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Analysis of Existing Problems and Improvement Countermeasures in Practical Teaching of Higher Vocational Nursing

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Abstract: Practical teaching of high vocational nursing programs is essential for the cultivation of high-tech talents. Teaching and practicing are separated from clinical practice, which is currently a problem of insufficient training grounds, a lack of practical teaching skills by staff who teach the courses, and this severely restricts the output of talent with competence. The principal difficulties that cause such matters have a curriculum which is outdated compared with the work needed, as well as an unsatisfactory collaboration between schools and hospitals, which results in too simple ways of evaluating students' skills. This paper puts forward some ideas about making improvements to jobs based on abilities, integrating theories and actions, and developing skills bit by bit. Modular course content restructuring is required, double-certification faculty teams need to be built, and advanced simulation training sites must be set up. To improve on all those by enhancing the operations of the school-hospital collaborations, putting in place multiple different types of evaluations, setting aside resources for investments, which will be constantly monitored. Countermeasures are proposed to systematically increase the level of practical teaching, so as to improve students' clinical adaptability and career growth possibilities.

Keywords: Higher vocational nursing; Practical teaching; Clinical disconnect; Double-qualified teachers; Simulation training

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1. Introduction

In the world of vocational nursing, it is the responsibility of nurses to be at the forefront of things, right down by those hospitals and health institutions. Practical teaching quality is closely connected to the job and patient safety that the students have after finishing their schooling. But traditional practical teaching models are just institution-based, classroom-type training models that create a wide gap between what they learn in the school and the real needs of clinical practice. Faced with many pressures, such as the aging population,

changes in diseases, and changes and improvements in nursing service methods, educators need to change how existing training is done. Such as deepening the realism of the dilemmas faced and root cause analysis of the problem in nursing education in higher vocational nursing, and offering feasible solutions. Improving the overall standard of talent cultivated by nursing programs in schools can promote good growth on educational grounds [1].

2. Current problems of practical teaching

2.1. Separation between what is taught and clinical practice

A big difference exists between what one teaches in practice and actually needed during real-time when working. A lot of places are still using practical training projects and operating processes from a couple of years ago, but hospitals all around have started adopting all kinds of different technology, machines, and new guidelines. Such as school students' practice with the IV infusion, catheterization, and oxygenation exercises that are usually practiced on the standardized person or simulation dummy, but are very different in a real clinical environment when they have the changeable state of the patient's feeling, as well as psychological response, and an emergency. There are also teachers who follow set steps to show things on how to be more operational and stuff, but do not show how to make medical choices and adjust them. And this separation causes quite a few problems for students right out of college; it takes preceptors quite some time to fix their ways of doing things before these students really hit the clinic floor.

2.2. Lack of training resources

Practical teaching resources' quantity and quality cannot satisfy increasing teaching needs, making it difficult. Some vocational nursing schools have old laboratory equipment and simulation manikins that can only simulate simple clinical situations, such as lacking the ability to simulate dynamic changes in vital signs or disease development. Limited open hours for training venues, and inadequate per-student training hours and equipment usage time do not allow sufficient practice. High fidelity simulation systems, virtual reality training devices, etc., which are expensive and not commonly found. Moreover, there is a lack of timely replenishment of consumables, and some schools require students to buy their own practice materials, which has some impact on the students' learning motivation and training effect.

2.3. Lacking practicality in teachers

Lots of nurses on the high school staff do not have a lot of long-term systematic clinic working expertise. Many go straight into teaching right after college, so even if they know lots about the theory side of healthcare, it does not mean they can put all that together when it comes time to do anything practical — because actually being hands-on around real patients can have quite a different experience [2]. Even those with clinical experience can lose their connection with hospital technology standards and management after being absent too long from hospital settings. School-run short-term clinical training often turns out to be just a formality; it is hard for teachers to take part in every step of the whole clinical nursing process. This shortage directly shows up in class teaching with fewer lively case studies, fewer typical procedures demonstrated, and not enough teaching of how students think through things in the clinic.

3. Analysis of problem Causes

3.1. Curriculum lags job requirements

The update of the nursing curriculum systems is way slower than the development of actual clinical nursing practice. Curricula have not changed much; it is still stuck on old subject-focused setups and does not really get that fundamental nursing, medical nursing, and surgical nursing should be more related rather than completely separate parts, so there ends up being too much repeating stuff and no proper mixing across different things. While more emphasis in clinical nursing is put on those things regarding caring for others, teaching how to be healthy, and going through changes in health, along with being surrounded by many different groups, the curricula do not reflect much on any of those things. The large number of text in books and the slow publishing time makes it slow to get new stuff from textbooks to the classrooms. Emphasis in the curriculum is placed upon simply memorizing sickness facts along with step-by-step procedures, which omits the creation of high-level skills like analyzing clinical situations, predicting danger, or communicating with teams [3].

3.2. Ineffective school-hospital collaboration mechanism

Between schools and hospitals, the cooperation is superficial, as there is no institutionalization and no solidified and deep integration. Cooperation agreements are mostly concentrated in student internships, with very little real collaboration in developing curricula, setting standards, and sharing teachers and resources. Time and pay for hospital clinical preceptors involved in school teaching do not have institutions giving guarantees; they teach, but no one notices. School teachers cannot go to hospitals for clinical training because the hospitals restrict their teachers from doing so for safety and productivity reasons. Differences over what schools and hospitals think about cultivating talents and making evaluations get in the way of becoming one educational team.

3.3. Single teaching evaluation method

The current practical teaching evaluation system relies too much on the summative evaluation without focusing enough on formative evaluation of the learning process. The practical skills of a student would be determined by just the final marks. Assessment items remain unchanged; procedures follow standardization. Repetitive training could achieve expertise, but it cannot represent one's actual level in dealing with complicated cases. Theory exams and skill assessment are separated, not good at assessing knowledge transfer and applicability. The system lacks a proper professional soft skills measuring tool, such as communication, humanistic qualities, teamworking, and critical thinking. The evaluation subjects are singular, mostly course teachers, with little involvement from clinical mentors, patients, and students in self-peer reviews.

4. Improvement ideas and principles

4.1. Orientation towards job competency

In practice, if educators are going to reform teaching, they must have nursing work capacity as the principal logical origin, and design the educational goals and curriculum system. Job skill comprises operation ability as well as many other things, including clinical judgment, communication and collaboration, health advice, moral decision and management, and security management. Institutes need to do regular surveys on industrial

needs. Invite clinic nursing experts to join in creating, improving training courses, and making clear the main qualification require for every level of nursing post. The teaching based on competence means changing "what the teacher instructs" into "what the students will do", thus making sure all projects, teaching cases, and evaluation criteria correspond exactly with practical jobs, so the learners can acquire what they should know for the job.

4.2. Deep integration of theory and practice

There can be no definitive sequential limit or artificial break point of theory teaching and applied learning; both need to blend naturally through all contents and times. Each lesson is taught around one of the clinical topics, forming a loop that starts with a case intro > knowledge analysis > simulation training> reflection discussion, and allows them to learn from theory by applying it to actual problems. The basics of nursing, specific nursing, and the stuff about how the body goes wrong and what drugs do should all be brought together so that students can see why things happen as they do when they are doing something on the body. The integrated design of teaching requires the breaking down of the old course walls, creating integrated theory and practice teaching books, as well as extending the period of uninterrupted time to give students ample time for their own hands-on practice and thoughts.

4.3. Tiered, progressive ability growth

Students' professional abilities develop according to the cognitive development rules, which start from simple to complex, and then become more comprehensive. Practical teaching should correspondingly form a tiered, advancing training path. First tier: Basic skills training stage, standardize and routinize individual nursing procedures. Second tier: Comprehensive scenario simulation stage, using standardized patients and high-fidelity manikins to create complex situations such as multiple comorbidities or sudden changes in conditions, training students' comprehensive assessment and emergency response skills. Third tier: Real clinical experience stage, using teaching hospitals to allow students to engage in actual nursing work with some responsibilities. These three tiers are connected one after another, advancing gradually, so that students can go from being a beginner to becoming a pre-nurse during their time at school [4].

5. Certain improvement approaches

5.1. Reorganizing modular course content

Changing the old discipline-based curricular system to many more capability units following the workflow in the hospital, as well as work activities that can commonly be done every day in a clinical setting. Each module corresponds to a type of clinical nursing situation, like the Admission Assessment Module, Perioperative Nursing Module, Critical/Emergency Identification and Management Module, and Discharge Guidance and Transitional Care Module. Integrate related knowledge, skills, and attitude goals into every single module, supplemented by a case library, video clips for demonstration purposes, and a standardized test plan. Course contents should be revised yearly with current clinical guidelines and nursing methods. The modular course can be updated quickly according to the changes in the needs of the industry, and it provides students with various options to take courses that suit them and make up for what they lack in competence, so as to adjust the contents of the lessons to the actual requirements in jobs.

5.2. "Double-qualified" teaching team construction

Create a teaching staff mechanism of college instructors who will work along with clinical adjunct instructors. Each one's responsibility is well defined, and the methods used to do it are clearly known. The school teachers, the hospital preachers, the ones who give out the courses, give out the theoretical knowledge, teach all these basics. They provide the clinical cases, acting as the simulation scenario mentors and the internship mentors. Create a clinical teaching rotation position and choose excellent young teachers to do full-time clinical rotations in partner hospitals for more than half a year, and invite experienced clinical nurses to become associate professors to regularly participate in school teaching and research activities. Enhance standards of identification, incentive policies for dual-qualified teachers linked to title assessments and wages based on clinical work experience, and foster a structure that encourages teachers to actively cultivate their skills.

5.3. Building high-level simulation training grounds

Create a state-of-the-art nursing simulation training facility centered around instruction and training, as well as evaluation and study, by following along with the design principles and operational structures as they pertain to an actual hospital. Functional areas such as simulated wards, ICU, E.R., O.R., high-fidelity manikins, virtual venipuncture training system, emergency scenario simulation system, etc. can be found in the center so that it could give real-time data on vital signs as well as allow for manipulated disease progression. Develop a library of standard patients and typical clinical scenario cases to support multi-role, multi-stage comprehensive simulation drills. An open access policy is implemented after school in the practical training base; self-learning guidance is provided. And then at the same time build up some kind of combined real/virtual remote training environment by way of employing virtual-reality technology, this is in lieu of there being a deficiency within the number of physical training environments available, as such, educators would be able to have better teaching resources extended to those who do not reside nearby.

6. Guarantee mechanism creation

6.1. School-hospital joint operation system improvement

Develop school hospital cooperative management rules that make clear what each party is entitled to and responsible for in talent cultivation, and elevate the cooperation level from an intangible agreement into an institutional arrangement. Build up a Realistic Training Steering Board shared between the school's academic supervisor and the hospital's nursing section chief; convene these quarterly boards every quarter to check over main problems like subject alteration, instructor deployment, and resource assignment. Sign school-hospital joint training agreements, integrate clinical teaching into the hospital's performance appraisal system, and give economic subsidies and title evaluation bonus points for teaching. Create a special fund for the school-hospital partnership for something like sharing educational apparatus, having teachers swap jobs with each other, improving lessons—make it so that working together is backed by the institution and given resources, and can be judged [5].

6.2. Setting up a multi-level evaluation system

Form a multidimensional evaluation system of knowledge, abilities, attitude, and so on, making both the sum and the development equally important. Increase subjective questions, such as case analysis and clinical

reasoning, in the theory test. Use standardized patient and scenario variables in skills assessment to look at student performance under uncertainty. Staged "skills passport" tests during learning, requiring each student to first achieve standards for one element before progressing to the next stage of training. Introduction of 360 eval by having the preceptors, classmates, the standard patients, and the student doing their own self evaluations, all going into the final grade. Electronic portfolios can be built that contain detailed documentation of materials such as practical training logs, case reflection, and operation videos that can provide data support for teaching improvement.

6.3. Mechanisms for sustained investment and dynamic monitoring

The schools have to allocate some real training budget every single year; their per pupil training cash has to go up every year too, then create this special equipment renewal pot that would ensure the simulated kit stayed as current as possible over a period of maybe three-year stretches. Create a database with practical education quality supervision data, continuously record student skills test scores, internship result reviews, license examination success proportions, and opinions from enterprises. Publish an annual practical teaching quality report, doing responsibility analysis of the problems which are found on each link. When monitoring a new discovery, start using an immediate reaction channel through the argument and experimenting before another period of educating. Sustain investment and constantly watch, make a full circle improvement ring: recognize problems, search for causes, think about solutions, and judge results.

7. Conclusion

In terms of changing practical training within higher vocational nursing programs, this kind of project has lots of complicated reasons behind it that involve different parts, like what the teachers teach, the people doing the teaching, all of the tools available to learn stuff, and places to do so, as well as methods to do things. Focus on how teaching and the clinic are disconnected with the core contradiction, analyzing the important problems related to limited amounts of resources, teachers' capabilities, working together between schools and hospitals, along with ways to measure success. Improving job competency and integration of theory with practice, and tiered progression. Three big ways: rebuilding the course system, making a double-qualified team, and setting up some bases to help each other out; at the same time, the school-hospital work system, multidimensional assessment system, and the dynamic monitoring system come together to serve us as the conditions for carrying out this reform. Only when persisting in a problem-oriented and systems thinking approach and promoting connotative growth of practical teaching continuously, high-quality nursing talents meeting the real needs of clinical positions can be cultivated.

Disclosure statement

The author declares no conflict of interest.

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