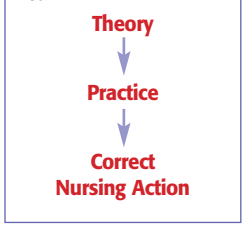
Lifelong Learning:
A Pathway to Expert Practice

BY Heather Orsted

Theorists have studied and defined the many aspects of nursing, yet the role of the nurse in his/her environment of practice remains complex and elusive. The practice of nursing, for the nurse, is often difficult to articulate and frequently remains invisible and undervalued.[1] Though nursing is couched in theoretical frameworks, rarely will bedside nurses define their role based on a framework. It is more likely they will define it based on a skill set of actions, a body of knowledge, an attitude or a combination of all three. Understanding what it takes to make and maintain nursing as a part of one's life requires an understanding of the practice of nursing in its entirety. Knowledge appears as the cornerstone of nursing, and Heath[2] acknowledges the traditional theory model that is applied to nursing (see Figure 1).

Traditional Theory Model[2]

FIGURE 1



Liaschenko and Fisher[1] theorize that nursing work requires specific knowledge and actions and believe strongly that nurses must learn to articulate and recognize the scope of their work. They define three different types of knowledge required in nursing to provide direct patient care:

1. *Case knowledge* is the knowledge of pathophysiology, disease processes, pharmacology and other therapeutic protocols.

Nurses Knowledge[1]

FIGURE 2

The social-patient-person knowledge bridge requires capabilities other than biomedical knowledge to connect the nurse to the other players, such as physicians. This connection enables the nurse to know the skill and working patterns of other care providers, and allows the nurse to match the required care or service with the appropriate provider. The social-patient-person knowledge connects the nurse with the patient. The nurse can then explore how the patient interacts with his/her environment in relation to his/her illness.

These levels reflect changes in three aspects of skilled nursing performance:

1. Movement from reliance on abstract principles to the use of past concrete experience as paradigms
2. Change in the learner's perception of the demand situation where the learner's focus is more on the whole situation in which only certain parts are relevant
3. Passage from the detached observer to involved performer, in which the performer is engaged in the situation

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2. *Patient knowledge* is the knowledge of how an individual becomes identified as a patient, knowledge of the indiviual's response to treatment and how to get things for the individual within and between institutions.
3. *Person knowledge* is the knowledge of the individual as a self with a personal biography who occupies a certain social space and acts according to his/her own desires and intentions for reasons that make sense only to him/her.

Theory Integration via Reflective Practice[2]

FIGURE 3

These clear designations of knowledge, according to Liaschenko and Fisher[1], offer the nurse a language to support the interaction between knowledge and action. They further identify another, more elusive type of knowledge – *social knowledge* – which encompasses the co-ordination of care (transmission and co-ordination of information) between the three more common types of knowledge. Although often undervalued and unrecognized, social knowledge is described as having importance in that it links the three types of formal knowledge together (see Figure 2). They further theorize that this informal, practical knowledge is not fully understood and articulated, yet it is essential to nurses' ability to make judgments, act wisely and get the work done. Unfortunately work is most often seen as an endpoint or an outcome with little thought given to the process.[1]

The competency levels identified by Benner[3] allow the setting of performance parameters from novice to expert, thereby enabling the nurse to be aware of his/her lack of knowledge.[2] Heath[2] uses the Benner model to contribute to and improve the theory model by defining the growth of the expert practitioner, stating nursing theory alone is insufficient to produce higher levels of performance (Figure 3). Nursing actions, according to Heath, are rarely simply right or wrong but are preformed at different levels with both formal theory and experience contributing to their decision making.

Schöns' Zone of Mastery[4]

FIGURE 4

Heath links traditional knowledge with the experience component of Benner and then adds the contribution of Donald Schön[4] to describe the benefits of reflective practice. Schön suggests that the capacity to reflect on action so as to engage in a process of continuous learning is one of the defining characteristics of professional practice. His theory explores the development of the capacity to reflect in action (while doing something) and reflect on action (after you have done it), which has become an important feature of professional training programs in many disciplines (Figure 4). It is seen as a particularly important aspect of mentoring the new health-care professional.[5]

By incorporating reflection into practice, Heath suggests that an awareness of unknowing occurs that allows the nurse to know he/she cannot completely understand the client, which keeps him/her alert to the client's perspective of the situation.[6] Therefore, assumptions based on the nurses' subjective view of reality may be avoided; the nurse listens to the client and a true working relationship can be established. It is on this foundation that the CAWC strives to support a pathway to advanced practice by providing interlinked progressive

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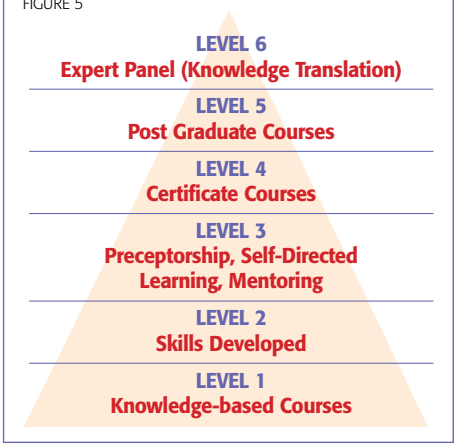
CAWC Learning Hierarchy

FIGURE 5



References

1. Liaschenko J, Fisher A. Theorizing the knowledge that nurses use in the conduct of their work. *Scholarly Inquiry for Nursing Practice: An International Journal.* 1999;13(1):29-41.
2. Heath H. Reflection and patterns of knowing in nursing. *Journal of Advanced Nursing.* 1998;27:1054-1059.
3. Benner P. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo, California: Addison-Wesley Publishing Company. 1984.
4. Schön D. *The Reflective Practitioner. How Professionals Think in Action.* London: Temple Smith. 1983. http://www.infed.org/thinkers/et-schon.htm.
5. Atherton, JS. *Learning and Teaching: Reflective Practice.* 2002. [On-line]: UK: Available:www.dmu.ac.uk/~jamesa/learning/reflecti.htm. Accessed: 1 September 2003
6. Munhall P. 'Unknowing': Towards another pattern of knowing in nursing. *Nursing Outlook*. 1993; 41(3):125-128.
7. Laverty SM. Herneneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*. 2003;2(3):Article 3.

Suggestions for Life-long Learning

- Participate in the CAWC S-Series
- Take wound-care courses
- Attend wound-care conferences
- Subscribe to wound-care publications
- Develop a relationship with a mentor/become a mentor
- Expand your professional network through discussion forums, Web sites, wound care events, courses
- Visit other wound-care facilities

learning based on the principles of Benner[3] and Schön[4] (Figure 5).

However, learning can only occur through recognition and acknowledgement of clinically related knowledge and learning needs (case, patient and personal knowledge, including social knowledge). According to Laverty[7], knowledge is seen as the best understanding we have been able to produce thus far, not as a statement of what is ultimately real. The challenge to gain knowledge is life-long. The CAWC endeavours to support safe, competent growth and development of knowledge, skills and attitudes as we continue to explore best practice initiatives and creative educational methods in which to deliver them.

Additional Reading

1. Benner P. The wisdom of our practice. *American Journal of Nursing*. 2000;100(10):99-105.
2. Benner P. & Wrubel J. Caring comes first. *American Journal of Nursing*. 1988;August:1072-1075.
3. Dreyfus H. & Dreyfus S. *Mind Over Machine: The Power of Human Intuition and Expertise in the Era of the Computer*. Oxford: Basil Blackwell Ltd. 1986.

Do you have a wound-care colleague who is not on the *Wound Care Canada* mailing list? Send us their name and address at cawc@sympatico.ca and we'll add them to the list!