Community-Based Nursing Education of Prelicensure Students:

SETTINGS AND SUPERVISION

BETSY FRANK, MARSHA H. ADAMS, JAN EDELSTEIN, ELIZABETH SPEAKMAN, AND MITCH SHELTON

A rapidly changing health care delivery system demands that students prepared at all academic levels have the ability to function in a variety of clinical settings. Porter O'Grady (1) notes that nursing care is moving away from fixed institutions, such as hospitals, to varied settings in the community. Yet, despite calls for community-based clinical placements, much of our nursing education continues to take place in hospitals.

The major nursing organizations, including the National League for Nursing (2), have called for nurse educators to revise their curricula in order to prepare graduates who can deliver health care in community-based as well as acute care settings. Their recommendations are supported in documents such as *Healthy People 2010* and the various Pew Reports, in particular the 1998 "Recreating Health Professional Practice for a New Century: The Fourth Report of the Pew Health Professions Commission" (3). *Healthy People 2010* (4) provides objectives that can guide community health clinical specialists in the provision of population-based care.

ABSTRACT This study of prelicensure nursing programs had a fourfold purpose: 1) describe what community-based settings are being used by faculties in associate degree (AD) and baccalaureate degree (BSN) programs to provide community-based nursing care experiences; 2) explore whether or not the settings used in AD and BSN programs differ; 3) describe how faculties in AD and BSN programs provide for supervision of students in community-based settings; and 4) synthesize from the data what might be best practices for faculty-student supervision in community-based settings. A web-based survey was sent to 827 accredited AD and BSN programs with usable email addresses; 324 programs (39 percent) completed and returned the surveys. Findings indicated that students were placed in a variety of settings, including public health departments, schools (K-12), prisons, and home care. Community-based activities were in the following categories: immunizations, surveillance, data collection, health teaching, case management, treatments, and procedures. Depending on the activity, students performed nursing functions independently 4 percent to 39 percent of the time. Depending on the activity, preceptors were sole supervisors 27 percent to 40 percent of the time. Telephones, cell phones, and pagers were the primary means of faculty-student contact. AD and BSN students in the same settings performed the same activities. The only significant differences were that BSN students were placed in K-12 schools for community-based experiences more often than AD students, and they engaged in case management more often than AD students. Based on these findings, a model for community-based education is proposed.

ASSOCIATE DEGREE AND BACCALAUREATE STUDENTS were placed in similar settings and performed SIMILAR ACTIVITIES. THE ONLY SIGNIFICANT DIFFERENCES were that BSN students were placed in schools for community-based experiences MORE FREQUENTLY than AD students and engaged in CASE MANAGEMENT PRACTICES more than AD students.

Nursing faculties need guidance regarding how to best provide community-based experiences for their students. Eshleman and Davidhizar (5) propose a five-stage model for integrating community concepts into a nursing curriculum. They state that nurse faculty must assess the community for available learning resources, develop a plan for improving the community's health and incorporate the plan into the nursing curriculum, design appropriate learning experiences, implement the experiences, and evaluate whether or not educational goals are achieved. This assessment process is also necessary for appropriate selection of preceptors.

The Eshleman and Davidhizar model is useful, but before it is used to change the curricula, educators must have a common understanding of what community-based education is. Zungolo (6) presents a glossary that clarifies the common terms used to describe the various aspects of community-based education. *Community health nursing* is population-focused nursing that promotes and maintains the health of populations. *Public health* focuses on health promotion and disease prevention within a governmental context. *Public health nursing* synthesizes knowledge from nursing and public health to improve the health of an entire community. Zungolo states that community-based nursing education includes "educational experiences generally associated with community nursing which encompass a variety of services that emerge from the needs of the community and are characterized by interdisciplinary effort." She adds, "Community-based nursing education requires partnership between education and the community" (6, p. 17).

Lundy and Janis (7) note that community-based nursing encompasses the settings where nursing is practiced and the roles performed in those settings. Buchanan (8) expands the notion of community-based nursing to include nursing care services rendered in the community that have an illness and individual-care focus. Associate degree students might deliver such care, whereas the population focus inherent in Zungolo's definition (6) might be more appropriate for baccalaureate-level students.

Choosing appropriate learning experiences for prelicensure students is essential. However, delivering community-based nursing education presents many challenges, including the need to provide supervision to students in a variety of clinical settings and ensuring their safety and security (9). Several questions come to mind. Which community-based settings are appropriate for students in the various nursing programs? Who can, and should, provide supervision in the clinical arena — faculty, staff preceptors, or both? What qualifications do preceptors need? What is their role in the educational process?

Dewar and Walker (10) note that control can be an issue for faculty who place students in nontraditional learning environments. They caution that faculty need to understand that their role is to facilitate learning, not control it. If faculty accept this notion, they may be able to envision placing students in more community-based settings.

Zungolo (6) points out that supervision issues in community settings are not very different from acute care settings. One must question how much direct observation a faculty member actually has with 10 students on one or more units in an acute care setting. Moreover, preceptors are often used in acute care settings, just as they are in community-based settings. Zungolo and Oneha, Magnussen, and Feletti (11) outline a number of quality assurance concerns, noting that it is essential to have strong links with community partners so that desired curricular outcomes can be achieved.

The assumption that a systematic exploration of the status of community-based education is needed in order to begin developing best educational practices guided the development of this study. The study had a fourfold purpose:

- Describe the community-based settings that are being used by faculties in associate degree (AD) and baccalaureate degree (BSN) nursing programs to provide community-based nursing care experiences.

- Explore whether or not settings used in AD and BSN programs differ.
- Describe how faculties in AD and BSN programs provide for supervision of their prelicensure students in community-based settings.
- Synthesize from the data what might be best practices for faculty-student supervision in community-based settings.

Method The authors developed a 32-item survey to address community-based settings, clinical experiences within courses, nursing activities, faculty/preceptor contact procedures, communication technology, and faculty relationships. The survey was pilot tested using nursing faculty whose expertise was community-based education. Following pilot testing, survey revision, and human subjects committee approval, an email announcement about the study and a website link to the survey were sent to AD and BSN programs with usable email addresses accredited by the National League for Nursing Accrediting Commission and the Commission on Collegiate Nursing Education. Two email reminders were sent, and announcements about the study were placed in issues of *NLN Update*, an electronic newsletter published biweekly by the NLN. There was a 39 percent response rate; 827 nursing programs were contacted, and 324 completed the survey.

Results and Discussion Data were analyzed using descriptive statistics. Respondents included deans and directors of nursing programs (37 percent), department chairpersons/assistant/associate deans (30 percent), and nursing faculty (33 percent). Fifty-nine percent of the respondents were from AD programs; 41 percent were from BSN programs. Respondents were distributed across the United States, in nine regions, and the majority (65 percent) represented public-supported educational institutions. The area with the most respondents was the east north-central area (Illinois, Indiana, Michigan, Ohio, Wisconsin) with 64 respondents (20.7 percent).

Respondents indicated that community-based educational experiences took place across all program levels, from freshman to senior. Students were placed in a variety of settings, including public health departments, schools, prisons, and home care. Community-based activities were categorized as immunizations, surveillance, data collection, health teaching, case management, and treatments and procedures. These activities were gleaned from the various reports and literature that have guided community-based nursing practice (2,3).

A faculty member, preceptor, or both were present 96 percent of the time for immunizations and 95 percent of the time for treatments and procedures. They were present less frequently for case management (83 percent of the time), surveillance (81 percent), health teaching (76 percent), and data collection (61 percent). In all cases, preceptors were sole supervisors up to 40 percent of the time.

AD and BSN students were placed in similar settings and performed similar activities. The only significant differences were that BSN students were placed in schools for community-based experiences more frequently than AD students ($p < .0001$) and engaged in case management practices ($p < .05$) more often than AD students.

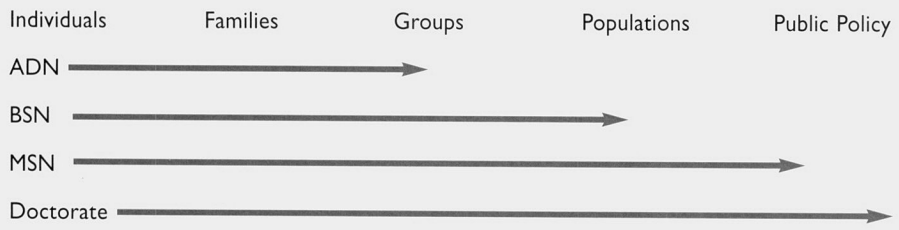
The preceptors were primarily staff nurses, but teachers, social workers, and others were also recognized as preceptors. Since community-based nursing practice is by its very nature interdisciplinary, preceptors came from a variety of disciplines.

Preceptors were evaluated by a variety of formal and informal methods; in some cases formal evaluation instruments were used, and in some cases evaluations consisted of informal conversations with students and/or the preceptors themselves. Telephones, cell phones, and pagers were the primary means of faculty-student contact. Given the development of wireless technology, one would expect that in the future, faculty will be able to supervise students using handheld wireless technology that includes video capabilities.

The original intent for this study was to establish benchmarks for clinical placement and clinical supervision in community-based settings. However, despite the fact that the majority of the survey consisted of forced-choice items, many respondents wrote unique responses. The result was a voluminous amount of data that did not lend itself to categorization or common practices that could be transformed into benchmark recommendations.

Based on these findings, a model (Figure 1) is proposed for community-based education. In the model, the authors suggest that AD students focus on individuals and families and begin to work with groups in community-based settings. Baccalaureate students should focus on individuals, families, and groups and begin to use a population-based approach. Although the study did not focus on graduate education, the findings do show how community-based education can be conceptualized across the full spectrum of undergraduate and graduate education.

Figure 1. Paradigm of Community Health Settings



Adapted from Buchanan, M., "The new system of care nursing and health," as cited in Tagliareni, M. E., & Marckx, B. B. (1999). Teaching in the community: Preparing nurses for the 21st century. *Sudbury, MA: Jones & Bartlett.*

Questions for Future Research It is clear that more research needs to be done in the area of community-based education and the supervision of prelicensure students. Therefore, the following research questions are proposed:

- How can preceptor evaluations provide more informative data related to effectiveness?
- What is the impact of wireless technology, particularly video phones and PDAs, on the supervision of prelicensure nursing students? Is faculty workload impacted by these technologies?
- What is the impact of community-based experiences on NCLEX-RN performance? Since the majority of the NCLEX exam focuses on acute care, how can an acute care focus be integrated with community-based education?

In summary, the majority of health care is no longer delivered exclusively in the acute care setting. Acuity is no longer a determinate of where nursing and health care are delivered. How best to prepare nursing students for changing practice environments will always be a concern for nursing faculty. The authors hope that the results of this study will give nursing faculty in AD and BSN programs some insight into the clinical placements and supervision strategies currently practiced in community-based nursing education throughout the United States. How community-based nursing is taught is evolving. Further exploration into the establishments of benchmarks for excellence will continue to evolve as well. NEP

About the Authors *Betsy Frank, PhD, RN, is a professor, Indiana State University School of Nursing, Terre Haute. Marsha H. Adams, DSN, RN, is an associate professor and director of undergraduate programs, The University of Alabama Capstone College of Nursing, Tuscaloosa. Jan Edelstein, EdD, RN-CS, is an associate professor of nursing studies, Marian College, Fond du Lac, Wisconsin. Elizabeth Speakman, EdD, RN, is an associate professor, Thomas Jefferson University College of Health Professions, Philadelphia, Pennsylvania. Mitch Shelton, PhD, RN, is an assistant professor, The University of Alabama Capstone College of Nursing.* *The authors acknowledge the National League for Nursing for its generous support for this study.* *For more information, contact Dr. Frank at Betsy-Frank@indstate.edu.*

Key Words Community-Based Nursing Education – Supervision – Experiential Learning

References

1. Porter O'Grady, T. (2003). A different age for leadership: Part 1. *Journal of Nursing Administration, 33*(2), 105-110.

2. National League for Nursing. (1997). *Visions II: Community-based nursing education project. Final report.* New York: Author.

3. Center for the Health Professions. (1998). *Recreating health professional practice for a new century: The fourth report of the Pew Health Professions Commission.* [On-line]. Available: http://futurehealth.ucsf.edu/pdf_files/recreate.pdf.

4. Office of Disease Prevention and Health Promotion, US Department of Health and Human Services. (2005). *Healthy People 2010.* [On-line]: Available: www.health.gov/healthypeople/

5. Eshleman, J., & Davidhizar, R. (1997). Community-based nursing education: A five-stage process. *International Nursing Review, 44,* 24-28.

6. Zungolo, E. (2000). Changing nursing education. In P. Matteson (Ed.), *Community-based nursing education* (pp. 8-35). New York: Springer Publishing.

7. Lundy, K. S., & Janes, S. (2001). *Community health nursing: Caring for the public's health.* Sudbury, MA: Jones & Bartlett.

8. Buchanan, M. (1999). The new system of nursing and health care. In M. E. Tagliareni & B. B. Marckx (Eds.), *Teaching in the community: Preparing nurses for the 21st century* (pp. 3-19). Sudbury, MA: Jones & Bartlett.

9. Larsen, P. D. (2000). Community-based curricula: New issues to address. *Journal of Nursing Education, 39,* 140-141.

10. Dewar, B. J., & Walker, E. (1999). Experiential learning: Issues for supervision. *Journal of Advanced Nursing, 30,* 1459-1467.

11. Oneha, M. F., Magnussen, L., & Feletti, G. (1998). Ensuring quality nursing education in community-based settings. *Nurse Educator, 23*(1), 26-31.