1.3: THE CLINICAL LEARNING ENVIRONMENT

“Correction does much, but encouragement does more. Encouragement after censure is as the sun after a shower.”
—Johann Wolfgang von Goethe

Today’s clinical learning environments can seem overwhelming. Learners, instructors and staff members all face extraordinary challenges in health care workplaces. Students can be recent high school graduates, adult learners supporting families, or newcomers to the country who are continuing to work on their language and literacy skills. Common concerns are high costs of tuition that result in unmanageable debt, and competition to achieve top marks. Many students travel significant distances to the clinical site and balance heavy study commitments.

Similarly, instructors are often employed only on a sessional or contract basis. They are also balancing work and family obligations that are separate from the clinical learning environment. As well, professional staff members at a clinical site, who are ultimately responsible for client safety and care, are frequently employed on a contract basis and may work at several different facilities. At times, professional staff members may view learners as an additional burden rather than an opportunity for professional development. Non-professional staff may find themselves assisting learners.

Creating a learning community among learners, teachers and staff cannot be left to chance. The complex social context of the current clinical learning environment makes intentional teaching approaches essential, approaches grounded in an understanding of how learning occurs for students. In this chapter we discuss the clinical learning environment, who the teachers are, and who the students are. We provide creative and easy-to-implement strategies that offer practical guidance to instructors for managing the everyday occurrences faced by clinical teachers in this unique ‘classroom.’

Picture of the Clinical Learning Environment

Students in health care education programs at universities complete practicums in a clinical learning environment in
addition to attending academic classes. Clinical practicums are considered essential to professional competence in most health-based professions. For example, clinical practicums are viewed as essential to the curriculum by programs in medicine (Ruesseler & Obertacke, 2011), nursing (Courtney-Pratt, FitzGerald, Ford, Marsden & Marlow, 2011), pharmacy (Krueger, 2013), physical therapy (Buccieri, Pivko & Olzenak, 2013; McCallum, Mosher, Jacobson, Gallivan & Giuffre, 2013), occupational therapy (Rodger, Fitzgerald, Davila, Millar & Allison, 2011), dietetics (Dietitians of Canada, n.d.), radiation therapy (Leaver, 2012), paramedic training (McCall, Wray & Lord, 2009) and dental hygiene (Paulis, 2011). Internationally, clinical practicum placements for students in these and other health care disciplines are in markedly short supply. Available placements may be in programs offering care only to seriously ill clients, may be inundated with learners from the health disciplines, and may be experiencing budget cuts and staff shortages (Brown et al, 2011; Roger, Webb, Devitt, Gilbert & Wrightson, 2008).

The real world learning environment where students in the health professions complete their clinical practicums is an “interactive network of forces” (Dunn & Burnett, 1995) rich in opportunities for learners to transfer theory to practice. Setting out sequences of learning activities in unpredictable clinical environments can be more difficult to plan and structure than in traditional classroom environments. Both planned and unplanned experiences must be taken into account.

Planned Experiences

Curriculum. Following direction from a curriculum is a widely used planned learning experience in the clinical learning environment of any professional health care program. At the curricular level, clinical practicums are usually arranged before students are granted admission to their program of study. A curriculum is the range of courses and experiences a learner must successfully complete in order to graduate. Curricula are expected to include a philosophical approach, outcomes, design, courses and evaluation strategies. Clinical practicums can be structured as courses in the curriculum, either as part of a theoretical course or as a standalone course. Clinical practicums must be considered in relation to available health care facilities that are able to accommodate students.

Curricula in programs educating future practitioners in health fields are strongly affected by requirements of professional associations, regulatory agencies and approval boards. Curricula must address discipline-specific competencies. Throughout the curricular planning process, program planners from educational institutions must negotiate with administrators of service agencies to find suitable clinical practicum sites.

Since the education of health care professionals now occurs in universities rather than in the agencies providing service, negotiating, designing and evaluating clinical practicums in relation to the overarching curriculum is seldom a linear process. One consideration is program structure, or the duration and division of learning to be undertaken by students. Here, modes of delivery matter: program structure could be framed around face to face settings in traditional classrooms, distance delivery or a blending of both. Partnerships between institutions and consortiums or collaborations among institutions also matter. When programs are structured to be delivered at a distance, learners may have to travel and find accommodation in a different geographical area in order to attend their practicums. In both face to face and distance programs, international practicum experiences may be available and even required.

Another consideration is the program model or organization of required courses, elective courses, laboratory experiences and clinical practicums within the curriculum. In clinical practicums, the program model guides the method of instruction that will be used. For example, the program model may require that students are taught in small groups by
a clinical instructor, in one-to-one interaction with a preceptor, or a combination of these and other instructional methods.

In the health disciplines, coordinating instruction extends well beyond the actual institutions of learning and into clinical agencies. Scheduling, faculty and budgets must all be addressed. The instructors and preceptors who teach students during their clinical practicums may have no other association with the university. Similarly, university faculty assigned to teach in a particular clinical area may have no current association with a particular agency.

**Program Design.** Program design configures the program of studies, including the courses selected, practicum experiences, relationships among courses, and the policies that communicate this information. Designs may include building with blocks of required study, building by spiralling back and adding to previous content at different points, and establishing opportunities for specific tasks such as an essential psychomotor skill. Clinical teachers seldom have input into how programs are structured, the type of model used to organize content, or the design influencing how and when information is presented. However, all those involved in educating students must seek a basic understanding of the ‘big picture’ curriculum that students follow.

Traditionally, curricular organizing strategies often revolved around the medical model. The hospital areas of medicine, surgery, pediatrics, maternity and psychiatry framed the focus of learning for health practitioners. This model is strongly aligned with hospital-based apprenticeship orientations to learning and is now considered somewhat outdated in today’s complex and ever-changing health care system (Benner, Sutphen, Leonard & Day, 2010; Diekelmann, 2003; Tanner, 2006).

Today, programs are more often organized around a conceptual framework generated within the discipline or around the outcomes expected of graduates. For example, with outcomes such as promoting health, thinking critically and making decisions, curriculum planners would organize content related to each of these outcomes in different courses throughout the program. Evaluation methods would be determined in relation to these outcomes and would include a wide range of educational measurements. Examples might be multiple choice exams and scholarly papers in academic classes, and skill mastery or client communication in clinical practicums.

**Levelling** is the process of linking program content, introduced at different times and in different courses, to the evaluated outcomes expected of graduates. Levelling requires planned opportunities for students to build on their previous knowledge and work incrementally towards achieving more complex outcomes. However, if a limited number of clinical placements are available, scheduling appropriate clinical opportunities for students at all levels is particularly challenging. Introductory level students may find themselves in practicums where they must care for acutely ill individuals. In many instances, practicum placements are more suited to advanced learners than to students in basic health care programs.

Further, instructors, staff and students can find it difficult to link the learning outcomes and evaluation methods that flow from a program’s unique conceptual framework with the day-to-day work of a clinical agency. This may be another consequence of the limited associations between universities and clinical agencies. Although links between learning outcomes and day-to-day practice are made during planning by representatives of the universities and the agencies, the links may not always be clearly communicated to the staff actually working with learners.

**Admission criteria** are another important curricular element in appreciating the complexities of planned aspects of clinical learning environments. Some learners come to a health-related program of study with less than a high school
Others come to post-secondary education with high school completion and are being introduced to a college, technical institute or university for the first time. Still other learners have at least one level of certification or an undergraduate or graduate degree. At any level, qualifications for admission may have been completed in another country and in another language. Learners may also have been awarded credit for prior learning or transfer programs.

Clinical agencies often host learners from a variety of different programs and admission requirements will be different for each program even within the same discipline. For example, while one registered nurse program may require high school completion, another may accept adult learners who have completed bridging programs. Inconsistent admission criteria among programs can leave agency staff members unsure of what learners are expected to know when they arrive, particularly when coupled with learning outcomes and evaluation methods that may not seem straightforward. In turn, staff can feel confused about how learners should be progressing and the specific task-based competencies they should be achieving.

**Creative Strategies**

**Big Picture Thinking**

As a new clinical teacher, find out as much as possible about the overarching curriculum that directs your learners’ program of study. What is the philosophical approach guiding the program? Go beyond considering expected student outcomes for the specific course you are teaching and think deeply about the outcomes expected of students after they graduate. Visualize your present course in relation to the design of the program.

In the big picture, ask yourself how the course you are teaching builds on previous courses. What specific skills or ways of thinking must students master to progress to the next level? Will supplemental activities be needed if opportunities to learn these foundational skills are not available? What are the evaluation methods in the course you are teaching familiar to students?

You can also consider the impact of admission criteria on the dynamics of your student group. For example, what life event factors might be distracting students from learning in the clinical environment? Could students away from home for the first time feel heightened anxiety? Could an adult learner reverting to a student role feel hampered in self-confidence? While none of these questions are likely to have immediate or easy answers, sorting through the planned aspects of a program and their implications establishes a foundation for managing the less predictable and unexpected aspects.

Curricular structure, model, design, outcomes, evaluation methods and admission requirements of a program are planned with great care. They offer ‘big picture’ direction and open doors for learning in the clinical environment. Even so, unpredictable events are sure to emerge once clinical practicums are underway. In the following section, we discuss the heart of any clinical learning environment for many students, instructors and staff, the unplanned aspects of clinical learning.

**Unplanned Experiences**

The clinical learning environment is equivalent to a classroom for students during their practicums (Chan, 2004), yet few clinical agencies resemble traditional classrooms. In their clinical classrooms, learners hope to integrate into agency routines and feel a sense of belongingness (Levett-Jones, Lathlean, Higgins & McMillan, 2008). Learners want to feel
welcome and accepted by staff and they want staff to help teach them how to practice confidently and competently (Courtney-Pratt, FitzGerald, Ford, Marsden & Marlow, 2011; Henderson, Cooke, Creedy & Walker, 2012). Students expect and require feedback on their performance and they must have opportunities for non-evaluated student–teacher discussion time (Melrose & Shapiro, 1999) and critical reflection (Duffy, 2009; Formeris & Peden-McAlpine, 2009; Mohide & Matthew-Maich, 2007). Learners need time to progress from one level of proficiency to another (Benner, 2001). Just as learners in classroom environments need support to develop competence in their chosen professions, learners in clinical practicums need a supportive clinical learning environment.

While supportive clinical classrooms are hoped for, clinical teachers must also be well prepared for unplanned experiences that raise barriers to learning. Research suggests that clinical learning environments may not be as supportive as learners would like. For example, Brown et al.’s (2011) work with undergraduate students from ten different health disciplines reveals significant differences between learners’ descriptions of their ideal learning environment and what they experience during their actual clinical practicums. Although participants in Brown et al.’s study express satisfaction with their learning experiences, they describe a mismatch between what they hoped for and what actually occurred. Similarly, recently graduated nurses indicate significant differences between the kinds of practicums they deem good preparation for practice and those they actually attended (Hickey, 2010).

Investigations into experiences of physical therapy students were unable to conclusively define a quality learning environment, in part because of the diverse instructional practices by different community agencies overseeing students’ practicums (McCallum et al., 2013). Over the last decade and in several different countries, student nurses rated their clinical experiences highly for their sense of achieving tasks but much lower for accommodating individual needs and views (Henderson, Cooke, Creedy & Walker, 2012). Although university students are encouraged to question existing practice and the status quo, students find that staff in their clinical placements are seldom open to innovation or challenges to routine practices (Henderson, Cooke, Creedy & Walker, 2012).

Staff shortages, and other issues with which clinical agencies struggle, can leave students feeling that they are not receiving the direction they need and that they are a burden to staff (Robinson, Andrews-Hall & Fassett, 2007). Students may feel alienation rather than the sense of belongingness they hope for (Levett-Jones, Higgins & McMillan, 2009). Students may express fear and discomfort in their relationships with staff (Cederbaum & Klusaritz, 2009, p. 423). Clinical learners have felt rejected, ignored, devalued and invisible (Curtis, Bowen & Reid, 2007). These findings suggest that in some instances health care students are not receiving the support they need.

By acknowledging that both unplanned and planned aspects of learning will occur in all clinical learning environments, educators can plan fitting responses. Clinical agencies will always have a professional duty to prioritize safe patient care over providing learners with clinical classrooms that align with their curriculum and individual needs. As a consequence, and in spite of careful planning by university and agency program representatives, students may perceive their learning environment as unsupportive.

However, international leaders in the health disciplines are calling on clinical agency staff to view clinical teaching as part of their own professional development. They ask clinical agency staff to aid the next generation of professionals by striving to provide quality clinical learning environments where students do feel supported (Courtney-Pratt, FitzGerald, Ford, Marsden & Marlow, 2011; Koontz, Mallory, Burns & Chapman, 2010). Programs are testing new models of instruction (Franklin, 2010). Individual clinical teachers are striving to implement innovative teaching approaches that can create mutually beneficial connections between learners and staff during clinical practicums. Recognizing when
unplanned aspects of clinical learning environments distract from student learning is an important first step in triggering change. Evaluation surveys are one way to cast a spotlight on troublesome areas.

**Creative Strategies**

**Giving Back**

Knowing that students want to feel a sense of belonging in clinical agency staff groups, you can find ways for students to contribute. Encourage students to reach out to staff members with offers of help, no matter what tasks are involved. To establish a more reciprocal climate of knowledge exchange, reverse the one-way flow of information from staff to student. Share students’ academic work with staff. For example, you can arrange student input into existing in-service presentations or initiate new presentations. Whenever possible, record any presentations and make them available online so those unable to attend can also benefit. Invite students to share any relevant assignments from any of their courses that staff might value. Request space on agency bulletin boards (physical or electronic) and post these assignments. Help students change the topics of posted assignments frequently and keep the information being shared as concise as possible.

**Clinical Learning Environment Inventory.** Surveys to measure the quality of clinical learning environments are available. For example, the Clinical Learning Environment Inventory (CLEI) was developed in Australia by Chan (2001, 2002, 2003) to measure student nurses’ perceptions of psychosocial elements in clinical practicums. The CLEI consists of an *Actual* form that assesses the actual learning environment and a *Preferred* form that assesses what the student would ideally like in a learning environment. The CLEI is a self-report instrument with 42 items classified into six scales: personalization, student involvement, task orientation, innovation, satisfaction and individualization. Students respond using a four-point Likert scale with the response options *Strongly Agree*, *Agree*, *Disagree* and *Strongly Disagree*. Inventory factors of the instrument have been modified to include student centredness (Newton, Jolly, Ockerby & Cross, 2010).

The CLEI has also been abbreviated to a 19-item scale measuring students’ satisfaction with their actual learning environment in two aspects of their clinical experience—clinical facilitator support of learning and the clinical learning environment. The Clinical Learning Environment Inventory-19 (CLEI-19; Salamonson, Bourgeois, Everett, Weaver, Peters & Jackson, 2011) is shown in Table 1. The CLEI-19 can be used in formal evaluation processes implemented by university program evaluators. It can also be used more informally by agency staff and clinical teachers interested in strengthening their own clinical classroom environments.

**Table 1. Abbreviated Clinical Learning Environment Inventory (CLEI-19)**

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Clinical facilitator support of learning component: Items 1, 2R, 4, 6, 8R, 9, 10, 12R, 14R, 16, 17R, 18R.


Items are scored 5, 4, 2 or 1 respectively for responses SA, A, D, and SD. Items marked with R are scored in the reverse manner. Omitted or invalidly answered items are scored 3.

**Instructions:** *We would like to know what your last clinical placement was ACTUALLY like.*

*Indicate your opinion about each statement by selecting your response*
Creative Strategies

Try a Survey

Use a survey instrument such as the Abbreviated Clinical Learning Environment Inventory (CLEI-19) to measure the quality of your clinical learning environment. The questions can be answered by the traditional anonymous individual method or used as prompts for group discussion. When appropriate, share the results with university and agency program planners. Survey responses can shed light on patterns of occurrences that may not otherwise be known to people organizing clinical practicums.

Incidental Learning.

Adult educators Marsick & Watkins (1990, 2001) name learning that can occur as an accidental by-product of doing something else as *incidental learning*. Incidental or unintentional learning differs from formal learning, where learners register with educational institutions to complete a program of study. Incidental learning also differs from informal learning where learners intentionally seek out further information by, for example, joining a study group.

Although incidental learning is unplanned, learners are aware after the experience that learning has occurred. Incidental learning occurs frequently while a person is completing a seemingly unrelated task, particularly in the workplace. It is situated, contextual and social. It can happen when watching or interacting with others, from making mistakes, or from...
being forced to accept or adapt to situations (Kerka, 2000). Clinical practicums, both those that students find supportive and those they do not find supportive, offer unprecedented opportunities for incidental learning. Tapping into these opportunities can turn potentially negative experiences into positive ones.

Creative Strategies

Celebrate Incidental Learning

Expect that unintentional or incidental learning will occur. Plan times and places for students to articulate and celebrate their incidental learning. Such learning may have occurred for them accidently and as they joined an agency staff member in an unrelated task.

Nurture New Relationships

Opportunities to achieve required learning outcomes in a clinical course may seem elusive. Possibilities emerge for thinking outside the box when clinical teachers nurture relationships with agency staff members, both in their own and other health care disciplines. You can ask whether a student might shadow a practitioner from another discipline and then lead peers in a discussion on how elements of critical thinking are both the same and different across professions. When appropriate, consider pairing a student with a para-professional or non-professional staff member to strengthen specific psychomotor skills or an understanding of the contributions of others to care.

In sum, the clinical learning environment is one of the most important classrooms for pre-service students. This environment offers a range of planned and unplanned opportunities for learners to practice and achieve the competencies they need. Clinical placements are in short supply for most disciplines and may not always be as supportive as learners hope for. Clinical teachers can find foundational guidance for their own courses in curricular structure, model, design, outcomes, evaluation methods, admission requirements and tactics for levelling student learning.

Both unplanned and planned aspects of learning must be expected. University training programs for health professionals are separate from most clinical agencies, so clinical staff responsible for guiding learners may not be fully aware of students' programs. Instruments such as the Abbreviated Clinical Learning Environment Inventory (CLEI-19) can serve as a measure of how students perceive their clinical practicums. Ensuring that incidental or accidental learning is acknowledged and celebrated can begin to turn potentially negative clinical experiences into times of valuable learning.

Who Are the Teachers?

Teaching in the health care professions is a dynamic process. Practitioners can share their clinical expertise with novices beginning their career or with more expert colleagues advancing their knowledge. One of the strongest motivators for becoming a clinical instructor is a desire to influence student success and shape the next generation of health professionals in your discipline, ultimately influencing the quality of care provided by future practitioners (Penn, Wilson & Rosseter, 2008). Clinical teachers are influential role models who continuously demonstrate professional skills, knowledge and attitudes (Davies, 1993; Hayajneh, 2011; Janssen, Macleod & Walker, 2008; Okoronkwo, Onyia-Pat, Agbo, Okpala & Ndu, 2013; Perry, 2009).
Becoming a Clinical Teacher

The Influence of Employment Category.

Employment categories exert an important influence on the clinical teaching role. Some clinical teachers are full- or part-time employees of universities or agencies hosting clinical practicums. Workload for these teachers is negotiated with their employers and they are given release time for preparation and attendance in their assigned clinical areas. Other clinical teachers may be employed only on a contract basis.

Over the past decade, contract faculty have become the new majority at universities (Charfauros & Tierney, 1999; Gappa, 2008; Meixner, Kruck & Madden, 2010). Contracts can offer positions such as limited-term full-time faculty (Rajagopal, 2004), part-time faculty, sessional instructors, term instructors (Puplampu, 2004), and adjunct faculty (Meixner, Kruck & Madden, 2010). These faculty “are paid per course taught and are seldom offered benefits such as health insurance or access to retirement plans” (Meixner, Kruck & Madden, 2010, p. 141). Clinical teachers may be employed in different ways and at several different institutions.

Although contract employment offers employees flexibility and independence, workers who are employed on a contract basis may feel less secure in their jobs, and their sense of well-being may be negatively affected (Bernhard-Oettel, Isaksson & Bellaagh, 2008). Contract employees can feel marginalized and disadvantaged (Guest, 2004).

In university health care programs, PhD qualifications are usually required for permanent academic positions, leaving many highly skilled practitioners under-qualified (Jackson, Peters, Andrew, Salamonson & Halcomb, 2011). Often, clinical teachers are continuing their own education through graduate studies at the masters or doctoral level at the same time that they are instructing in clinical practicums. However, contract work may not accommodate the time that clinical teachers need to complete assignments for their own studies or to attend to family matters. Given the high demand for placements at clinical agencies, the times that students are scheduled to attend practicums cannot be altered and substitute instruction is seldom available.

Uncertainty about whether their employment contract will be continued can leave clinical teachers who are employed only on time-limited contracts hesitant to risk implementing new ideas. Student evaluations of teachers can reflect issues that are beyond teacher control, and yet these evaluations influence contract renewals. Student feedback is the main form of assessment for effectiveness of clinical teachers (Center for Research on Teaching and Learning, 2014; Fong & McCauley, 1993; Kelly, 2007). For some practitioners, contract employment with a university may seem less predictable than a clinical agency position.

Creative Strategies

What Happens When I’m Ill?

When a clinical teacher is ill, what steps are in place to arrange for a substitute teacher? When substitute teachers are unavailable, what additional steps are in place to notify the clinical agency and all members of the student group that the clinical experience will be cancelled?

If no formal steps are outlined at the curricular level, establish a plan with your group of students. For example, draft a
phone fan-out list where each student is responsible for notifying the student whose name is next on the list. Each student must continue contacting their designated peer until the last student reports to the first that the fan-out is complete. Keeping this list up to date will save students the inconvenience of arriving at their clinical placement only to find that they are unable to work because their clinical teacher is ill. For some students, privacy issues may be a concern and opt-out options must always be available.

From the Field

Self-Orientation to the Clinical Setting

In most instances, becoming a clinical teacher involves self-orientation to the practicum placement area. Instructors who are new to the particular clinical setting where they will be teaching or who have not practiced there recently often choose to ‘buddy’ or partner with an experienced staff member. Teresa Evans shares the following suggestions:

1. Call and make an appointment for your buddy shifts (it is often good to do two days in a row).
2. Make an appointment to meet with the unit manager during that time. It is good to know that everyone is starting on the same page, and clear communication from the beginning is essential. Some things to discuss with the unit manager include:
   - when you start teaching, how long you are there, and what days of the week you will be there (roughly). The Placement Coordinator will send out a letter containing all relevant information to the facility in advance of your clinical starting date.
   - a course outline and what you hope the students get out of this clinical experience.
   - briefly, the assignments the students are doing during that course.
   - the unit manager’s expectations of you and the students. What worked well in the past? What would they like to change?
   - your expectations of the staff.
3. Go through policies and procedures that will be used during the course of the clinical experience (e.g., administering blood and blood products)
4. Ask the staff what typical skills, conditions and interventions they see or perform on a regular basis. Research or ask any questions about these. You may want to find some research about these for your clinical binder.
5. Understand how the normal routine of the day goes.
   - When are meals?
   - When are vital signs typically done if they are routine?
   - How often is bedding changed? Where does soiled linen go?
   - How is the assist tub used?
   - Where is report taken? When does report occur?
   - What are the physio/occupational therapy schedules?
6. Look through the charts and have someone run through typical charting for the day and expectations re times of completion.
7. Do an admission or have someone walk you through the admission process.
8. What needs to be done for discharge? Transfers?
9. Orient yourself to where all the supplies are. Go through all storage areas so you know where everything is.

10. How are medications given and by whom? Do students usually have a separate binder for their own clients? Who has keys to the medication carts and how many are there?

11. The primary role for you during your buddy shift is to get to know the staff and have them get to know you. Also discuss what you and the students will be doing on the floor.
   ◦ What year are the students in?
   ◦ What skills do they have? It can be helpful to bring a year skills list and post it for the staff.
   ◦ What role do you need the staff to fulfill?
   ◦ What will the students do on the floor (e.g., charting, vital signs, bed baths)?
   ◦ What expectations do you have of the staff?

12. Do a.m. care, assessments, vital signs, and then ask to chart and have a staff member look over the information to make sure it is complete.

13. Talk with the unit clerk. They are crucial gatekeepers of information. Ask them what typically happens when orders are received, where to put charts, how orders are processed, what to do if we need supplies ordered, etc. Unit Clerks sometimes have concerns with students, especially when students take charts and don’t understand that orders need to be processed, so discuss this with them in advance.

14. Look through patient charts to get a feel for how they are set up and what types of clients the unit generally receives.

15. Are there clipboards that vital signs are recorded on? Where are they recorded in the charts?

16. Ask staff how they know if samples (urinalysis, sputums, etc.) need to be collected?

17. Ask about what certifications are needed to work on the floor. It might be prudent to talk to the appropriate individual and see if you can set up a date/time to complete these certifications if necessary, such as IV starts & Central Lines.

18. Are there teaching tools the unit uses for patients? Review these so you are familiar enough to alert students to them when they need them.

19. If you are not familiar with any of the equipment, arrange an in-service (IV Pumps, Vital Machines, Glucometers, Lifts, etc.)

**Hint:**

*Instructors set an example for students to follow…ensure you are as prepared as possible.*

*Nursing is a team profession; encourage your students to embrace interdisciplinary team work where appropriate.*

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