How to Be an Effective Clinical Instructor

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Understanding Student Expectations

Students come to the clinical experience with definite expectations of their clinical instructor. In a recent study by Gignac-Caille and Oermann (2001), students identified the following characteristics of effective clinical instructors:

- Demonstrates clinical skill and judgment.
- Explains clearly.
- Does not criticize students in front of others.
- Is approachable.
- Emphasizes what is important.
- Corrects students' mistakes without belittling them.

Recognizing the Stress in Clinical Practice

Research indicates that clinical practice is extremely stressful for students.

> The teacher should always remember that learning in the clinical setting is a public event. Students can not hide their lack of understanding or skill as they might in class. In clinical practice the possibility exists for many people to observe the student's performance – the teacher, client, peers, nursing staff, and other health providers. The nature of clinical learning, in and of itself, may create stress for learning in any health field (Oermann & Gaberson, 1998, p. 171).

Feelings of inadequacy, and concern about making an error and harming the patient are common sources of stress, but the other major source of stress which students consistently comment on, is the instructor.

Initially, all students are intimidated by clinical instructors. You don't even have to have done anything to make this happen, it happens by virtue of your position. You are seen by students as a powerful person, who has the ability to 'kick them out of the program' if you see fit. Because even the kindest clinical instructor is seen as a threat by students, you need to work on establishing a supportive climate for learning in the clinical setting, to develop trusting relationships with students, and to be aware of your own behaviors and actions that may add to student stress. Increasing a student's stress does not increase performance, it decreases it.

Breathe Through Your Nose

In order to not be a source of stress to your students, one thing you certainly must do is to manage your own stress level. Even if you are feeling stressed, you must try not to let it show. Students identify the

ability to remain calm as an important characteristic of clinical instructors (Davis et al., 1992). They expect you to manage crises and conflicts without falling apart or flying into a rage and to operate “above the fray”, not getting involved in staff politics or student battles (O’Conner, 2001).

Visualize Yourself as a Partner

The instructor’s way of being is of paramount importance in the clinical setting because in that environment students become socialized to the profession and its values (Reilly & Oermann, 1992). As an instructor, you should be modeling the same values and behaviors which you expect your students to demonstrate. If one of the behaviors you expect to see is caring behavior toward patients, then it only makes sense that you also demonstrate caring toward students, as well as patients.

Although the philosophy of many nursing programs is based on caring and holistic values, nursing students and their instructors often relate to each other in an adversarial manner (Diekelmann, 1989). Adult students are not prepared for the rigid and oppressive atmosphere which has historically surrounded nursing education. They resent being treated like children, and feel that they should be respected for the life experience they bring with them to nursing (Hayden-Miles, 2002). They are right!

Hayden-Miles (2002) states that “The education of nursing students evolves out of a partnership between students and instructors and involves cooperation and mutual responsibilities as both work toward their common goal. It is crucial to the clinical learning experience that students and instructors build a trusting relationship as quickly as possible”.

She describes a relationship which she calls ‘Teacher as Partner’, in which the use of humor helped students and instructors come to know each other first as human beings.

> Working together as adults, they then were able to create partnerships in which there was mutual respect and trust. Students felt comfortable approaching instructors with questions and admissions of errors, and the instructors trusted that students would do so. Assured that their instructors always would be there to help them, students were more willing to try new things. Their confidence and self-esteem were enhanced, and they looked forward to the clinical experience, as well as to the day they would graduate. The students viewed their clinical instructors as partners in education who shared their knowledge and expertise and guided them along the way (Hayden-Miles, 2002, p. 422).

In the same study, a contrasting pattern of “Teacher as Despot” emerged:

> …absolute power rested in the hands of the clinical instructor. Acting as tyrannical rulers, these instructors controlled the students and meted out punishment when students did not meet their expectations. The students felt subordinate to the instructors, whom they could not trust. The relationship was such that it transformed the primary objective of the clinical experience from caring for patients to avoiding the instructor at all costs. The students spoke of learning little or nothing from these experiences and of losing confidence in their ability to perform (Hayden-Miles, 2002, p.422).

Using Humor Helps

A 2002 study (Hayden-Miles) explored the meaning of humor for nursing students within their relationships with their clinical instructors. The students in the study described humor as a positive experience. These students did not mean “uproarious laughter”, but described humor as “looking on the light side of things”.

You may be uncomfortable with the idea of humor in the clinical setting. Yes, teaching students and caring for patients is serious business, but I believe that the judicious use of humor can really lighten up a very stressful situation. An instructor with a sense of humor is seen by students as human and much more approachable. Please keep in mind however, that ridicule and sarcasm is not humor.

Questions, Questions, Questions

A huge part of clinical instruction involves answering and asking questions. I remember one day I was out in my garage after a typical clinical day in which I heard my name ‘a thousand times’. Fran, where do I find the soap? Fran, I can’t find “Ecasa” (EC ASA) in the drug book. Fran, the Kardex says the patient is to get 3 liters of O2. How do I know when the 3 liters are in? (I’m not making this up). Anyway, while out in the garage I thought I heard another ‘Fran…’ and instinctively responded ‘What?’ when I realized that no one was there, and it was actually my neighbor in her back yard calling for her son Graham! You just get used to the constant questions. Of course, the questions should get less frequent and more sophisticated as the student progresses through the course and through the program.

Even the best instructors though, can sometimes break under the shear volume and basic level of questions they receive. Just try to remember, that if you are getting a lot of questions, that is a good thing, because that means that students see you as approachable. If students are afraid to ask you questions, you need to be worried. The reason may be because they have seen others receive a sarcastic or belittling response, such as ‘go look it up’, or ‘you should know that’. No matter how frustrated you may feel with a particular student, it is better that they ask the question than to be afraid to ask, then make a mistake and hurt someone.

You too, must ask questions of the student. As an instructor, questioning students gives you insight into the student’s thought process and preparation. I highly recommend that you read the module on Critical Thinking, as it goes into detail on the concept of Socratic questioning.

I must caution you that I have seen instructors begin questioning, and then as students falter and are unable to answer the instructor’s questions the exchange deteriorates into ‘an inquisition’. If a student doesn’t know the answer to your first question, you may try posing it a different way, but if they don’t have the answer the second time, the student often becomes more anxious, and further questioning will not usually yield a positive result. You must use good judgment in these situations, and explain the answer to the student, rather than belittling them or leaving them hanging.

Along with asking questions, listen carefully to what the students say both to you and to patients, staff and peers. I have learned a lot about what students understand and don’t understand, by walking softly and having big ears!

Observing and Assisting Students With Skills

Skill performance is a major focus for nursing students, especially beginners. To students, the ability to perform these skills is what “makes them feel like nurses”. Frequently, after the lab in which students learn how to give injections, I have heard at least one student exclaim, “Now I feel like a real nurse – I know how to give a shot”. As instructors and experienced nurses, we know that there is a lot more to being a nurse than giving a shot or performing some other skill. In fact, these skills have become second nature to us and often we don’t even remember where or how we learned them.

I have a distinct memory of my first semester as a teacher, when I was in the skill lab and observed an experienced teacher teach the lab on sterile asepsis. Even though I had done hundreds of sterile dressing changes, and done them competently, I could not have listed all the principles of sterile asepsis, such as never reaching over a sterile field, and the outside one inch of the field is considered contaminated, and anything outside your line of vision is considered contaminated, etc. I was wide-eyed in amazement that this was the level at which I needed to approach my teaching with the beginning student. I had to break down each skill into small steps that could be stacked like building blocks to create the whole. More complex skills could be taught on the basis that the concepts contained in this skill were the foundations for further skill and knowledge development. I still consider that day a kind of epiphany in my teaching career.

The idea then, is that we need to recognize the importance that students place on performing even the most basic skills, and part of the clinical instructor's job is to locate opportunities for students to practice these skills in the clinical setting. Often this means, proactively talking with the staff and assuring that they do not do the procedure before the student has a chance to. Because students are often slow, staff may assume it is not going to be done and need reassurance that it will be.

One of the hardest parts of being a clinical instructor is to watch an awkward student perform a new skill and refrain from jumping in and taking over for the student. It can take an infinite amount of patience sometimes. "The instructor's need to teach must not be allowed to intrude on the student's need to learn" (O'Conner, 2001), and the only way to learn skills is by doing them.

If it's the students first or second time performing a skill, I like to review the skill with the student. Prior to entering the patient's room, I usually have the student visualize performing the skill and talk through the steps involved. This gives me the chance to anticipate where the student may have difficulty. I then give a few helpful hints, and we enter the patient room together.

Once in the room, I try to keep my hands folded, watch carefully, have an air of calm reassurance, and provide words of encouragement along the way. Gentle prompting is usually helpful to the student and does not distress the patient. Be cautious not only about what you say, but how you say it. It's important not to make the patient feel that the student is incompetent or doesn't know what she/he is doing, and patients will pick up on your voice modulations, facial expressions and body language.
A useful technique is to talk the patient and or family through the procedure. This distracts the patient from focusing on the student, and at the same time provides slightly hidden prompts to the student.

You may need to step in and assist the student with a certain aspect of the procedure, without taking over entirely from the student. After assisting, step back into the coach and observer role. This happens most frequently in more complex sterile procedures, such as foley catheter insertion or complicated dressings. I carry a package of sterile gloves in my lab coat pocket so that they are immediately available if I need to assist.

There are occasions when you must intervene, and you must be prepared to do so quickly. In these instances, the student's actions or inaction jeopardize patient safety. In a calm voice, tell the student that you will finish the procedure, and give them direction on what they should do. Refrain from frightening the patient, and make every attempt to prevent loss of face by the student. Once the patient's needs are met, find a private place to go over what happened with the student.

Whenever students have completed performing a skill, whether it went well or not, be sure to take them aside and give feedback on how they did. Praise what they did well, point out what could be improved, outline the steps they should take to polish the skill, or identify what remediation should take place before the next clinical experience.

When discussing skill performance with students, they frequently say something like "You made me nervous". I do not allow students to give me that much power. I tell them that I didn't do that, "You allowed

yourself to be nervous while I was present". The idea that they have control over how they respond in a situation may be quite revolutionary to some students. Try to get them to take back their power, by viewing future situations in a different way.

Avoiding Common Pitfalls

This section could also be called 'Preventing Headaches for Yourself'. As any good nurse knows, the easiest way to deal with mistakes is to prevent them from happening in the first place. The following are common pitfalls and suggested preventive practices:

COMMON PITFALLS	PREVENTIVE PRACTICES
• Believing everything students tell you about their patients	• Students make mistakes because they are novices. Review the Kardexes for the students' assigned patients and use a worksheet for yourself to keep track of the basics, such as V/S, IV, diet, activity, tests, and treatments for the shift, etc.
• Charting omissions, forgetting to sign, etc.	• Check all charting before students leave the floor at the end of the shift.
• Medication errors	• Use a worksheet, and at the beginning of the shift list the times each student has medications to give. Cross them off, as the students give them, that way you can keep track along the way. Don't wait until the end of the shift to find out a 9AM med wasn't given. • Require that students have you check all meds against the med sheet with them, before they administer the med. (mainly 1st and 2nd semester students) • Emphasize that armbands must be checked against the med sheet. Place students in written counseling for failure to follow the 5 rights. • Allow students to pour meds for only one patient at a time. This prevents giving pt. A meds to pt. B. • Check all med administration records before students leave the floor to be sure all meds are charted and sheets are signed.
• Mishandling Narcotics	• If you are assigned to a hospital that still uses narcotic keys, do not allow students to carry the keys. Be sure to check that none of the students has the keys before students leave the floor. • Be sure students follow the proper procedure for wasting narcotics, include having a witness, and having the waste record cosigned. • Place students in written counseling for failure to follow the proper procedure for handling and documenting narcotics.

Be sure that the nurse manager has your pager number, or some way to reach you in case there is a question after you have left the unit. The sooner any problem or question can be resolved, the less likely it is that it will come back to haunt you the next time you're on the unit.

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