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Instructor comfort level in high-fidelity simulation ☆

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SUMMARY

Background: The literature in the use of simulation in nursing education has expanded significantly over the past 5–10 years. What it is like as an instructor who facilitates this experience is largely unexplored. This paper is part of a larger ethnographic study, and represents findings related to the comfort level of instructors facilitating in high-fidelity simulation (HFS).
Objectives: The question of what is it like to engage in simulated clinical experiences as an instructor is presented in this paper.
Design and participants: Twenty instructors participated in two separate focus groups and two instructors participated in individual interviews. The average years of nursing experience for this group was over 20 years, whereas the number of years of experience as a clinical instructor was less than five years.
Methods: Ethical approval was obtained from two academic institutions. A focused ethnography was conducted and included two terms of participant observations, recorded field notes, individual interviews and focus groups. Data was coded and then sorted for themes related to the instructor experience.
Results: The primary results focus on the comfort level of instructors in HFS, and what instructors believe this meant to student learning in HFS.
Conclusions: What the instructor does during HFS and how they feel about their ability to facilitate HFS has a perceived effect on student learning.
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Introduction

Most nursing education programs across North America use simulation in either a skills laboratory or in a separate simulation center. The primary purpose of the skills lab is to provide students with an environment that contains equipment and resources that support the acquisition of psychomotor skills in an artificially created environment (Infante, 1985). With simulation, the focus however is not solely on the acquisition of psychomotor skills, but the development of clinical reasoning and judgment skills (Benner et al., 2010). In this artificial setting, students can practice a series of psychomotor skills and clinical judgment skills before implementing them with the patient population. Many nursing skills are difficult to learn from audio-visual or text resources alone, so the ability to practice, evaluate and improve these nursing skills is a necessary component of clinical skills acquisition (Tapler and Johnson-Russell, 2007). By providing these experiences, it assists with development of cognitive, psychomotor and affective competencies through trial and error (Murray et al., 2007).

Much of the emerging literature in simulation use is focused on the outcomes of participants engaging in simulation. This includes performance outcomes evaluated by way of structured examinations, as well as looking at confidence levels after participating in simulation experiences. To our knowledge there are no previously published reports of studies that have examined instructors' perceptions about the HFS learning context. The results of this study unveil possible factors that affect the comfort level of instructors in HFS. This represents important ground work for further qualitative and quantitative research to explore the influence of instructor confidence on learning outcomes and instructor performance.

Background/Literature

Simulation is an approach to teaching and learning (Gaba, 2007), and a strategy used to teach in a supportive environment that mimics reality (Murray et al., 2007). While the literature is continually emerging in this area, the benefits of simulation in nursing education are well documented (Curtin and Dupuis, 2007). Teaching with high fidelity simulation provides a way to decrease errors, improve clinical judgment, and is useful for teaching and evaluating specific clinical skills (Bearnson and Wiker, 2005). Combined with the continued pressures on clinical practice sites in many health care areas, alternative methods

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and means of teaching clinical education to nursing students have been explored and have resulted in innovative uses of technology. While not a panacea, simulations can assist in the preparation of clinically proficient nursing students. Simulation appeals to technology savvy students and instructors as it provides greater engagement than other passive forms of instruction (Aldrich, 2009; Pardue et al., 2005).

The Teachers

In Canada and the United States, between 40 and 60% of nursing faculty are ages 50 or older (www.aacn.nche.edu; www.casn.ca). Most schools and faculties of nursing have instructors that are over 50 years of age, and a student population that is under 30 years of age. While the generation gap is obvious, one difference of significant note is the exposure that these two generations have had with respect to technology. Many instructors have grown up and lived without computers and other advanced technology and see it more as an adjunct to what they already have or use (Mangold, 2007). The perceived necessity and use of technology can be different between faculty and students. Given that high-fidelity simulation is considered a technological teaching tool, the concept of comfort with technology is important to discuss.

According to Myrick (2005), the pedagogical process is rapidly changing because of the proliferation of technology. Myrick recognizes the importance of educators to explore ways to allow students to respond to an increasingly complex and rapidly changing environment, however cautions that the quality of the teaching-learning process should not be compromised. The healthcare professions in general have been slow to respond to changing technology and nursing education lags even further behind (Jensen et al., 2009). Faculty of today do not dispute that technology has an important place in nursing education, however may not be equipped to navigate through these changes.

Methods

A focused ethnography was used to address the question of what is it like to engage in simulated clinical experiences as an instructor. Ethics approval was obtained from the appropriate review boards and administrative approval was obtained from the dean responsible for the undergraduate program where the study was conducted. All instructors who agreed to participate in the study were asked to take part in one of the following two activities: (1) allow the researcher to observe the instructor during an HFS activity and then take part in an interview about the HFS activity or (2) participate in a tape-recorded semi-structured focus group. Data collection occurred in 2010 over the course of two academic terms.

In addition to the use of an iterative approach to data collection and interpretation using different data sources (transcripts and field notes) and the use of data saturation to determine sample size, several other strategies recommended by Lincoln and Guba (1985) were used to ensure rigor. An audit trail was established using detailed field notes to establish transparency (Barbour, 2001; Hansen, 2006). Two external researchers independently read and analyzed the transcripts and then met to discuss the data and establish a consensus on its interpretation. Member checks were conducted with four key informants to ensure that the interpretation perspectives were credible (Wolf, 2007). Given the researchers' past work experience in HFS, bracketing was used to reduce the influence of any biases or preconceptions about HFS.

The researchers were in no position of hiring or disciplining the instructors, nor were they involved in teaching or evaluating the students, thus limiting the influence of power or coercion on their study participation. Any activity that occurred during the simulation or any comments made during the interviews were kept anonymous in the documentation and are not traceable back to the participant. Written consent was obtained from the participants prior to their scheduled simulation experience. The consent forms will be kept in a locked cabinet for seven years along with all other data collected from this study.

Demographics

There were a total of 38 instructors who were approached, all of whom were scheduled to participate in HFS during the time the study was conducted. Two agreed to participate in individual interviews, and 18 agreed to participate in a focus group. All but two instructors completed a demographic questionnaire that was administered at the end of the focus group. The two who did not submit this had to leave the focus group about 10 min early. A summary of the demographic characteristics of the instructor participants is presented in Table 1.

Data/Results

This section represents the analysis of the instructors' experiences and perceptions of what it is like to engage in HFS as an instructor. The data includes results from individual interviews with two faculty members, as well as the information gathered during two focus groups. Pseudonyms were used for all clinical instructors. The primary theme that is discussed in this paper is that of instructor confidence. This theme addresses the instructors' comfort level in teaching with simulation.

Instructor Confidence

At this institution, participation in HFS was mandatory. Each clinical group in their third year was assigned one day during the term to participate in simulation. Some instructors were enthusiastic about this experience while others were not. While it had been over five years since simulation was implemented at this institution, due to clinical instructor turnover, many instructors were still new to using this teaching tool. Instructors who participated in the interviews and focus groups made mention of how they felt as they facilitated simulation with their students. During the focus group interviews, the opening question that was put forward to them was “what is it like for you to participate in a simulation activity with nursing students?”

The experience of teaching with simulation had an impact on many instructors. For Kate, it was an experience that she “dreaded” having:

> I'm very nervous with sim lab. I'm more nervous about that than any other thing in teaching. […] I don't really relax during the whole thing. So for me, it's something that I really actually kind of dread.

Kate continued by saying that she did not like silence and that when she stepped back, she felt that there was too much silence. She believed that if the students were silent and there was little activity, it was her responsibility to ensure that something happened. She stated that she felt more comfortable teaching didactically in HFS and believed that this increased student learning.

Kate's dread of teaching in simulation was beyond a simple nervousness of doing something new. Kate specifically said that she did

Table 1
Clinical instructor focus group demographic data.

Age in years			Years of nursing experience					Years of teaching experience		
	f	%	0–5	11–15	16–20	21–25	>25	0–5	6–10	11–15
<40	4	20	0	2	2	0	0	4	0	0
41–45	8	40	1	0	2	5	0	6	1	1
46–50	5	25	0	0	1	0	4	2	2	1
>50	3	15	0	0	0	0	3	1	1	1

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