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Lessons Learned from Commendations and Recommendations in PAASCU Level II and III Accredited Nursing Programs on Teaching and Learning in the laboratory, hospital, and community settings

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Executive Summary

This study examined lessons drawn from commendations and recommendations contained in Philippine Accrediting Association of Schools, Colleges and Universities (PAASCU) accreditation reports concerning Teaching and Learning in the Laboratory, Hospital, and Community Settings (Sub-area 4.2b) of accredited nursing programs. It aimed to identify recurring strengths, concerns, and quality improvement directions in the implementation of related learning experiences (RLE) under PAASCU's standards-based assessment framework.

A retrospective qualitative documentary design was used. The study analyzed final PAASCU accreditation reports of 15 nursing programs reviewed from 2023 to 2025 using the revised standards-based instrument. The sample included eight Level III and seven Level II programs from public and private institutions. Analysis focused on narratives, commendations, and recommendations specific to Sub-area 4.2b. A structured thematic analysis was conducted using a coding framework, with coding performed by at least two independent researchers. Differences were resolved through consensus, and an audit trail was maintained to support transparency, traceability, and analytic rigor.

Five interrelated themes emerged. First, RLE systems were generally supported by formal governance structures such as manuals, clinical teaching plans, rotation systems, quality assurance mechanisms, and institutional partnerships. However, governance maturity depended on the consistent operationalization, review, coordination, and monitoring of these structures rather than on documentation alone. Second, outcomes-based and competency-oriented RLE design was widely evident, with many programs aligning learning experiences with institutional goals, program outcomes, year-level expectations, and competency frameworks. Nevertheless, inconsistencies remained in the developmental alignment of competencies, clinical exposure, RLE hours, and sequencing across levels.

Third, rotation planning and theory–practice synchronization served as central mechanisms for translating the curriculum into experiential learning. Their effectiveness was affected by scheduling disruptions, delayed coordination, limited learning spaces, and uneven readiness or utilization of laboratory and simulation resources. Fourth, monitoring systems commonly used checklists, rubrics, and competency-based evaluation tools, but broader feedback ecosystems were less consistently developed. Formal remediation, reflective processes, stakeholder participation, and systematic use of feedback for continuous quality improvement remained variable. Fifth, experiential learning was strongly dependent on hospitals, community agencies, public health institutions, and clinical personnel. Stronger programs involved these partners in competency development, assessment, feedback, and quality improvement rather than treating them solely as placement sites.

Overall, the findings indicate that Level II and III re-accredited nursing programs have substantially institutionalized structured, outcomes-based approaches to experiential learning, but varying levels of RLE system maturity remain. The principal areas requiring further strengthening are governance enactment, developmental alignment, theory–practice concurrency, infrastructure readiness, integrated feedback, and stakeholder participation.

The study suggests that nursing programs should strengthen periodic RLE review, lecture–clinical faculty coordination, competency progression, simulation and laboratory readiness, participatory assessment, remediation systems, and formal collaboration with clinical and community partners. For PAASCU, the findings support accreditation practices that examine not only the presence of policies, plans, affiliations, and tools, but also their actual implementation, integration, effectiveness, and contribution to continuous quality improvement.

The findings should be interpreted within the study's limitations. The analysis was confined to

documented Survey Team narratives, commendations, and recommendations and did not include full annexes, direct interviews, or participant validation. It was also limited to Level II and III re-accredited nursing programs reviewed from 2023 to 2025. Within this scope, the study provides an evidence-based synthesis of recurring strengths and improvement needs in experiential nursing education and offers practical directions for nursing programs, accreditors, and PAASCU.

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Introduction

Accreditation serves as a critical quality assurance mechanism for higher education institutions, particularly in professional programs like nursing, where public health and safety are directly influenced by the quality of education provided (Carroll et al., 2016; McAtee et al., 2021). In the Philippines, the Philippine Accrediting Association of Schools, Colleges, and Universities (PAASCU), one of the external accrediting bodies, plays a pivotal role in upholding educational standards across disciplines, including nursing and allied health. The PAASCU accreditation process is widely recognized not only as a compliance measure but also as a strategic opportunity for institutions to engage in structured self-reflection and continuous improvement.

In 2020, PAASCU introduced a significant innovation in its approach to quality assurance by launching the standards-based assessment framework, approved by its Board of Trustees and publicly made available through its official portal (PAASCU, 2022). This framework marks a shift from a checklist-based system to a more outcomes-oriented and qualitative evaluation process, emphasizing coherence, contextual relevance, and evidence-informed decision-making. In the same year, the Commission of Allied Health and Sciences Education (CAHSE) became a stand- alone commission after being part of the Commission on Tertiary Education (Dychangco, 2025). In the succeeding year, CAHSE, together with the other commissions, implemented the new standards-based assessment framework. The team that reviewed the instrument decided to add a specific component to Area 4: Teaching-Learning, which is not present in any other commission instruments, that is 4.2b: Teaching and Learning in the laboratory, hospital, and community settings. Nursing and allied health programs that underwent accreditation using this updated framework represent a valuable first cohort whose experiences can yield insights into how institutions interpret, adapt to, and operationalize this unique sub-area.

Within nursing education, experiential learning occupies a central role in professional formation. Through related learning experiences, clinical placements, community immersion, simulation-based learning, and internship experiences, students progressively develop the competencies necessary for safe and effective nursing practice. Consequently, understanding how nursing programs organize, govern, monitor, and continuously improve experiential learning systems has important implications for educational quality assurance and accreditation readiness.

Despite the increasing prominence of standards-based accreditation, there remains limited empirical literature examining the content of accreditation feedback related to experiential learning implementation. Existing studies predominantly focus on accreditation outcomes, stakeholder perceptions, or institutional benefits of accreditation. Less attention has been devoted to understanding the specific governance structures, curricular mechanisms, assessment systems, and stakeholder relationships identified by accreditors as indicators of quality experiential learning. This study sought to address this gap by systematically analyzing accreditation feedback related to Sub-area 4.2b teaching and learning in the laboratory, hospital, and community settings within nursing education. The primary objective of this study was to describe and analyze the common commendations and recommendations documented in PAASCU accreditation reports for Levels II and III nursing programs assessed specifically on Sub-area 4.2b, which can serve as a springboard for reflection and continuous improvement.

Methodology

The study employed a retrospective qualitative design, using thematic content analysis of documentary data drawn exclusively from PAASCU accreditation reports. The data set comprised final accreditation reports issued to nursing programs that were reviewed under PAASCU's standards-based framework beginning in 2021. These reports served as the primary source for identifying and analyzing

patterns in commendations and recommendations.

Purposive sampling was used, focusing on the initial cohort of level II and III nursing programs evaluated using the revised standards with visits from 2023 to 2025. There were no programs that used the new instrument in 2022. This cohort represents a timely and relevant group through which the implementation and interpretation of the standards-based framework can be explored. Reports from both public and private institutions were included to reflect institutional diversity, although the study will not compare outcomes between types of institutions or accreditation results. A total of 15 nursing programs met the criteria on level of accreditation and use of the new tool, eight (8) with level III status and seven (7) with level II status. The reports were provided by the PAASCU headquarters, and anonymity was maintained by removing the names of the schools in all the narratives. Only the narratives, commendations, and recommendations application to sub-area 4.2b were sent.

Data analysis involved a structured thematic analysis. A coding framework was developed with sub-codes reflecting specific commendations and recommendations as articulated by PAASCU accreditors. Thematic coding was conducted using qualitative analysis software to ensure systematic organization and transparency in identifying recurring patterns. To maintain analytic rigor, coding was performed by at least two independent researchers. Discrepancies in coding were discussed and resolved through consensus. An audit trail was maintained to document coding decisions and ensure the reproducibility of the analysis.

Results and Analysis

The directed thematic synthesis generated five (5) interrelated themes describing how re- accredited nursing programs operationalize teaching–learning processes in laboratory, hospital, and community settings under PAASCU Sub-area 4.2b. The themes collectively demonstrate that most programs possess established structures for RLE implementation, competency-oriented curricular alignment, and operational coordination of clinical exposure; however, the findings also reveal recurring tensions between policy presence and governance enactment, competency articulation and developmental calibration, operational scheduling and instructional synchronization, and assessment documentation and feedback integration.

Theme 1. RLE Systems Are Commonly Supported by Formal Governance Structures, but Governance Maturity Depends on Operationalization Rather Than Documentation Alone

Most programs demonstrated the presence of formal governance structures supporting RLE implementation. These structures included internship manuals, clinical teaching plans, rotation systems, quality assurance frameworks, and formal affiliations with hospitals and community partners. Seven programs particularly demonstrated mature documentary structures, while one program described a "three-tier quality assurance system" governing RLE implementation, and another demonstrated semester-based alignment review processes conducted by program chairs.

However, governance maturity varied substantially across programs. Programs did not explicitly describe a periodic review mechanism for the RLE program, demonstrated largely informal coordination with affiliated partners despite the presence of documented policies, and reported insufficient documentation of coordination between lecture faculty and clinical faculty. Infrastructure governance concerns were also repeatedly identified, such as a lack of a formal laboratory asset monitoring system and incomplete laboratory development planning.

These findings indicate that the existence of governance documents does not necessarily ensure operational coherence or continuous quality improvement. Governance maturity appeared stronger in programs where policy structures were accompanied by routine review, coordinated communication, and operational monitoring systems.

Theme 2. Outcomes-Based and Competency-Oriented RLE Design Is Widely Embedded, but Developmental Alignment Across Levels and Experiences Remains Uneven

The findings demonstrated strong integration of outcomes-based education principles within RLE systems. Most programs explicitly linked experiential learning activities to VMGO, program outcomes, year-level expectations, and competency frameworks through clinical focus guides, syllabi, performance checklists, and clinical teaching plans.

Ten programs, three Level 2 and seven Level 3, demonstrated explicit alignment between RLE activities and competency. One program specifically utilized "clinical focus guides" aligned with VMGO and competency attainment, while another linked structured RLE activities directly with syllabi and intended competencies. Assessment tools frequently served as operational mechanisms for documenting competency attainment and used performance checklists or rubrics to monitor expected competencies during clinical exposure.

Despite this broad alignment, developmental inconsistencies were repeatedly identified, namely mismatch between required clinical exposure and level-specific competencies, inconsistencies between RLE hour allocation and curricular unit requirements, and concurrency disruptions which weakened continuity of competency progression. The findings suggest that competency-oriented RLE design is strongly institutionalized among re-accredited programs, but developmental calibration across levels, timing, and exposure sequencing remains uneven.

Theme 3. Rotation Planning and Theory–Practice Synchronization Function as Core Mechanisms for Translating Curriculum into Experiential Learning, but Resource Readiness remains a challenge.

Clinical rotation systems emerged as the central operational mechanism through which nursing curricula were translated into experiential learning activities. Four programs, two Level 2 and two Level 3, described structured deployment or master rotation plans organizing clinical exposure across learning settings. Two programs additionally demonstrated that rotation systems facilitated broad exposure to hospital, community, and public health settings. One program specifically described exposure to DOH programs and COPAR-based community experiences, while several programs demonstrated strong synchronization between classroom instruction and clinical exposure.

Conversely, disruptions in concurrency emerged as significant concerns in several programs, specifically misalignment between classroom instruction and clinical duty schedules among higher-year students, alternate-week and summer arrangements that disrupted learning continuity, and delayed dissemination of the clinical rotation schedule.

Infrastructure limitations further shaped implementation quality, such as underutilized simulation resources due to inadequate faculty and laboratory training, makeshift laboratory facilities during infrastructure transition, and limited learning space affecting implementation. The findings suggest that instructional coherence depends not only on curriculum mapping but also on operational synchronization, infrastructure readiness, and coordinated deployment systems.

Theme 4. Monitoring Systems Are Commonly Tool-Based, but Feedback Ecosystems and Participatory Assessment Structures Are Less Mature

Structured assessment and monitoring tools were widely present across the sampled programs, manifesting use of clinical performance checklists, rubrics, or competency-based evaluation forms. One program demonstrated relatively transparent assessment implementation by providing rubrics and performance tools prior to clinical duty assignments, while another integrated industry feedback and outcome inventories into annual evaluation processes. Nevertheless, broader feedback ecosystems appeared less consistently formalized, such as not explicitly describing formalized feedback mechanisms, informal industry partner feedback systems, lack of portfolio-based assessment mechanisms, inconsistent implementation of clinical teaching plan formats, and limited participation of clinical nurses in formal student evaluation processes.

These findings indicate that while monitoring systems are commonly present, the integration of feedback, standardization, stakeholder participation, and quality improvement processes remains variable. The findings suggest that assessment maturity depends not only on the
existence of evaluation tools but also on the extent to which feedback systems support remediation, reflection, stakeholder participation, and continuous quality improvement.

Theme 5. Experiential Learning is largely Partnership-Dependent, but Integration of Clinical and Community Stakeholders into Educational Governance and Evaluation remains Inconsistent

The findings demonstrated that experiential learning systems are fundamentally dependent on partnerships with hospitals, community agencies, public health institutions, and clinical supervisors. While some programs demonstrated relatively advanced stakeholder integration, such as the creation of advisory councils and clear stakeholder feedback mechanisms, several programs demonstrated uneven integration of clinical stakeholders into governance and assessment systems. These uneven integrations were observed in inconsistent dissemination of clinical focus guidelines to partner hospital personnel, informal coordination structures, and lack of consistent documentation of coordination between lecture and clinical faculty. There was also limited participation of clinical nurses in formal student evaluation.

Additionally, the findings suggest that stronger RLE systems treat hospitals, community agencies, and clinical personnel not merely as placement sites but as active collaborators in competency development, monitoring, feedback, and quality improvement processes.

Discussion and Lessons Learned

The findings of this study demonstrate that re-accredited nursing programs have substantially institutionalized outcomes-based and policy-oriented approaches to experiential learning. Across the sampled programs, RLE systems were commonly supported by documented governance structures, competency-linked learning activities, structured clinical deployment systems, and assessment mechanisms. These findings align with broader nursing education literature emphasizing that contemporary experiential learning systems increasingly rely on formalized competency frameworks, constructive alignment, and integrated clinical governance structures to support professional preparation.

The widespread use of competency-based assessment tools and VMGO-aligned RLE structures observed in this analysis reflects the broader shift toward outcomes-based nursing education reported internationally. Studies on competency-based nursing curricula consistently emphasize the importance of aligning learning experiences, assessment systems, and progression mechanisms with professional competencies and expected practice outcomes. The findings of this study similarly demonstrate that most programs have already embedded the language and operational structures of outcomes-based education within their RLE systems.

However, the synthesis also demonstrates that policy presence alone does not necessarily translate into mature governance enactment. Several programs maintained formal manuals, teaching plans, and affiliated partnerships while simultaneously demonstrating gaps in review cycles, coordination systems, feedback integration, or infrastructure planning. These finding parallels implementation-focused educational literature suggesting that educational quality depends not only on structural compliance but also on operational integration, communication, enactment, and organizational learning. In this study, governance maturity appeared strongest when institutions demonstrated evidence of routine review, coordinated stakeholder engagement, and operational quality improvement processes.

The findings regarding theory–practice synchronization are particularly important within nursing education. Programs demonstrating strong concurrency systems showed clearer integration between classroom concepts and clinical experiences, whereas non-concurrent scheduling arrangements weakened

continuity and developmental progression. Similar concerns have been widely documented in nursing education literature, where gaps between theoretical instruction and clinical placement timing contribute to fragmented learning experiences, reduced confidence, and difficulties transferring knowledge into practice settings. The present findings reinforce the importance of treating concurrency not merely as a scheduling issue but as a pedagogical and developmental condition affecting competency formation.

Infrastructure-related findings also deserve careful attention. Laboratory limitations, underutilized simulation resources, inadequate asset monitoring systems, and constrained learning spaces repeatedly emerged as factors shaping RLE implementation. These findings align with simulation and clinical education literature emphasizing that educational infrastructure is not simply a logistical concern but an active determinant of experiential learning quality. Simulation laboratories, skills centers, and coordinated learning environments are increasingly recognized as integral pedagogical spaces supporting safe practice, competency rehearsal, and transition into clinical settings.

The findings additionally suggest that monitoring systems among the sampled programs remain more tool-driven than feedback-driven. While performance checklists, rubrics, and evaluation tools were commonly present, fewer programs demonstrated fully integrated feedback ecosystems involving remediation systems, structured reflection, stakeholder participation, and continuous quality improvement. Similar tensions have been reported in nursing education literature, where competency checklists often dominate assessment systems while formative feedback, reflective practice, and participatory evaluation remain inconsistently operationalized.

Partnership integration emerged as another major differentiating condition among programs. Stronger systems treated hospitals, community agencies, and industry partners as active collaborators in educational governance, assessment, and quality improvement rather than simply as placement providers. This finding aligns with contemporary perspectives on clinical education partnerships, which emphasize co-governance, shared accountability, and collaborative competency development between academic institutions and practice environments.

The findings of this study have several implications for nursing education quality assurance. First, accreditation systems may benefit from moving beyond documentary verification toward deeper evaluation of governance enactment, concurrency systems, feedback integration, and CQI utilization. Second, programs may need to strengthen developmental calibration of RLE experiences across year levels to ensure that competency progression remains synchronized with theoretical preparation and clinical exposure. Third, the findings suggest the need for stronger
integration of simulation infrastructure, faculty development, and stakeholder participation within experiential learning systems.

Several limitations must also be acknowledged. The analysis was limited to Survey Team observations, commendations, and recommendations contained within uploaded reports and did not include full annexes, direct institutional interviews, or participant validation processes. As a result, the findings reflect documented accreditation evidence rather than lived experiences of students, faculty, or clinical partners. The sample was also limited to Level II and Level III re- accredited nursing programs between 2023 and 2025, which may limit transferability to programs with different accreditation levels or institutional contexts.

Reflexively, the analysis was conducted within a quality assurance and nursing education lens that recognizes experiential learning as both a curricular and governance process. To minimize interpretive overreach, the study maintained a low-inference descriptive orientation and preserved explicit traceability between extracts, codes, clusters, and themes. Negative and deviant cases were retained throughout analysis to avoid premature homogenization of findings.

The trustworthiness of the study was strengthened through systematic de-identification, consecutive extraction coding, transparent clustering procedures, and maintenance of a complete audit trail linking themes to raw extracted statements. Credibility was enhanced through cross-case comparison and retention of deviant cases.

Transferability was supported through thick description of RLE structures and institutional processes. Dependability was strengthened through explicit methodological documentation and codebook development. Confirmability was reinforced through traceable evidence mapping and reflexive analytic notes.

Overall, the findings suggest that re-accredited nursing programs have largely institutionalized outcomes-based experiential learning systems, but important developmental tensions remain in governance enactment, concurrency, infrastructure readiness, assessment ecosystems, and stakeholder integration. These tensions are not simply operational gaps but indicators of differing levels of RLE system maturity across nursing programs.

Anticipated Contributions

This study is expected to make several contributions to the scholarship and practice of nursing education in the Philippines. First, it will provide empirical insights into how institutions interpret and implement the standards-based assessment framework introduced by PAASCU in 2021. Second, it will identify key institutional practices and features associated with accreditation success, offering a resource for nursing programs preparing for future accreditation cycles. Third, it will contribute to the discourse on outcomes-based quality assurance in higher education, particularly in low- and middle-income settings where accreditation systems continue to evolve. Finally, findings from this study may inform PAASCU's own continuous improvement efforts, particularly in relation to feedback mechanisms and support for capacity-building in underperforming institutions.

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References

Carroll, V., Thomas, G., & Dewolff, D. (2006). Academic Quality Improvement Program: Using Quality Improvement as Tool for the Accreditation of Nursing Education. *Quality Management in Health Care*, 15, 291–295. https://doi.org/10.1097/00019514-200610000- 00012

Davis, S. W., Weed, D., & Forehand, J. (2015). Improving the nursing accreditation process. *Teaching and Learning in Nursing*, 10, 35–38. https://doi.org/10.1016/J.TELN.2014.09.003

El-Jardali, F., Jamal, D., Dimassi, H., Ammar, W., & Tchaghchaghian, V. (2007). The impact of hospital accreditation on quality of care: perception of Lebanese nurses. *International Journal for Quality in Health Care*, 20(5), 363–371. https://doi.org/10.1093/intqhc/mzn023

Ellis, P., & Halstead, J. (2012). Understanding the commission on collegiate nursing education accreditation process and the role of the continuous improvement progress report. *Journal of Professional Nursing*, 28(1), 18–26. https://doi.org/10.1016/j.profnurs.2011.10.004

Gabriel, C. S., Bogarin, D. F., Mikael, S., Cummings, G., Bernardes, A., Gutierrez, L., & Caldana, G. (2017). Brazilian Nurses' Perspective on the Impact of Hospital Accreditation. *Enfermería Global*, 17(1), 381–419. https://doi.org/10.6018/EGLOBAL.17.1.283981

Kim, K. (2011). Faculty Perceptions of the Improvement and Effort for the Achievement of Quality in Nursing Education through Accreditation in Baccalaureate Nursing Programs. *Korean Medical Education Review*. https://doi.org/10.17496/kmer.2011.13.2.059

McAtee, B., Shellenbarger, T., & Chicca, J. (2024). Dispelling Accreditation Myths to Enhance Nursing Education. *Teaching and Learning in Nursing*. https://doi.org/10.1016/j.teln.2024.08.016

PAASCU (2022). *Standards and Instruments.* Retrieved from: https://paascu.org.ph/index.php/standards/. Accessed April 2, 2025.

Ziefle, K., Koschmann, K. S., Colsch, R., Campbell, J. A., & Graeve, C. (2021). Innovation and accreditation: A quality improvement process. *Teaching and Learning in Nursing*. https://doi.org/10.1016/J.TELN.2021.01.007