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DEVELOPING EDUCATION SKILLS TO ENHANCE SKILL ACQUISITION FOR NURSES IN A RURAL HOSPITAL: AN RNAO FELLOWSHIP FROM A PERSONAL PERSPECTIVE

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ABSTRACT

This article highlights the learning journey and successes of a rural nurse developing expertise in instructing adult learners on the skills required in an operating room setting for application in a rural hospital setting. This opportunity was made possible through a leadership and education RNAO ACFP Fellowship. This article is written based on the author's personal experience from her individual perspective.

INTRODUCTION

I have always known that I would one day be a Registered Nurse. I did not know, back at my graduation in St. John's, NL, in 1992 that I would eventually become a Perioperative Registered Nurse nor did I know how much I would learn to love this dynamic and rewarding career. When I fell in to the perioperative world, in 1992, I was unaware that I was embarking on a career that I would still love more than 20 years later.

But by 2014 I was tired. I was dry. I was stale. This career that I loved was not feeding me in the same way. I was no longer satisfied by the work. I needed to re-ignite my passion, re-charge, and re-energize.

Opportunity knocked for me, as 2014 drew to a close, when Dr. K.A. Hogan, RN, PhD, a new employee at the hospital where I was working, Winchester District Memorial Hospital (WDMH) in rural Eastern Ontario, attended the staff morning huddle. She advised the group of RNs that the Registered Nurses Association of Ontario (RNAO) offers an Advanced Clinical Practice Fellowship (ACPF). I felt a door open and saw a great opportunity.

RNAO offers its ACPF program to all of Ontario's 135,280 nurses.[1] The ACPF "Registered Nurses (RN) or Nurse Practitioners (NP) the opportunity to have a focused self-directed learning experience to develop clinical,

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The author instructs a WDMH employee the proper way to remove soiled gown and gloves.

leadership or best practice guideline implementation knowledge and skills, with the support from a mentor(s), the organization where the RN is employed, and the RNAO. This initiative is aimed at developing and promoting nursing knowledge and expertise, and improving client care and health outcomes in Ontario. Clients are defined as individuals, families, groups or communities."[2]

This initiative is funded in partnership between the RNAO and the nurse's employer for a total of 450 hours over 12 weeks (full-time) or 20 weeks (part-time). The nurse, in collaboration with the mentor, develops a set of learning objectives, which upon completion of the fellowship, will develop his/her own skills for use within the employing organization. As a part time employee, my fellowship time was completed over a 20-week time frame.

Fellowship Application:

By January 2015, as deadlines for application were quickly closing, Dr. Hogan and I were able to meet. In order for me to apply for the fellowship program that year we would have to work quickly.

It was through our discussion that I began to recognize my passion for nursing education and, specifically, for perioperative nursing. Dr. Hogan was instrumental in working with me to facilitate my fellowship application including drawing on her network of connections to help me develop a mentorship team. My fellowship supervisor arranged for me to work with professors and coordinators at Algonquin College, in Ottawa, as that school offers a perioperative graduate certificate. I had the opportunity to participate in a class, with RN students, in order to develop my instructor skills in a simulation lab setting. The use of simulation labs to support experiential learning would prove to be a perfect fit with my emerging learning objectives. After much deliberation and preparation my fellowship application emerged. "Developing Education Skills to Enhance Skill Acquisition for Nurses in a Rural Hospital" was the title of my submission and I was accepted in to the fellowship program and obtained a fellowship grant. The hard work was just beginning.

The Beginning:

The first step in the fellowship was acting upon my learning objectives. As part of the application process I had outlined the following five objectives:

1. To acquire theoretical knowledge of learning theories and principles of adult learning;
2. To acquire skills to enable me to develop and implement a learning plan that teaches an adult learner a technical skill;
3. To gain knowledge required to facilitate an operating room nursing skills lab, incorporating a learning plan and principles of adult learning, by the end of this fellowship;
4. To learn how to plan, execute, and evaluate a nursing skills day in collaboration with a health care team; and
5. To develop my academic writing skills in order to successfully disseminate information with large and diverse audiences.

The first task at hand was to research learning theories and principles of adult learning. After more than 20 years of clinical nursing this was, indeed, an alien environment and one outside of my initial comfort zone. I researched these theories, online, from home. Journaling was a helpful endeavour to help organize my thoughts and ideas. One of my first

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The author demonstrates proper use of a Balfour retractor to WDMH employees.

journal entries indicates how foreign this was. "How did I get here?" and "Where do I begin?" was the theme of my journal entry for May 15, 2015. But I settled in and got down to work.

Research & Planning:

My search on the subject of andragogy, the art and science of adult learning,[3] revealed what seemed obvious to me – adult and child learners are inherently different. Andragogy contrasts with pedagogy, the art and science of educating children, which traditionally embodies instructor-focused education.
Knowles[3] identified four principles of andragogy:

1. Involved adult learners: the adult learner is involved in the planning and evaluation of their instruction.
2. Adult learner's experience: experiences of the adult learner, including mistakes, can provide for the basis of learning activities.
3. Relevance and impact to the learner: adults are more interested in learning subjects which have immediate use and impact to their professional and personal life.
4. Problem centered: adult learning is problem-centered as opposed to content-centered.

Two theories of adult learning resonate, with me, in regard to perioperative education: transformative and experiential learning.

Mezirow[4] described transformative learning as the process of using a prior interpretation of the meaning of one's experience in order to guide future action. However, in the context of a simulation setting, my view of the definition of transformative learning was expanded to refer to learners who are actively engaged through critical reflection and discourse and who question assumptions, expectations and context to achieve meaning and new perspectives to guide their actions. This learning process helps guide actions and transform behaviours.

Experiential learning, first described by David Kolb in 1984, is broadly defined as any learning that supports students in applying their knowledge and conceptual understanding to real-world problems or situations where the instructor directs and facilitates learning.[5] Kolb's experiential learning model describes stages of learning as: concrete experience, observation and reflection, abstract conceptualization and generalization, and active experimentation or testing of knowledge in new situations. Jarvis[6] elaborated on Kolb's model by identifying the non-linear, complex aspect of the experiential learning trajectory. Many processes can, in other words occur simultaneously and learning does not necessarily occur in a simple, step by step, linear, and orderly manner. Experiential learning is relevant in healthcare education where there is the necessity to apply theory directly to practice. Theory advances a profession and creates an evidence-based practice. Yet experience and hands-on practice are key identifiers of the knowledge base of the professionals within the discipline.[7]

In an operating room (OR) simulation lab learners can practice the hands-on work of the perioperative nurse since, as noted by DeYoung, an "overdependence on lecture is indefensible for teaching these practical skills and processes."[8] Within the context of this fellowship my personal goal was to help transform the way nurse learners think and practice in the OR setting.

The learning activities I created for myself during the fellowship consumed much of my time. I discussed learning theories with nursing colleagues, friends, and family members. An instructor in a Bachelor of Science in Nursing (BScN) program told me how she used "experiential story-telling," relating experiences from her own career, to illustrate a particular point or need to

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Interactive display highlighting instrument groups and sterility.

her students. Similarly, in a perioperative work environment, it has been my experience that nurses can help each other learn by passing on knowledge, triumphs and can sometimes, inadvertently, help perpetuate errors or substandard practices.

Simulation is a form of experiential learning and was yet another framework for me to learn. Simulation labs provide flexible environments for nurses to learn, practise, and be assessed on hands-on patient care skills and procedures prior to entering authentic operating rooms. It offers skill training in an experiential environment.[7] Simulation scenarios can also be used to develop teamwork in the OR setting. Cummings[9] described two key points about simulation learning: first, that a major benefit of a high-fidelity simulation is that it provides an active learning environment, whereby the student is free to make mistakes and learn from them without risk to a patient. The second point is that simulation can also be used to identify gaps in the curriculum and in a student's preparedness that might not be as easily identified through classroom or clinical evaluation. Both of these aspects were apparent to me during my time in the simulation lab and the experience enabled me to enhance my teaching strategies.

Simulation Labs:

After initially observing some labs I then became actively involved and engaged in the labs. The RN instructors were kind enough to involve me in their classes and demonstrations. They asked my opinion and used my clinical expertise to draw on as an example. I was able to observe the style of the instructors and the class reaction to an OR simulation setting. I noted instructor and student attitudes and approaches. One key factor was that learners were free to talk amongst themselves during instructional time because the instructors recognized that their conversations could be beneficial to the learning environment. Student discussion may, for example, help clarify a point for a colleague and also build collegiality amongst students.

The following are examples of how I was able to apply Kolb's model[5] to student discussions in the lab setting.

1. Concrete experience: "I remember that happening at work last week."
2. Observation and reflection - reviewing/reflecting on the experience: "This is why that happened."
3. Abstract conceptualization - concluding/learning from the experience: "So that's why it didn't work."
4. Active experimentation of planning/trying out what was learned: "Next time I should…."

After each simulation lab I debriefed with the instructors and together, we debriefed with students when necessary. We reviewed the effectiveness of the lab, identified weaknesses in student learning and explored gaps between theory and practice. After each lab, we discussed aspects that we felt the students had not grasped or concepts that we believed need re-enforcing. We were, in this way, able to adapt future teaching sessions in ways that helped close gaps in knowledge and skill, as well as furthering the students' recognition of the importance and relevance of each skill set. Debriefing with other instructors and/or students after labs

allows for concrete feedback regarding sub-optimal performance. By reviewing performance, with learners, we were successful in closing negative performance gaps and reinforcing excellent performance.[10]

Teaching Plan:

My next challenge was to plan a lab that I would deliver independently. I developed, in preparation, my own teaching/learning plan that included objectives, format and an evaluation form. The topic was Prepping and Draping the Patient. I discussed with Sue Eldred, one of my mentors and a BSCN instructor at Algonquin College, the goals and objectives of the lab and reviewed instructional styles and ideas for learner participation and engagement. It is well documented that the theoretical rationale for performing skills must be integrated into lab teaching in order to provide background for the three stages of skill acquisition: learning the steps of the procedure, learning to perform the steps, and, finally, practicing enough so the actions become instinctive and the learner is able to multi-task actions.[11]

In the simulation labs there was a ratio of ten RNs to two instructors. RNs ranged in experience from new graduates to those with more than 20 years of experience. This range of background, work history, and prior knowledge among the diverse members of the group challenged me to create a plan that addressed the diverse needs of the group. To capitalize on the experiences of the learners I adapted my approach to address the various characteristics of adults as learners as described by Cross.[12] I questioned students, in order to engage the experienced learners, and encouraged them to share some of their experiences and to demonstrate nursing skills they used both within and outside of the OR. I encouraged newer graduates to

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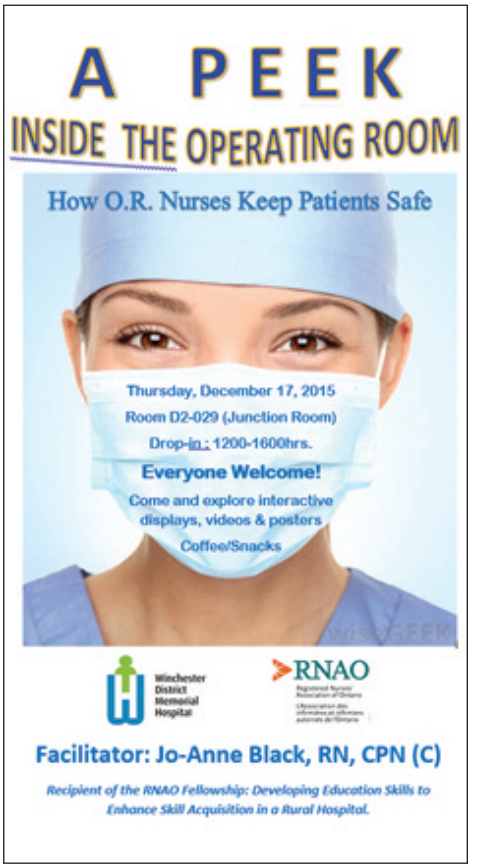
A group of WDMH employees taking part in an in service, held as part of the fellowship. This in service highlighted many of the instruments, tools and skills of a perioperative nurse.

Courtesy J. Black



Poster, inviting WDMH to an in service to exhibit safety and perioperative nursing.

participate when demonstrating basic nursing skills and principles, such as transferring a patient from the OR bed to a stretcher, to allow them to replicate the hands-on experience others had been able to practice on the job.

Not surprisingly, my first independently led simulation lab was the most difficult for me. I was concerned about addressing the technical requirements and set-up needs, that can vary from one facility to the next, while ensuring conformity to evidence-based standards. As an example, I needed to address how different institutions set up instruments on their back tables and Mayo trays. In addition to addressing these variations I also needed to ensure I provided general and novice level instruction, supported by the texts, and gave specific examples based on personal experience.

Obtaining Feedback:

After teaching my first two labs (both in the same day) I debriefed with the two instructors who had been present. Both were supportive and encouraging and stated that the two lab sessions that day had gone well. I had incorporated an evaluation into the lesson plan as an opportunity for me to receive learner feedback on my instruction. At the end of this teaching day, buoyed by adrenalin, I glanced through the comment section of the evaluation forms. While the evaluations were primarily favourable, there were some notes of criticism that, as I care very much about how people view me, were initially difficult for me to read. I had been tasked with providing education to help prepare these RNs to care for our perioperative patients and it was an uncomfortable feeling to hear that I did not completely fulfill my obligation.

Initially I tucked away all of the evaluations and tried to forget about them and the feelings that had surfaced. This was not, of course, helpful in the long run. Nor was it constructive or professional. It took me a couple of days before I was able to review them with my mentor. Once I had done so I was able to shift my perspective and learned to appreciate what I had perceived as 'negative comments'. They now provided me with the potential for growth as an instructor. I was now able to see that the learners were helping me by identifying areas for improvement and ways to further develop my teaching skills. Not only did I now appreciate their evaluations but I also found that I agreed with them. I learned that negative feedback, while often an uncomfortable experience, is an incredible opportunity for learning and growth. Evaluations that had begun as an obstacle to my learning and to proceeding forward in my fellowship, due to my emotional reaction, had, in the end, provided me with the best opportunity for personal and professional growth.

Adapting to Feedback:

Two weeks later I presented my second a lab session entitled "Positioning the Patient." I was again nervous but forced myself to sound confident as I recognized that 'believing is becoming.' I had given even more consideration to my lesson plan. I felt prepared and again, the evaluations were predominantly positive, with some critiques. What I found striking was that some of the negative feedback was in direct opposition to some of the positive feedback. For example, one learner

Courtesy J. Black

Poster displaying learning resulting from the RNAO fellowship.

commented it was a "Great interactive presentation" while another suggested I "Increase the interactive section." It was a great demonstration of how difficult it is to teach to the wide variety of learning styles that exist within a group. Not everyone learns well from one approach. Information can be repeated in various ways to ensure the message is received by all learners. Teachers need to foster learning by using two or more approaches to address various thinking/learning styles. Feedback is also beneficial in that the more we know about our students the more we can be effective in meeting everyone's needs.[13]

Results of the Fellowship

This fellowship provided me with a wonderful learning journey and helped develop my skills in instructing adult learners for application in a rural hospital setting. The fellowship helped me grow personally as well as professionally.

I learned that feedback from learners was intended to guide my development as an effective educator. The negative learner feedback prompted me to research about how I could deal with the dissonance between supportive and critical learner comments. The Harvard Business Review online provided clarity. I read "Never invite feedback before you are ready for it". 'Ready' means you want to hear the truth, not simply validation that the teaching occurred. I realized I was not ready for the truth but was seeking validation of being a "great teacher", a notion supported in my professional life by colleagues and students.

This experience will serve me well in the future and have already led to more professional growth. Following completion of the fellowship I received

ORNAC Standards pertaining to this article topic can be found in the *Operating Room Nurses Association of Canada* (ORNAC) Standards for Perioperative Registered Nursing Practice (13th edition, April 2017), Section 1, p.52, Standard 1.2.15.

new teaching opportunities in the perioperative graduate certificate program and am proud to have taken this step and tackled this invaluable opportunity as few perioperative nurses have contributed to the RNAO fellowships. I completed my fellowship on February 17, 2016 and presented my educational poster at the Operating Room Nurses Association of Ontario (ORNAO) provincial nursing conference, in Toronto, in the spring of 2016 (figure 1).

CONCLUSION:

Participating in the fellowship has broadened my career and scope of influence on colleagues – one of whom is now engaged in her own RNAO Fellowship experience. ORNAC's Mission Statement includes a commitment to "the professional growth, competence and personal enhancement of the ORNAC membership."[14] I believe that we, as nurses should always be searching out and availing of opportunities for growth. It helps us develop as nursing professionals, raises the standard of care for our patients, and promotes excellence in nursing.

I have never regretted taking on the challenge of this Fellowship and I encourage my peers to seek opportunities to enhance their perioperative practice.

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