



“I will go if I don't have to talk”: Nursing students' perceptions of reflective, debriefing discussions and intent to participate[☆]

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ABSTRACT

Background/Objectives: The ability to be a reflective practitioner is recognized by nursing regulatory bodies as a component of professional competence and becoming a reflective practitioner is an essential part of learning to become a nurse. In this multi-site study, we explored undergraduate nursing students' beliefs, capacities and intentions to participate in reflective, debriefing discussions facilitated by clinical instructors. At the same time, we tested the effectiveness of a period of rest and an intervention designed to refresh and inspire them.

Design: A randomized crossover design.

Sample: Our analyzed sample consisted of 106 students; 87.7% were female and 65.1% were less than 20 years old.

Method: This study was guided by the Theory of Planned Behaviour and consisted of five steps: instrument development, recruitment, random assignment to intervention, data collection at two time points using four tools, and data analysis. One hundred and forty-one first year nursing students used a learning management system to sign up to one of 15 potential clinical groups; maximum 10 students per group. Eight groups were randomly assigned to an intervention during post-clinical discussions; seven groups participated in the usual post-clinical discussions for the same length of time. After six weeks, the groups 'crossed-over' (switched).

Results: Students had a negative attitude towards routine discussions that occur after clinical practice experiences which did not significantly improve despite a period of rest and an intervention. Most did not feel in control and felt social pressure to participate. Additional results revealed that most students arrived at reflective post-clinical discussions with an underlying intent not to talk. Intent to remain silent (not participate) did not significantly improve despite a period of rest and intervention.

Conclusions: The context and timing of the routine discussions may dramatically influence students' decision-making regarding intent to participate. Reflective processes require time and routine reflective debriefing discussions could be delayed until later in the week after students have had a chance to absorb and assimilate their experiences.

In most undergraduate nursing programs, students engage in reflective, debriefing discussions after clinical practice experiences. Students share information about their clinical day, explain their clinical hypotheses, analyze situations or significant events, and are

expected to reflect on their actions. Although the most consistent empirical evidence points to the importance of reflective debriefing clinical discussions, little is known about students' opinions of discussions or their intentions to engage in them in a meaningful way. Moreover,

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empirical evidence suggests that it can be difficult for some clinical instructors to engage undergraduate nursing students consistently and effectively in face-to-face reflective post-clinical discussions (Berkstresser, 2016). Known constraints to student engagement include boredom, fatigue, discomfort, self-consciousness, anxiety, and fear of negative evaluation (Chernomas and Shapiro, 2013; Cox Dzurec et al., 2007; Jimenez et al., 2010; Kim, 2003). Very little evidence exists about practices or strategies that might enhance the quality of these discussions.

In this multi-site study, we used a randomized crossover design (Wellek and Blettner, 2012) to explore undergraduate nursing students' beliefs, capacities and intentions to participate in face-to-face reflective discussions facilitated by their clinical instructors. At the same time, we tested the effectiveness of an intervention designed to refresh and inspire them and enhance their capacities to generate ideas.

The study was guided by the Theory of Planned Behaviour (Ajzen, 2003; Francis et al., 2004). According to this theory, nursing students' intentions to engage in reflective discussions are predictable and guided by their beliefs about: a) the likely consequences of participating, producing either favorable or unfavorable attitudes towards discussions, b) what is normally expected of them during discussions, producing perceived social pressure, and c) factors that facilitate or impede their performance. The primary research question was: What are undergraduate nursing students' attitudes, beliefs, and intentions towards reflective, debriefing post-clinical discussions? The secondary research question was: What are the effects of an intervention on students' intentions to participate, perceived energy levels, concentration, pleasurable engagement, fear of being negatively evaluated, and overall satisfaction with the discussions?

1. Method

The study consisted of five steps: instrument development, recruitment, random assignment to intervention, data collection at two time points using four tools, and data analysis. These steps are described in greater detail in later paragraphs. The four tools were:

1. 48-item Theory of Planned Behaviour Questionnaire (TPBQ) developed specifically for the study
2. Positive and Negative Affect Questionnaire (PANAS) (Watson et al., 1988). The PANAS is a brief, reliable, and valid measure of mood. High positive affect is a state of energy, full concentration, and pleasurable engagement while high negative affect is characterized by displeasure and avoidance.
3. Brief Fear of Negative Evaluation Scale II (BFNE II) which contains 12 positively worded items and demonstrates high reliability ($\alpha = 0.97$) (Carleton et al., 2007).
4. Basic satisfaction rating of post-clinical discussions, on a semantic differential scale.

Eight clinical groups were randomly assigned to an intervention during post-clinical discussions, while seven clinical groups participated in the usual post-clinical discussions for the same length of time. After six weeks, the groups 'crossed-over' (switched). All consenting students were first-year nursing students with no prior clinical experiences and no experiential knowledge of post-clinical discussions. A pre-test post-test design, therefore, was not an option and tools were administered at midpoint and end-of-study rather than beginning, midpoint, and end-of-study (Fig. 1).

The intervention was a 10-minute period of rest followed by an unrelated distracting task with light cognitive load. A complex colouring page for adults was the unrelated distracting task. This intervention was aimed at preventing students from constrained or focused concentration on their instructor's prompts in order to allow their creative and less accessible ideas to surface (Dijksterhuis and Meurs, 2006). Creative and less accessible ideas are associated with regions in

the brain that are most active when the brain is allowed to rest and wander (Buckner et al., 2008; Mason et al., 2007). To meet adult students' needs and expectations we used quality art tools (gel pens, pencils, and fine art markers). The process was undemanding, self-paced, and repetitive, meaning that students did not draw freely. Consenting students in the intervention groups coloured throughout their entire post-clinical discussions, every time these discussions occurred.

1.1. Instrument Development

No instruments have been designed specifically to measure students' beliefs, capacities and intentions to participate in post-clinical discussions. Therefore, we created an instrument using a two-step process outlined by Ajzen (2003) and Francis et al. (2004). First, we elicited salient beliefs about discussions from a small sample of second year students ($N = 50$) who were representative of the research population and had recent experiential knowledge of post-clinical discussions. These students responded to open-ended questions based on the theoretical main constructs - attitudes, beliefs, intent, control, and social pressure (Ajzen, 2003; Francis et al., 2004):

1. What do you see as advantages and disadvantages of participating in reflective post-clinical discussions?
2. Describe someone who would approve of your participation in reflective post-clinical discussions and someone who would disapprove of your participation.
3. Describe someone is most likely to participate in reflective post-clinical discussions and someone who is least likely to participate.
4. List factors or circumstances that make it easy for you to participate in reflective post-clinical discussions and factors or circumstances that make it difficult for you to participate.
5. What else comes to mind when you think about reflective post-clinical discussions?

In step two, we performed a content analysis of the responses which enabled us to construct items to be included in the Theory of Planned Behaviour Questionnaire (TPBQ) for first-year students. We tested the draft questionnaire for face validity, content validity, and usability with a smaller group of 20 second-year nursing students. After minor revisions, our final 48-item TPBQ contained response options in the form of a 7-point Likert scale (1 = disagree to 7 = agree).

1.2. Recruitment of First Year Students

After ethical approvals were obtained, we recruited 15 groups of first-year undergraduate baccalaureate nursing students (8 to 10 students per group) from two post-secondary educational institutions (college and university) located in Western Canada. This was as large a sample as possible within feasibility constraints. Both institutions followed the same undergraduate nursing Intentional Learning curriculum. Students had previously used a learning management system to sign up to a clinical group; maximum 10 students per group. Instructors in an Intentional Learning curriculum replace "random access opportunities" for patient assignments with purposefully assigned, clearly defined, structured, focused opportunities for clinical learning that are linked with classroom or theory content. Clinical practice opportunities are intentions that are consciously planned and initiated by the instructors who collaborate with the theory teachers. Therefore, the learning goals and associated debriefing discussions were well defined rather than incidental and were linked to the theory topics and laboratory skills practice (Neilsen et al., 2013).

All clinical instructors assigned to the groups ($n = 15$) consented to allow us to collect data in the clinical settings (six nursing homes). All students completed one clinical shift per week (0700 to 1400 h) for 12 weeks. Debriefing discussions generally occurred in quiet spaces

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