



Do dummies make good teachers? A paradigm shift for clinical educators



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Summary This discussion paper will explore contemporary clinical nursing in Australia and simulation technologies used in universities to educate Bachelor of Nursing (BN) students. Informed by auto-ethnographic principles the authors reflect on their teaching experiences in both clinical and tertiary sectors with specific reference to challenges encountered through the use of simulation technologies. Further, increased reliance on simulation as a teaching tool in nursing education is discussed and techniques for embracing this explored. The authors' pedagogical goal is to ensure students develop the capacity to competently process patient information, enabling them to safely plan, implement and evaluate interventions and outcomes. © 2015 Australian College of Nursing Ltd. Published by Elsevier Ltd.

1. Introduction

Clinical education in nursing can be described as a process of contextual and experiential learning that involves a relationship between patients, clinicians, educators and students, ultimately supporting the translation of nursing theory into

clinical knowledge and practice (Kelly, 2007). It involves the opportunity for students to apply theory to practice, enriching further learning through knowledge gained from experience in practice, including the ability to apply clinical reasoning and critical thinking (Benner, Sutphen, Leonard, & Day, 2009). Providing appropriate and contemporary clinical education for undergraduate nursing students presents significant challenges for educators, for they are committed to developing competent, critically thinking graduates who are able to attain registration standards (Forbes, 2010). It is particularly difficult for some educators, including the authors, to transition from clinical environments where patients are the practice models, to the simulation world

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of the nursing laboratory where programmed mannequins (or dummies) replace real life experiences. Clinical educators have previously been more familiar with the ‘‘see one, practice one, do one’’ teaching culture of the past (Ziv, Ben-David, & Ziv, 2005, p. 196), where skills were primarily practised on patients. Thus, the use of simulation technologies in the academic environment demands that nurse educators embrace and develop a new set of skills to support their current teaching and learning roles.

2. Auto-ethnography

Auto-ethnography is a self-narrative research methodology that endorses personal reflections on a specified topic within a cultural milieu (Chang, 2008). The four authors described and weaved their personal experiences of nursing education in their clinical and academic worlds into a shared narrative that informed the generation of this paper. Through this endeavour the authors aimed to more fully understand and explicate the complexities of simulated learning for educators and the potential benefits to be gained by nursing students who are preparing for clinical practice.

Auto-ethnography grew out of the long established qualitative ethnographic research methodology (Burns & Grove, 2005). According to these authors the term ethnographic means ‘portrait of a people’, with the methodology emerging from the discipline of anthropology (Burns & Grove, 2011, p. 424). Anthropology, which began in the middle of the 19th Century, corresponding with the development of modern nursing, had two basic research approaches: *emic* and *etic* (Burns & Grove, 2005, 2011). These approaches continue to guide nursing ethnographic studies in the 21st Century. *Emic* relates to the study of behaviours within the culture and *etic* the study of behaviours outside the culture (Burns & Grove, 2005, 2011). The ethnographic research approach focuses on the study of culture or cultural groups and the discovery of cultural knowledge (Streubert & Carpenter, 2011; Taylor & Francis, 2013). Boyle (1994) acknowledges that there are ‘variations within the different types of ethnography’, but they all attempt to be ‘holistic, reflexive and contextual’ (Cutcliffe, 2005, p. 67). Brewer (2000) suggests that ‘ethnography is not a particular data collection method but a style of research’, which attempts to understand cultural groups (Tham, 2003, p. 180). While there may be subtle differences in approach, the methodology is informed by common elements, leading to an overarching shared purpose. According to Polgar and Thomas (2013) the unifying intention is the provision of ‘a detailed description of a particular set of circumstances and to encourage readers to make their own interpretations’ (Polgar & Thomas, 2013, p. 113). This may account for Wolcott (2009) being somewhat dismissive of ‘ethnographic intent’, claiming that ethnographers ‘... have it better than most other qualitative researchers ...’ given the loose parameters of the methodology (p. 36).

Notwithstanding, auto-ethnography emerged from this root stock, with a specific focus on the study of ‘personal experience that is culturally positioned’ (Taylor & Francis, 2013, p. 67). Grbich (1999) expands, stating that ‘the ethnography of personal experience (*auto-ethnography*) is becoming popular ... often presented using

the impressionist techniques of poetry, narrative, drama and visual representation’ (pp. 166–167). According to Ellis, Adams, and Bochner (2011) ‘a researcher uses tenets of autobiography and ethnography to do and write auto-ethnography. Thus as a method auto-ethnography is both a process and a product’ (p. 345). Guided by Grbich, the authors will be both subjects and the narrators, with their voices resonating throughout the text to add depth to the nursing literature (p. 156). Further, the authors will combine ‘emotional, physical and cognitive’ elements to the unfolding narrative (Grbich, 1999, p. 167). They will select from their past experiences, as products of a largely hospital trained nursing culture, reflecting on their roles as educators and sharing ‘remembered moments’, and relating these to their current or recent academic educator roles in the world of simulation (Ellis et al., 2011, p. 347).

3. Background discussion

In the early 1970s clinical educators and other clinical staff often resorted to devising their own simulation equipment to enhance student learning.

When I was in charge of a male urology ward I often provided students with instruction on how to undertake manual bladder washouts for patients following prostatectomy. Given that there were no teaching aids of any description available in the ward I needed to be creative with basic ward stock, including sterile dressing packs, catheters, bladder syringes, solutions and drainage bags. Under instruction students engaged in simulation experiences using these supplies and when they were deemed competent they conducted procedures under supervision with real patients (Author 2).

Over time simulation equipment became more common in the healthcare domain, having had a presence in many clinical areas for at least 15 years (Traynor, Gallagher, Martin, & Smyth, 2010). Although it has improved the scope and quality of clinical education, perceived limitations lingered.

As a clinical educator in an intensive care environment I found simulation technologies such as mannequins a vital teaching tool for students, but they could not replace real people. Whilst the skills associated with techniques such as a full abdominal assessment could be demonstrated and practiced on the mannequins, in my view this could never replace touching, palpating and listening to the abdomen of a real patient (Author 1).

The authors, however, accept that the new age mannequins are far superior to those that were used in ‘our day’. Reilly and Spratt (2007) believe that access to simulation equipment has undoubtedly offered the opportunity for students to ‘practice repeatedly without causing harm to the patient; receive immediate feedback on their ability to perform the psychomotor skills and the accompanying clinical reasoning or judgement’ (Traynor et al., 2010, p. 1422).

Following the transfer of nursing education into the tertiary sector in the 1980s the provision of this type of practical tuition became a shared university and health sector

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