia (Hollingworth 1997).

Developing the learning environment

Several papers have suggested ways in which lecturers can work with staff in a range of practice settings to improve the learning environment for students (Ogier 1980, Owen 1993, Aston et al. 2000). Arguably both students and salaried staff have to fulfil certain learning criteria; for example students have to achieve set competencies for courses, health care assistants have to provide evidence for National Vocational Qualifications, and trained staff have to meet the requirements of Post Registration Education and Practice. It therefore makes sense to work with both staff and students to foster an environment that is...
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conducive to learning at all levels. A warm, supportive atmosphere where people feel free to ask questions, seek help, question practice, thus helping all staff and students to support nursing interventions with the best available evidence.

Nurse lecturers can help staff develop a learning culture that provides opportunities for personal and professional development. A number of key factors have the potential to enhance or inhibit such a culture. These include the behaviour and influence of the team leader or ward manager, the attitude of the practice team to students and each other, the amount and type of support and resources available, the organization and implementation of teaching and assessing in practice, and the relationship between practice and the academic institution (Mallik 2001).

The first task is to develop a good working relationship with the staff on the units where you will be working. Although this will take time, it is important to acknowledge that you are a transient member of the team and that the success of the collaboration will depend very much on how you are viewed and accepted by the staff team. Once this has been achieved, your contribution towards developing the learning culture can be negotiated with the staff. Tangible tasks might include doing some unit-based teaching; providing research evidence to support or change selected nursing interventions on the unit; supporting mentors by providing information on the different courses, the capabilities of students and assessment documentation associated with each course; helping the unit to develop their working philosophy; and attending and providing input on staff ‘away-days’.

Such collaboration provides a lecturer with an ideal opportunity to talk with practitioners about their practice, and to observe nursing practice being carried out. This in turn results in an enhanced and up-to-date understanding of the potential learning experiences available for students.

Getting involved in practice development

Increasingly the notion of evidence-based practice is becoming a reality in clinical settings. There have been problems of getting evidence into practice (Kitson et al. 1998), and moving practice from ritualized and routinized delivery of health care to effective health care (Ward & McCormack 2001). Research utilization requires a culture that supports its incorporation and provides nurses with the skills and resources to access and critically appraise the evidence, and implement the findings into practice (Rodgers 2000).

Many Trusts are now looking towards accreditation as a component of clinical effectiveness and the advancement of health care services within their organization, measured against explicit criteria. The accreditation process is usually seen as a journey of discovery and development, which will enable an organization or unit to adapt to changes in health care policy and reach their expected goals, through innovation, creativity and ‘leading edge’ practice. Each accreditation centre, such as the one at the Centre for the Development of Nursing Policy and Practice at Leeds University, has a number of criteria which need to be met in to achieve accreditation (Centre of the Development of Nursing Policy and Practice 2000). Not surprisingly, these criteria highlight the importance of a meaningful collaboration between the organization seeking accreditation and the local university, ideally the School of Nursing and Midwifery. The collaborating School of Nursing and Midwifery then has the responsibility for contributing to the advancement of knowledge within the unit, disseminating advancements in practice evaluated by the unit through its student programmes, and ensuring that such advancements are disseminated to wider audiences through publication and educational activities.

Our involvement with local services seeking accreditation for innovations in practice has been very rewarding in terms of enhancing links with practitioners, users and carers, and keeping in touch with developments in client care. For example, a mental health residential unit in the Nottinghamshire Health Care Trust has been working for a year towards accreditation as a practice development unit. The aims of the practice development unit are to improve the experience of service users and
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carers, improve the experience of staff that provide the service, and to develop a framework within which to assess and monitor its clinical effectiveness. A steering group consisting of an educationalist/researcher, practitioners, user and carer representatives, senior medical and nursing staff and representatives from the social services, health authority and voluntary sectors met monthly to oversee the work being undertaken by the unit to achieve accreditation. Issues discussed in the meetings included care pathways, developing creative therapies, setting up a carers’ support group, health promotion, user-focused monitoring, user involvement, services for women, developing an evaluation framework, enhancing the learning environment and communication structures. Now that accreditation has been achieved, it is anticipated that steering group members will now get more directly involved in specific practice related projects on the unit.

Developing links with the local trust

All trusts have a range of fora where nurses, practitioners from other disciplines, and increasingly user and carer representatives meet to discuss issues related to practice. These obviously range from unit based meetings that focus primarily on clinical issues, to meetings where the emphasis is primarily strategic such as interpreting health policy directives and planning how these are to be translated into practice. Ask to sit on some of the key groups where practice issues are discussed; through sharing theoretical knowledge we can contribute to practice development. Useful meetings or committees to consider are those which focus on clinical governance and quality issues, nursing (often combined with other disciplines) procedures, evidence-based practice groups or those which have been set up to look at particular issues such as equal opportunities, gender and race, sexuality, involving users and carers, and violence and aggression in the workplace.

In our experience, trusts welcome educational input, particularly if the lecturer attends the meetings regularly, contributes, and is willing to help with the tasks and ongoing work generated by the meetings.

Involving clinicians in teaching

With the rapid changes that are constantly occurring in practice, it is unrealistic to expect that lecturers can be completely up-to-date with all developments occurring in their field of practice. Indeed, many lecturers teach a range of topics under the broad umbrellas of mental health, learning disabilities, adult and children’s nursing, or the biological and social sciences for example when their particular field of expertise may be very specialized such as oncology, cognitive behaviour therapy or care of the elderly. It is therefore considered good practice (and indeed interesting for the students) to invite clinicians to teach the students about particular practice issues that a lecturer may know little about. Rather than seeing this as an opportunity to catch up on paperwork, we have found that sitting in with the students and listening to clinicians talk about their particular speciality is a good way of keeping up-to-date.

Offer to run a learning set

Action learning is learning by doing and an action learning set is a formalized arrangement to enhance people’s opportunities to learn from experiences and to speed up the process (Weinstein 1995). An action learning set consists of a small group of people, usually four to eight, who attend regular meetings lasting a full day. The time is divided between the members to provide equal ‘air space’ for everyone to present and reflect on the issues that they have brought to the set. All action learning sets need to have a project or task to focus the learning. The sets are run by facilitators who are responsible for time keeping, ensuring that the group adhere to the project or task, and that learning and the subsequent action is encouraged through active listening, questioning, and giving feedback and support. Sets usually meet for a minimum of 6 months in order to see results. The benefits of action learning sets for the participants include time and space for reflection; hearing about other people’s
insights, knowledge and experiences; being challenged to think differently; a sense of belonging and achievement; and an opportunity to share confusions and uncertainties whilst doing something constructive about it.

One of us is currently involved in facilitating an action learning set in a local trust. The set is one of several organized by the evidence-based practice coordinator in the trust. The sets have been established to support each of the multi-disciplinary staff participants to develop a portfolio of evidence to support identified client-focused interventions that underpin their practice. To prepare the invited facilitators for their role, the trust ran a 4-day training programme designed by an academic from a local university. The programme covered the purpose, processes, principles and practical potential of action learning; defined the role of learning set facilitators and the factors which determine effective facilitation; and identified the principles for learning set operation and facilitation. The set has now been running for 4 months and involves monthly meetings of 3 hours' duration. Ideally the set should meet for longer, but this proved difficult with clinical and other work commitments.

The main benefit of facilitating this learning set is that it provides a really good forum to hear about the current interventions that are being used with clients and an opportunity to keep up-to-date with the current evidence underpinning them. Insight has also been gained into the practicalities of endeavouring to underpin practice by the often incomplete, non-existent of contradictory research evidence available. Lecturers interested in becoming involved in facilitating a practice-based action learning set will find good introductions to the process by Revens (1998) and Weinstein (1998).

Undertake clinically orientated research

Universities demand that lecturers, including nurse lecturers, pursue research and scholarship in their individual disciplines. This includes carrying out original research, publishing scholarly papers and seeking research funds (Holland 2001, Owen & Maslin-Prothero 2001). Both of us have consciously chosen to develop our research interests within clinical rather than educational fields as a means of keeping in touch with current developments in practice. Examples include: women’s experiences of being involved in breast cancer trials (Maslin-Prothero et al. 1999, Maslin-Prothero 2000), evaluating services for women with serious and enduring mental health problems (Owen et al. 1998), and more recently practitioners’ knowledge and use of evidence-based interventions for people with learning disabilities and challenging behaviour.

It is also useful to consider the approach you might take to inform, improve and develop practice in light of your research findings and recommendations; and the continuing work regarding monitoring and sustaining change. One of us is currently working with a group of practitioners who are endeavouring to improve services for women with serious and enduring mental health problems. Much of the development work is building on the recommendations made in the original research (Owen et al. 1998). For example, the setting up of a Women’s Special Interest Group in the local mental health trust and the launch of the women’s network which provides an opportunity for women users, in contact with the local mental health services, to regularly meet one another in a relaxed and informal atmosphere at a café in the centre of Nottingham away from the statutory services (Owen & Milburn 2001). This development work has not only led to further research but has also provided an invaluable opportunity to spend time with both practitioners and users and therefore keep in touch with current issues, concerns and developments. Thus nurse lecturers can contribute to the development of professional practice and actively be involved, and advance their own knowledge base through research activities and regular contact with experts in practice.

Run a staff support group

A number of studies and campaigns have highlighted the stressful nature of health work (Mumford 2001). Stressed individuals or indeed entire teams are more likely to experience low morale, gain little satisfaction from their work and take time off for short or
long-term sickness (Oswald & Gardner 2001). Many organizations are seeking to address this problem in a variety of ways, including more flexible working hours, providing facilities such as good quality child care, access to continuing education, and setting up support mechanisms such as counselling services and staff support groups.

Support groups provide an opportunity for staff to meet regularly and spend time discussing their feelings about work related issues in a safe and supported atmosphere. The most effective groups have an external facilitator who ensures that the groups take place, maintains personal safety, and provides a sense of cohesion as the staff that attend the groups inevitably change from week to week. Units often struggle to find people willing and experienced enough in facilitation to run such groups; many nurse lecturers are in an ideal position to take on this role and our experience of running such groups has been enormously satisfying. Not only are you helping to support the clinical workforce and thus strengthening links between education and practice, but also you are in the privileged position of being able to hear about the realities (good and bad) of contemporary practice. Inevitably, many of the discussions focus on clinical issues and developments in treatment, which is yet another way of ensuring that your knowledge reflects current concerns.

Conclusion

In addition to carrying out research, teaching and administering courses, nurse lecturers are expected to maintain clinical credibility and competence in order to be able to integrate theory and practice (Holland 2001). Whilst the difficulties of juggling these competing demands are acknowledged, we feel that it is vital that teachers underpin their work with students with an up-to-date understanding of current practice issues. The fact that there is not a universally accepted model for the role of the lecturer in practice is a good thing. This provides an opportunity for lecturers to develop an individualized practice-based role geared to their particular needs. This paper has hopefully provided a number of pragmatic and realistic examples of how this might be achieved.

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