

Learning Nursing Practice: A Multisite, Multimethod Investigation of Clinical Education

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Nurses agree that direct practice with actual patients is vital, but the teaching methodologies and faculty-student relationships that optimize students' learning in clinical settings have not been documented. This study examined students' thinking and their interactions with faculty during clinical experiences at three academic nursing programs. Findings suggest that missed opportunities for learning, inadequate measures for clinical progress and learning, and lack of interprofessional practice are failing to optimize student clinical learning experiences.

Calls to transform nursing education (Benner, Sutphen, Leonard, & Day, 2010; Institute of Medicine [IOM], 2010) have intensified the dialogue about how to improve students' readiness for practice. Because the discipline generally and regulators specifically assume that experience with actual patients is the gold standard for students learning nursing practice, what and how students learn in these clinical settings have rarely been called into question. The shortage of quality sites available for learning clinical practice (McNelis, Fonacier, McDonald, & Ironside, 2011) is prompting many schools of nursing to ask their state board of nursing for guidance in determining how many alternative activities (such as simulation) can be substituted for clinical time. Although current research is investigating learning outcomes associated with different percentages of simulation, it is prudent to simultaneously investigate what and how students learn during their experiences in clinical settings.

The purpose of this study was to investigate the clinical experiences of students and faculty members at three geographically diverse U.S. universities. Providing rich descriptions of students' thinking and their interactions with educators during these experiences can help regulators understand the contributions and limitations of current approaches to clinical education and the potential of emerging alternatives.

Background

According to the Institute of Medicine's report on the future of nursing (IOM, 2010), success in improving health

care in the United States will require a multifaceted strategy, including revamping the education and training of health care professionals. This report challenges educators to create programs in which students move quickly from the idealistically focused world of education to the reality-based world of clinical practice. The development of novel educational pedagogies and technology, such as dedicated educational units and sophisticated simulations to facilitate students' readiness for practice, offers alternatives to clinical faculty. The diversity of pedagogic choices to foster experiential learning, however, makes regulation difficult because little evidence exists to document if and how these approaches improve on traditional clinical education models. Furthermore, easily measured characteristics of a program's approach to clinical experiences (e.g., number of hours students spent in clinical practice settings or student-faculty ratios) fail to reflect student learning, practice abilities, and the quality of student-faculty interactions (Ironside & McNelis, 2009).

Traditionally, clinical courses include faculty-supervised patient care followed by a conference. This model of clinical education (one faculty member with a small group of students) persists despite documented shortcomings in preparing students for the complexity of practice (Benner et al., 2010). Many programs also use preceptors to oversee students, particularly in capstone or advanced clinical courses. This model evolved from earlier apprenticeship relationships in which students worked with registered nurses (RNs) to learn nursing practice (Papastavrou, Lambrinou, Tsangari, Saarikoski, & Leino-Kilpi, 2010). Most recently, dedicated education units have expanded the preceptor role

to foster students' interactions with expert clinical nurses (Rhodes, Meyers, & Underhill, 2012). Though such innovation is important, research has yet to document if and how these models contribute to students' learning, readiness for practice, or actual practice competencies.

The difficulties of regulating clinical learning experiences are further compounded by the complexity of actual nursing (Ebright, Patterson, Chalko, & Render, 2003; Ebright, Urden, Patterson, & Chalko, 2004). Speziale and Jacobsen (2005) reviewed basic nursing education program curricula requirements and reported little content related to workload management (including supervision and delegation) or managing the complexities of health care environments. As a result, educators, administrators, and regulators are increasingly seeking evidence to guide decisions regarding high-quality clinical education. This study attempted to provide evidence by investigating student and faculty experiences in clinical nursing education and describing students' thinking about their decisions, behaviors, and activities.

Method

A descriptive, multimethod, qualitative design using observation and individual interviews of participants was conducted to describe clinical education experiences and student-faculty interactions in clinical settings. Cognitive task analysis methods provided a framework for systematically identifying and analyzing the cognitive work of participants (Crandall, Klein, & Hoffman, 2006). Members of the research team collected data after in-depth training conducted by the lead investigator, experienced in the methods, and a human factors engineering expert. This multisite study included three universities with reputations for high-quality prelicensure programs. Six clinical sites (two sites at each of the three geographically dispersed universities [a Midwest public research-intensive university; a large East Coast private, not-for-profit, research-intensive university; and a smaller West Coast private, not-for-profit, liberal arts university]) were used to gain a national and diverse perspective. A convenience sample of students currently completing their final medical-surgical clinical course and their instructors was recruited at each site by a local site coordinator. Ten students and 2 faculty members were recruited at each site for an overall sample of 30 students and 6 faculty members.

Data Collection and Procedures

Participants were assured that the purpose of the study was not to evaluate their clinical practice or teaching and consented to participate. Following institutional review board

approval, data were collected using investigator observation and interviews. An investigator observed one participant and documented all observable behavior, including direct patient care, interactions with other health care professionals, and conferences between educators and students. Observations took place over 3 continuous hours (including a variety of times during the day, evening, and night shifts). Within a few days after the observation, investigators collected demographic information and conducted a 1-hour interview with participants, using Critical Decision Method (CDM) techniques. The CDM (Crandall et al., 2006) guided investigators in exploring participants' thinking associated with observed activities by focusing on participants' situation awareness, cues for action, and pattern recognition during the clinical experience (Crandall et al., 2006). The observer conducted the interview to maintain participant trust and encourage openness. This combination of observation and interview facilitated investigators' exploration of participants' experiences and interactions, their intentions and goals for the clinical experience, and their thinking while engaged in the experience.

Analysis

Two experienced transcriptionists converted handwritten observation notes and audio-recorded interviews into texts for analysis. The observing investigator verified the transcription for accuracy, removed any personal identifiers, and assigned a pseudonym to the participant to protect confidentiality. To begin analysis, the research team, composed of the investigators, a master's-prepared nurse educator, a graduate student in nursing education, and a baccalaureate student, used a start list (Sandelowski, 2000) of codes developed from the CDM interview elicitation categories (cues, goals, expectations, rationale for decisions related to clinical situations, and learning). To establish credibility of the coding, two team members coded each transcript, and the full team reviewed all code assignments. When disagreements over code assignments occurred, team members returned to the transcribed text to clarify the timing of events, observed actions, and participants' description of the experience. Transcripts and codes were stored in MAXQDA (qualitative data analysis software) to facilitate comparison of texts and assigned codes. Team members also identified additional codes as the analysis progressed. These codes reflected team consensus on recurring experiences or descriptions that were identified in more than one interview but not reflected in the original code list. Discussion among team members during coding focused on identifying emerging themes in the data. A theme is a recurring description that highlights participants' common experiences or understandings of the observed learning situations. Throughout

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