



CRITICAL PEDAGOGY IN NURSING

TRANSFORMATIONAL APPROACHES
TO NURSE EDUCATION IN
A GLOBALIZED WORLD

SUE E DYSON



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'Education either functions as an instrument which is used to facilitate integration of the younger generation into the logic of the present system and bring about conformity or it becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world'. (Paulo Freire, 1972: Pedagogy of the Oppressed)

This book is written in the belief that caring nurses are brought into being, not in the form of personality traits, judged through checklists at admission interview, but rather through a form of nursing education that is capable of nurturing students from those same communities which, as qualified nurses, those students will go on to serve. As such, nurses deserve an education as much as any university student and not merely to be professionally trained.

It follows that notions of elite nursing or elite nurses are not ones I can condone. Therefore, this book is dedicated not to some nurses but to all nurses, all nurse educators and all nursing students.

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While I recognise my limitations as a writer and researcher, having come late to the party so to speak, I am grateful to my husband Simon Dyson for his ability to see around my oft less than fully formed ideas, and for offering suggestions as to how to develop the arguments further and to articulate what I believe is an essential consideration for nurse education, namely, the potential for transformative pedagogy to shape the nursing curriculum. This is of great importance for me in that as a doctor of education, I consider education to be my practice, but as a nurse and midwife, it is also important that I should articulate a view of nurse education as praxis.

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1

Introduction

Most people reading this book will know only too well of the scandal surrounding Mid Staffordshire NHS Foundation Trust, whereby poor care between 2005 and 2009 reportedly contributed to the avoidable deaths of many patients. The public inquiry which followed cost the taxpayer £13 million, interviewed more than 160 witnesses, sifted through one million pages of evidence and resulted in 290 recommendations contained within a four-volume report that stretched over 1800 pages (Kapur, 2014). Failings were identified at every level including individuals, management, regulators of nursing, the nursing profession and nurse education (Francis, 2013). The inquiry drew on the oral accounts and written witness statements of almost 300 patients and families, before concluding that nurses at the hospital lacked the skills to care and the inherent qualities to do so with compassion. While any criticism of the profession is difficult to accept, failings in compassionate care are particularly concerning, given the defining characteristics of nursing include “to respect the dignity, autonomy and uniqueness of human beings” (RCN, 2003, p. 3). There is no doubt that emphasis needs to be placed on care and compassion in nursing, for these are fundamental values underpinning nursing. In this respect, the public have a right to expect, when admitted

to hospital or when receiving nursing care in the community, that they will be treated with the dignity and respect they deserve. With that said, there needs also to be an acknowledgement of the contextual factors impacting nursing work, for example perceived autonomy or lack thereof, involvement in decision-making, workload issues, and associated stress and burnout (Wallin, Ewald, Wikblad, Scott-Finley, & Arnetz, 2006). Without such acknowledgement, it is difficult for nurse education to conceptualise nursing in such a way as to ameliorate the factors impacting the ability of nurses to provide high-quality care, and to do so with compassion.

Nurse education needs to play its part in preparing nurses who are able to respond appropriately when nursing values are called into question. Critical thinking skills and critically reflective practice are essential tools for contemporary nursing practice and should therefore be an integral component of the nursing curriculum. This requires nurse educators to have knowledge of theories and practice in curriculum development in order to ensure nursing programmes prepare nurses who demonstrate competency in practice, alongside caring and compassionate behaviours and attitudes.

The premise on which this book rests is for a mindful consideration of pedagogy in nursing to sit alongside the measures taken by the government, by the Nursing and Midwifery Council (NMC) and by the Council of Deans of Health (CoDH) to address the issue of quality of care in nursing. This introduction begins by examining the response to the Francis Inquiry from the National Health Service (NHS), the Royal College of Nursing (RCN), the CoDH and the NMC, within the context of their impact on discourse around care, compassion, values based recruitment (VBR) and apprenticeships in nursing. The chapter introduces the notion of transformative pedagogy in nurse education as a leit-motif throughout the book.

The National Health Service

The response of the NHS to the Francis Report was immediate, with most healthcare organisations accepting the recommendations and instigating changes in the short, medium and long term. The Nuffield Trust, in research carried out within a year of the report's publication, found the

Francis Report has been taken very seriously by those working in NHS acute trusts. Furthermore, “the welfare of patients and high quality care was uppermost in their minds” (Nuffield Trust, 2014, p. 37). The Nuffield Trust, while recognising the limitations of the research, which provided a glimpse of activity and views of one-third of hospital trusts, nevertheless concluded that it remains to be seen whether the Francis Report will result in measurably improved care for patients and how extensive this will be across hospital trusts more generally. Critical to this is the fundamental tension between commitments to care quality, safe staffing and zero harm, on the one hand, and the relentless financial constraints facing the NHS for the foreseeable future, on the other (Nuffield Trust, 2014, p. 44).

The Royal College of Nursing

The RCN is the world’s largest nursing union and professional body, representing more than 435,000 nurses, student nurses, midwives and healthcare assistants in the UK and internationally. Governed by an elected council of 31 members, who delegate the running and management of the organisation to a Chief Executive and General Secretary, the RCN is a Royal Charter body registered with the Privy Council. Along with normal trade union activities, for example negotiating pay terms and conditions for NHS staff and staff working within independent sector organisations, the RCN, through its lobby activities, influences governments and other bodies across the UK to develop, influence and implement policy to improve the quality of patient care (RCN, 2016). With respect to the Francis Report’s recommendations concerning nurse education, in particular the call for prospective nursing students to spend up to three months working on direct patient care under the supervision of a qualified nurse, the RCN responded by stating:

we firmly believe that the 2300 hours that student nurses currently spend on clinical placements is sufficient preparation for the world of practice and patient care. Furthermore, there is no evidence that newly qualified nurses are exhibiting any behaviours that should give rise to the kinds of concerns that would warrant such a radical change to the current system. (RCN, 2013a, p. 6)

The RCN, in this respect, shared the view of the Willis Commission on the future of nurse education, who saw no major shortcomings in the way future nurses are trained (Willis, 2012). Irrespective of the RCN's confidence in the current system, stakeholders in nurse education have a duty to consider the efficacy of the current system in preparing nurses for the emotional burden of their work (Proctor, Wallbank, & Dhaliwal, 2013).

The Council of Deans of Health

The CoDH represents the UK's university faculties engaged in education and research for nurses, midwives and allied health professionals. Considered to be the voice of the professions, the CoDH operates across the UK at the heart of policy and political debate (www.councilofdeans.org.uk). In a discussion paper on educating the future nurse, the CoDH suggests that developing clear competencies for the newly graduated nurse is a significant opportunity to articulate the value and contribution of the profession. However, at the same time, the CoDH highlights the limitations of competency-based models and the risk of creating a formulaic, box-ticking educational culture, which stifles innovation and creativity (CoDH, 2016).

The Nursing and Midwifery Council

The NMC is the regulator of nurses, midwives and health visitors in the UK, whose primary purpose is to protect the public by setting standards of education, training, conduct and performance. The NMC holds the register for all nurses who have qualified and meet the standards. In addition, the NMC is responsible for fair and effective fitness to practice processes to investigate and deal with nurses and midwives who fall short of the standards. With respect to nurse education, the NMC responded to the first Francis Independent Inquiry in 2010 by publishing new standards for preregistration nurse education, which placed significant emphasis on care and compassion for patients. The NMC's response to

the Francis Report of 2013 concentrated on issues concerning healthcare assistants and support workers, on complaints, on professional regulation and on safety (NMC, 2013).

Care and Compassion in Nursing

Since the Francis Report ‘care and compassion’ has become a trope, a figure of speech, used in this instance to support the speakers (undeclared) neoliberal agenda. In other words, a call to reform both the NHS and nurse education, by claiming neither is fit for the purpose in the twenty-first century. The problem with putting the words together compels the reader to attend to both concepts as psychological traits or behavioural tendencies held (or not held) by individuals: a nurse is either a caring and compassionate individual, or they are not, as the case might be. This enables the ‘problem’ to lie within the individual and not with organisational factors, which ultimately determine how health services are organised, managed and delivered. On the other hand, if care is viewed as physical labour, emotional labour and organisation then ‘care’ is more than attitude. Nurses may or may not have control over the flow, pace and indeed goals of the work they undertake. Context may determine if emotional labour compromises the capacity of nurses to undertake care in a compassionate manner. The organisation necessary for care determines whether the nurse has the positive freedom to care, whether they have the resources and infrastructure to undertake care work (James, 1992).

The current trend to engage in dialogue intrinsically coupling care with compassion has resulted in a blame culture, whereby nurse practitioners point the figure at nurse education, and nurse educators reciprocate by pointing to poor nursing practice (Bewley, 2016). Apportioning blame is a falsely reassuring response to quality issues (Baker, 2015). Blame is a comforting but counterproductive reaction when attached to quality failures. Blaming nurse education and nursing practice for quality failures supports prescriptive approaches to nurse education, evidenced by redevelopment of standards for preregistration nurse education (NMC, 2010), revalidation for qualified practitioners (NMC, 2016a) and a focus on VBR (HEE, 2016).

Compassion in nursing practice is a complex phenomenon to describe, in that it is entirely subjective with everyone, be it patients, nurses and politicians having a personal, subjective view of what constitutes compassionate nursing practice. This raises obvious difficulties for nurse education in that views as to what is and is not compassionate practice will drive particular agendas and policies. For example, if compassionate practice rests on the ability of nurses to demonstrate technologically advanced practice then nurse education needs to ensure these skills are embedded within nursing programmes. However, if compassionate practice rests on the ability of nurses to demonstrate highly developed communication skills, then this also needs to be evident within the nursing curriculum. Of course, these are of equal importance within the nursing curriculum, alongside other skills such as an understanding of innovation and research. However, contextual issues often impact the ability for compassionate practice to become a transferable skill for nurses, for example lack of time, lack of resources, increased levels of stress and burnout. In times such as these, instrumental caring, which includes the required skills and knowledge, and expressive caring involving the emotional aspects of the relationship may be compromised, which might explain but not justify the events at Mid Staffordshire NHS Foundation Trust.

It may be argued that nurse educators have a responsibility to identify applicants to nursing programmes who can demonstrate the characteristics of compassion. However, this is extremely difficult to do given the subjective nature of compassion and the fact that these characteristics are not in themselves clear (Proctor et al., 2013). How a student might go about proving herself/himself to be a compassionate individual is at least as difficult as a nurse educator's task in reviewing the evidence. Even if it were possible to make a reasonable attempt to assess the presence or not, as the case might be, of characteristics of compassion within a potential nursing student, whether it is acceptable to reject a potential student on this basis is questionable. Admission to nursing programmes does not require students to demonstrate advance knowledge of technologies in nursing, or anatomy and physiology, rather ensuring this is covered in the curriculum. It is reasonable therefore to suggest nursing programmes take the same approach to learning and teaching about compassion. The problem, however, lies in how this is taught and how

the efficacy of such teaching is evaluated upon completion of the programme. It is for these reasons, that other approaches to the identification of a predisposition towards compassion have been promulgated, for example VBR.

Values Based Recruitment in Nursing

VBR is an approach which attracts and selects students on the basis that their individual values and behaviours align with the values of the NHS constitution. The NHS constitution establishes the principles and values of the NHS in England, and sets out rights to which patients, public and staff are entitled. Health Education England (HEE), which works across England to deliver high-quality education and training, has a statutory duty to promote the NHS constitution. HEE's work on VBR is to promote and support the embedding of the values of the NHS Constitution in healthcare, education and training (HEE, 2016).

A major problem with the notion of VBR in nursing and midwifery is that this individualises an issue that is more adequately conceptualised as about social relations. Chattoo and Ahmad (2008) demonstrate that care is an emergent property of social relationships, therefore the potential for caring cannot be reduced to alleged qualities residing inside the person. In addition, values, and how these are enacted, are likely to vary according to class, gender and ethnicity (Skeggs, 2014). Thus, the focus on VBR not only ignores the social relations at play in contemporary nursing practice, but also perpetuates the idea that nurses are in control of the context in which they practice. The focus on the values agenda across the NHS ignores organisational factors which impact quality of care. VBR is a response to concerns raised by the Francis Inquiry that nurses lack the behaviours consistent with caring and compassionate practice. However, VBR is by its very nature, a behaviourist framework. The locus of control over events and outcomes, including how care is delivered and in what manner is seen to reside internally with the individual nurse, as opposed to externally whereby outside forces impact events and their outcomes, which are in effect outside the control of the individual nurse.

Contextual Issues in Nurse Education

Traditional models of nurse education were based on an apprenticeship model, which saw nurses learning by doing: on the job, under the control of skilled practitioners (Aldrich, 2006). Nursing students, within an apprenticeship framework were inducted into a community of nursing practice, with learning taking place in a 'safe environment', guided by 'expert practitioners'. While the apprenticeship model has long declined in nursing, with hospital-based training replaced by 'academy-based' education, nevertheless nurse education is redolent of apprenticeship, for example reliance on mentorship by registered practitioners, and provision of a safe learning environment (all clinical placements used in undergraduate nursing programmes are subject to audit for suitability by participating; Approved Education Institutions, QAA, 2015). The current context of healthcare clearly impacts the concept of safe environment and expert practitioner as evidenced by the Francis Inquiry and other similar reports, which recognise the relationship between quality of care and availability of qualified nurses (Ball, Murrells, Rafferty, Morrow, & Griffiths, 2013). However, it is within this context that the current government is considering introducing apprenticeships in nursing, midwifery and the allied professions.

Nationally, the apprenticeship agenda is rapidly gaining pace. The government is committed to achieving three million apprenticeships by 2020 as part of its productivity agenda. With the introduction of the employees' apprenticeship levy due to start in April 2017 all employers with a UK pay bill of over £3 million, including higher education institutions (public and private), will be required to pay 0.5% of the pay bill into a levy, which is then ring fenced via an electronic voucher system to purchase apprenticeship training (BPP, 2016). While apprenticeships in the wider economy have, up to this point, been below degree level, the emphasis is now on the development of degree level apprenticeships, which by definition will include undergraduate degrees in nursing and midwifery.

The government's ambitions around nursing apprenticeships raise a number of concerns for nursing and midwifery, not least the requirement for end-point assessment (EPA). EPA is a new way of assuring quality in

the apprenticeship system, replacing the existing model of continuous assessment resulting in qualifications. Clearly EPA has major implications for degrees in nursing and midwifery, which rely almost entirely on continuous assessment in line with NMC standards. Degree level apprenticeships which will result in a degree awarded by a university (which is subject to QA) and, in the case of nursing, tied to rigorous NMC standards could potentially be at odds with EPA carried out by employers (CoDH, 2016).

EPA of nursing apprenticeship programmes, should it be carried out by the NHS, will need to take account of the conditions of the workplace, whereby skilled staff are in short supply, and where heavy reliance on agency and international nurses often results in priority given to upskilling the registered workforce (Allan & Larson, 2003). Notwithstanding the government's plans around apprenticeships nurses have a right to expect nurse education should equip them with knowledge and skills to enable them to recognise, examine and address the issues in the contemporary nursing workplace. In view of this nurse educators have a responsibility to carefully determine pedagogy and to design nursing curricula to enable students to not only practice competently, but know the important distinction between what is 'good enough' and what should not be tolerated. Critical pedagogy for nurse education is the means by which nurses are educated to not only know this difference, but also have the skills to act when care is unacceptable and be assured that concerns about care, raised in good faith, will be robustly addressed.

Pedagogy in Nurse Education

Pedagogy in nurse education is concerned with what nurses need to know in order to understand nursing as a social enterprise, as a political activity and as a technically demanding profession in an age where patients, families and carers have access to medical- and health-related information on a global scale. The goal of nurse education is thus to prepare nurses to meet the challenges of contemporary nursing practice. However, despite this rhetoric, pedagogy in nurse education has not kept pace with societal, organisational and technological change. Instead nurse education

displays elements of apprenticeship style training reminiscent of nurse training prior to the reforms of the early 1990s, commonly termed 'Project 2000' whereby the academic level of training was established at a minimum of a higher education diploma (Eaton, 2012). The NMC, in its response to the initial Francis Inquiry's concerns around nurses' apparent lack of skills and behaviours for compassionate care, has revisited standards for initial nurse education while at the same time remaining committed to an outcomes driven competency-based framework. This, together with the government's focus on behaviourist approaches to nursing recruitment, has resulted in a restricted, as opposed to elaborated language or code (Bernstein, 1971) on which to base nursing pedagogy. The language concerning nurse education, for example standards, competencies and VBR, reflects the assumptions of the protagonists, namely government and the NMC. As a result, nurse educators have little opportunity to explore the potential for critical pedagogies to transform nurse education. This book argues that in times of uncertainty around health-care policy and subsequent healthcare provision nurse educators are constrained by conventional approaches to curriculum design, which no longer serve nurse education well.

This Book

The book will be of interest to nurse educators, working within higher education, who are interested to develop the nursing curriculum in ways which will enable nurses to meet the challenges of twenty-first-century healthcare, but where patients, client and their families deserve the highest standards of care. A romanticised view of nursing will not suffice in the current climate. Nurses need to be educated to recognise what constitutes acceptable care and what should not be tolerated, and to know the difference. This is a key concept within the book and is addressed through a detailed and critical exploration of innovative nursing pedagogies.

The book will also be of interest to practitioners, educators and student nurses interested to understand why the theory–practice gap in nursing persists, despite attempts over time to reform nurse education. The book takes a unique approach in detailing the current context for healthcare in