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Integrating a Professional Apprenticeship Model with Clinical Simulation for Psychiatric Nursing Students

Abstract

In this paper we present a theory-based application of clinical simulation in psychiatric/mental health nursing education. As described by Benner, Sutphen, Leonard, and Day (2010), a three-pronged apprenticeship that integrates intellectual, practical, and ethical aspects of the professional role is critical in development of practical reasoning in the education and training of nurses. Clinical encounters are often fraught with ambiguity and uncertainty. Therefore, educating for a practice discipline requires experiential and situated learning. Utilizing the three-pronged experiential model in simulated psychiatric/mental health nursing practice supports the development of critical nursing skills, ethics, and theoretical concepts. A clinical scenario is presented demonstrating the application of this model of professional apprenticeship in psychiatric/mental health education.

Keywords: Professional education, professional apprenticeship, nursing education, simulation, psychiatric/mental health nursing, practical reasoning

Introduction

In this paper we present a theory-based application of clinical simulation for use in undergraduate psychiatric/mental health nursing education. The education of professionals requires attention to intellectual, practical, and ethical aspects of the role. As described by Benner et al. (2010), a three-pronged apprenticeship that integrates these three types of learning is critical in development of practical reasoning in the education and training of professional nurses. Clinical situations are often unpredictable and require specific skills by a practitioner to ensure the highest quality, most efficiency, and safest patient outcomes. Therefore, educating for a practice discipline such as nursing requires experiential and situated learning. Clinical simulation can be a powerful adjunct teaching strategy alongside actual encounters in the clinical setting. Utilizing the three-pronged experiential model (Benner, et al) in simulated psychiatric/mental health nursing practice supports the development of critical nursing skills, ethics, and theoretical concepts in the education of a psychiatric/mental health nurse generalist. A clinical scenario is presented to demonstrate the application of the concepts of professional apprenticeships in a simulated educational curriculum for undergraduate nursing education.

Literature Review

Clinical simulation in the teaching of undergraduate nursing students is utilized in nursing schools across the U.S. Seropian, Brown, Gavilanes, and Diggers (2003) provided a detailed description of simulation and its use in health care education since the late 1980s. Other scholars have focused on the quality of simulation in teaching and use in improving patient safety by developing single simulations for participation by nursing and medical students (Kyrkjebø, Brattebo, & Smith-Strom, 2006). However, exploration of the use of simulation in teaching undergraduate psychiatric-mental health nursing (PMHN) has been limited.

Clinical simulation use in teaching PMHN skills has been demonstrated by Kudless and White (2007) as a method to evaluate basic clinical competencies to the advanced beginner of PMHN. Cleary, Horsfall, and Happell (2009) explored the use of simulation as an educational orientation to the specialty of PMHN, and Brown (2008) examined the specific use of simulation in teaching undergraduate PMHN practice skills threaded throughout a nursing curriculum. Robinson-Smith, Bradley, and Meakim (2009) evaluated undergraduate student satisfaction in simulating psychiatric-mental health clinical situations.

A needed area of focus in PMHN education (Gilje, Klose, & Birger, 2007) is the utilization of clinical simulation to teach the concept of communication. Patzel, Ellinger, and Hamera (2007) explored the obstacles in providing adequate, quality PMHN clinical experiences for undergraduate nursing students, specifically noting faculty expression of the effective use of simulation in teaching therapeutic communication as a means to supplement and to improve efficiency of the student clinical experience. The application of simulation in the teaching of therapeutic communication in undergraduate PMHN has been described by Sleeper and Thompson (2008). Additionally, Kameg, Mitchell, Clochesy, Howard, and Suresky (2009) provided a beginning perspective on the use of human patient simulation, utilizing live actors as patients, and addressed the lack of literature on its use in teaching nursing students communication skills.

Additionally, the literature provides some perspective on the use of theoretical concepts in simulating clinical application of therapeutic communication. Melrose (2002) provided a qualitative analysis of undergraduate education in an introductory course on PMHN, suggesting the need for theoretic components in helping students learn the clinical content. These components included the understanding of the clinical area as a personal process, recognizing student anxiety triggered by not knowing how to help patients, and establishing group activities and cohesion. These components are easily integrated in a simulation scenario addressing therapeutic communication, allowing the student

to practice the therapeutic use of self, practice with specific patient clinical presentations, and utilize debriefing to demonstrate group dynamics and provide time for instructor mentoring.

Other scholarly work has examined theoretical models for use in simulation. These contributions include the use of Benner's Novice to Expert theory (Larew, C., Lessans, S., Spunt, S., Foster, D., & Covington, 2006; Waldner & Olson, 2007) and Kolb's experiential learning theory (Waldner & Olson) Paige and Daley (2009) addressed the importance of situated cognition in providing a social context to the simulated learning experience.

Psychiatric-mental health nurse educators have embraced the clinical teaching opportunities provided through simulation. As we look to best prepare the registered nurse (RN) for today's ever challenging health care environment, including the psychiatric setting, we must incorporate the most contemporary perspectives in teaching clinical professionals. The integration of the three apprenticeships (Benner et al., 2010) throughout a nursing curriculum, including that of PMHN, is meant to provide a contextual framework for the integration of knowledge, skill, and ethical comportment in the professional development of a registered nurse.

The Three Professional Apprenticeships

A national study of nursing, medicine, engineering, clergy, and law proposed that professional practice is anchored in three apprenticeships: intellectual, practical, and ethical (Benner et al., 2010). However, contrary to the learning domains of cognitive, psychomotor, and affective skills, the researchers noted that in the formation of a professional identity the three apprenticeships are wholly integrated through the practitioner's concrete experiences, including the care of patients.

The intellectual apprenticeship is most readily seen in classroom lectures. For PMHN this often is the learning of psychiatric conditions, including symptom manifestations, and coinciding medical and nursing treatment. The classroom teaching includes the full spectrum of PMHN, including the care of

individual clients, families, and communities. These lectures typically emphasize the role of the registered nurse as a member of a multidisciplinary team in providing treatment to persons with mental illness, thus presenting the team approach to care in the classroom then later reinforcing it in the clinical setting.

As noted by Benner et al. (2010), nursing knowledge and science are often taught as decontextualized concepts via power point presentations during lectures. Instead these researchers suggest more usage of unfolding case scenarios that incorporate specific theoretical knowledge with application in a clinical setting that demonstrates clinical reasoning in transition over time.

Practical knowledge, also referred to as “skilled know how” (Benner et al., 2010, p 27), is learned by engaging in actual situations of care marked by uncertainty. For the novice practitioner, knowing what to do in a particular clinical situation is learned through ‘doing’, typically alongside skilled practitioners with whom the novice forms an apprenticeship relationship. This practical apprenticeship goes well beyond practicing psychomotor skills as these skills are developed through human interaction and dialog, incorporating compromises based on what the client desires and needs.

The ethical apprenticeship exceeds the boundaries of learning traditional formal ethics. It includes everyday ethical comportment whereby the student nurse responds relationally to another individual (the patient) who is in a vulnerable state, by providing empathetic and caring actions. These actions are transformative as a professional identity is forged through the experiences of acting on behalf of a client and integrating practical knowledge, nursing science, and ethical comportment to *form* new capacities, character, and identity. The integration of these three professional apprenticeships in the teaching of PMHN would include the acquisition and the application of knowledge in providing direct patient care. As opportunities for student/patient interaction and even student/community involvement occur, the student is likely to face personal and ethical challenges to their existing understanding and beliefs about psychiatric illness, systems of care, and social policies. These challenges, even conflicts, when addressed and assisted by a faculty member, help the student to form

the third apprenticeship of ethical comportment. Creating and integrating these opportunities through a simulated psychiatric clinical scenario is meant to enhance the student's professional development while providing nursing care in the clinical setting.

Simulating a Nursing Undergraduate Clinical Experience: Introducing Students to the Development of a Therapeutic Relationship

Introducing one scenario focused on establishing a therapeutic nurse/patient relationship allows nursing students to be introduced to the first phase of establishing therapeutic relationships. This scenario was chosen because nursing students have consistently expressed to the authors their greatest fear in beginning their clinical rotation in psychiatric/mental health nursing as not knowing how to approach the patient to begin a dialogue, and anxiety about saying or behaving in a manner that exacerbates the patient's condition.

The Scenario

This clinical simulation introduces the undergraduate nursing student to the concept of developing a therapeutic relationship with a patient diagnosed with chronic schizophrenia. The patient, displaying symptoms of paranoia, auditory and visual hallucinations, and disorganized speech, has been recently admitted to the psychiatric unit. The case summary is presented in the Storyboard, table 1. By creating a storyboard, specific details of the scenario can be developed, shared, edited, and practiced by faculty before enactment with students. The storyboard includes background information that assists in creating an actual clinical event. Because the scenario can never fully replicate the actual clinical setting, the storyboard helps to 'simulate' that setting as close as possible in order to provide an adequate educational experience for the student. This scenario introduces students who have no previous experience with a patient with psychiatric illness. The desired change/overall goal of the scenario is also noted in the Storyboard. It is important to note that the four desired outcomes are congruent with the student learning objectives for the PMHN clinical rotation.

Specific critical performance elements are also identified. These elements reflect the desired behaviors/actions of the student in responding to the simulation. They also provide objectives for further discussion when debriefing the student's 'performance,' or clinical practice during the simulation

Described in frames, the scenario provides for content consistency across use with a number of students. The scenario is presented in frames to help the instructor connect the scenario and student performance with the stated desired changes/overall goals. Finally, the Storyboard provides the specific elements important to incorporate in the faculty led student group debriefing session, occurring after review of the recorded simulation (see table 1).

The simulation case flow should last no more than 20 minutes and the debriefing no more than 40 minutes, as recommended by the Bay Area Simulation Consortium in California (BASC, 2009). For this reason, this scenario focuses on just the introductory phase in developing a therapeutic nurse/patient relationship in a specific patient clinical presentation. Other scenarios can be developed to assist the student in experiencing the practice of therapeutic communication in a variety of clinical situations. A scenario depicting the termination phase of a therapeutic relationship would complete the simulated educational experience of the therapeutic nurse/patient relationship.

Debriefing the Simulated Experience

Debriefing occurs immediately after the scenario is completed. Students watching the scenario on a video monitor join students involved in the scenario to watch the scenario again and comment on their observations. Often those involved in the scenario are invited to speak first, providing an immediate opportunity to reflect on their actions. As the unfolding case is viewed the 'world' of the clinical presentation of a person with schizophrenia comes alive.

The students have been introduced to the diagnosis of schizophrenia in lecture (intellectual apprenticeship), including manifestations such as paranoia, hallucinations, and disorganized speech. Students gain specific theoretical knowledge of the therapeutic use of self, professional boundaries, and safety concerns. As the video proceeds, the clinical faculty can frequently 'pause' the action to invite the

students to comment on what they are seeing (or feeling). Why did the student approach the patient slowly (or did he or she)? What is a safe therapeutic distance? Faculty can also point out the many points where 'clinical reasoning in transition' (Benner et al. 2010) is observed, for example, the point within the simulation when the student nurse invited the client to accompany the student to a quieter place.

The debriefing is a safe environment in which students can explore their feelings about caring for patients that are non-communicative, disheveled, and/or malodorous. Developing a self-identity that is professional, nonjudgmental, and caring happens through experiential learning in context-filled environments such as the one described (and enacted) in this scenario. For the student interacting with the PMH client for the first time, the student's tendency may be to focus on the psychiatric diagnosis. Such an occurrence neglects the client's experience with his illness, including the contributions of his physical condition, support systems, environmental placement, and their influence on the individualized symptoms experienced by the client. Benner et al. (2010) refer to this ability to recognize the unique patient in a particular situation as contextualization, and point out that contextualization avoids overgeneralization or stereotyping. This ability to 'meet' the unique patient is part of the ethical apprenticeship of nursing.

Simulations in psychiatric-mental health allow students to rehearse their use of practical reasoning in a 'near real' setting that is safe, where students can make mistakes and learn from their mistakes without harm to themselves or their clients. Debriefing encourages students to reflect immediately on their ability to apply their theoretical knowledge in a practical setting that unfolds over time.

Conclusion

It is important for nurse educators to explore and implement best practices in both clinical and classroom settings. New technology in clinical simulation is allowing nursing students to enhance their professional education through simulated clinical scenarios. Students safely integrate their learning with

clinical reasoning, including immediate feedback from faculty. Combining this technology with the knowledge gained from the recently completed studies by the Carnegie Foundation for the Advancement of Teaching 'Preparation for the Professions', including the study of nursing education (Benner et al. 2010), provides a safe, fully integrated and situated setting for experiential learning.

The presentation here of one simulated scenario addressing therapeutic communication with a patient with schizophrenia demonstrates the opportunity that simulation provides in enhancing the professional role development of the nursing student. Further development and examination of scenarios in PMHN need to occur, and critical analysis of their impact in the development of professional skills and behavior within the nursing student are critical. Developing simulations framed in the three apprenticeships of professional practice should be encouraged throughout the nursing education curriculum.

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