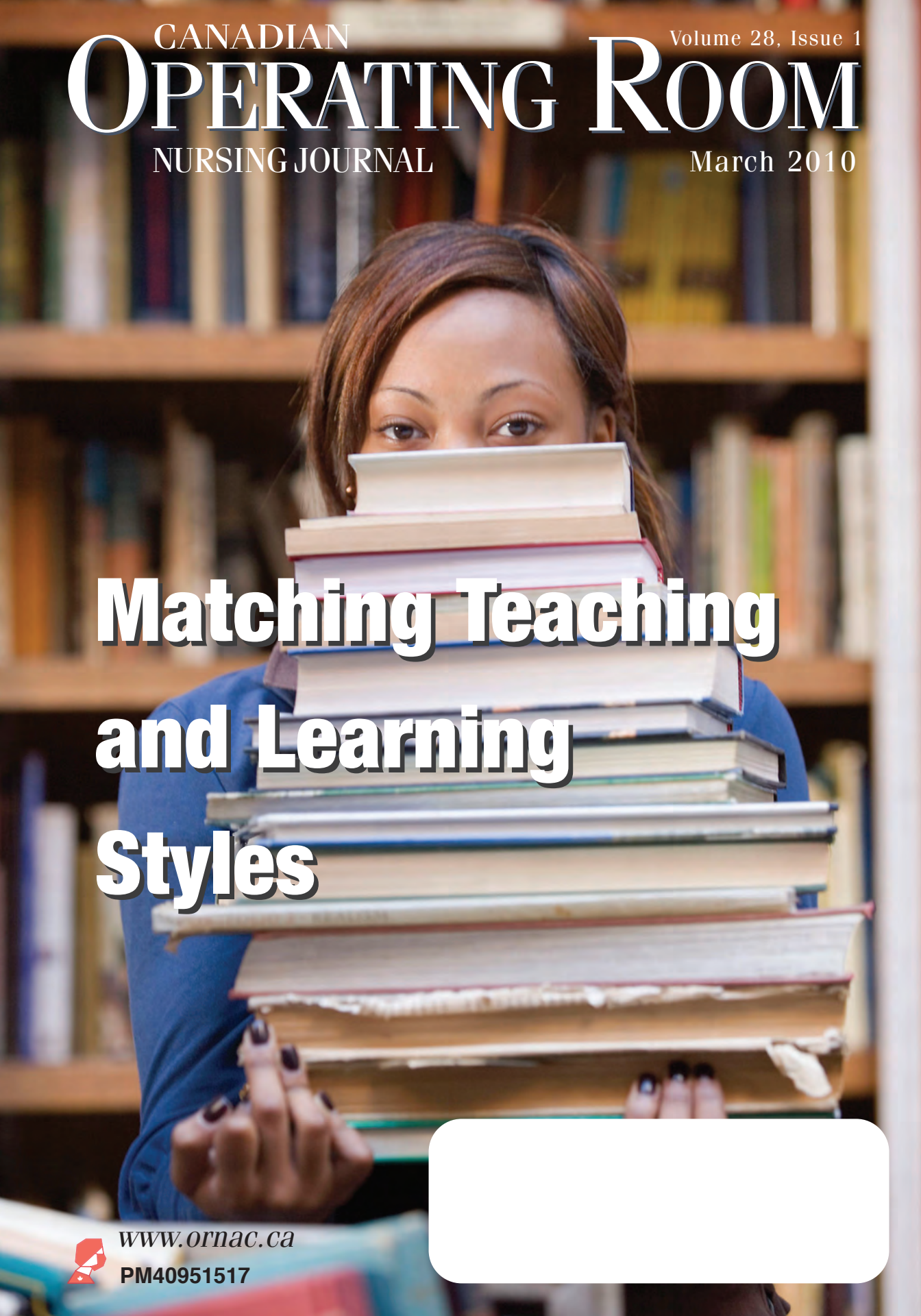


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President's Message

It's not so much that we're afraid of change or so in love with the old ways, but it's that place in between that we fearIt's like being between trapezes. It's Linus when his blanket is in the dryer. There's nothing to hold on to.

Marilyn Ferguson, American futurist

As we progress quickly through 2010 I am reminded of the saying "the past is a prologue to the future." Knowing where we've come from, and where we're going, is essential if we are going to actually get anywhere.

The agenda for the 2009 Fall board meeting of the ORNAC executive and provincial representatives was guided by the key issues that ORNAC is facing, both now and in the future: membership structure; interprofessional relationships; and national conference planning.

As I contemplated these issues and what the future holds for ORNAC, I believe that knowing where we are is a vital part of the planning involved in moving the association toward the future and facing the potential challenges in today's health care practice environment. During my subsequent research on NurseONE (www.nurseone.ca) I discovered the Canadian Nurses Association (CNA) action guide for nurses — "Improve Your Practice Environment"* — that is available to help nurses create and maintain healthy work environments. Indicators of a successful change process, provided on the website's "Get Started" page, are elements that the ORNAC board will strive to achieve and maintain:

- Committed leadership;
- Shared vision and values;
- Team approach;
- Clearly defined scope and objectives;
- Outcomes link to organizational goals;
- Plan with clear timelines, goals and measureable outcomes;
- Ongoing, open communication about progress; and
- Learning through ongoing reflection.¹

The action guide also lists evaluation as an important step in the change process. This creative, and rewarding, process requires

the commitment of everyone involved.

I ask each ORNAC member to participate in this process by getting involved with their local, provincial, and national perioperative association. Share your opinions about what is working within ORNAC and we'll all have a clearer idea of where ORNAC needs to go.

I welcome your comments, ideas, questions and critique — I can be reached at president@ornac.ca.

My best wishes for your health and happiness in 2010 and beyond.



Bonnie W. McLeod

1. Canadian Nurses Association (CNA). (2009). *Improve Your Practice Environment: CNA's Action Guide for Nurses*. Retrieved December 15, 2009, from http://ex.php?option=com_content&view=article&id=507&Itemid=472&lang=en

* The action guide *Improve Your Practice Environment* was developed under the leadership of the Canadian Nurses Association with the support of nurses across Canada and other health-care partners. Much of the content of this action guide has been adapted from *Making a Measurable Difference: Evaluating Quality of Work Life Interventions* by Graham S. Lowe

Bonnie W. McLeod, RN, BScN, MN, CPN(C), is Clinical Nurse Educator - Perioperative, Fraser Health Authority, Ridge Meadows Hospital site, the ORNAC representative on the Canadian Patient Safety Institute, and the past Chair of the ORNAC Standards committee.

Mot de la président

« Ce n'est pas tellement que nous avons peur du changement ou que nous sommes épris de nos habitudes, mais c'est l'entre-deux qui nous fait peur...c'est comme être entre deux trapèzes, c'est Linus [Charlie Brown] lorsque sa couverture est dans la sècheuse. Nous n'avons rien auquel s'accrocher. »

Marilyn Ferguson, futuriste américaine

Alors que nous commençons rapidement 2010, je me rappelle du dicton « le passé est le prologue de l'avenir ». Il est essentiel de savoir d'où nous venons et où nous allons pour arriver en quelque part.

L'ordre du jour de la réunion du conseil de la direction et des représentants provinciaux de l'AIISOC en automne 2009 s'inspirait des problèmes principaux auxquels l'AIISOC fait face dans le présent et à l'avenir : la structure de l'adhésion des membres, les relations interprofessionnelles et la planification des conférences nationales.

En approfondissant ces problèmes et ce qui se pointe dans l'avenir de l'AIISOC, je crois qu'il est essentiel de savoir où nous en sommes afin de planifier le développement de l'association et d'affronter les difficultés potentielles du milieu de soins de santé d'aujourd'hui. Au cours de mes recherches subséquentes sur le site INF-Fusion (www.inf-fusion.ca), j'ai découvert le *Guide d'intervention de l'AIIC pour les infirmières et infirmiers (Améliorez votre milieu de travail)* — qui est offert pour aider le personnel infirmier à créer et à maintenir un milieu de travail de qualité. Les indicateurs d'un processus de changement réussi, offerts sur la page « Démarrer » du site web, sont des éléments que le conseil de l'AIISOC s'efforcera d'offrir et de maintenir :

- Un leadership engagé;
- Une vision et des valeurs communes;
- Une approche en équipe;
- Des objectifs et des compétences bien définis;
- Des résultats reliés aux objectifs organisationnels;
- Un plan avec des échéanciers, des objectifs et des résultats mesurables clairs;
- Une communication continue et ouverte sur le progrès; et
- L'apprentissage par la réflexion continue.¹

Le guide d'intervention mentionne aussi l'évaluation comme étant une étape importante dans

le processus de changement. Ce processus créatif et valorisant demande l'engagement de tout le personnel impliqué.

J'ai demandé à chaque membre de l'AIISOC de participer à ce processus en s'impliquant dans leurs associations locales, provinciales et nationales de professionnels en soins périopératoires. Partagez vos opinions sur ce qui fonctionne pour l'AIISOC et nous aurons une meilleure idée de la direction que l'AIISOC devrait prendre.

J'accueille vos commentaires, vos idées, vos questions et votre critique; vous pouvez me rejoindre à president@ornac.ca.

Mes meilleurs vœux de santé et de bonheur pour 2010 et au-delà.

1. Association des infirmières et infirmiers du Canada (AIIC). (2009). *Améliorez votre milieu de travail : Guide d'intervention de l'AIIC pour les infirmières et infirmiers*. Récupéré le 15 décembre 2009 à partir du http://ex.php?option=com_content&view=article&id=507&Itemid=472&lang=en

* Le guide d'intervention *Améliorez votre milieu de travail* a été rédigé sous le leadership de l'Association canadienne des infirmières et infirmiers du Canada (AIIC) avec l'appui d'infirmières et d'infirmiers de partout au pays et d'autres partenaires en soins de santé. Une grande partie du contenu de ce guide d'intervention a été adapté de *Making a Measurable Difference: Evaluating Quality of Work Life Interventions* de Graham S. Lowe

Bonnie W. McLeod, infirmière autorisée, BScN, MN, CPN(C), est infirmière clinicienne enseignante (périopératoire) à la Fraser Health Authority, Ridge Meadows Hospital, représentante de l'AIISOC auprès de l'Institut canadien pour la sécurité des patients et ancienne présidente du comité des normes de l'AIISOC.



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ASK A QUESTION – ORNAC STANDARDS:

QUESTION:

Is it acceptable for staff members to eat and drink in the OR?

ANSWER:

Thank you for your question. In module 4 under waste management you will find point 1.7 addresses this issue. "Work practice controls should include prohibition of eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses in work areas where there is reasonable likelihood of occupational exposure to bloodborne pathogens."

All staff should be allowed nutritional relief but this should not occur in the OR theater.

QUESTION:

I am doing a presentation on wearing surgical masks in the OR and I have read many articles that state that wearing a surgical mask may cause more harm than good. Is there a standard across Canada that states that we MUST wear surgical masks in the OR? Is it up to each hospital?

ANSWER:

In the ORNAC standards module 2, you will find the practice and rationale for wearing masks in the OR. I know there is some controversy out there regarding the use of masks. However as the rationale states "masks should be considered both a patient and personal protection item." I personally would not be involved in a case without wearing a mask and I would suggest that hospitals have policies/procedures that mandate the use of masks as personal protective equipment if you are using laser or electrosurgery. Another hospital resource would be your infection prevention and control department as I'm sure they would have policies regarding routine practices, airborne, contact, and droplet precautions

POSEZ UNE QUESTION – LES NORMES DE L'AISOC :

QUESTION :

Est-ce acceptable pour les membres du personnel de manger et de boire dans la salle d'opération?

RÉPONSE :

Merci de votre question. Dans le module 4, sous la section traitant de la gestion des pertes, le point 1,7 s'attarde sur cette question. « Le contrôle des pratiques professionnelles devrait comprendre l'interdiction de manger, de boire, de fumer, d'appliquer du maquillage ou du baume pour les lèvres et de manipuler des verres de contact dans les lieux de travail où il ya un risque raisonnable d'exposition professionnelle à des pathogènes transmissibles par le sang. »

Tous les membres du personnel devraient avoir des pauses de repas, mais ces pauses ne devraient pas être prises dans les salles d'opération.

QUESTION :

Je fais une présentation sur le port de masques chirurgicaux dans les salles d'opération et j'ai lu plusieurs articles qui déclarent que le port d'un masque chirurgical pourrait être plus néfaste que salutaire. Existe-t-il une norme au Canada qui EXIGE le port de masques chirurgicaux dans les salles d'opération? En revient-il aux hôpitaux de décider?

RÉPONSE :

Dans les normes de l'AISOC, module 2, vous trouverez l'explication de la pratique et du raisonnement appuyant le port de masques dans les salles d'opération. Je sais qu'il existe une certaine controverse sur le sujet; cependant, comme le raisonnement l'explique : « les masques devraient être considérés comme un article de protection pour le personnel et le patient ». Personnellement, je ne m'impliquerais pas dans un cas sans porter de masque et je suggérerais que les hôpitaux établissent des politiques et procédures qui exigent le port de masques comme équipement de protection si vous utilisez la chirurgie laser ou l'électrochirurgie. Une autre ressource hospitalière à votre disposition serait votre service de prévention et de contrôle des infections, puisque j'ai la certitude qu'il aura des politiques relatives aux pratiques routinières et aux précautions à prendre relatives aux pathogènes aéroportés et aux autres risques de contact avec des agents pathogènes.

LA PLANIFICATION DU PRÉCEPTORAT EST ESSENTIELLE À LA RÉTENTION DU PERSONNEL INFIRMIER PÉRIOPÉRATOIRE :

ASSOCIER LES STYLES D'ENSEIGNEMENT ET D'APPRENTISSAGE.

Auteure : Tara Willemsen-McBride IA, B.Sc.Inf, CNOR, est diplômée du programme de sciences infirmières de l'université McMaster. Elle est enseignante périopératoire à l'hôpital St. Mary's General à Kitchener, en Ontario. Tara prépare actuellement sa maîtrise en enseignement à l'université Brock de Saint-Catherines, en Ontario.

RÉSUMÉ :

Les carences actuelles en personnel infirmier en plus de l'échec des programmes d'orientation en soins infirmiers ont été des préoccupations majeures au cours de la dernière décennie puisqu'ils ont causé un faible taux de rétention du personnel, des soins de moins bonne qualité auprès des patients, une satisfaction professionnelle en déclin et un coût financier élevé pour l'organisation. Les spécialités comme la salle d'opération (SO) sont encore plus vulnérables à cause du milieu de travail stressant et l'ensemble des compétences en soins intensifs nécessaires. Nous estimons qu'environ 35 % à 65 % des nouveaux diplômés quitteront leur milieu de travail au cours de leur première année d'emploi, ce qui veut dire un taux de roulement du personnel de 55 %. Le coût d'orientation d'une nouvelle infirmière ou d'un nouvel infirmier dans un rôle périopératoire est d'environ 50 000 \$ à 59 000 \$ US. Il est donc impératif d'améliorer le programme d'orientation pour les nouvelles recrues ainsi que le personnel infirmier plus ancien. L'association du style d'enseignement du précepteur et du style d'apprentissage des infirmiers à sa charge est une façon de rehausser le niveau de satisfaction. Cet article revoit la documentation sur le préceptorat et offre des suggestions sur comment améliorer les programmes d'orientation existants.

Les normes de l'AIISOC relatives à cet article figurent dans la publication *Normes, lignes directrices et énoncés de positions pour la pratique de soins infirmiers périopératoires autorisés* (9^e édition) de l'Association des infirmiers et infirmières de salle d'opération du Canada (AISSOC) de juin 2009, section 3, p.218, Normes 3.3.1.

PRECEPTORSHIP PLANNING IS ESSENTIAL TO PERIOPERATIVE NURSING RETENTION:

MATCHING TEACHING AND LEARNING STYLES

Author: Tara Willemsen-McBride RN, BScN, CNOR, is a graduate of the McMaster University nursing degree program and a member of ORNAO. She is the perioperative educator at St. Mary's General Hospital in Kitchener, ON. Tara is currently working on her Masters in Education at Brock University, St. Catherine's, ON.

ABSTRACT:

Current nursing shortages along with unsuccessful nursing orientation programs have been a major concern for the past decade because they result in poor retention, reduced quality of patient care, decreased job satisfaction and high financial costs to the organization. Specialty areas, such as the Operating Room (OR), are even more vulnerable due to the stressful working environment and critical care skill set. It has been estimated that approximately 35-65% of new graduates will leave their work place within the first year of employment, lending to the 55% nursing turnover rate. The cost of orientating a new nurse to the perioperative role is estimated to cost between \$50,000 and \$59,000 US. Thus, it is imperative to improve the orientation experience for both new and senior perioperative nurses. Matching preceptor/preceptee learning styles is one way to

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enhance job satisfaction levels. This paper revisits the literature on preceptorship and provides suggestions on how to enhance existing orientation programs.

Current nursing shortages and unsuccessful nursing orientation programs have been major concerns for the past decade because they result in poor retention, reduced quality of patient care, decreased job satisfaction and high financial costs to healthcare organizations.^{1,2} It has been estimated that approximately 35-65% of new graduates will leave their work place within the first year of employment, a key factor in the current 55% turnover rate in nursing.³ Specialty areas, such as the Operating Room (OR), are even more vulnerable due to the stressful working environment and required critical care skill set. With the average cost of orientating a new nurse to the perioperative role ranging between US\$50,000 and US\$59,000 perioperative nursing leaders need to continue investigating the causes of resignation and implementing strategies for retention.⁴

Orientation is a critical period for newly hired nurses to either accept or reject their recent change in career path. Orientation programs, accordingly, need to provide a positive, supportive, and welcoming learning environment. Preceptoring nurses, however, experience heavy workloads and have an inadequate amount of time available to provide useful learning experiences to the students, new graduates, or novice nurses they are orientating.⁷ Schools of Nursing and health care institutions are not, unfortunately, providing formal preparation to assist nurses in acquiring the knowledge along with mastering the skills required to act in a preceptoring role.⁶ Despite these challenges the Canadian Nurses Association (CNA) states that it is a nurse's professional obligation to support (preceptor) their peers in building and maintaining competencies required for safe, ethical, and effective nursing practice.

Schools and nursing associations, together with health care institutions, are working diligently to resolve this issue, and create solutions, by developing a variety of preceptorship handbooks, guides and workshops that review adult learning principles, facilitation strategies,

and evaluation techniques. These resources, however, fail to include information about learning styles and, as a result, nurses continue to have negative preceptorship experiences.

The term preceptor is one used throughout the nursing profession around the world. Within Canada it refers to a highly qualified, competent nurse who acts as a mentor and a resource, providing a safe experiential learning opportunity for students in the form of preceptorship.⁷ Preceptorship is defined as a:

“...frequently employed teaching and learning method using nurses as clinical role models. It is a formal, one-to-one relationship of pre-determined length, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to and performing a new role.”⁵

A preceptee may be a nursing student, new graduate, or an experienced nurse hired as a new employee. The concept of preceptorship is deeply rooted in the foundations of experiential learning. Therefore the purpose of preceptorship is to provide the preceptee with a clinical learning environment in order to facilitate understanding by means of applying academic knowledge to a real patient situation.

The purpose of this article is four-fold:

1. to review the evolution of nursing education;
2. to highlight issues with preceptor preparation;
3. to share information about Kolb's Learning Style Inventory (LSI); and
4. to make recommendations for improving the preceptorship experience.

The information provided refers specifically to the perioperative environment although it may also be applied to nursing practice in general.

Nursing Education in Retrospect

Historically, student nurses gained competency through a hospital sponsored

apprenticeship program whereby all learning occurred within the clinical setting at the patients' bedside. This traditional 'hands-on' approach to nursing was taught by a "head" nurse.⁵ Early nursing programs covered the general fundamentals of nursing care and were completed in under a year.

A transition began in the 1970s when Schools of Nursing became more formalized and learning started to occur in the college classroom as well as in the hospital setting with a nursing instructor.⁸ College programs were extended in length to two years and later to three years. Nursing students would consolidate their didactic education on hospital wards such as surgery, maternity, and psychiatry, while accompanied by their nursing instructor.

Today the majority of learning for nursing students occurs within a university lecture hall or online, via the internet, as taught by a nursing professor. The nursing program has expanded to an average of four years, in order to accommodate the advances in medicine, science and technology. The curriculum ranges from basic anatomy and physiology to pharmacology and nursing research. There are a multitude of additional clinical areas such as cardiology, neurology, respirology, urology, obstetrics, gynaecology, paediatrics, oncology, etc. Undergraduate didactic clinical education is now a selective experience, gained through preceptorship with a staff nurse, in a variety of external health care settings.

Today's nursing students, as a result, graduate as generalists meeting entry-to-practice standards set by the CNA. Due to the advances in the health care environment, areas of expertise (such as the OR) have been removed from the earlier hospital-based curriculum.⁹ This decline in exposure has led to a lack of awareness about career opportunities and the relevance of specialty technical training. The advanced knowledge required for the perioperative area is gained through additional continuing education (CE) courses. These advanced educational opportunities are offered

through hospitals, colleges, and universities and vary from six weeks to one year in length. All perioperative programs combine classroom theory with clinical practice. Novice perioperative nurses, preceptored by OR nurses, perform their newly acquired surgical skills within the theater. Perioperative courses may be taken prior to, during, or after a nurse begins employment in the OR.

Issues with Perioperative Preceptorship

The changes in affiliation between hospitals and nursing education have affected the level of hospital investment in nursing students. The didactic requirements have evolved and fewer clinical placements are in hospitals than was the case in the past.⁵ Hospitals are now expected to provide "practical" experiences for nursing students who come from a variety of undergraduate or CE programs. Expert senior nurses are now required to preceptor students – a role that was formerly filled by the nursing instructor. Most staff nurses have had little or no formal training on how to precept, nor do they have an understanding of current program curricula, program structures, and what is expected of them as preceptors. Academic programs and hospitals also often neglect to reward or acknowledge the preceptor for their dedication to the preceptee, organization and profession.

Students begin their clinical placement in the perioperative environment with one of many levels of clinical competence and learning needs that vary depending on their program's curriculum requirements. Since these novice nurses are learning within the clinical environment, while providing patient care, it is important that assignments are within their scope of practice and can gradually increase in complexity in accordance with their learning objectives. This is problematic as each preceptee has a different starting point of knowledge and needs and the OR surgical list can vary greatly, with a combination of short and straightforward or long and complex cases, throughout the day and from one day to the next.

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PRECEPTORSHIP (cont.)

At present the majority of ORs choose to randomly pair a senior, experienced, nurse with a novice nurse. This assignment may be based on:

- (a) scheduling convenience for the charge nurse, educator, or manager as determined by employee availability;
- (b) a personal request by the staff nurse; or
- (c) the level of experience of nursing staff.^{8,10}

Once a preceptor is chosen various scheduling challenges, such as sick-days or shift work, result in novice nurses often being re-assigned to one or more preceptors during their preceptorship experience. Another dilemma arises when some nurses are not trained to work in all the surgical services. As there are many sub-specialties within the OR there are often designated teams available to perform specialty services such as cardiac, paediatric, or robotic surgery. Novice nurses are often paired with different service-specific nurses. Neither the preceptor's teaching and learning styles (as adults usually teach using the style that suits their own learning preferences) nor the preceptee's learning style are taken in to consideration when pairing nurses for preceptorship. Literature regarding learning styles suggests that the preceptor's teaching and preceptee's learning experiences may, as a result, be unsatisfactory.¹¹

When selecting a nurse to precept, scholars of andragogy (learning strategies focused on adults) suggest that consideration be given to pairing the teaching/learning style of the preceptor with the learning style of the preceptee. Research studies have reported a positive correlation between matched teaching/learning styles and successful preceptorship experiences.^{8,12} Increased comfort and decreased anxiety lead to improved confidence in the preceptee when his/her learning style is well matched with their preceptor's teaching style. Dorothy MacKeracher, a professor of adult education, writes about learning style mismatch resulting in a mutually unsatisfactory experience for both the teacher and the learner. Adults are adept at knowing intuitively when teachers and learning situations are not congruent with how they

learn. They tend, therefore, to choose teachers and environments that are compatible with their preferred learning style.¹¹ An in-depth understanding of learning styles is required in order for it to be of benefit to the nursing profession.

Each adult has his/her own preferred way or style of learning.¹³ An adult will acquire knowledge through a variety of means and will generally favour some methods over others. Within the field of andragogy, Kolb's *Learning Style Inventory* (LSI) is a tool often used to define an individual's learning styles.

Kolb's Learning Style Inventory

In 1984 David A. Kolb, an adult educational theorist, developed a cycle, inventory, and model related to learning styles. Kolb's work was influenced by theorists of psychology including Carl Jung and Jean Piaget.¹⁴ While scholars of education might find Kolb's explanation of learning styles to be straightforward, many health care professionals may, however, find the terminology to be unfamiliar and confusing. Thus, layperson terminology and descriptions have been provided here in order to better help the nursing profession understand and incorporate Kolb's work into preceptorship practice.

Kolb's model of learning styles, based on experiential learning, continues to be one of the most commonly used approaches when working with adult learners.^{13,15} Kolb divided the learning process into four phases of an experiential learning cycle (See Figure 1 on pg 20). The learning cycle can be initiated at any point in the circle depending on the learner's preferences. Starting at the top of the cycle, the phases are:

1. **Concrete Experience** (feeling):
Learning from specific experiences, being sensitive to feelings and people;
2. **Reflective Observation** (watching):
Observing before making judgments, viewing issues from different perspectives, looking for the meaning of things;

Continued on Page 18

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3. Abstract Conceptualization (thinking):

Logically analyzing ideas, planning systematically, acting on an intellectual basis; and

4. Experimentation (action):

Learning through hands on' activities, dealing with people and events through action.^{11,13,14,15}

Kolb discovered that people do not participate equally in all phases of the learning cycle. He noted that learners are influenced by their heredity, culture, past experiences, employment, and real life situations.¹⁴ When studying adults, Kolb observed consistent characteristics demonstrated by learners, when processing information, which he later divided into four learning styles. Each of the four styles corresponds to specific phases in the learning cycle. Kolb divided the cycle into two dimensions, on opposing axes, pairing Concrete Experience with Abstract Conceptualization (abstract-concrete dimensions) and Active Experimentation with Reflective Observation (active-reflective dimensions) (See Figure 2 on pg 20). When completing the LSI, an individual can self-assess which style of learning they inherently prefer.

Since its creation, in 1984, Kolb's LSI has gone through many revisions, based on new data gathered from larger sample sizes. The latest version of the LSI uses a description ranking scale designed to determine adult learning style preferences. After completing the LSI the calculated sum of the ranks is placed into a matrix, between the axes to provide a learning style profile. The LSI is useful because it can help nurses explore their preferred teaching style and compare it to the learning style of their preceptees.¹³

Learning Style Preferences:

A **diverger (creator)** is a learner whose LSI results lie between Concrete Experience and Reflective Observation. Adults of this learning style are creative and imaginative. They are excellent "brainstormers", interact well with people, and look at an experience from many perspectives. One weakness of divergent learners is that they have difficulty selecting and staying focused on one task.^{11,13,14,15}

A **converger (decision maker)** is a learner whose score is between Abstract Conceptualization and Active Experimentation. They have practical ideas, are problem solvers and decision makers. They prefer to work with things rather than with people and have a tendency to make decisions quickly.

An **assimilator (planner)** is an individual whose LSI results lie between Reflective Observation and Abstract Conceptualization. Assimilators, although not always practical, can create models and theories derived from their concrete experiences. Assimilators prefer to participate in learning through reading, listening, observing and reflection.

An **accommodator ("do-er")** is a learner whose score is between Concrete Experiences and Active Experimentation. They pursue opportunities that involve action and taking risks. They enjoy a trial and error, experiential, approach to learning.

When explaining how the model applies to learning, Kolb indicates that people are not equally skilled at employing each of the four styles of learning. None of the styles is more valued than another and none are directly associated with higher intelligence or performance. Identifying individual learning styles simply helps adults recognize their personal learning strengths and weakness. A diverger (creator), for example, may excel at creativity but may need to improve his or her decision-making skills. Individual learning style preferences are susceptible to change and learning strengths and weaknesses will require reassessment over time.¹¹ Kolb's work in the learning style inventory, the experiential learning cycle, and the model of learning styles is usually described using "high level concepts" that require training in the field of education. Nursing leaders need to adapt this information in order to help their colleagues understand the relevance of learning styles. This knowledge may then be used, by nurse preceptors, to choose a precise facilitation strategy or evaluation tool that is suited to the learning style of their preceptee.

Recommendations for Improvement

While one learning style is no better than another, each nurse will demonstrate strengths

and weaknesses based on her/his preferred method of learning. Having an awareness of one's own preferred learning style could help a nurse preceptor recognize if her preceptee has a similar learning style or if there will be different preferences in learning methods. This knowledge could improve the expert nurse preceptor's ability to meet the learning needs of the preceptee by allowing for the use of favoured teaching strategies and evaluation assessments. Matched learning styles can optimize the time, resources and capabilities of both the preceptor and preceptee and create a more enjoyable and productive experience for both parties.

To implement this strategy, the educator or manager would distribute the LSI instrument to nurses interested in preceptoring as well as to student or novice nurses being preceptored. The nurses would then answer the questions on the instrument to determine their style of learning. The educator or manager would then pair preceptors and preceptees based on learning & teaching styles. The concept of matching preceptor/preceptee learning styles is not an unknown concept as it has been attempted in the past by other nursing leaders and the research results have been encouraging.

In 1998, Anderson used the Myer-Briggs Type Indicator (a tool used to determine personality type)¹⁷ to investigate the relationship between students and nurses, some of whom had been matched based on learning styles, and to measure their perceived satisfaction with the orientation process. The study reported a significantly higher level of satisfaction among preceptees and preceptors whose learning styles were matched when compared with those who were not matched.¹⁸

Brunt and Kopp attempted to validate these findings by repeating a similar pilot study in 2003. They expanded the assessment process by including two additional instruments, Kolb's Learning Style Inventory (LSI) and Dunn and Dunn's Productivity Environmental Preference Survey (PEPS)¹⁸. They concluded that there was a positive correlation between matched learning styles and satisfaction, although the findings

were not significant. They accredited the inconclusive findings to a small sample size and the challenge of matching preceptor/preceptee learning styles with three assessment instruments.¹²

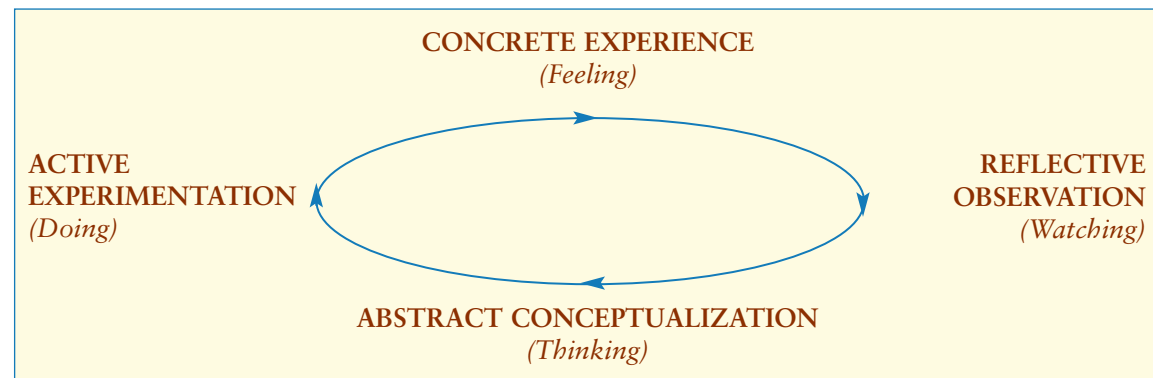
Although the model of matching learning styles of preceptors and preceptees could result in many positive outcomes for perioperative preceptorship, implementing such a program is, however, not always easy. Identifying the expert nurse preceptors' teaching/learning style and matching it with the novice preceptee's learning style requires education, time, and resources (there is a monetary fee involved in the distribution and use of Kolb's LSI). It can also be problematic when a facility is not able to accommodate a preceptor/preceptee match due to lack of available preceptor candidates. Some writers also argue against pairing the same learning styles and instead encourage a mismatch, believing it will challenge nurses to teach and learn in different ways.¹¹

CONCLUSION:

Orientation experiences can leave a permanent impression on nurses and affect their perception of the profession. The author would like the following scenario to be considered when justifying the importance of choosing preceptor/preceptee teams.

A junior nurse, Ava, nervously stands among her classmates as the educator reviews the list of eligible preceptors. As the educator reads aloud the name of each student the preceptor, Ava, realizes she has been assigned to the senior nurse who she fears most, Helga. Helga was the "master of her domain", an expert in every surgical service, could perform both the scrub and circulatory role, had decades of experience, and was assertive with the surgeons. From a manager's, educator's, and charge nurse's perspective Helga was the ultimate preceptor. But as her preceptee, Ava was terrified of her! A lot was learned over the next few weeks but there was often too much apprehension involved in asking questions and worry about making a mistake. This left an anxious, and often nauseous, preceptee. Then, to make an uncomfortable situation worse, Helga was

Figure 1. Kolb's Experiential Learning Cycle



(HayGroup, 2009; MacKeracher, 2004, p. 57)

unavailable one morning and another preceptor was assigned to the task. The new preceptor ignored Ava and provided no support while she was scrubbed. An error was made, which the surgeon abruptly corrected. Ava, feeling disgraced by the situation, left the OR in tears, went to the change room and emptied out her locker. The educator learned of the incident and convinced Ava not to leave. It was extremely difficult for Ava to face the staff the following day knowing that they were aware of the

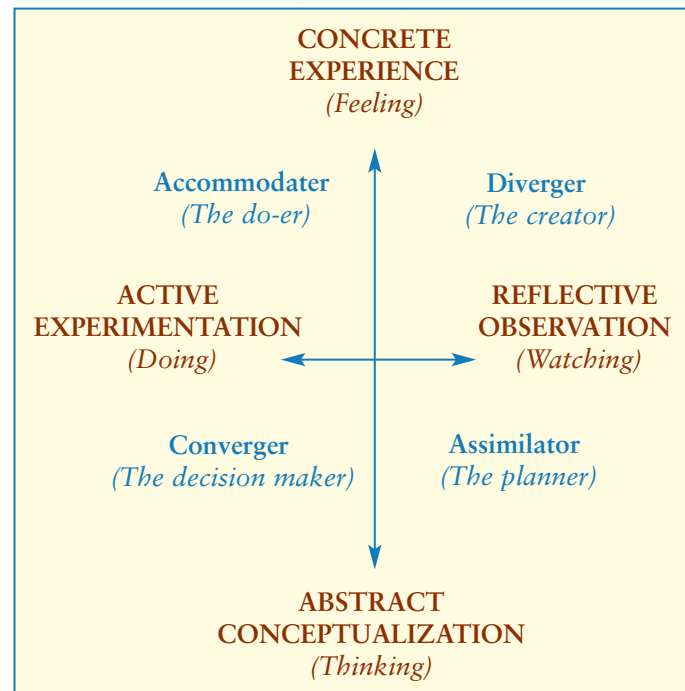
incident from the day before and to make matters worse she was then reprimanded by Helga for being too sensitive!

Many novice nurses who are put in this position might not return. With a surplus of nursing employment opportunities why would they? Reflecting upon this experience, the author would speculate that the preceptor was a converger (decision maker) and the preceptee to be an accommodator (do-er). The negative orientation incident could have been avoided if the preceptee was consistently paired with a preceptor who she did not find intimidating, who she felt comfortable learning from, and who understood how she learned.

The purpose of preceptorship is to enhance the quality of learning in the clinical environment, which in return helps novice nurses achieve excellence and confidence in their professional practice. In addition, the mentoring relationship between the preceptor and the preceptee assists with socialization into the profession.¹⁶ A positive preceptorship experience also improves performance, job satisfaction, and retention levels of both the preceptor and the preceptee.^{5,6,16} In order for this to successfully occur, the selection, development, and training of each

nurse, who serves as either preceptee or

Figure 2. Kolb's Learning Styles



(HayGroup, 2009; MacKeracher, 2004, p. 84)

preceptor, is vital.¹ Choosing a preceptor for a preceptee needs to be a collaborative process between the educator, senior staff and novice nurse. Matching the learning styles of the preceptor with the preceptee is one suggestion for improving this experience. Expert nurses are our greatest resource and we need to utilize them as preceptors accordingly – and novice nurses are our future and as such require the right teaching and support.

ORNAC Standards pertaining to this article can be found in the Operating Room Nurses Association of Canada (ORNAC) (June 2009) *Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (9th edition), Section 3, p. 218, Standard 3.3.1.

REFERENCES:

1. Jane J. Baltimore. "The hospital clinical preceptor: Essential preparation for success". *Journal of Continuing Education in Nursing* 35.3 (2004) : 133-140.
2. M. VanOyen Force. "The relationship between effective nurse managers and nursing retention". *Journal of Nursing Administration* 35.7 (2005) : 336-341.
3. J.M.Hayes & A.S. Scott. "Mentoring partnerships as the wave of the future for new graduates". *National League of Nursing, Nursing Education Perspective* 28.1 (2007) : 27-29.
4. Lucy B. Trice, Catherine Brandvold & Elizabeth Bruno. "Practice and Education: Partnering to address the perioperative nursing shortage". *AORN Journal*, 86.2 (2007) : 259-264.
5. Canadian Nurses Association (2004). *Achieving excellence in professional practice: A guide to preceptorship and mentoring*. Ottawa: Canadian Nurses Association. Retrieved September 2008 http://www.canaiic.ca/bookstore/freepdfs/AchievingExcellence2004_e.pdf
6. Margo Kertis. "The One-Minute Preceptor, A Five-Step Tool to Improve clinical Teaching Skills". *Journal for Nurses in Staff Development*. 23.5 (2007) : 238-242.
7. Kristiina Hyrkas & Martha Shoemaker. "Changes in the preceptor role: re-visiting

8. Judy Anderson. "Orientation with style, matching teaching/learning style." *Journal for Nurses in Staff Development* 14.4 (1998) : 192-197.
9. Karin Page-Cuttrara. "Perioperative nursing education in Canada: Current and future perspectives." *Canadian Operating Room Nursing Journal*. 25.1 (2007) : 10-19.
10. Suzy Lockwood-Rayermann. "Preceptor leadership style and the nursing practicum." *Journal of Professional Nursing*. 19.1 (2003) : 32-37.
11. Dorothy MacKeracher. *Making sense of adult learning* (2nd ed.). (Toronto: University of Toronto Press 2004) 71-91.
12. Barbara A. Brunt & Denise J. Kopp. "Impact of preceptor and orientee learning styles on satisfaction, a pilot study." *Journal for Nurses in Staff Development*. 23.1(2007) : 36-44.
13. Patricia Cranton. Theoretical Foundations of Adult Education, In *Planning Instruction for Adult Learners 2nd Ed.* (Toronto: Wall & Emerson 2000) 6-24.
14. Anne Poonwassie. Facilitating Adult Education: A Practitioner's Perspective. In D.H. Poonwassie & A. Poonwassie (Eds.), *Fundamentals of Adult Education*. (Toronto: Thompson Educational Publishing 2001) 67-158.
15. HayGroup, Kolb's Learning Style Inventory, Author Unknown, Retrieved April 8, 2009, from: http://haygroup.com/tl/Downloads/Why_People_Learn.pdf
16. Amanda Henderson, Robyn Fox & Kristina Malko-Nyhan. "An Evaluation of Preceptors' Perceptions of Educational Preparation and Organizational support for Their Role." *The Journal of Continuing Education in Nursing*. 37.3 (2006) : 130-136.
17. The Myers Briggs Foundation. Retrieved October 2009 <http://www.myersbriggs.org/>
18. Rita Dunn, Shirley A. Griggs, Jeffery Olson, Mark Beasley & Bernard S. Gorman "A Meta-Analytic Validation of the Dunn and Dunn Model of Learning-Style Preferences." *The Journal of Educational Research*. 88.6 (1995) :353-362

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DIX RAISONS POUR LESQUELLES LES PRATICIENS DANS LES BLOCS OPÉRATOIRES ET LE PERSONNEL INFIRMIER DE SALLE D'OPÉRATION NE VOUDRONT PEUT-ÊTRE PAS CITER CET ARTICLE

*Auteur : Bernard V. Pennington, BA (Spéc.),
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La rédaction académique peut terroriser les étudiants avant et après leur inscription au programme. Les étudiants construisent souvent leurs travaux autour de passages reformulés à partir de leur matériel de référence. Cette pratique produit du travail de qualité inférieure, des mauvaises notes et de la frustration. Le but de cet article est d'informer les étudiants qui entreprennent des études supérieures sur ce qu'est la rédaction académique et, tout aussi important, ce qu'elle n'est pas.

INTRODUCTION

Vous voyez-vous comme l'un des ses praticiens de blocs opératoires qui suivent ou considèrent suivre un programme d'études supérieures, mais qui préfèrent les demandes pratiques du rôle au fardeau académique? Si vous sondiez des praticiens en posant cette question, je soupçonne que la majorité d'entre-nous se retrouverait dans cette catégorie. La plupart d'entre nous ne sommes pas des académiques « naturels », alors nous entrons un monde qui nous est étrange et très loin de notre zone de confort. Il devient très difficile de nous exprimer avec assurance alors que nous sommes entourés de travaux merveilleusement écrits. La tendance est donc de construire le travail demandé autour de citations ou de reformulations fidèles au matériel de référence. Il y a, cependant, de très bonnes raisons pour lesquelles cette approche est peu judicieuse.

Traduction du résumé apparaissant dans le *Journal of Perioperative Practice*, volume 18, numéro 12, pp. 529-530. *Ten Reasons why Operating Department Practitioners and Theatre Nurses might not want to quote or cite from this article* de Bernard V Pennington. Copyright 2008, réimprimé avec la permission de l'Association for Perioperative Practice (AfPP).

TEN REASONS WHY OPERATING DEPARTMENT PRACTITIONERS AND THEATRE NURSES MIGHT NOT WANT TO QUOTE OR CITE FROM THIS ARTICLE

*Author: Bernard V. Pennington, BA (Hons),
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Academic writing can fill pre- and post-registration students with fear and dread. Students often construct written work around re-worded passages from their sources. This results in poor quality work, low marks and frustration. The aim of this article is to inform students embarking on courses in higher education about what academic writing is – and equally importantly what it is not.

INTRODUCTION

Do you view yourself as one of those theatre practitioners on, or considering a higher education program, that enjoys the practical demands of the role much more than the academic burden? If you took a survey of practitioners asking this question I suspect you might find that most of us might fall into this category. Most of us are not 'natural' academics and so we enter a world that is strange to us and far-removed from our comfort zone. It becomes very difficult therefore to express ourselves with confidence whilst surrounded by beautiful written works. The tendency then is construct assignment work around quoted or closely paraphrased source material. There are some

TOP TEN REASONS (cont.)

very good reasons why this approach is ill-advised however.

1. Quotes don't demonstrate understanding

Let's be more specific: quotes don't demonstrate your understanding. If you quote a line from this article it will say something about my knowledge and maybe my understanding but not a lot about yours. This is why you are better off writing in your own words where possible and then backing your words up with a reference. Worried that it doesn't look academic? A common mistake is to think that academic writing needs to look and sound like it is taken from a book or journal. What is academic writing? It is clear, concise writing that gets to the point and stays there. It does not need to be flowery or long-winded or contain big words. Just say it how it is and back up what you say with a reference or better still several references. When is a good time to use quotes? Definitions or statistics are usually better quoted because it is very difficult to claim them as your own work.

2. Paraphrasing can be a risky business

This is not strictly true but it is extremely risky if you don't understand paraphrasing. Paraphrasing is a legitimate form of writing. The trouble with paraphrasing is that a lot of students (and tutors) confuse it with reproduction. Changing a word or two in a sentence or joining two sentences or a list together with 'and' or 'also' is not paraphrasing. Paraphrasing involves taking an author's idea or concept and applying it to practice or an issue. This is not an easy skill and if you try to paraphrase single sentences or small paragraphs you will inevitably end up copying (usually muttering the words 'I couldn't write it any other way'). The point here is that copying or reproduction of any form will not gain you marks. You may well have enjoyed success with 'reproductive' writing techniques prior to entering higher education but in higher education we look for something more.

Take a look at the marking criteria for your university or college. There is unlikely to be

many marks awarded for quoting hard facts. Sure, you need something to base your discussion on, but the real marks are for 'analysis', 'reflection', 'synthesis' and 'evidence of wide reading'. These terms will not be the subject of discussion here. Except to note that in each case it is what you do with what you have learned from the literature rather than the actual words of the literature that influences the quality of your work. It sounds complex but look at this another way - does your assignment guidance advise you to copy a load of paragraphs from books and journals, change a few words and pretend it's your own?

3. This article has very little to do with theatre practice

This is a key point when you consider selection of literature. There is a temptation to carry out a literature search using key words such as 'operating department practitioners' or 'theatre nursing' and then include everything (nothing is wasted). This article would appear quite high on the resulting list of citations simply because it has ODP in the title. However, as you have gathered by now this article is about academic writing generally and could be applied to pretty much any discipline. Subsequently it is unlikely that anything stated here is of value to your assignment in terms of content. There is more discussion around the value of certain types of literature in the next section.

4. This article is opinion and is not backed up with a comprehensive reference list

Take a look at the reference list (citations) at the end of this article. Nothing there? What does this say about the quality of the content? It strongly suggests that this is an 'opinion' piece. So now you have to decide if my opinion is worth anything. This would be a bit easier if there was a reference list to show how my opinions were constructed and on which they were based. This is pure opinion however, so now you are left deciding if I am qualified to make these claims or whether to put this article down. This could open up a

TOP TEN REASONS (cont.)

discussion around where opinion or 'expert opinion' sits in 'hierarchies of evidence' - but one step at a time. There is a question of credibility. Credibility, in literature terms, depends on a number of factors. The first question is the one discussed above - that is the issue of whether the person(s) writing the article is/are suitably qualified/experienced to be taken seriously. If the author is not identified, as can be the case when utilising internet sources, then (unless accessing a universally accepted website, ie, the Department of Health, not PatientUK or Wikipedia) you have to question whether the reference has any value and whether to include it in your essay.

So how about Wikipedia? The answer to this lies in the title. A 'wiki' is an online resource that can be created and edited by anybody at any time. So even when you have a really good entry that explains an issue or principle very well you would be ill

advised to use it. When your tutor comes to mark your work and looks at your reference list three weeks later he/she may take a look at the entry in Wikipedia that has been subsequently changed.

5. Look at the way this is written

One word describes this piece: 'journalistic'. I have tended to pose questions rather than answer them. This is a very discursive style. This is fine for a journal article or discussion board entry because the idea is to provoke debate and encourage questioning. This style will not gain many marks in an academic essay however. How many times have you been given feedback such as 'very descriptive', 'mainly narrative'? (There I go again - so many questions). It can be considered poor writing technique to pose questions - particularly if you then fail to answer them within an academic essay.



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TOP TEN REASONS (cont.)

This goes back to the points made earlier. Get to the point, stick to the point. Just say it how it is. It also highlights why it is ill advised to look at a journal or book and try to 'reproduce' the glossy words in front of you. The purpose of your work is different, as is your audience. This brings us to a key point. The purpose of your work is to demonstrate that you have achieved some learning outcomes. It is unlikely that those outcomes include 'Demonstrate the ability to copy paragraphs from sources, change a few words and pretend it's your own'.


6. This article is misleading

Inaccurate would be a better word. There are actually only six reasons for not quoting this article listed here. In any literature there will be limitations or flaws. It does not matter whether (as in this case) they are deliberate or not. What matters is that you recognise the limitations or inaccuracies firstly in selecting which literature to cite and secondly in the way in which it is cited.

I recently read an interesting research article examining delay causes in an operating department. It was clear from early data that theatre personnel skilling was a minimal cause of delays in comparison to skill issues in the areas of surgery and anaesthesia (doctors) and yet the researcher then spent a considerable amount of time and effort 'proving' that significant improvements could be made by multi-skilling theatre personnel rather than addressing the real cause of delays. It was a beautifully written article, the researcher was sufficiently qualified and situated to claim expertise but unfortunately it was complete pants. I won't be citing that one in any of my essays. Whoops, I just did – but I've left it out of my reference list just to make my earlier point. Another inaccuracy? What is the point of this article if you can't cite from it? The aim here is to dispel the myth of 'academic writing' and reassure students that they are not competing with the literature. The literature is there to inform your opinion and then, when you are writing, to back you up. Students entering higher education are understandably nervous about

academic writing. Nobody wants to copy but equally it is difficult, at the start, to have confidence in your own writing. This is particularly true when you surround yourself with numerous glossy 'works' and your own efforts appear to pale in comparison. The temptation is then to 'reproduce' work from sources rather than creating original work. The key to beating this is to remember that your sources are there to back you up – not the other way round. If you find yourself moaning that '...it just can't be written any other way!', then you are probably looking at it from the wrong direction. ✱

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References

¹ The Joint Commission. The Statistics page. Available at: http://www.joint-commission.org/NR/rdonlyres/D7836542-A372-4F93-8BD7-DDD11D43E484/0/SE_Stats_12_07.pdf. Accessed March 13, 2008.

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