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Confident to seek help: The development of skill and judgement in nurse practitioners. A mixed methods study

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SUMMARY

Background: Healthcare is undergoing a transformation in terms of traditional role and skill assignations of staff, with an attendant blurring of boundaries. Expert judgement is used in order to develop and assess learners as they prepare for these new roles.
Objectives: To determine factors related to the perceived usefulness of feedback, to find out how participants use expert judgement, to develop skill and to examine how the context of learning affects the development of judgement.
Setting: Four NHS Health Board areas within Scotland.
Participants: 95 nurse practitioners who had successfully completed a specified course of skills based education between September 2008 and August 2010. 10 participants agreed to follow up interview.
Design: Survey and follow-up semi-structured interviews.
Methods: Mixed methods. 20 item, internet based questionnaire ($n = 85$) and semi-structured interviews ($n = 10$), collected between September 2010 and February 2011.
Results: Response rate was 55%—confidence level of 99%, this sample yields a confidence interval of 12.9%. The results demonstrate that the demonstration of skill and the perception of expertise of the supervisor are related to the perceived usefulness of feedback ($p < 0.004$). The participants use feedback as one strategy to develop skill and judgement, although the mining of the tacit knowledge of medical colleagues, reference to associated theory and peer support and learning strategies are also seen to be important. The development of judgement is restricted by the tightly controlled learning environment.
Conclusions: Identification of participants with the expertise of the supervisory group reveals a group who are highly aspirational and for whom the governance of learning leads the participants to be confident to seek help and not the confidence to identify learning needs. Learning is seen to be dominated by the context in which it is set and as the participants learn motor skills, they learn to fit in and manage a brittle working environment.

Introduction

The view that knowledge is constructed as a dynamic interaction between the individual learner and the context in which learning occurs has become known, discussed and studied under the general banner term of social constructivism. Social constructivism within education was initially expounded separately by Dewey (1916), Piaget (1972) and Vygotsky (1978) and although each of these theorists started from a separated theoretical perspective, each came to understand that knowledge construction is influenced by experience and dialogue with others (Beck and Kosnik, 2006). Learners make interpretations on information based on the context in which it is placed and, thus, learning is an essentially social activity and can be considered to be the intersection between the person and the social world, with the context of learning placed at the centre of the experience. For the participants of the study reported here, their learning has been placed in the context of, on one hand, established mores, traditions and hierarchy and, on the other, metamorphosis. It has aimed to examine how feedback from a supervisor within this context has been used to develop and sustain skill in a group of nurse practitioners and in this way, explore the dynamic between the student, their development and the specific context in which the learning takes place.

The preceding 20 years have witnessed a well documented change in the working practices of health professionals predominately in Europe, Australasia and North America. Steered by social, economic and professional drivers, these changes have resulted in the blurring of boundaries of practice for many health professionals (Dixon et al., 2009; Dunn, 1997) and have led to the formation of new roles and responsibilities within health care environments. For the new breed of practitioners which have subsequently been created, this has often meant the adoption of tasks and duties which were, hitherto, those of doctors. Amongst the first, and one of the most important of these changes, were those that were implemented post-1993 in response to

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the European directive on working times which curtailed the number of hours that employees within the European Union (EU) were permitted to work and which triggered a shortfall in the availability of junior doctors in secondary care, particularly at night (Council of the European Union, 1993). In response to this, health services within the UK followed the example set by US health systems and trained nurses to fill this shortfall (Dunn, 1997): the medical profession made the pragmatic decision to shed what may be considered to be the "routine" or "low end" of medical activity, for example tending to common and minor injuries in Accident and Emergency Departments or renewing intravenous access for patients. Nurses who were trained to fill this breach were, typically, trained to undertake routine skills and make decisions based mostly on pre-defined protocols or other decision making tools.

Within Scotland, where this study is set, since this first wave of practice developments nurses have developed roles in a very wide variety of practice areas at the medical/nursing interface within primary and secondary care. However, it has been noted that these developments have occurred with scant regard for clarity of role (Bryant-Lukosius et al., 2004) and a wide array of activity is noted. Further, Fotheringham et al. (2011) note that these roles and services have been adopted with the aid of a variety of titles with little standardisation of nomenclature or requirement for educational level and the terminologies of "nurse practitioner" or "advanced nurse practitioner" are commonly, but not exclusively, used to denote this group of nurses.

Originally based on The National Organization of Nurse Practitioner Faculties core competency statements from the USA (NONPF, 2012), the RCN in the UK have outlined their definition of advanced nurse practitioners and core competencies for this level of practice (RCN, 2012). These competencies describe level of practice which involves nursing decision making as part of a care delivery team in the case management of patients and their families. However, McConnell et al. (2012) note that the use of protocols, prescribing rights and other "permissions" are means by which both medics and hospital management control, the roles as they develop with the use of such tools and policies commonplace. The above comments notwithstanding, the roles developed are found to be efficacious for the system that they serve and both (Laurant et al., 2005; Sakr et al., 1999) in their influential reports, for example, detail a nursing service which is at least as effective as that which it is replacing.

This change is occurring within a well recorded socio-professional context (Friedson, 1970) and perhaps not surprisingly, as this *status quo* is disrupted and the occupational comfort zone is challenged (Fagin and Garelick, 2004) and a new equilibrium sought, there have been well recorded voices of resistance to these changes from a group who are giving up skills (the doctors) and those who are adopting them (Walsh, 1999, p. 354; Farrell, 2001). Further, the changes have necessitated an attendant change in separate educational provision, almost all of which has occurred at post-registration level: nurses are educated in a traditional context to the point of registration and then the skills of assessment, diagnosis, treatment and management specific to particular patient groups is superimposed after a period of post-registration experience. The participants of this study are trainee nurse practitioners who are undergoing a programme of education to prepare them in these in a variety of clinical settings. However, the successful adoption of these new roles will depend not only on developing skill but also in sustaining this skill base and although there is a long history of research and comment into the development and assessment of skill, little has been written on the sustainability of this learning. This process relies upon the development of accurate judgement and self-monitoring in the learner and on their ability to evaluate their own level of ability and diagnose their learning needs (Boud, 2000).

A common feature of courses and programmes devised for this development is the use of an expert supervisor who is often (but not always) the doctor for whom the training is designed, at least in part, to replace and who oversees the practical aspects of learning. A key feature of this learning journey is the judicious use of feedback by the supervisor.

There exists an extensive literature on the use of educational feedback in all educational settings and within healthcare education much has been written and studied within the field of feedback for clinical skills and some common themes are seen to emerge. Both Veloski et al. (2006) and Porte et al. (2007) agree that good feedback from a supervisor can aid skill development and Clynes and Raftery (2008) and Cantillon and Sargeant (2008) note that the personal qualities of the student, the supervisor and manner in which feedback is given is vital to the efficacy of feedback. Nicol and Macfarlane Dick (2006), Fotheringham (2011) and Gigante et al. (2011) have summarised the key themes to consider when defining good feedback and may be summarised thus:

- Comments are non-judgemental and of practical benefit.
- A "feedback conversation" should be established and student re-observed over time.
- The opinion of learner should be sought.
- The person delivering the feedback should be perceived as an expert.
- Feedback should be unequivocal and precise
- The relationship should be voluntary and confidential.

These themes have been utilised in this study in order to gauge the perceived value of feedback given to students by supervisors and to evaluate how the students use this feedback in order to develop and sustain skill.

The Study

Design

A mixed methods design was used in order to determine what participant or supervisor factors may be related to the usefulness of feedback in this learning context, how the participants had used this feedback to develop skill and judgement and examine how the context of learning has influenced this process. Mixed methods was utilised in order to gain a more complete picture of the situation by using different forms of complementary data, to attempt to offset the strengths and weakness of each type of research method and to assist in sampling. The type of study adopted here is described by Creswell and Plano Clark (2011) as an explanatory sequential design, valuable when there are well-defined quantitative variables to be explored.

Participants

This study was undertaken on a group of nurse practitioners in Scotland between September 2010 and March 2011 who had previously undergone an educational programme in preparation for this role. Inclusion and exclusion criteria are outlined in Table 1. Potential participants were excluded mainly on pragmatic grounds: since the study required multi-site approval, practitioners who were not nurses and nurses practising outside Scotland were excluded, although there is no evidence within the published documentation that the geographical location of nurses affects their response to feedback or that nurses responded differently from other professional groups.

The participants were employed in a variety of clinical settings, had varying lengths of service as nurses and had been practising as nurse practitioners for a varying number of years. Additionally, the supervisors involved were both doctors and nurses and these participant and supervisor features formed the basis of the 11 predictor variables used in the survey phase, outlined in Tables 3 and 4. The predictor variables were used to gauge if any of these features