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WARD TEACHING SKILLS - AN INVESTIGATION INTO THE BEHAVIOURAL CHARACTERISTICS OF EFFECTIVE WARD TEACHERS

by

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ABSTRACT

Ward Teaching Skills - an investigation into the behavioural characteristics of effective ward teachers - by Sheila N. Marson

This study is an exploration of the teaching and learning of nursing in the work environment.

The research was designed to answer the following questions:-

1. What routines and procedures are used for the induction, support and instruction of trainees in service areas?
2. How do trained nurses and nurse learners perceive teaching and learning?
3. What experiences do trainees consider result in significant learning?
4. What, in the learner's opinion, constitutes a missed learning opportunity?
5. Has the good 'teacher', viewed from the learner's perspective, any identifiable characteristics?
6. How do trained nurses communicate verbally with trainees?

The attitudes and perceptions of ward sisters, student and pupil nurses were investigated by interviews. The data concerning the perceived characteristics of good teachers were developed into a questionnaire. The questionnaire was completed by a further 96 trainee nurses and the results factor analysed. A profile was constructed from the factors identified.

Finally, trained nurse-trainee verbal communications were observed, categorised and analysed on four wards for a four week period. This was followed by a further study of six identified good teachers.

Analysis of the data leads to the conclusion that 'on the job' teaching of nurse learners is a complex global act in which the role model presented to the learner is a powerful influence. Nurses perceived as effective teachers express, generally, an attitude of care and concern for the welfare of others and a commitment to the training of nurse learners in particular.

While it could not be said conclusively that 'effective' teachers use a 'participative' mode of communication, this trend was noted in two identified good teachers.

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CHAPTER I

OUTLINE OF RESEARCH

INTRODUCTION

Nurse training has been problematic for a number of years. Many of the problems are associated with the apprenticeship type of training. Used in the context of nursing, this term refers to a training course consisting of short periods of formal instruction in a classroom setting, sandwiched between longer periods of work experience in hospitals and the community.

The majority*, that is approximately 99.5% of the trained nurse workforce, has undergone this type of training, the remainder being educated in institutes of higher education (Hayward, 1978).

Learners, under an apprenticeship system of training, have a right to expect an 'on the job' teaching programme; from time to time however, complaints are raised that ward teaching is absent or too haphazard to be effective (Crout, 1980). The researcher's personal experience as a surgical ward sister, then, as a nurse teacher, has made her only too aware of the difficulties. In spite of a deep personal commitment as a ward sister to the support and training of learners, the problems arising from reductions in the number of working hours, a higher patient turnover and shortages of staff militated against providing continuity and structure in ward teaching. Viewing the problem from the 'other side' as a nurse teacher, highlighted the difficulties of integrating theoretical teaching with practice when learners form part of the labour force.

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* NB Some 8,000 nursing trainees successfully complete a basic nursing course each year, qualifying as either State Registered (3 year training) or State Enrolled (2 year training) nurses.

they are under the control of clinical staff who are practitioners, not qualified instructors, for 80% of their training time.

RATIONALE OF THE STUDY - Ward Teaching

The opportunities for imparting knowledge and skills in the clinical situation do exist and may be taken up to a greater or lesser degree. When pressures build up, however, the teaching of trainees has often to be abandoned, other things taking priority. If a broader view of teaching is taken, that is, the view that

> 'teaching includes any of those activities which enable learning to take place' (Hirst, 1971),

then formal instruction in the traditional sense may be of less importance to learning.

Rogers (1969), whose work is increasingly influencing higher education, takes a non-traditional view of teaching. He feels it is unfortunate that educators and the public have focussed on teaching; it leads to a host of questions that may be irrelevant as far as real education is concerned. In Rogers' view, to focus on learning, how, why and when students learn and how learning feels to them, may be more profitable.

The researcher's 12 years' experience in developing instructional media (Marson, 1976) has convinced her that, with modern instructional technology, theoretical knowledge and some skills can be acquired with minimal aid from a teacher. Given the increasing pressures on ward sisters, it may be unrealistic to expect them to increase the amount of formal teaching given; indeed it may be more profitable to develop other skills inherent in a ward sister's supervisory role. To date, few attempts have been made to analyse the behaviours, skills and attitudes possessed by service staff known to be skilled at ward teaching, hence the personal interest of the researcher in investigating this problem.

research:

> 'there is little research illuminating the situation within nurse training, except in the field of recruitment and wastage' (Bendall, 1975 p11)
>
> 'the total research picture shows a marked absence of research activity in the field of nurse education per se' (Dodd, 1973).

ORGANISATIONAL IMPLICATION

Nurse education is currently undergoing a period of development catalysed by the report of the Royal Commission on Nursing (Briggs, 1972), by the regulations of the European Economic Community governing nurse training and the emergence of the more scientific approach to nursing care embodied in the Nursing Process. In this kind of climate it is essential that the education and service divisions of nursing work together. It is the researcher's opinion that there will be a greater need than ever for in-service training to develop the role of the nurse. With regard to the teaching function inherent in the nursing role, it is vital that any in-service training programme starts from a research base: hence the need for this kind of study.

AIM OF STUDY

The main aim of the study was to isolate those behaviours that trainee nurses consider help them learn from work experience. Starting from a general framework of behavioural characteristics, collected at interview and later subjected to further analysis by questionnaire, the researcher moved in to observe at close hand trained nurse/trainee verbal interactions. In approaching the problem from several angles it was hoped that a profile of 'good teaching behaviour', as viewed from the nurse learner's perspective, could be constructed. With this aim in view the following techniques were selected as being appropriate to the problem to be studied.

The study was conducted in a local district school of nursing. The subjects were student and pupil nurses studying for the Register and Roll and 35 trained nurses. The trained nurses taking part were State Registered and State Enrolled nurses employed on teaching wards* in four small acute general hopsitals and two geriatric hospitals. These hospitals are in a two-district Area Health Authority. This particular school of nursing was chosen as being representative of schools of nursing attached to provincial non-teaching hospitals. It is in this kind of environment that a large proportion of nurses are trained in the United Kingdom.. The research worker was well known to the tutorial staff of the school, having been involved in other projects; hence a relationship had been established.

The study was designed to take place in three phases; because of the dearth of studies on the process of learning and teaching nurses, the first phase had, of necessity, to be an exploratory one.

Phase 1 was designed with the objective of:-

(a) Identifying routines and procedures used for the induction, support and instruction of trainees in service areas.

(b) Ascertaining trainee and trained nurse perceptions of teaching and learning.

(c) Identifying factors involved in experiences trainees considered resulted in significant learning and those considered to be missed learning opportunities.

(d) Obtaining a description of the behavioural characteristics of the good ward teacher.

The information was obtained by interviewing a randomly selected group of trainees and sister.

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* NB This term is applied to wards providing practical experience for trainee nurses.

Phase 2 entailed testing the good teacher findings with a larger population of trainee nurses. The method to be used in this stage was a questionnaire developed from the interview findings.

(It was originally intended to use a critical incident technique in phase 2 but this was eventually abandoned, see Chapter 5 page 61).

Phase 3 - The objective of this phase was to observe and analyse the verbal interactions between trained and trainee nurses in selected wards and to determine any relationship between verbal behaviours and perceived 'good teaching'. Interactive analysis tools have been devised for the classroom (Flanders, 1970) and industrial and commercial training (Rackham, 1977). Rackham's verbal behaviour categories were finally selected as being, with some modifications, the most applicable to the clinical environment.

For further clarification the next two chapters will explore in more depth the underlying premises on which the study is based; that is:-

1. The development of nursing and the educational changes accompanying this development, with particular emphasis on the last two decades;
2. The ward learning environment with particular reference to the factors that influence the learning climate;
3. Definitions of teaching and learning in the light of current educational research and development.

CHAPTER II

STATEMENT OF THE PROBLEM

Three themes will be developed concurrently in this chapter: the development of nursing per se, educational changes accompanying this development,and the ward as a learning environment.

HISTORICAL ROOTS

Nursing did not emerge as a formalised range of activities until the middle of the nineteenth century. Although there were religious orders dedicated to the care of the sick in the Middle Ages, these orders did not have a distinctive training and largely disappeared in Britain with the dissolution of the monasteries.

The immediate antecedents of modern nursing were described as domestic servants, doing little more than a specialised form of 'charring' (Abel Smith 1960). Under the influence of the social reformer Florence Nightingale, nursing began to emerge as a discipline in the second half of the nineteenth century. Florence Nightingale was one of the first practitioners to realise the importance of the methodical recording of vital statistics, these statistics in some instances showing the hospital often did the sick harm.

From these significant beginnings nursing developed into a ritualised vocation. Nursing, a predominantly female occupation, was regarded as a calling and nurses were expected to identify with a submissive, caring and non-questioning role. The emphasis was on performing the routine tasks characteristic of the female role in society. Nurses were taught and supervised on the job by experienced nurses who acted as role models. Nurse education could be seen as a process of socialisation 'transferring

current work practices into valued work practices' (Van Maaen, 1979). Theoretical knowledge had some importance but the main emphasis was on nursing skills and attitudes. The attitudes particularly valued in the first half of the twentieth century were commitment, discipline and obedience.

With the introduction of State Registration in 1919 and the setting up of a statutory body to regulate nurse training and conduct examinations, the first of which was held in 1925, theoretical knowledge became much more important. Selected nurses were trained as teachers to ensure that nurses in training received sufficient theoretical instruction to meet the General Nursing Council's examination requirements. This theoretical instruction took place in a classroom away from the wards, ward sisters still supervising trainees in their practical experience. It must be noted at this point that from its inception in the mid-nineteenth century, nursing has remained firmly rooted in the hospital, giving nursing a sickness rather than a health orientation and placing it in a bureaucratic structure. Hence the tendency to routinise and depersonalise nursing to lessen stress, first noted by Menzies (1960) and commented on again by Fretwell (1979). Technical developments in medical practice over the last three decades have had their effect on nursing, more theoretical knowledge and technical skills have to be learned; it is important to know not only <u>how</u> a thing is done but <u>why</u>. This has created an impression that emphasis in nursing had moved away from patient care to a medical knowledge orientation.

PRESENT AND FUTURE TRENDS

In the last decade nursing has taken a major step forward. The Report of the Committee on Nursing (Briggs, 1972) expressed the desirability of putting nursing on a research base, giving considerable

impetus to the development of nursing research in the United Kingdom. This research has yet to make an impact on nursing practice, however. Another significant development is that of the Nursing Process (McFarlane, 1977), an approach designed to individualise nursing care. This could be described as a systematic approach, involving an analysis and preparation of nursing care plans, their implementation and evaluation. The General Nursing Council in the 1977 Educational Policy document has suggested the adoption of the Nursing Process as a 'unifying thread' in curriculum development. This approach should move nursing away from routine and ritual toward research-based practice. The research approach to nursing will need people capable of initiating ideas, analysing and evaluating situations, making decisions and being accountable for them, and meeting and negotiating on equal terms with other members of the health care team (Heath and Marson, 1979).

The developments outlined in the last paragraph have, to date, been initiated in University and College based nursing courses. Changes are beginning to take place in courses rooted in the National Health Service, but these tend to be in the area of nursing theory rather than practice. Nursing practice in hospitals remains much as it always has been, a task-oriented process, apart from one or two innovatory centres.

WARD SISTER'S ROLE - effect of organisational change

Organisational changes in the last two decades have had an impact on the ward sister's managerial role. Routine tasks traditionally done by nurses are now carried out by an army of ancillary workers. A ward sister has many more personnel to deal with in day to day administration. These organisational changes,

namely changes in the nursing management structure (Salmon, 1968) and re-organisation of the Health Service in 1974, have tended to take authority away from the ward sister without in any way lightening the administrative load. With a higher turnover of staff and patients, more administrative channels to go through and a shorter working week, responsibilities have increased rather than lessened (Pembrey, 1978). For most ward sisters the instruction of trainee nurses is of secondary importance and therefore the first to be jettisoned under pressure.

Clinical teachers were introduced in the mid-sixties in an attempt to alleviate the problem of inadequate ward teaching. In theory this appeared an ideal solution, a teacher based in the ward situation supervising clinical experience and correlating theory with practice. In reality the solution did not meet expectations. Clinical teachers are too few in number to make any real impact and in some instances they are used to help with classroom teaching, taking them away from the clinical area. The ambiguities associated with the role cause many clinical tutors to move on to train as classroom teachers, resulting in a high attrition rate. The gulf between theory and practice seems to be in danger of becoming an uncrossable chasm.

WARD SISTER AS TEACHER

The nurse manager's responsibility for the supervision and training of learners is continually stressed by the General Nursing Council with each revision of the training syllabus (1960, 1969, 1972). The Report of the Committee on Nursing (Briggs, 1972) reiterated the need to improve the quality of ward teaching and Halsbury (1974) recognised the need for a high level of competence from qualified staff supervising trainees. More recently the General Nursing Council's Educational

Policy document (1977) and European Economic Community's Directives on Nursing re-emphasise the need for concurrent teaching in the clinical area and the importance of correlating theory with practice. Other writers have also drawn attention to the significance of the ward sister in the socialisation of trainees (Sheahan,1978; Ford, Redmond, Roach, 1979).

From this brief historical résumé it will be apparent that the ward sister has always been regarded as an essential element in the training of future members of the profession. Logically she is the most suitable person to teach the skills of nursing both from her position as team leader and as an experienced nurse with knowledge and expertise to pass on. It is with regret, however, that many ward sisters feel they have to relinquish their teaching role in order to attend to the many other pressures upon them. Others state that they do not wish to teach, if they had 'wanted to go into teaching' they would have 'trained as a teacher and not as a nurse'. Yet others feel they would like to know how to teach, they are not sure they are 'doing it right'. Those with positive attitudes say time can be found in the working day if a sister wants to teach (see Chapter VI, page 107). There are, therefore, many conflicts surrounding the present system of training nurses.

SUMMARY OF CHAPTER II

From this brief résumé of the historical development of nursing and nurse education the following conflicts surrounding the apprenticeship system of training have been identified:

1. The difficulties of finding sufficient time and inclination for planning and implementing a structured programme of 'on the job' teaching.
2. The lack of correlation between the theory of nursing, as taught, and the realities of practice in the wards and departments. (There is a danger that this will get more problematic with the introduc-

tion of the nursing process.)

3. Inadequate preparation for the training function of a nurse manager's role.
4. The failure of the clinical teacher role to alleviate these problems.

Issues 1, 2 and 3 will be examined in more depth with a review of relevant literature in Chapter III.

CHAPTER III

TEACHING AND LEARNING ON THE WARD - a review of the literature

SERVICE v EDUCATION

At a time when nursing is developing rapidly, yet facing ethical, industrial relations and manpower problems never envisaged in its early history, it is inevitable that pressure to separate nurse training from service should arise once more. The Wood Committee's report published in 1947 was the first to recommend student status for nurses in training in order to alleviate the problem of a high wastage rate (Wood 1947). The Platt report published in 1964 also recommended the separation of nurse education from service as a matter of urgency in the reform of nurse education (Platt 1964). Neither of these recommendations has been acted upon.

Traditionally, as outlined in Chapter II, the emphasis in nurse training has been on practice as a worker in wards and departments with all the responsibilities that may ensue. To summarise a typical training programme: the statutory length of training is 156 weeks (3 years); this period is inclusive of 18 weeks' leave and approximately 25 weeks in study block. The term 'study block' refers to those periods of training spent in the classroom receiving tuition from nurse teachers. Study blocks are sandwiched in between periods of practical work experience in wards and departments. Where possible, subjects studied in the blocks are related to the practical work experience. When allocated to wards and departments, trainees work as a member of the nursing team under the control of service staff. The ward sister as team leader is the key fig-

ure in creating the ward learning climate (noted by Fretwell, 1979 and Orton, 1979). The quantity and quality of ward teaching tends to vary from ward to ward and depends upon the values, attitudes and orientation of the sister in charge; both Fretwell and Orton have identified wards with high and low trainee orientation.

> 'The hallmark of a high student orientation ward was the combination of teamwork, consultation and ward sister awareness of the needs of subordinates (Orton, 1979 p. 144 para. 2).

There is no doubt that trainee nurses do derive job satisfaction and professional motivation from their practical work experience. Wyatt, in comparing teacher training with nurse training, feels this is nurse training's greatest asset. He goes on to say:

> 'this is not an unmixed advantage, many difficulties arise from the unique combination of caring and learning and of the role of student and employee'. (Wyatt, 1978).

While those involved in all aspects of nurse training are only too familiar with the problems arising from the apprenticeship system, it is worth considering carefully the comments of a professional from another field of education. Dr.Bendall, a former Registrar for the General Nursing Council (Bendall, 1976), stresses that the motivation to care, good will and openness of the aspiring entrant to nurse training is a very precious asset. Unfortunately, Bendall states, this asset can be converted into ritualised responses and a pre-occupation with routine jobs instead of with people when training curricula are out of date or irrelevant.

WARD TEACHING

A review of the research literature shows that although numerous working parties, committees and individuals have explored various problem areas in nurse education, few studies have investigated teaching and learning as a process.

Research findings forming the background to the Report of the Committee on Nursing led the members of the Committee to conclude that:

> 'there is a widely held view within the profession that nurses must train among people needing nursing skills and not in the classroom'. (Briggs, 1972 paras. 204 - 255. Attitudes to Aspects of Education).

Furthermore, it is reported that this viewpoint was also taken by most of the major training bodies giving evidence to the Committee (paragraph 207).

The practical element in nurse training, then, would seem to meet with approval both from within and without the profession. There are, however, drawbacks to the system, one of which is that the needs of the labour force may take precedence over the training needs. There have been complaints from trainees that they have been allocated to wards that appear to bear no relationship to their training needs. In practice, however, this is less likely to happen today with more systematised approaches to allocation of trainees introduced in the last decade.

CORRELATION OF THEORY AND PRACTICE

To return to the Report of the Committee on Nursing (Briggs, 1972) another complaint noted was that

> 'there is little relationship between work in the ward and work in the nursing school'. (Briggs, 1972 para. 208).

This type of conflict can result in trainees developing dual standards, one for tutors and examiners and one for wards (Dodd, 1973). Two other studies were concerned with the relationship between theory and practice (Bendall, 1973, Hend, 1975). Bendall's study showed a lack of correlation between verbal descriptions of nursing behaviour, that is 'what I would do' and real observed nursing behaviour in 73% of

subjects studied. In other words, for the non-correlators, theory and practice were in two separate compartments. The ideal, as taught in theory in the nursing school, conflicted with the reality of practice in the wards. Hend's findings also highlight the conflict between nursing theory and the realities of practice on the wards.

Further evidence in the report showed a general dissatisfaction with quality of teaching on the wards.

ONE ASPECT OF TRAINING WHICH MOST NEEDS IMPROVING

	All trainees and recent trainees
Weighted base:	3,027
	%
The quality of teaching on the wards	32
The link between theory and practice	18
The supervision of practical work	17
The balance between learning and working	12
The time allowed for study	10
The length of training time on each ward	6
The quality of teaching in classes	4
Don't know	2

Source: personal interview survey.

Report of the Committee on Nursing table 15 page 67.

Other sources have also reported dissatisfaction with the quantity and quality of ward instruction. Lelean 1975, Lamond 1974, Pomeranz 1972, McGuire 1969, Revans 1964, Goddard 1963 and Catnach and Noughton 1961, found that ward sisters spent little time communicating face to face with trainees.

> 'Little formal training takes place on the ward situation, training often falls short of expectations, life is fraught with major and minor disasters which leave some students feeling that the hospital lacks regard for them as individuals' (McGuire 1969 p 87).

In the Lamond study, State Enrolled nurses, staff nurses and peers were found to be important figures in the transmission of nursing skills.

It would appear from a review of the literature that a confused and ambiguous situation exists. On the one hand there is an institutionalised opinion that nurses best learn their skills as workers at the bedside. On the other hand, research evidence to show that the quantity and quality of 'on the job' teaching leaves much to be desired. In spite of this apparently one-sided evidence most nurses, when questioned, can recall from their own experience, trained nurses from whom they learned a great deal.

In order to see more clearly how these ambiguities have arisen we need to consider the relative goals of education and service, and the conflicts arising out of these, in more depth.

A CONFLICT OF GOALS

Corrocan (1977) - writing of experience in the United States of America - observes that the major focus of the education system is on the future. The training school is concerned with the 'relative when', that is, developing skills and knowledge that will prepare the 'would be' nurse practitioner to care for future clients. The service area is concerned with the 'positive now' and trainees therefore have to function in an organised and relatively skilled effective manner from the beginning. Corrocan feels that these differences in operation can give rise to conflicts within the trainee and between the service and education divisions. Trainees may see the ward as where the 'real learning' takes place and school as a place to rest and recoup from their labours. A criticism often levelled at the training school by service staff is 'you don't send us nurses who can nurse any more!'

Has experience in American nursing circles, where full student status has been strived for and attained, failed to solve the problems of providing effective 'on the job' training? Nayer, in an article calling for unification of nursing service and nursing education, comments on the problems that have arisen following the separation of nursing education from service (Nayer, 1980).

> 'Educators began to complain about the lack of role models for their students and the declining quality of nursing care. Nursing service directors complained about the inadequacies of newly graduated nurses as competent care givers. It was obvious that educators and nursing service administrators needed to come together if patient care was to improve.'

British nurses need to consider carefully the comments at this critical stage in the development of nursing in the United Kingdom.

LEARNING FROM WARD EXPERIENCE

Corrocan draws attention to the fact that during the last decade educationalists have paid increasing attention to the relationship between real life experience and the process of learning. The idea of learning through reality is not a new one however, to quote from Dewey (1953)

> 'There is an intimate and necessary relation between the processes of actual experience and education, however experience and education cannot be directly equated, some experiences are miseducative'. (page 13).

There is no doubt that working in a service setting is a real life experience. Trainees are exposed from the beginning to the grim realities of practice. How far this experience is educative or mis-educative in achieving the desired outcomes of learning is open to question.

To summarise the positive aspects: the service setting provides trainee nurses with many role models. The importance of significant others in the process of socialising members into a society has been

noted elsewhere (Danzigger, 1970). With regard to nursing, studies have shown that trainee nurses place the ward sister high on the list of those from whom they would learn (Wyatt, 1979, Sheahan, 1978). The status ascribed to the ward sister role gives her a clear lead over others in gaining a trainee's attention.

Skills learned in theory in the nurse training school can be practised and reinforced in the real life, work situation. The wide variety of nursing problems encountered should provide ample scope for applying, synthesising and evaluating knowledge and skills acquired in the classroom.

The opportunity to help others and assume responsibility as a working member of the nursing team should help develop maturity in the trainee and smooth the transition from learner to professional practitioner.

The need of the learner to achieve status within that team also acts as a motivator to the acquisition of more knowledge and skills. These are the positive aspects of learning from work experience; there are, however, negative aspects.

For Dewey, an experience which is worth while educationally is one which takes places in an environment which promotes growth in general. This is an environment that encourages observation, investgation and experimentation, and promotes curiosity, questioning and risk-taking within appropriate limits. The experience should build on a student's previous experience. It could be argued that nurses are left to experiment and take risks with nursing care when left in charge on night duty, for example. This is usually a covert activity carried out with the expediency of 'getting the work done' rather than as a learning experience. The results of the experiment are rarely dis-

cussed with an experienced nurse and therefore cannot be called educative. Dewey goes further to say if the experience does not fulfil these requirements the results will be miseducative resulting in

> 'callousness, lack of sensitivity, increased automatic skills, dissipated energy, dis-integrated habits and inability to control future experiences'. (Dewey, 1953 page 25).

Other educationalists also stress growth. Sexton and Ungerer (1975) state the results of an effective learning experience are

> 'increased power and growth, informed conviction, sympathetic attitudes of understanding in learning how to face and meet new experiences with some sense of mastery, without fear or panic or relying on the treadmill of 'blind routine!' (Sexton and Ungerer, 1975 page 20).

Bearing in mind the words of Dewey on miseducative experiences, the question 'how far does the service environment, activities and atmosphere meet the criteria of an effective learning experience?' needs to be raised. The conflict of emphasis outlined in preceding paragraphs can create an environment that is not growth-promoting. A trainee nurse does not have the right to experiment at the expense of the patient. She cannot afford to fail; a trained nurse must intervene on behalf of the patient if a wrong choice is made. Often the fear of failure may prevent a trainee from exploring, investigating, experimenting and thereby learning. There is little control that can be exerted in the ward environment over ends (outcomes of learning) and means (learning experiences). At present there is also general vagueness over what objectives can be achieved in the ward setting. These, if specified at all, are often presented in terms of nursing experiences available rather than skills to be achieved.

With regard to role models, to reiterate, the service environment provides the trainee with many role models, but how does she pick an appropriate one? Wrong attitudes and skills can be acquired,

'The impact of what is 'seen to be done' may be greater than what the trainee is learning she 'ought to do''(Corrocan, 1977).

Many questions arise around reinforcement, restructuring and transfer of knowledge and skills. When a great deal of interesting and exciting activity is going on, the trainee may be distracted from the learning objectives on hand. These activities may not build on past experiences; the trainee may not be ready for them. Alternatively she may be wasting too much time on skills already mastered. The trainee, to put it bluntly, may be overworked or bored.

What is learnt on the wards is likely to be a practical solution to a particular problem. The solution may be a good one but also may be only the best available at the time. Frequently the time factor operating in the service setting leaves the trainee's questions unanswered, her curiosity unsatisfied. Unless trained staff are exceptionally sensitive and make time after an event to talk the trainee through the options, the chance for restructuring knowledge is lost. (Chapter VI page 81).

The advantages of learning from work experience need to be weighed very carefully against the disadvantages in the search to find solutions to the problems arising from the present system of training nurses.

SUMMARY OF CHAPTER III

In this chapter the conflicts surrounding the apprenticeship system have been examined in more depth under the following headings:

1. Education versus service

   Historical aspects of the conflicts surrounding the apprenticeship system of nurse training were reviewed. Particular attention was drawn to the thoughts of two contemporary writers on the subject, one within and one without the nursing profession. Reference is made to current literature from the United States on this issue.

2. Ward teaching

   Research findings were reviewed which led to the conclusion that an ambiguous situation exists i.e. on the one hand an institutionalised opinion exists that nursing is best learnt on the job and on the other there is research evidence to show there is dissatisfaction with the quality and quantity of ward teaching.

3. Conflict of goals

   Goals of the education and service divisions were examined in the light of the ambiguities linking these to early and contemporary educational views on learning from experience.

4. Learning from ward experience

   The positive and negative aspects of learning from experience were reviewed from the perspective of the researcher's own experience as a ward sister, then nurse teacher, and the review of the literature.

CHAPTER IV

THE PROCESS OF LEARNING AND TEACHING -

a review of the literature

INTRODUCTION

In reviewing the nursing literature on ward teaching and learning, a number of questions came into mind. Firstly, what was meant by learning in the context of ward teaching? What factors aid or inhibit learning from ward experience? What activities do trainees perceive as teaching? What do they feel they lack in ward teaching? What do trained nurses acknowledged to be good at teaching do? Where do their ideas on teaching methods originate?

Little evidence exists that any of these questions has been investigated in the nursing field at the time of the initial literature survey. The exceptions were the Bendall study quoted in Chapter III; and a study by Nolan (Nolan, 1973). Nolan, investigating methods of teaching human biology, writes:

> 'telling does not result in effective learning; unless what we learn becomes a necessary and useful part of our functioning as individuals we quickly forget it, we learn through experience'.

Nolan's study, however, was limited to teaching in the classroom.

Turning to general education, the past twenty years have seen the emergence of 'new' philosophies and/or approaches to teaching (Rogers, 1969). Some educationalists take up a stance for one philosophy or theory and reject others. This tendency has also been noted in nurse education (Marson, 1979). In the light of these developments and the issues raised in the first paragraph, it was decided to include a more detailed review of teaching and learning theories than was originally intended.

LEARNING

On the whole the lay person tends to hold a simplistic view of teaching and learning. Learning is rarely seen as problematic and teaching is seen as a process of telling, showing, praising and punishing. When children fail to learn, teachers are frequently blamed. Teachers, however, tend to blame 'lack of motivation' or 'the system' when pupils fail to learn.

The same may be said of nurse education. When trainee nurses fail to meet expectations tutors can be blamed for being out of touch with reality. Trainees are also sometimes labelled as lacking in motivation or self discipline. What then is learning?

The Oxford English Dictionary defines learning as:-

> 'to get knowledge of (subject) or skill in (art etc.) by study, experience or being taught'.

Webster's International Dictionary:-

> 'to acquire (as a skill or habit or modification of an existing habit) through experience or practice'.

Edicts on teaching and learning can be found in early history. The writings of Quintillan, a Roman Orator, (AD 35-100 Treatise on the training of the Orator) foreshadowed the work of the twentieth century behaviourist school of psychology in that the techniques of behaviour shaping are clearly described in his work. It is only within the last three hundred years, however, that more or less systematic theories of learning have emerged, with a proliferation in the twentieth century. The last twenty years have been particularly fruitful in empirical studies in teaching, some catalysed by the programmed learning movement (Hartley, 1974). Bigge (1976) also commenting on this proliferation notes that as 'new' theories of learning emerge to challenge existing ones they are:-

> 'typically not translated into school practice until between 25 and 75 years have elapsed. As a new theory comes to affect school policy it does not displace its predecessor, it merely

Bigge also goes on to say that the way a 'teacher' builds his curriculum, selects his material and chooses instructional techniques depends on how she or he views learning. Whilst this may be true of some nurse teachers, little evidence exists in nursing literature to confirm this viewpoint in regard to ward teaching.

CONTEMPORARY THEORIES

Psychologists take a different view of learning from the compilers of dictionaries. Gagné (1970) defines learning as follows:-

> 'a change in human disposition or capability which can be retained and which is not simply ascribable to growth'.

Gagné goes on to say

> 'The kind of change called learning exhibits itself as a behavior, and the inference of learning is made by comparing what behavior was possible before the individual was placed in a "learning situation" and what behavior can be exhibited after such treatment. The change may be, and often is, an increased capability for some type of performance. It may also be an altered disposition of the sort called "attitude", or "interest," or "value." The change must have more than momentary permanence; it must be capable of being retained over some period of time. Finally, it must be distinguishable from the kind of change that is attributable to growth'.

diversity and its permanence.

The Gestalt field psychologists describe learning in somewhat different terms. Bigge, reviewing differing learning theories, says of Gestalt field theories,

> 'They regard learning as a process of developing new insights or modifying old ones. Insights occur when an individual in pursuing his purposes sees new ways of utilizing elements of his environment including his own bodily structure. The noun 'learning' denotes the new insights or meanings that are acquired (Bigge, 1976 page 95).

The Gestalt field psychologists would seem to challenge the behaviourist view that a change in behaviour is the learning:

out so much behaviour' [1].

In other words learning can be viewed as a process as well as a product.

An approach to teaching and learning known as the cognitive process theory has grown out of Gestalt field psychology.

Carl Rogers (1969), a humanistic psychologist, defines the elements involved in what he terms experiential learning, that is, learning from experience rather than being taught.

> 'It has a quality of personal involvement, the whole person in both his feeling and cognitive aspects being in the learning event. It is self-initiated. Even when the impetus or stimulus comes from outside, the sense of discovery, or reaching out of grasping comprehending comes from within, it is pervasive. It makes a difference in the behaviours, the attitudes perhaps even the personality of the learner. It is evaluated by the learner. He knows whether it is meeting his need, whether it leads towards what he wants to know, whether it illuminates the dark area of ignorance he is experiencing. The focus of evaluation we might say, resides definitely in the learner. Its essence is meaning. When such learning takes place, the element of meaning to the learner is built into the whole experience'. (page 5)

Rogers emphasises the meaningfulness and significance to the learner of this type of learning. He also suggests that schools locked into a traditional and conventional approach make 'significant' learning improbable if not impossible.

There would appear to be general agreement among educational psychologists that a change in behaviour constitutes evidence that learning has taken place. The change in behaviour may be overt and readily observed as in practical skills or covert, that is, a change in thinking processes or attitude. Where the theorists disagree is in the labelling of the actual changed behaviour as learning, some theorists insisting that the change is not the process of learning, only the product.

LEARNING THEORIES IN FOCUS

Bendall (1977), writing of the future of British Nurse Education, argues that an application of Gagné's approach will turn the syllabus

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1. Rollo May. Psychology and The Human Dilema, New York. Van Nostrand Reinhold, 1967 page 126.

practice.

> 'In my view Gagné's theories are totally applicable for teaching the large part of the nursing syllabus. It means that the learner starts in reality, discovers and discriminates; is helped to categorise and in discussion with the teacher, builds categories into rules or principles, with the teacher feeding in extra essential knowledge at this stage. If a teacher of nursing follows this theory he or she will automatically reactivate his own skills as a practitioner, will help to turn a syllabus into a curriculum and will discover the real'.

Gagné's work has made a major contribution to learning theory. Bigge describes Gagné's approach as a behaviourist eclectic approach to the psychology of learning. Bigge goes on further to say:-

> 'his (Gagné's) conditions of learning are often employed by methodologists and curriculum specialists to implement the achievement of the stated performance objectives of their behaviouristic, eclectic methologies. Hence Gagné's psychology often is used to underpin the mechanistic instructional technology that is associated with behaviour modification and performance or competency based education.' (Bigge 1976, p 168).

BEHAVIOURISM

To summarise - the central theme of this school of learning is the concept of behaviour as a response to a stimulus.

The implications are that specific responses can become linked to specific stimuli by a process known as conditioning and that the process can be used to modify and shape behaviour. These links are thought to be biological, that is synaptic changes in the nervous system. From the studies of animal behaviour Thorndike formulated a number of laws of learning, which are worth a second look; (Thorndike, 1949).

1. The law of readiness. Thorndike postulates that because of the structure of the nervous system, in a given situation certain groups of neurones are more predisposed to conduct than others.

This is certainly true of the learning that takes place due to maturation.

2. The law of exercise or repetition. This law postulates that the more times a stimulus induced response is repeated the longer it will be retained. This is certainly true of learning psychomotor skills, how far it can be related to cognitive learning is debatable. Repetition has been found to have little effect on the learning of concepts (Davies, 1971).
3. The law of effect. This law of Thorndike's makes explicit the pleasure-pain principle, that is, a response is strengthened if followed by pleasure, weakened if followed by pain or displeasure.

Critics of the application of these laws to human learning may say firstly that they are very mechanistic, secondly they seem to leave out any sort of thought insight or purpose of action in man or animal. The work of the early behaviourists has been developed and applied to human learning, however, the most influential being Skinner as previously mentioned and Gagné (Skinner 1954, Gagné 1970). In the researcher's experience Skinner's and Gagné's work appears to have had far-reaching effects on vocational training; general and higher education, however, have not been influenced to the same extent.

In the light of Bendall's statement, page 26, Gagné's theories of learning are summarised briefly. He distinguishes eight stages of learning from most basic, that is, learning to respond to a signal, to the most complex act of learning to solve problems. Gagné emphasises the hierarchical nature of each of the eight stages; that is, the simpler stages serve as pre-requisites for the more complex acts. The conditions for learning chains, for example, are that the individual must previously have acquired the stimulus-response connections which

form the chain.

Gagné recognises that there are some psychological problems of great importance to education that cannot be solved by applying his conditions of learning.

> 'The reader needs to be made aware also that there are some problems of great importance to education which cannot be solved by applying a knowledge of the principles of learning as they are here described. For example there are many aspects of the personal interaction between a teacher and his students that do not pertain in a strict sense to the acquisition of skills and knowledges that typically form the contents of a curriculum. These varieties of interaction include those of motivating, persuading and the establishment of attitudes and values' (Gagné, 1970).

While basically agreeing with Bendall's view of the application of Gagné's theories[1], I would challenge the statement 'Gagné's conditions will help nurse teachers discover the 'real'.' A variety of approaches may be necessary to achieve the goal of training for reality, behaviourist, cognitive and humanistic.

COGNITIVE FIELD THEORIES

Bigge, in his book Learning Theories for Teachers, differentiates between behaviourist and cognitive field theorists in the following way:

> 'Whereas a behaviourist teacher desires to change the behaviours of his students in a significant way, a Gestalt (cognitive) field oriented teacher aspires to help students change their understanding of significant problems and situations'. (pp 11-12).

Turning to Bruner, probably the most well known of contemporary educationalists, it would appear that one of his major concerns is the means by which people actively select and retain information. He is interested in what they do with information and with how they go beyond apparently unrelated bits of information to

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(1) Gagné's types and pre-requisites for learning can be applied to nursing as my own 12 years' experience in developing, or teaching others to develop, packaged learning material has clearly demonstrated. (See Appendix A page I).

achieve generalised insight or understanding.

> 'Subjects do not mechanically associate specific responses with specific stimuli but rather tend to infer principles or rules underlying the patterns which allow them to transfer their learning to a different problem'. (Bruner and Anglin, 1973, pages 421-422).

There are two recurring themes in Bruner's work -

- the acquisition of knowledge as an active process
- the construction of knowledge through relating incoming information to a previously acquired psychological frame of reference.

Thus cognitive field learning approaches are based in Gestalt psychology*. The emphasis is on the learner gaining insight by seeing for himself the whole conceptual pattern of what he is learning. "Things suddenly clicked into place" is often a verbal reaction of a learner who after a period of working hard, thinking, puzzling, suddenly recognises a conceptual pattern.

SUMMARY

According to Bigge (1976) twentieth century learning theories can be divided into two broadly based categories of behaviourist and cognitive field theories. The third category based on humanistic psychology, perhaps more rightly described as a philosophy rather than a theory, will be described more fully in the section on 'The Process of Learning'.

Behaviourists see man as a biological organism centred in his environment and the emphasis is on observable behaviour and single units, that is, one individual one stimulus, one response, one reinforcer. Cognitive field theorists stress the psychological aspects of man and are concerned with overt behaviour only so far as it gives indications as to what is happening psychologically. They also deal with the concept of a person in his total environment.

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*NB This school of psychology arose out of the German philosopher/psychologist's view, first stated in 1912, that an 'organised whole is greater than the sum of its parts'.

The application of learning theories to the teaching of nursing practice highlights the inadequacy of the extremes of either of the two schools of learning theory. Both theoretical approaches have a sound basis in logical thought and experiment and a high rate of success when translated into educational practice (Marson, 1974). To adhere rigidly to one theoretical approach to the exclusion of the other when planning learning experiences is to deny the multi-face nature of human learning (for behaviourism versus humanism see Marson, 1979). In the researcher's opinion it would seem that nurse teachers and trainers need to be educational eclectics choosing from both schools of thought those parts that seem the most reliable, practical and appropriate to the objectives which need to be achieved. Before this can be done, however, there is a need to find areas of agreement about learning that span both schools of thought. The next section, Process and Conditions of Learning, will review these common areas in order to apply a theory of learning to the ward environment.

THE PROCESS OF LEARNING

The process of learning has been described as having distinguishable phases, each phase being associated with internal states or capabilities in the learner. The process is supported by events occurring both outside and inside the learner, that is, events in the environment and physiological and psychological changes in the individual. The two major schools of learning theory describe the process of learning somewhat differently but there are in fact many similarities.

To reiterate, behaviourists see learning in terms of the stimulus - response bond and the emphasis is on events external to the learner. This type of learning is distinguished from classical conditioning in that the reinforcing stimulus occurs not simultaneously with, nor preceding, the response but following the response. In other words the organism must first make the desired response and then a reward is provided. The response is instrumental in bringing about its reinforcement. The essence of learning, therefore, is not stimulus substitution as in classical conditioning but response modification. In learning there is feedback from the reinforcing stimulus to the previous response.

stimulus ⟶ response ⟶ reinforcement ⟶ feedback

When the required response has occured, the application of a reinforcer will increase the probability of that response being repeated. Witholding reinforcement will gradually diminish the probability of it being repeated and eventually lead to extinction of that particular response.

When a learner makes a correct response a teacher may acknowledge his choice by verbal approval, 'yes, that's right', 'very good', and so on; non-verbal reinforcers are often in the form of smiles and nods. In this way a teacher reinforces the correct response. Skinner (Skinner, 1967) has this to say of the use of approval as a reinforcer;

> 'A common generalised conditioned reinforcer is approval. It is often difficult to specify its dimensions. It may be little more than a nod or a smile on the part of someone who characteristically supplies a variety of reinforcements ... because signs of approval frequently precede specific reinforcements appropriate to many states of deprivation. The behaviour they reinforce is likely to be in strength most of the time'. (p. 54)

conditions necessary for the reinforcement of behaviour. One is the learner's attitude toward the reinforcing agent, the second is the pattern of reinforcement. This view is also expressed by Danzigger (1970) who states that:

> 'Socialisation is the product of the reinforcement history of the individual in particular situations'.

Most of the studies reviewed by the researcher on reinforcement as a factor in learning, were carried out in the laboratory by behavioural scientists. (Skinner 1967, Craig 1966, Van Wagenen 1963). The problem in shaping human behaviour in the real life situation, would seem to be finding the appropriate stimulus to raise the desired response and appropriate reinforcers. The use of reinforcement in the teaching of nursing would, therefore, be the subject of a study in its own right.

Other behaviourists have enlarged upon the simple S-R-R- model. Gagné (1975) in his book Essentials of Learning for Instruction - Chapter II The Process of Learning contends that -

> 'learning occurs as a result of the interaction between a learner and his environment. We know learning has taken place when we observe that the learner's performance has been modified'. (page 25)

He goes on the say that it is possible to identify some common characeristics in learning to perform skills as diverse as learning to ride a bicycle or solving mathematical problems, he distinguishes between events external to and events internal to the learner. The internal events are termed processes and Gagné distinguishes 8 phases in the act of learning and the associated processes (see figure I, page 33).

To enlarge upon these phases:-

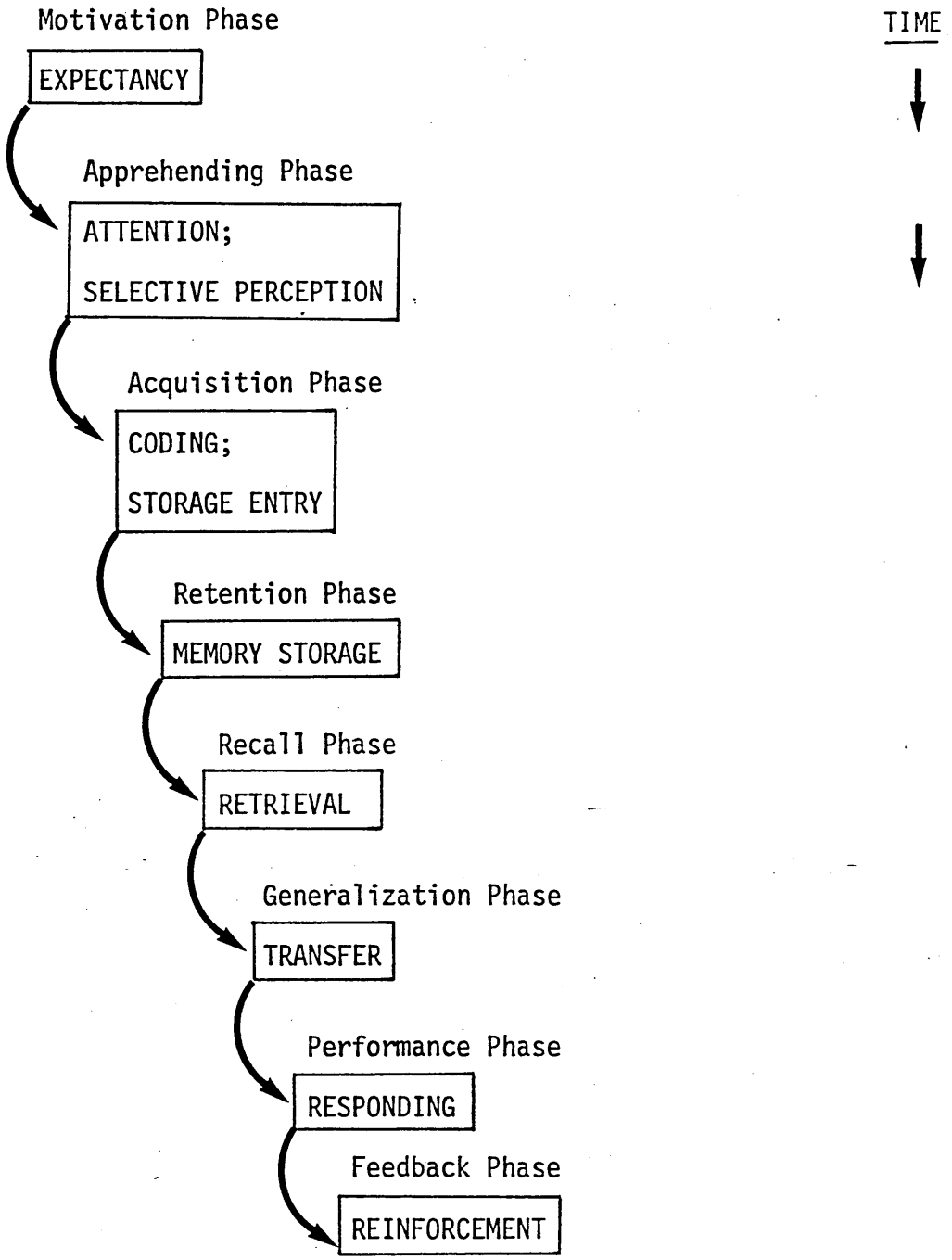

FIG. I

The phases of an act of learning, and

the processes associated with them.

Gagné R M (1975) Essentials of Learning for Instruction, p 28.

Motivation Phase

It is true to say that in order for learning to occur there must be a motivation to learn within the individual. There are many drives which motivate human behaviour;some are relevant to teaching and learning,some are not. The type of motivation we are dealing with in learning is primarily incentive motivation,that is, a striving to achieve some sort of goal, the achievement of which carries some reward for the individual. An individual enters nurse training in order to achieve the goal of a recognised qualification, state registration or state enrolment for example. Other terms applied to incentive motivation are 'achievement motivation' or 'urge for mastery'. Some psychologists view it as a basic human drive to manipulate, dominate and 'master' the environment. (White 1959).

Establishing motivation. Gagné draws attention to the fact that the learner may not be initially motivated by the incentive of achieving a goal; in this case motivation must be established by generating expectancy in the learner,that is,the anticipation of the reward he will receive when he does achieve some goal. To relate this process to the nurse learner: while the primary incentive is the achievement of the goal of state registration or other relevant qualification, incentives may be lacking to achieve intermediate goals. That is some nursing experiences may not be seen to be relevant. The ward sister/charge nurse has an important role to play in generating expectancy within the learner of the goals that can be achieved from a particular work experience.

Apprehending Phase

A motivated learner needs to attend to the stimulation arising from a potential learning experience in order to process the incoming

information. This may involve one or all of the senses - sight, touch, smell, hearing and/or the kinaesthetic sense. The process of attending is conceived as a temporary internal state called a mental set. Once established, the set acts, alerting the individual to be receptive to certain kinds of stimulation.

Once a mental set is adopted it determines what aspects of the external stimulation are perceived by the learner; the external features need to be distinguished or discriminated. In other words the registration of stimuli by the learner becomes a matter perhaps of selective perceptions, guided initially by a teacher or more experienced worker, or by other cues, either written or recorded. Eventually selective perception arises from within from previous learning and experience.

Acquisition phase

Once the external situation has been attended to and perceived, learning can proceed. The learning incident, transformed into an entity meaningful to the learner, passes into short term memory, later to be further transformed into a more persistent state and transferred to the long term memory.

Many studies have been done which show that what is stored in the short term memory is not an exact replica of what was directly perceived the material presented seems to be distorted in some way, sometimes simplified, sometimes embellished.

Coding. Further transformation of the retained material needs to take place in order to ensure long term retention; this is referred to as coding. The incoming information is classified and linked to previously learned concepts or simplified into a principle to ensure greater retention. Teachers use many tactics to aid retention; the use of mnemonics, paired associates and diagrammatic representations are some examples. (Russell, 1979)

Retention Phase

Less is known about long term memory; it would, however, seem to be almost limitless. Some things we learn seem to be stored with undiminished intensity throughout the years, others undergo gradual fading. It was once thought that newer memories obscured older ones. It is now not certain that this is an effect of memory storage; it may be a problem of retrieval. (Adams, 1967)

Recall Phase

To return to the definition of learning (see page 24): an act of learning must include a phase in which the learning can be recalled and exhibited as a 'performance'. If learning is not demonstrable then we cannot say it has taken place. The process is called retrieval. Sometimes the learner may need to have a cue to jog his memory. Retrieval cues seem to be more effective when used as a strategy to aid initial learning.

Generalisation Phase

Retrieval of what is learned does not always occur in the same situation or within the same context as the original learning took place. Once the principles of asepsis have been learned a nurse should be able to apply these to any situation; this is known as transfer of learning.

Since transfer should be the goal of any learning, then instruction should include strategies to ensure retrieval in as great a variety of contexts as possible.

Performance

This phase is reasonably straightforward. When all phases have been accomplished the learner should be able to organise his responses in a way that allows him to demonstrate what he has learned. This prepares the way for the important function of feedback.

Feedback Phase

Once the 'new' learned performance has been demonstrated the learner can perceive whether or not the goal has been achieved. This informational feedback may be evident in the task itself, for example lowering of a patient's temperature following a tepid sponge, or may be supplied by the teacher. To behaviourists this is the essence of the learning process which is known as reinforcement.

With regard to the external events that critically influence learning, Gagné has this to say:-

> 'Even though the processes of learning are not directly observable they nevertheless can be subjected to influences from the learners environment. This is what a 'learner situation' amounts to in practice;the 'teacher' brings to bear certain external factors which influence the processes of learning. Thus events may be made to occur which affect motivation of the learner, his attention or any of the other processes'. (Gagné 1975, page 29)

The way in which Gagné relates learning phases to instructional events is illustrated in figure II overleaf.

There would seem to be, then, four main ways of influencing the learning process: by direct presentation of stimuli, by activating mental set to learn, by stimulating recall and by providing reinforcement in the feedback phase. The last three would seem to be most applicable to learning 'on the job', (the use of reinforcement is discussed in more depth in Chapter VII - Reflections, Implications and Recommendations page 151)

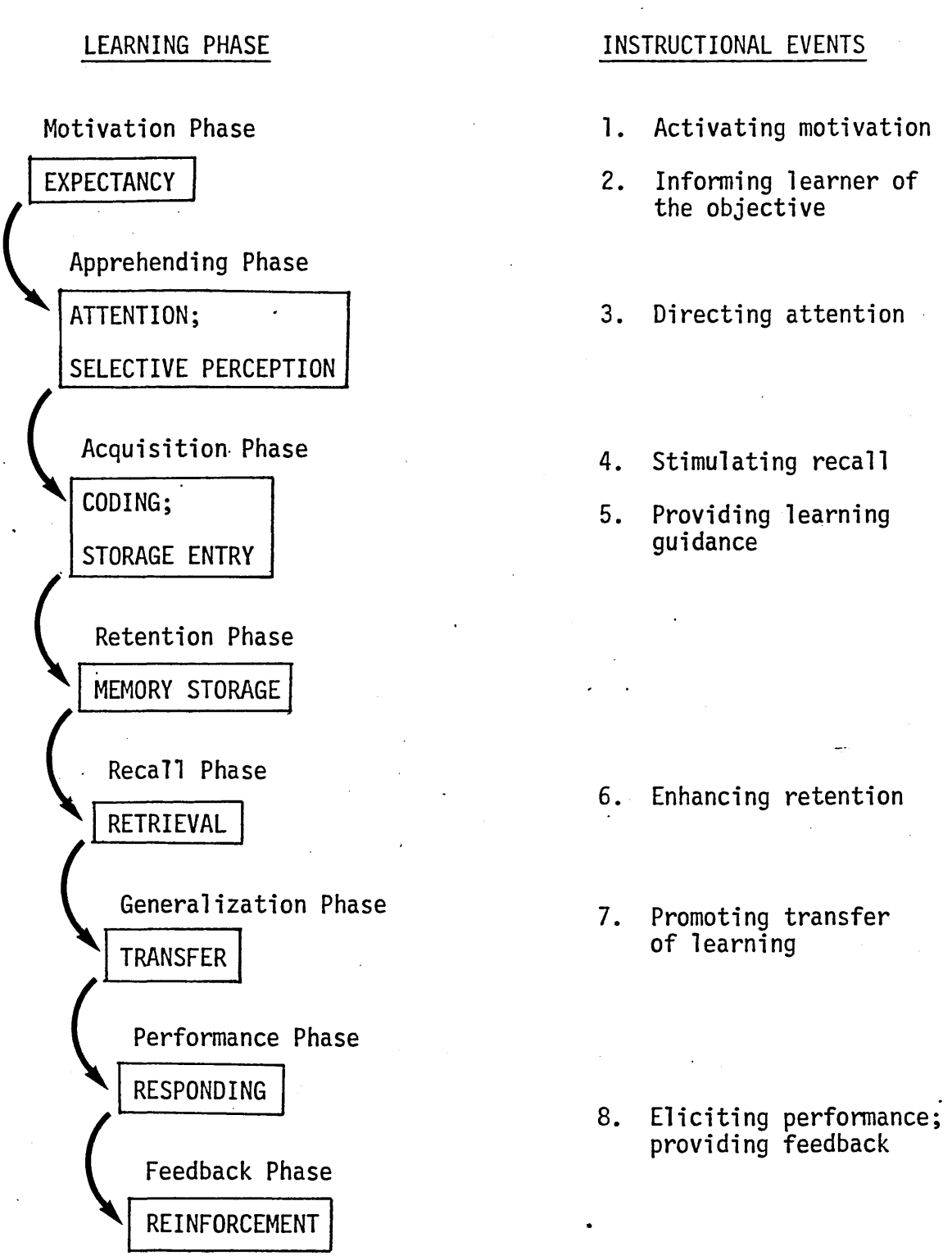

FIG. II

Relation of the phases of learning

to instructional events.

Gagné R M (1975) Essentials of Learning for Instruction, p. 119.

THE COGNITIVE VIEW

For Bruner, learning is a process of connecting things and events that have features in common and linking them into structures that have a significance for the learner. He sees this as an active process of construction rather than a passive one of reception.

Bigge commenting on Bruner's cognitive psychology approach to learning and teaching,

> 'Learning at its best is thinking and thinking is the process whereby one makes sense of a hodge podge of perceived facts through a process called either conceptualisation or categorisation'. Human beings from an early age have a remarkable capacity to discriminate objects and processes in the environment and to categorize these'. (Bigge, 1976, p. 254).

Any parent of a young child is aware of this. Children are capable of processing large amounts of information about the inhabitants of their environment e.g. cars, aeroplanes, trains etc.

The theme throughout Bruner's work is that a thinker can rarely describe the process by which he reaches his thought goal. Sometimes it can be described in a fragmentary and therefore misleading way and at others it is thought that the answer came in a flash of insight. Inability of a thinker to verbalise the process by which he has learned does not mean that nothing describable has occurred. There has been a lengthy series of acts weighing evidence and making decisions that the thinker performed at a non-verbal level.

THE ACT OF LEARNING

Bruner writes of the act of learning which he sees as consisting of three almost simultaneous phases.

1. 'First there is acquisition of new information - often information that runs counter to or is a replacement for what the person has previously known implicitly or explicitly'.

When teaching the structure and function of the alimentary tract, for instance, students may have difficulty in grasping the concept of the tract as a continuous tube. They may have vague knowledge of the individual parts, for example, the stomach or the colon, but may not have considered the digestive system as an integrated whole.

2. 'A second aspect of learning may be called transformation - the process of manipulating knowledge to make it fit new tasks'.

In other words we analyse information in a way that permits us to deduce further facts from the data or to convert the data to another form

'we deal with the information in order to go beyond it'.

3. 'A third aspect of learning is evaluation. Checking whether the way we have manipulated information is adequate to the task'. (Bruner & Anglin 1973, page 421).

Bruner suggests that a teacher may be crucial in helping with evaluation.

Bruner's three phases would appear to be analogous with Gagné's 'acquisition' and 'feedback' phases of the learning process; while Gagné's model would seem to be applicable to all kinds of learning, Bruner's has its main application to the acquisition of knowledge.

A HUMANISTIC VIEW OF LEARNING

A different view of the learning process is taken by Carl Rogers (1969) as a humanist. Rogers' work is increasingly influencing teaching practices in higher education. Rogers described two kinds of learning, that which involves the mind only, and learning that involves the whole person or <u>significant learning</u>. He feels teachers

'fail to recognise that much of the material presented to students in the classroom has,for the student, the same perplexing meaningless quality that learning a list of nonsense syllables has for us', (p. 3)

the material has no relevance for the whole person. He contrasts this with significant, meaningful or experiential learning as it is sometimes termed:-

'The child who has memorised two plus two equals four may one day in his play with blocks or marbles suddenly realise that two and two does make four'. (p. 4)

To re-iterate, the elements involved in significant or experiential learning are defined by Rogers as follows:-

'It has a quality of personal involvement the whole person in both his feeling and cognitive aspects being in the learning event.
It is self initiated. Even when the impetus or stimulus comes from the outside the sense of discovery, of reaching out of grasping, comprehending comes from within. It is pervasive. It makes a difference in the behaviour, the attitudes, perhaps even the personality of the learner. It is evaluated by the learner. He knows whether it is meeting his needs, whether it leads towards what he wants to know,whether it illuminates the dark area of ignorance he is experiencing. The locus of evaluation,we might say, resides definitely in the learner. Its' essence is meaning. When such learning takes place the element of meaning to the learner is built into the whole experience'. (p. 5)

For Rogers,then, learning becomes meaningful when it involves the whole person,feelings as well as cognitions (see chapter VI page 80 significant learning events). It is self initiated and self evaluated.

If significant learning is the aim of education, what are the processes by which it comes about?

Rogers outlines a number of principles culled from his own and others' current research and experience in facilitating* learning.

1. Human beings have a natural potentiality for learning. (p. 157)

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* Rogers prefers to use this term instead of the more traditional one i.e. teaching.

Rogers feels that this natural curiosity and eagerness to learn about the world can be blunted by our educational system. Many nurse teachers will sympathise with this view. They will no doubt have experienced the effect the 'system' can have on some youngsters who initially entered nurse training 'fresh' and eager to learn. Fortunately many retain their commitment in spite of the system, and often go on to become innovators of nursing care.

2. Significant learning takes place when the subject matter is perceived by the student as having relevance for his own purpose. (p. 158)

Evidence from nursing literature along with personal experience would seem to support this principle.

3. Learning which involves a change in self-organisation, in the perception of oneself, is threatening and tends to be resisted. (p. 159)

To comment, the rapid rate of social and technical change society is undergoing means the individual is constantly having to re-examine his values. Any learning arising out of the dilemma of conflicting value systems is painful and involves a change in the structure of self. Trainee nurses are more likely to meet such conflicting ethical and moral issues today; how are we to help them learn from these experiences? The profession is just beginning to appreciate that helpers also need help. (Ashton, 1979).

4. Those learnings which are threatening to the self are more easily perceived and assimilated when external threats are at a minimum. (p. 159)

What Rogers is referring to here is the need for a supportive understanding climate to allow learners to develop to their full potential (a supportive climate is not synonymous with a permissive one). Rogers quotes an example of a class of delinquent intellectually retarded boys who made rapid,remarkable strides in educational achieve-

ment when placed in a supportive climate with an understanding teacher (Williams, 1930).

5. When threat to self is low, experience can be perceived in a differentiated fashion and learning can proceed. (p. 161)

This principle is an extension or explanation of the previous one. The question must be raised here 'how far are trainees encouraged to express positive and negative feelings about their work with patients and colleagues, without fear of censure?' Would the ability to do so help them integrate and learn from work experience?

6. Much significant learning is acquired through doing.

'Placing the student in direct experiential confrontation with practical problems, social problems and personal issues is one of the most effective modes of promoting learning' (p. 162)

The trainee nurse faces these sorts of problems from the commencement of her training. How far do we help her solve them and how often is she given a ready-made solution?

7. Learning is facilitated when the student participates responsibly in the learning process. (p. 162)

By participating responsibly, Rogers means the learner chooses his own directions, discovers his own resources, formulates his own problems, decides his own course of action and lives with the consequences of his own choice. With the introduction of the Nursing Process approach to Nursing we have a tool to allow the nurse to participate in her own learning in the Rogerian sense. We must consider very carefully,however,the statement,

'lives with the consequences of his own choices'

How far can we go along this road in a profession such as nursing?

8. Self-initiated learning which involves the whole person - feelings as well as intellect - is the most lasting and pervasive. (p. 162)

learning which can be profound and pervasive, particularly if it is cognitively appraised and internalised.

9. Independence, creativity and self-reliance are all facilitated when self-criticism and self-evaluation are basic and evaluation by others is of secondary importance. (p. 163)

This principle is of great importance to nursing if it is to emerge into full professional status. Nurses must learn to be accountable for their own actions, and to critically evaluate their own performance.

10. The most socially useful learning in the modern world is the learning of the process of learning, a continuing openness to experience and incorporation into oneself of the process of change. (p. 163).

Rogers makes the point that 'if our present culture survives it will be because we have been able to develop individuals for whom change is the central fact of life'.

Rogers' principles of learning must surely give nurse educators and trainers (and in this must be included service staff) much food for thought. It may be pertinent to ask: 'Are the teachers of today teaching the nurses of tomorrow with the tools of yesterday?'*

It would seem from this brief résumé of learning theories and the processes and conditions of learning that there is some, but no conclusive, evidence as to which instructional process would be best for a particular set of circumstances. There are no universally agreed laws or rules that govern the learning process and how best to facilitate it. The very complexity of learning and the range of individual differences among learners** precludes any such definitive set of rules.

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* Quotation source unknown.

** The fact that not a great deal of space has been devoted in the text to differences among learners does not mean that these are discounted. The researcher sees that differences in learning styles could well form the subject of a separate study. The focus of this study is teaching behaviour and its relation to learning.

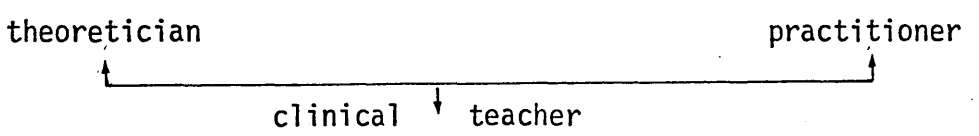
What would seem to be important is that a teacher should be aware of personal values and beliefs and how these affect teaching and have a knowledge of the differing learning theories on which to base appropriate teaching strategies. In the researcher's opinion the work of Gagné and Bruner complement rather than conflict. Gagné's emphasis is on the end product of learning and the most efficient way of achieving this. Bruner's is on the process and as such is more rightly the province of the qualified nurse teacher rather than the clinical specialist. The work of Gagné can be, and indeed has been, applied to learning on the job. Rogers' philosophy has yet to be explored and evaluated in the field of nurse education; with its emphasis on experiential learning however, it would appear to have much relevance to ward teaching.

MODELS OF TEACHING

WHAT IS TEACHING?

Chapter I traced the origins and historical development of the 'teaching' role of trained nurses. The publication of the Royal Commission on Nursing (Briggs, 1972) coupled with the evolution of the Nursing Process philosophy (McFarlane, 1977) has re-emphasised the teaching role of trained nurses. There is also a growing awareness of the role nurses could and do play as health educators for the general public. What, however, is meant by 'teaching', who 'teaches' whom', what is being 'taught' and 'how'?

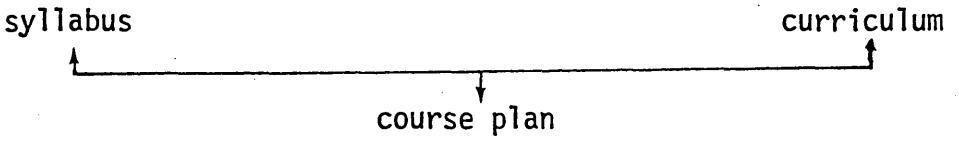
In answer to the question 'who teaches nurses?', we need to include such professionals as doctors, para-medicals, clergy and management lecturers, to name a few. All of these groups make an input into nurse education, at both basic and post-basic levels. To turn to the 'teachers of nursing': Bendall (1977) has described them as being on a continuum from theory to practice.



Teachers of nursing include the theoreticians, i.e. nurse teachers who have undergone a one or two year course of teacher training, who teach but do not practise nursing. Nurse theoreticians have regular contact with trainee nurses for about 20% of their training period. For the remaining 80% of the time nurse learners are under the control of clinical staff who are practitioners, not qualified instructors. Practitioners may or may not 'teach'. In the middle are clinical teachers who have no formalised role as practitioners, neither are they seen as theoreticians.

Hence, Bendall sees the problem of dualism arising in nurse training, one standard for the school and one for the wards.

In looking at what is being taught, Bendall sees the continuum as one of from syllabus to curriculum.



A syllabus can be defined as a list of topics to be included in a course; a curriculum as a prescription for a set of integrated learning experiences organised around a conceptual model (Heath, 1977). The General Nursing Council (1977) in its educational policy document has prescribed a curriculum using the nursing process as the unifying thread, Heath (1979) has suggested that this approach will lead to a 'new' kind of nurse. A question yet to be answered is how far does what is being taught by the theoreticians match up with what is being practised in the clinical area. Will the gap between theory and practice become wider than ever?

The main concern of this study is, however, how a teacher 'teaches'. The Oxford English Dictionary defines teaching thus:-

> 'To show by way of information or instruction ... to impart or convey knowledge'.

The lay image of the teacher is of someone telling, showing or instructing. Other methods used by teachers to bring about learning such as 'learning by discovery' or 'learning through play' are often viewed with scepticism. Indeed, such methods have been heavily criticised from informed as well as uninformed sources.

When one turns to the literature on teaching methodologies, however, there is much less certainty about what teaching is.

Hirst (1971) feels that in the discussion of such methods as discovery learning, learning through play etc. that there is much misunderstanding of what teaching is and therefore what it involves. This misunderstanding often leads to a very distorted view of the whole educational scene.

To be clear about what teaching is would seem to be very important, because how teachers understand teaching will affect what they attempt to do in the classroom. Similarly what a ward sister understands about teaching will affect what she does or feels she has to attempt to do, in the ward situation.

To return to Hirst: the question he raises relates to how the activity of teaching is characterised to distinguish it from all other activities. If we take a number of activities that a classroom teacher may engage in in a teaching session, he may, for instance, tell the class a personal anecdote, perform an experiment, distribute some books, write on the blackboard; which of these is teaching? The question could also be raised, which of the activities

undertaken by trained nurses 'on the job' could be labelled teaching? Hirst goes on to say that the concept of teaching is totally dependent for its characterisation on the concept of learning. What the 'task' of teaching implies is the intention to bring about learning. Teaching activities must seek to bridge the gap between pupil and teacher. Teaching activities therefore must take place at a level where the learner can take on what it is he should learn.

> 'the end or aim of learning is, I suggest, always some specific achievement or end state ... believing something which one did not believe before, knowing something one did not know before or being able to do something one could not do before ... I have so far argued that in its central use, teaching is the label for all those activities of a person 'A', the intention of which is to bring about in another person 'B' the intentional learning of X'.

When we turn to other educationalists a somewhat different view is given. Joyce and Weil (1972) see educational practices as stemming from an individual's general beliefs about human nature and about the kinds of goals and environments that enhance human beings.

> 'We think of teaching as a process by which teacher and student create a shared environment including a set of values, beliefs (agreements about what is important) which in turn colour their view of reality' (p. 3).

Rogers' (1969) view is that it is a mistake to focus on teaching; that the problem of facilitating learning is the real issue.

> '... it is most unfortunate that the educators and the public think about and focus on teaching. It leads them into a host of questions which are either irrelevant or absurd so far as real education is concerned ... if we focused on the facilitation of learning - how, why and when the student learns, and how learning seems and feels from the inside, we might be on a much more profitable track' (p. 125)

Rogers feels that we have some but need more knowledge of the kinds of conditions that facilitate learning. This view seems to link up with that of Joyce and Weil. All three emphasise the creation of a climate in which learning can take place, rather than the activity of teaching.

RESEARCH INTO TEACHING

A review of the literature on teaching research indicates much activity in this area, which according to Forman (1979) has had relatively little 'spin off'. Research into teaching, he feels, has yet to come up with practical solutions to teaching and learning problems. Little was revealed that could be directly applied to 'on the job' teaching. Similarly a review of industrial training research failed to produce anything of note that could be used by the researcher in this particular study.*

To return to teaching research. Historically, research seems to have centred on the qualities of a teacher rather than the nature of teaching.

> 'Early research tended to neglect the activities of the teacher in the classroom i.e. the actual processes of instruction ... Research on teaching recognises the importance of personality variables as one of the numbers of factors which must be considered in teaching but it does not consider personality as the sole or the most important indicator of effective teaching'. (Forman, 1979)

Mackie (1973) in a more recent study found little evidence to support the view that certain teacher personality characteristics have an important part to play on pupil achievement.

Teachers were found to be effective in the classroom regardless of their personality styles or beliefs.

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* An exception is the systematic approach to industrial and vocational training which has been discussed more fully elsewhere (Marson 1970).

As few conclusions could be drawn from these early studies, would research on what characterises the good teacher, that is, what good teachers do in the classroom, throw any more light on the subject?

Ryans (1960) felt that teaching effectiveness was an ambiguous concept:

> 'it may be said that teaching is effective to the extent that the teacher acts in ways that are favourable to the development of basic skills, understandings, work habits, desirable attitudes, value judgements and adequate personal adjustment of the pupil'.

At the time of Ryans' research relatively little progress had been made in operationalising this definition with descriptions of competent teaching or the characteristics of effective teachers in specific situations or cultural settings.

Ryans went on to study 6,000 teachers in 1,700 schools in the United States with the aim of describing the major dimensions of teacher behaviour. Using systematic observations by trained observers 22 such dimensions of teacher and pupil behaviour were described.

In a similar study of Ryans', a rating scale was developed to evaluate teaching behaviours in a college of further education (Greenwood et al 1973). In this study 60 items were finally drawn up which described effective teaching behaviours. It was found that there was a good deal of agreement between students and teaching staff views on what constitutes good teaching behaviour.

Further progress was made in the late sixties with the studies on microteaching, that is, the analysis of teaching skills, (Allen, Ryans, 1969, McAleese, Unwin, 1970), and the work of Flanders on interaction analysis in the classroom.

The work of Flanders aroused a great deal of interest in the teaching world. Flanders saw teaching as:-

> 'a series of overt acts over a period of time. How many different acts depend upon what one is looking for'. (Flanders 1970)

Flanders went on to develop a system for analysing and categorising teacher/pupil verbal communications. Ten categories in all were described, seven relating to teacher talk, two relating to pupil talk, the tenth being silence.

Rackham (1977) developed a similar instrument for analysing interactive behaviours in an industrial/commercial setting. (Part of the field work in this study is based on the work of Flanders and Rackham, this will therefore be discussed in more depth in Chapter V.)

The review of the literature on the nature of teaching only served to emphasise to the researcher the complexity and variability of the teaching process. To focus in on one activity is possibly to miss the 'whole'. When one turns to the book on models of teaching (Joyce and Weil) the authors state:-

> 'Educators and millenia have sought the perfect (teaching model' ...
>
> 'The search for Good teaching the one right way is fallacy'.

THEORETICAL APPROACHES TO TEACHING

We need to turn now to approaches to the teaching task. What views of teaching and learning give rise to what approaches? How much is the approach related to personality of the teacher? How much should teaching be varied to suit different situations and reach different students? Weil and Joyce suggest:-

> 'There are many kinds of good teaching and that the concept of good, when applied to teaching, is better stated good for what and good for whom?' (p. 4)

Joyce and Weil group models of teaching into four main families, each of which expresses a different view of man in his environment.

Of the four models described the following three appear to have relevance to nurse training. Teaching practice based on information processing sources aims to improve the learner's capacity to handle and process incoming data (see The Process of Learning - The Cognitive View, p. 39). One such approach that is based on problem solving is the McMaster Curriculum for medical training (Hamilton, 1976). Problem solving models of teaching would seem to have a great deal to offer to nurse education. Indeed, some nursing schools are experimenting with approaches similar to the McMaster curriculum.

To teach via an information processing model does however, entail having a thorough knowledge of the subject matter and the attributes of the concepts within that body of knowledge. It is also necessary to diagnose a student's difficulties with accuracy to teach effectively. On this count, information processing models would seem to be a province of the qualified nurse teacher rather than the clinical specialist.

Instructional models based on behaviour modification sources emerged in the sixties as an attempt to creat efficient systems for

sequencing learning activities and shaping behaviour by manipulating reinforcement. The application of Gagné's work has been discussed in depth in the section on learning theories.

Whatever one's view is of the morality of using behaviour modification techniques in education there is no doubt that the work of the neo-behaviourists stimulated a great deal of empirical research into teaching and learning (Hartley 1974). This research has introduced and brought to light the concept of accountability in education. Prior to this what a teacher did when he entered the classroom was shrouded in mystery and the results of his instruction were often not evaluated until much later on. Stemming directly from this work a movement for change known as the systems approach began to make its impact on training and education in the sixties. This movement has also had its influence in nurse training. (Marson 1970, Townsend 1978 and Heath 1977).

The frame of reference of the fourth model, personal sources, is the individual, his personal development, his construct of reality and emotional life. The focus of educational goals and means in this model is on self as the avenue to other goals. Central to all models in this group is the relationship between the learner and his teacher. (See Rogers' ideas outlined earlier, pp 41-44).

These models would seem to be in direct contrast to the behaviourist group. In fact, they seem to create a paradox. If the individual is to be the source of educational ideas and develop on his own terms, how far can the teacher impose his own ideas? How much advanced planning can be done or is it simply a case of providing support and pointing out avenues that the learner can travel under his own volition? Indeed, can one teach at all if one's main aim is to put the student in

the centre of the learning process?

> Rogers, 'We cannot teach another person directly; we can only facilitate his learning'.

We need to return to Rogers to explore further the role of the teacher as a facilitator, in a self-directed learning system. In discussing the conditions that facilitate learning Rogers considers one of the most important of these is:-

> 'the attitudinal quality of the interpersonal relationship between facilitator and learner' (p 106).

These attitudinal qualities include:-

> 'transparent realness in the facilitator, a willingness to be and live the feelings and thoughts of the moment'. (p 113).
>
> 'A prizing caring trust and respect for the learner'. (p 109).
>
> 'Sensitive accurate empathic listening'.

Rogers feels that these personal attributes create a freeing climate which stimulates self-initiated learning and growth, the student is trusted to develop. True facilitators are more concerned with releasing the potential of their students than with their deficiencies.

Rogers also stresses sensitive empathic listening as a quality that facilitates learning. Turning to the literature on counselling and psychotherapy to find out more about empathy,

Murray Cox (1978) distinguishes empathy from sympathy:-

> 'True empathy is always welcome compared with sympathy which may be rejected because of an implicit or deliberate act of movement towards, rather than being with, and almost being one with'.
>
> 'Listening and empathy are inextricably associated'.
>
> 'Empathy also implies the ability to look out on behalf of someone else as well as to look inside him'. (p 130).

Good teachers need to be skilled listeners in the empathic sense.

CONCLUSION

Good teaching would seem to be relative; a person's concept of a good teacher depends upon his own past experience, the culture he

comes from, the values, attitudes and beliefs he holds; the personality of the teacher viz à viz the personality of the learner.

There would however, appear to be two major dimensions to this complex and many sided activity which demands a variety of human traits and abilities.

1. Those that involve a teacher's mental abilities and skills, that is, his understanding of the generalities and specifics of the subject matter to be taught (Ausubel 1966, Bruner 1973, Taba 1966).
2. Those qualities stemming from a teacher's personality, values and belief and his behaviour in forming relationships with pupils and others in working life, that is, his ability to create a climate for learning (Rogers 1969, Flanders 1970, Joyce & Weil 1972).

The aim of this study is to try to define what constitutes good teaching from the viewpoint of the nurse learner adapting to the real life experience of nursing. The results may help us clarify what approaches to teaching are appropriate for what ends, and what models could be adopted and adapted in particular, to the 'on the job' training situation.

SUMMARY OF CHAPTER IV

In Chapter IV current literature and research on teaching and learning is reviewed in order to abstract a contemporary view of the conditions for learning and the process of teaching.

1. Definitions and perceptions of teaching and learning both lay and professional are briefly reviewed.
2. Three contemporary learning theories/philosophies influencing modern teaching practice are examined in more detail, with particular attention being paid to behaviourist theories in the light of findings from the nursing literature.

3. Conditions for learning as expressed by each of the three major schools, that is behaviourist, cognitive field and humanistic, are reviewed and the findings applied to the nurse training situation.

4. Current research into the process of teaching is reviewed. A contemporary view of models for teaching is examined and linked to the findings from the section on learning theories.

5. Particular attention is paid to the behaviourist and humanistic models, their influence on contemporary thought, on teaching and learning and potential for nurse training.

DESIGN OF THE STUDY

This chapter outlines the rationale behind the choice of methods and instruments used in the investigatory part of the study. Reasons are given for the change in the method of data collection in phase 2, that is, from the use of critical incidents to a questionnaire. Selection of participants for all three phases is discussed in some detail, also the techniques used to operationalise each stage. Finally, the methods of statistical analysis are described, giving reason for the choice.

Purpose

The general aim of the study was to isolate those behaviours that trainee nurses consider help them learn from work experience. In particular, trained nurse-trainee verbal interactions were studied in order to determine any relationship between verbal behaviours of trained staff and a trainee nurse's perception of good teaching.

The major focus of the study was on the learners and their perceptions of teaching and learning. The justification for this approach lies in the fact that trainee nurses spend eighty per cent of their training time in the relatively unstructured learning environment of the work place. The desire to enquire and experiment and therefore to learn must frequently come from them.

The General Nursing Council, in its Educational Policy Document (1977), has stressed the importance of providing a 'good climate for learning'. It would seem important, therefore, to explore teaching and learning from the learner's viewpoint. This approach is further justified in the light of the growing emphasis, in general and management education, on learning as a self-directed activity (Rogers, 1969, Boydell, 1976, Revans, 1980).

PHASE 1

As stated in the opening chapter 'Outline of the Research', the project was conducted in three distinct phases, the first being of necessity exploratory in nature (see page 4). A structured interview technique was used focusing on specific areas. Part A concerned the ward environment and work routines, parts B and C teaching and learning on the ward.

In the case of ward sisters one or two questions were included on their managerial role and responsibilities. (See Appendix B pp III-X for interview schedules).

The first few questions asked for biographical information, length of time on the ward, stage in training, study blocks attended, assessments taken, and so on*. These questions helped the interviewees to relax and settle in to the interview. The questions were open-ended to allow for richness and depth of response. When questions were around key variables, attitudes to teaching and learning and critical learning events, for example, probing questions of a non-directive nature were asked in order not to bias the response. To give some examples:-

'I'd like to know more about that'.

'What were your feelings then?'

'Why do you think that?'

The interview schedule was tested on six volunteers prior to the main study. Minor alterations to the wording of some questions were made for the sake of clarity.

Selecting the Sample

Thirty trainee nurses were selected by a stratified random sampling method. That is, every tenth name was abstracted from lists of first,

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*I am indebted to Joan Fretwell for allowing me to use some of her ideas in developing the interview schedules.

second and third year students and first and second year pupil nurses in training for the General part of the Register or Roll (see Table 1).

Table 1

Year	1	2	3	Total
Student Nurses	5	5	5	15
Pupil Nurses	8	7	-	15
		total		30

This represented a 10% sample of trainees.

The ward sisters were selected by a random sampling method and represented a 42% sample. (For ward distribution see table 2).

Table 2

Wards	Surgical	Medical	Geriatric	Orthopaedic	Gynaecology	ENT	A/E	Paediatric
	3M	1HD	2XM	1F	1	1	1MX	1
Sisters	3F	2F	1M					
		1M	4F					
TOTAL	6	4	7	1	1	1	1	1
	= 22							

Key: A/E Accident & Emergency
ENT Ear, Nose and Throat
HD High Dependency
M Male
F Female
MX Mixed

The sisters participating were employed on teaching wards used by the School for practical experience, in four small acute general hospitals and two geriatric hospitals.

Conducting the Interviews

The subjects were contacted by a letter which explained the nature

and purpose of the study. Their co-operation was sought and only two individuals declined to participate, a sister on the paediatric ward and one pupil nurse.

Trainees, when possible, were interviewed when in the School of Nursing in study block to save withdrawing them from the service area. Sisters were interviewed at a time and place chosen by themselves.

Prior to approaching the subjects, contact had been made with all the management tiers involved, to obtain their permission to conduct the study. This involved writing to, and meeting with, the Area Nursing Officer, District Nursing Officer, Director of Nurse Education and Senior Nursing Officers of the hospitals concerned. All were most co-operative and facilitated the administrative procedures necessary to carry out the study.

Few difficulties were encountered and with one or two exceptions the researcher was warmly welcomed. Two sisters were rather apprehensive when asked permission to tape the interview, but soon relaxed when given the guarantee of anonymity. The interviews took from 40 to 60 minutes to complete and all were taped. The tapes were reviewed and transcribed on to index cards, one card for each subject.

The key questions in terms of production of useful data proved to be questions eight to thirteen in part B of the trainees' interview schedule.

The data collected from these questions also gave fresh guidelines for designing phase 2 of the study.

PHASE 2

The original intention was to use a critical incident technique to collect data from learners on effective teaching and learning behaviours.

The critical incident technique is a method of collecting information based on direct observation. Opinion, generalization and personal judge-

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* The introductory letter is included in the Appendix B page XI.

are reported. Among those known to use this technique to evaluate nursing behaviours are Fivars and Gosnel (1966), Smith and Kendall (1963) and Simms (1976).

Interview question number eight, section B, asked the trainee to recall an effective learning incident. Twenty-four subjects were able to describe such an incident in behavioural terms with the assistance of the researcher. At the end of the interview trainees were given 'ward diaries' on which to record critical learning incidents during the next three months of work experience. (See Appendix B page XII). A stamped addressed envelope was also included in which to return the completed diaries. Unfortunately only a 17% return was achieved in spite of reminders given three then six months after the interview. The result was a collection of 10 usable incidents, insufficient evidence on which to base any conclusions. Simms (1976) also ran into problems when using the technique as a possible tool from which to develop nursing report forms, which led him to conclude that the critical incident technique presents problems to the researcher in gaining nurses' acceptance of its value and understanding of its purpose. Experience in this study would seem to confirm this viewpoint.

With limited resources at my disposal it was not possible to train a group of observers in the technique in order to collect sufficient incidents to make the study valid. Fortunately sufficient data to develop a questionnaire had been collected at the interviews to allow an alternative strategy for phase 2.

Developing the questionnaire

A total of forty-nine statements were collected during the interviews describing some characteristics of the good ward teacher. The characteristics described were found in sisters/charge nurses, staff

The statements furnished sufficient material from which to develop a questionnaire using a Likert-type response scale. The original forty-nine statements were included plus thirteen statements expressing a characteristic in different words, for example -*

No. 48 'Understands how trainees feel' (original)

No. 41 'Is sensitive to trainees' feelings (reworded)

Eight negative statements, i.e. statements contradicting the original findings, were also included, for example -

No. 33 'corrects trainee immediately whenever and wherever a mistake is made regardless of who is present'.

This statement would indicate insensitivity rather than sensitivity to trainees' feelings.

Purpose

The questionnaire was developed to test out the interview findings with a larger group of subjects. It was anticipated that statistical analysis could lead to the development of a valid good teacher profile.

Pilot Study

The questionnaire was tried out on 16 subjects before the main study, in order to 'iron' out any ambiguities in the wording. Four statements were modified following the trial; feedback from the trainees suggested that there were some difficulties of interpretation with these particular statements.

Administration

The questionnaire was given to ninety-six trainees, none of whom had taken part in the interviews. The questionnaire subjects were directly comparable to those taking part in the interviews.

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* The full questionnaire is given in the Appendix B pages XIII - XVII

21 1st year pupil nurses

22 2nd year pupil nurses

16 1st year student nurses

17 2nd year student nurses

20 3rd year student nurses

The trainees selected were a 'captive audience', that is, they were in study blocks in the school of nursing. This was a convenient method of reaching a larger number of trainees. The purpose of the research was explained to each group. They were then asked to rate each of the 70 statements according to how that attribute related to the 'good teacher'.

Trainees were asked to think of an individual from whom they had learned a great deal in any work experience as a base to work from. If, for instance, it was felt that being 'a good nurse with high standards' was a marked characteristic of a good teacher then a tick was to be placed in the strongly-related column. If 'having a sense of humour' was helpful but not essential, then a mark in the moderately related column was appropriate and so on. It was emphasised that the research concerned clinical practitioners not qualified teachers. The questionnaire took between 10 to 20 minutes to complete.

PHASE 3

This stage of the study consisted of observations and analysis of the way in which nurses in a supervisory role communicate verbally with trainees. Systems have been developed in the last decade for analysing and categorising person to person verbal interactions. Notably Flanders (1970) for use in a classroom setting and Rackham (1977) in an industrial setting. Turning to Flanders,

> 'Teaching may be conceived of as a series of overt acts over a period of time. How many different kinds of acts to be seen depends on what one is looking for. Suppose one restricted himself to verbal behaviour and chose to classify communication into three categories, for example - teacher talk, student talk and silence or confusion. For only three categories based on who was talking observer reliability would be high but the psychological usefulness of the data would be limited. Suppose one had a great number of categories based on such microscopic detail that each verbal act was seen as slightly different from the next. With so much to keep track of, observer reliability would be low or non-existent; the efficiency of the observation process would be very low and tabulation problems high; and the data would be too complex to analyse'.

The problem with analysing verbal behaviours would seem to be finding an optimum number of categories which observers can comfortably use and that will provide usable, reliable data. Flanders devised 10 such categories for analysing classroom behaviour, 7 of which related to teacher behaviour. Flanders postulates that teaching can be improved by identifying specific behavioural patterns and converting these into training exercises. He suggests that prescriptive intentions, that is, 'shoulds' and 'oughts', about teaching describe an end point of self development but fail to suggest ways of reaching it. Rackham, working from the same premise, devised a system of 13 categories or behavioural units, for analysing verbal interactions in an industrial setting (see Appendix B page XVIII). The categories identify the manner in which a person is behaving rather than the content of the message. Rackham's research showed that the categories could be linked to favourable and unfavourable outcomes. Skilled negotiators, chairmen, or interviewers have been shown to use certain categories more than others in different situations.

'From the table we can see that the 'expert' appraiser behaves differently from his average counterpart ...

Behaviour differences between expert and average appraisers

	Percentage of total behaviour	
	Expert appraisers (n = 93)	Average appraisers (n = 61)
Proposing	8.1	16.2
Building	4.7	1.8
Supporting	11.7	8.3
Disagreeing	7.2	6.8
Defending/attacking	0.2	1.3
Testing understanding	8.3	3.1
Summarizing	6.4	2.3
Seeking information	15.1	12.7
Seeking proposals/solutions	6.4	2.0
Giving internal information	14.9	12.0
Giving external information	17.0	33.5

... he makes fewer proposals, uses more building behaviour, he tests understanding more often, he summarises more often, he asks more questions ...'. (Rackham 1977, p. 265)

As previously stated, phase 3 of the research is an attempt to investigate any relationships between effective teaching and verbal behaviours, based on the assumption that verbal communications are an important facet of the teaching situation. Both Flanders' and Rackham's systems were examined. Rackham's method was finally selected for the following reasons:-

1. It appeared more appropriate to the analysis of verbal interactions in an 'on the job' situation.
2. The research worker had undergone training in the method prior to the study and had used the categories as a training tool within the National Health Service. A reasonable degree of confidence in the applicability of the categories existed, their use as a research tool was unexplored, however.

It could be argued that a system devised for an industrial situation would be inappropriate in a nursing situation. Behaviour analysis is a relatively 'new' technique in nursing research; this limited the field in the search for a suitable tool. Hays and Larsonn (1963) had developed categories for analysing nurse-patient verbal interactions. These were rejected; in the researcher's opinion the categories were too numerous to ensure reliability of observations and not relevant to this study.

Adapting the Categories

Rackham's categories were modified in the following way. The categories of 'shutting out' and 'bringing in' were considered more appropriate to a meeting's situation so were therefore omitted. The categories seeking and giving information were sub-divided as follows:-

- seeking information - social i.e. questions eliciting personal as opposed to professional information
  - job related i.e. seeking job knowledge and progress
  - theory i.e. seeking knowledge of theoretical concepts

- theory in depth* - ditto in depth

- giving information - opinion

- instruction - relates to job instruction

- explanation - includes theoretical facts

These modifications in the giving and seeking information categories. were an attempt to separate theoretical 'teaching' from 'job' activity.

Training of a Research Assistant

A small grant was obtained from the Nursing Research Division of the Department of Health and Social Security in order to employ an assistant for phase three.

An experienced nurse with a Diploma in Advanced Nursing was appointed and training given in behavioural analysis. A rank order correlation coefficient of 0.95 was achieved in the course, indicating that the research assistant had achieved a satisfactory standard of reliability in using Rackham's behaviour categories**.

Trial observations were carried out on a geriatric unit using the modified analysis sheet. Research worker and the research assistant each monitored and recorded verbal interactions between trained staff and trainees for an 8 hour period. A correlation coefficient between the observation of researcher and assistant of 0.90 was noted***. Arrangements were made to carry out the observations in selected wards.

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* Theory in depth relates to Bloom's taxonomy (Bloom 1956) i.e. questions which ask for more than simple recall of factual knowledge e.g. comprehension, application of knowledge.

** For details see Rackham 1977, Behaviour Analysis pp 291-296.

*** Rank order correlation (Spearman's Rho) was used as a measure of the reliability of the observations made.

The Sample

Four wards were selected for observation: one surgical ward, one medical high dependency unit and two general medical wards, one female, one male. The surgical ward and the medical high dependency unit were particularly recommended by the school of nursing as good teaching wards. This fact was not known to the research assistant carrying out the observations. The research assistant spent one week on each ward (40 hours) ensuring she was 'on duty' whenever trainees were available. The researcher remained as unobtrusive as possible, moving in whenever a trainee and trained nurse came together for an interaction covering a reasonable time span (variations of from 10 to 45 minutes were recorded). The verbal interactions were categorised and recorded on data sheets according to Rackham's categories (see Appendix B page XX). The purpose, time and duration of the interaction were noted, also the names of the participants. Observations covered most nursing activities, basic and technical procedures, drug rounds and ward reports. Trainees were interviewed* towards the end of the period to ascertain their views on the teaching they had received on that particular ward. They were asked to identify the person who had taught them the most.

Statistical Methods Employed

Making sense of data collected in research requires both the powers of creative imagination and logical inferences based on scientific methods. Methods of data analysis provide a set of tools which help to further this end. In this way the ideas generated by research can be evaluated. (Open University 1973).

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* See Appendix B pp XXI-XXIV for post-observation interview schedule.

The datum collected in phase 1 did not require sophisticated statistical analysis and is therefore presented in its raw form (see Chapter 6).

Phase 2

Data from the questionnaires were analysed initially in the following way:

Percentage of learners rating a characteristic strongly related.

Percentage of learners rating a characteristic related or moderately related.

Percentage rating a characteristic slightly or not related.

Means and standard deviations were calculated to determine the spread of scores for each statement, the total group (n 96) and each of the five sub groups (students 1st year, n=16, 2nd year, n=17, 3rd year, n=20: Pupils 1st year, n=21, 2nd year, n=22).

Entropies* were calculated for each of the 70 statements in order to expedite ranking of the statements and to differentiate between the way each sub-group responded.

Finally, data from the questionnaire were subjected to factor analysis. This technique was used to determine the minimum number of dimensions (factors) underlying the set of variables described in the statements; and the strength of the relationship between each variable and each factor. In this way a reliable and valid profile of good teaching behaviour could be constructed.

Phase 3

Analysis in this phase consisted of converting the raw frequencies of units of observed behaviours into percentages. Where differ-

* Entropy is a measure of uncertainty; the higher the resulting number the more uncertainty exists. The formula for calculating entropy score is in Appendix C page XLI.

ences in frequencies were noted, for individuals or groups, chi-square was used to determine statistical significance. There are difficulties with this technique,however, the result can be affected by low frequencies, making interpretation unreliable. Some of the observations came in this category.

With the design of the study described and statistical methods to be used to analyse the data outlined, the scene is now set for presentation of the findings.

FINDINGS PHASE I

THE LEARNING ENVIRONMENT -

Analysis of data from the interviews

INTRODUCTION

As discussed earlier, little evidence existed in the nursing literature of the study of ward learning and teaching as a process. An exploratory phase was therefore necessary to prepare the ground for the main study.

In this section of chapter VI the data collected from the interviews will be reviewed in pursuance of the objectives specified in chapter I, page 4, namely:-

1. To identify routines and procedures used to induct, support and instruct trainees in service areas.
2. To ascertain trainee and trained nurse perceptions of teaching and learning.
3. To identify factors involved in experiences trainees considered resulted in significant learning and those considered to be missed learning opportunities.
4. To obtain a description of the behavioural characteristics of those trained staff perceived as 'good teachers'.

INTERVIEW FINDINGS - TRAINEES

The first four questions asked for biographical information: length of time in training, study blocks attended, assessments taken and so on. (ref. Appendix B page III). The main aim and objective of these questions was to help interviewees relax and 'settle in' to the interview. Questions 5 and 6, 'which experience did you enjoy/like the least', opened the way for in-depth interviewing.

Most enjoyable ward experience

Responses were as follows:-

WARD	NUMBER NAMING	REASON MOST FREQUENTLY GIVEN
SURGICAL	7	Variety and pace
MEDICAL	7	Amount of teaching
PAEDIATRIC	4	Empathy with children
CASUALTY	4	Variety and pace
THEATRE	2	Staff attitudes
ORTHOPAEDIC	1	Ward atmosphere
OUT PATIENTS	1	Admiration for a member of staff
GERIATRIC	1	Empathy with elderly patients
GYNAECOLOGY	1	Ward atmosphere

It is probably true to say that no particular trend emerged, choices ranging widely over all types of nursing experience. The apparent popularity of medical and surgical nursing probably reflects the limited experience of first year nurses; these interviewees would have no experience of clinical specialities such as orthopaedics or gynaecology at the time of interview.

Reasons given

The reasons given for enjoyment included personal preferences for particular age groups, expressed by four of the interviewees, all pupil nurses.

'I like children'

'I like doing things for old people'

Feeling active and involved was quoted by seven (four students, three pupils).

'I liked the fast pace'

'There was a lot of variety'

'I felt involved'

Being taught or learning a lot was given by seven,

'There was a lot to learn'

'Sister taught me a lot on there'

'The staff took time to teach you; you got your questions answered'

Good interpersonal relationships and/or ward atmosphere were also an important factor, five giving this as reason for enjoying a ward experience,

'I liked the free atmosphere'

'The attitude of the staff was good'

'The staff were friendly'

Dislike of a ward experience

Seventeen trainees (56%) named at least one work experience they had not enjoyed. Three had enjoyed all their experiences up to the time of interview. The remainder felt unable to respond to this question.

Relationship problems, that is, trained staff attitudes, were mentioned by eight as the main reason for disliking a ward (four pupils and four students). Lack of stimulation or boredom was given by six, all student nurses. These responses correspond with those answers given to the previous question. The main factors influencing whether

or not a particular work experience is enjoyed would appear to be staff attitudes and interpersonal relationships, variety and stimulation.

Ward routines

This group of questions concerned the trainees' most recent ward experience. When asked how much there was to learn on their last ward, twenty-three trainees responded positively, for example,

'A great deal'

'A lot'

'Quite a lot'

Two trainees reported 'not learning much', one had been on a medical convalescent ward, the other on an orthopaedic unit.

With regard to work routines, seventeen reported that sister allocated the work on their last ward; five reported having a written work list to follow as well as verbal instructions and the Cardex to refer to.

One trainee only had experienced working on a ward practising total patient care. The Nursing Process approach had not been implemented in this particular hospital at the time of the interviews.

Slack Periods

As concern about the deficiencies in 'on the job teaching' has mounted, ward sisters have been increasingly encouraged to utilise quiet periods for teaching purposes. Traditionally, nurses were expected to carry out routine cleaning and clerical tasks during these periods.

When questioned about what was done in slack periods on their last ward, trainees' responses were as follows:-

Self directed study	10
Study involving trained staff	11
Cleaning/clerical tasks	5
Meeting patients'/relatives' needs	5

Self-directed study refers to study involving trainees only. Although trained nurses may have suggested that the slack period be used in this way, they did not participate. The trainees studied case notes or text books on their own or in groups. Study involving trained staff took the form of case discussion or in some instances quizzes and questions, the trained staff taking part. Doctors were also reported as being involved, giving lectures on occasions. It is surprising that one third of trainees interviewed reported carrying out cleaning tasks and other duties in slack periods.

With regard to meeting patients' and relatives' needs, the trainees reporting this had been on a geriatric ward. They were encouraged to take part in social activities with patients during slack periods. How well these activities meet the learning needs of trainees is open to question. Their value will depend on whether or not learners are helped to evaluate and integrate these activities into the general context of caring for elderly patients.

Induction procedures

Routines for inducting trainees into the ward team tend to follow a standard pattern. It was surprising, therefore, to find some variations.

Taken round ward by person in charge of ward	56%
Taken round ward by other staff e.g. SEN, nursing auxiliary*	24%
Interview with sister, then put to work with another member of staff for a period	4%
No formal induction period	12%

*The induction by a nursing auxiliary was much appreciated.

One trainee reported an ophthalmic ward sister helping her to set learning objectives for that particular ward experience. The trainee had found this unusual but very helpful. It should be noted that the interviews were conducted in 1977. Since that time more attempts have been made to clarify ward experience in terms of learning objectives.

Supervision of nursing procedures

The trainees were, on the whole, satisfied with the support given when carrying out a new nursing procedure on their last ward. All reported being supervised by a trained or much more experienced nurse when carrying out something new and feeling free to ask for supervision when needed.

To whom do they go?

When asked whom they went to for help, the sister was reported by eighteen (62%) as the person most frequently approached for answers to theoretical questions.

For practical nursing skills the responses were evenly spread over sisters (seven), staff nurses (seven) State Enrolled nurses and auxiliaries (seven). When asked who they would approach on the ward with a personal/interpersonal problem that was affecting their work, a sister, a staff nurse and a State Enrolled nurse were identified by

three (i.e. 12%) of the trainees as a person whom they would approach with a personal problem, but they had not actually done so at the time of interview.

67% stated they would not approach anyone on the ward. (This would appear to be a significant finding in the light of this small study.)*

Teaching and learning

The second half of the interview schedule (section B) consisted of 14 questions focusing on perceptions of teaching and learning.

Definitions

When asked to define learning, approximately a third defined it in terms of acquiring knowledge; similarly a third defined teaching in terms of giving information. Put into other words, teaching and learning is seen as a one-way process.

Learning	No.	Teaching	No.
'Gaining knowledge'	11	'Giving information'	11
'Understanding something new'	6	'Making something simple'	6
'Acquiring knowledge and skill'	5	'Encouraging understanding'	4
'Being able to do something new'	2	'Stimulate learning'	4
'Being taught'	2	'Showing the right way'	3
'Remembering'	1	'Don't know'	2
'Don't know'	2	'Don't know'	2

Practical skills

When asked: 'Where are practical nursing skills best taught?' 90% of trainees stated categorically the wards. Reasons given included:-

*For a fuller discussion of this finding see Chapter VII page 163.

'It's more realistic on the ward'

'It's like play acting in school'

'You feel more involved on the ward'

The three who chose the nursing school as the best place to teach practical nursing were pupils; the reasons given were:-

'They teach you the right way'

'You can do things properly there'

Pupil nurses in this study would seem to have a greater need to conform than do student nurses.

There was less agreement on whether or not procedures should be practised as taught in theory in the nurse training school.

Responses were as follows:-

'Ideally yes' (some reservations)	-	11
'Some variations are unavoidable/ you have to adapt'	-	8
'Unqualified yes'	-	5
'Some should' (e.g. asepsis)	-	2
'They can never be the same'	-	1
'No comments'	-	1

These results echo the conflict between 'ideal and real', highlighted in the Hend and Bendall studies, (Bendall 1973, Hend 1975).

Trainees, when probed, recognised that confusion was the result of dual standards, i.e. one standard for school, one for the ward.

Reasons given for the discrepancy included:-

'Not enough time (space/equipment) on wards'

'Idleness'

'Procedures are too rigid, they should be guidelines only'

'Some sisters have their own way'

What can/cannot be taught on wards

Theory was selected by 14 of the trainees as being difficult to teach in the wards. The main difficulties were seen as a lack of time and facilities and too many distractions. More surprising was the response made by three trainees that relationships and attitudes to patients and relatives could not be taught on the ward.* Three also placed coping with life-threatening emergencies in this category. The view that most things could be taught on the ward, given time, was held by five, the advantage being seen as:-

'The learning is more meaningful and sticks'.

Who should teach on the ward

The responses to this question were as follows:

'All qualified staff'	11	
'Sister/charge nurse'	10	
'Qualified teachers'	5	(3 giving this response were pupils)
'Staff nurses'	1	
'Anyone with more experience'	1	
'Trainee should be responsible for her own learning'	1	

These responses indicate that the teaching responsibility of qualified nurses is clearly recognised by trainees. Only one trainee saw the main responsibility resting on the trainee him/herself.

Where help is needed

Responses to this question were varied, indicating individual needs. The most frequent response was for help with theory (6), or help with applying theory to practice (4). A further six were unable

*The significance of this finding is discussed in depth in Chapter VII page 162.

to think of any one particular area of nursing theory or practice for which they required help. One trainee responded: 'I need help with everything.' One felt more feedback on progress would be helpful:

> 'If you had appraisals every three months to see if you're doing all right. I don't know how I am doing.'

Of the remainder, six would have liked more support from trained staff in the work situation.

> 'Surgical, I was worried to death, I hadn't been on surgery before and I was in my third year,'
>
> 'It would help if people would find out from you whether or not you have done a procedure before giving instructions to do it,'

Four trainees commented on deficiencies in a particular type of experience.

> 'I haven't been on an orthopaedic ward,'

Learning experiences

The remaining questions produced a wealth of data in terms of 'what helps learning'. The first two questions asked trainees to recall a recent meaningful learning experience and/or a recent missed learning opportunity.

They were asked to say:-

(a) who was involved in the incident

(b) what was said or done

(c) why it was felt that that particular learning experience was important/or alternatively, a missed learning opportunity.

24 such incidents were described.

38% of the incidents recalled referred to life-threatening emergencies (e.g. haemorrhage, cardiac arrest, respiratory collapse) or management problems. These learning experiences were probably asso-

ciated with heightened emotional tension and the satisfaction of coping in an emergency:-

> 'I learned to be really sure of myself (of the facts) before taking action,' (Ward Management problem),
>
> 'I knew what to do, it was a feeling I could do it. I could now cope with that situation'.
> (Accident and Emergency, dealing with a drug overdose).
>
> 'It's important, a patient's life may be at stake, I always check (the blood pressure) myself now before bringing a patient back,' (Surgical ward),

When this kind of experience is coupled with feedback the incident becomes even more meaningful.

> 'I didn't think I could do in practice what I had learned in theory. Afterwards the nurse in charge took me stage by stage through what I had done (half hour after). This was a hundred per cent helpful, she calmed me down ... she told me what I had done right and what else I could have done ... it was rewarding, the patient lived ... (Patient in bath had a cardiac arrest).

Correction by an authority figure was the factor in 20% of incidents; the association was of acute embarrassment or loss of face ...

> 'When I made a mistake by leaving a cot-side down ... I put the baby (6-7 months) back in the cot to see to the admission, night sister came round a few minutes later and found the cot-side down, I got a roasting, I can tell you. I'll never forget that again'.

The remaining 42% of incidents described concerned technical learning experiences. The associated factor in these experiences was the support of a more experienced nurse who demonstrated clearly or talked the trainee through a technical nursing procedure. Hints, tips and suggestions were given based on the supporting nurse's own experience.

> 'That helped me a great deal, she gave me some good tips.' (Aseptic technique demonstrated by 2nd year nurse).
>
> 'I was having difficulty finding the pulse but it got easier after that tip' (Taking the blood pressure).

Each trainee was issued with a ward 'diary' at interview in which they were asked to record, during their next ward allocation, significant events which they considered effective or ineffective as learning experiences. Unfortunately, only a 17% return was achieved in spite of reminders three months and then six months after the interview. Eleven incidents were described in all, nine being effective, two ineffective.

Effective Incidents (written accounts)

Analysis of the incidents recorded in the ward diaries revealed the following:-

One incident related to responsibility - the learning factor was heightened emotional awareness.

Three concerned a trained nurse relating theory to practice and providing a role model of how to deal with patients and relatives.

Two related to demonstrations of a technical nursing skill by a trained nurse.

Two were lectures given by trained staff followed by opportunity to practise what was taught.

One was a problem set by sister which trainees were asked to solve (calculating a dose of insulin). This was followed by sister giving a verbal explanation supported by a formula.

Missed learning opportunities

Verbal and written descriptions of 17 missed learning opportunities were given.

These could be classified into the following categories:

Time factors - Three gave examples of time being available but not utilised for teaching.

Three related to emergency incidents or patients with unusual conditions. In each case the trainee wished to ask questions but pressure of work or a move off the ward prevented this.

Readiness factor	-	Two trainees expressed regret at not getting the best out of a ward experience which was thought to have come too soon to be appreciated (nursing of diabetic patients for example).
Work pressure factor	-	Four trainees described incidents when they were prevented from participating in an experience they felt they needed, by being diverted to do jobs not related to their learning needs, jobs they felt could have easily been done by other staff.
Knowledge factor	-	Three trainees gave examples of questions that were worrying them for which trained staff were unable, or in some instances unwilling, to give answers.
Emotional factor	-	Two trainees gave examples of emotional problems e.g. a personality clash and a high level of anxiety during theatre experience, which interfered with learning.

In the light of this small study we may assume that the factors that enable learning to take place include:-

(a) Heightened awareness:- an emergency situation or accepting increased responsibility.

(b) Relation of theory to practice by a more experienced person esteemed by the learner.

(c) Role models:- experienced staff's handling of patients and relatives.

(d) Support when carrying out technical procedures.

(e) Having to solve a real life problem and being given feedback on performance.

(f) Being given hints and tips to aid learning.

Inhibitors of learning are:-

(a) Lack of interest on the part of trained staff.

(b) Lack of time to follow up a line of enquiry due to work pressure.

(c) Readiness factors:- a particular experience coming too soon to be appreciated.

(d) Knowledge:- this factor is related to (c), that is, trainee lacks background knowledge with which to relate new materials or trained staff lack knowledge to answer trainees questions.

(e) Emotional factors:- personality clashes, anxiety or boredom can interfere with learning.

It is probably pertinent at this point in the thesis to return to the learning theories reviewed in Chapter IV, (pp 40-44). In the incidents quoted there are examples of Rogerian types of learning. Rogers (1969) refers to significant learning, that is, learning which is pervasive, that makes a difference to the attitudes, behaviour and perhaps the personality of the learner. It involves the whole person, feelings as well as cognitions, 38% of the incidents described were of this type.

Rogers also states that learning is more likely to take place when theory is seen as having relevance to the learner's needs. When a person esteemed by the learner, the ward sister, for example, takes the trouble to relate theory to practice, learning becomes meaningful and is more likely to be retained and recalled. Several of the incidents could be said to be of this type.

Another factor noted in the incidents was that of emotional support for learners. This, too, can be viewed in Rogerian terms (see page 42 para 4). When faced with a 'threatening situation', having to perform a technical nursing procedure for the first time, for example, to have the support of a trained nurse who is non-judgemental helps the learner to assimilate the experience.

There are also examples of Gagne's conditions and processes of learning in some of the incidents described. Gagné draws attention to the need for coding to ensure long term retention (see thesis page 35 para 5). That is, incoming information is classified and linked to previously learned concepts or simplified into a principle to ensure greater retention. Trained nurses who take the trouble to give a learner 'hints and tips' from their own training experience, although they may not realise it, are in fact facilitating learning.

There is general agreement among theorists that feedback is an important condition of learning. The State Enrolled nurse who helped the trainee evaluate her behaviour following a 'threatening' experience was adding the vital ingredient that turns a 'real life' event into a learning experience, that of feedback (page 37, para 2).

Behavioural characteristics of effective/ineffective ward teachers

Questions 10 to 13 concerned the behavioural characteristics of trained staff in relation to their teaching role.

Trainees were asked to talk about the person from whom they had learned the most,and conversely the least, in any work experiences.

The following table indicates the frequency with which a grade of nurse was mentioned by a trainee:-

Ward sister/charge nurse	named by	16
Staff nurse	" "	7
State Enrolled nurse	" "	5
Peers	" "	1

In all, 49 descriptive statements about 'good teachers' were collected (see Appendix C page XXV, this table also includes data from the interviews with the sisters).

Effective teachers

The statements when analysed concerned:-

1. Professional qualities:- 'She kept good standards of nursing'.
2. Managerial abilities:- 'The ward ran like clockwork'.
3. Personality traits:- 'She was approachable and friendly'.
4. Empathic qualities:- 'She seemed to know how learners feel' and
5. Teaching abilities:- 'He asked me questions to find out what I already knew'. 'She spoke to you in your own language... she explained medical terms'.

Ineffective teachers

Eleven of the trainees (approximately one third) were able to recall a trained nurse who was ineffective as a ward teacher. The following characteristics emerged;

Trained staff perceived as ineffective teachers:-

1. Distance themselves physically from trainees -

   'Sister stayed in the office all the time, gave all her orders from there'.

   'She sat in the office all the time, she didn't do any work. If you asked her any questions she would fob you off or say: "Look it up in a book".'

   'I was on eight weeks and I hardly ever saw her, she was always in the office. If she had anything to say she would say it through other people'.

and/or

2. Distance themselves psychologically i.e. trainees are unable to feel relaxed with them. They often avoid direct communication with trainees, appear uninterested and are unable or unwilling to ask or answer questions.

'She was a difficult person to approach'.

'Yes, someone who just didn't want to know, hadn't got time for you'.

'A senior State Enrolled nurse, she would answer questions if asked but never offered. She just didn't seem interested'.

'A sister on surgery, the staff nurses were the same, if you asked her anything she said: "Look it up" as though she couldn't be bothered to tell you'.

They are also

3. Insensitive to trainees' needs, often showing itself in the way correction is given or in the ward atmosphere.

'She pulled you up on little things in a sarcastic way. She told you off in the middle of the ward'.

'She was a difficult person to approach. She did tend to teach sometimes and quite well, but you couldn't ask her questions, you were afraid she would snap your head off'.

'The trained staff seemed so involved they didn't have much to do with junior staff. I didn't feel part of the team. The trained staff stuck together'.

Other factors mentioned included an inability to organise:

'The ward was chaotic when she was on'.

And staff who are doctor and/or administration oriented, that is, doctors' and administrative needs are given priority over trainees and patients.

'Those who sit in the office. They sit there and wait for the doctors to come. They want to please the doctors rather than help the nurse'.

'They are always too busy, they are more paperwork people than nursing people'.

This latter finding corresponds with Revans' findings (Revans 1964).

Improving Training

The last question in the trainees' interview schedule concerned the ways of improving nurse training. 93% of students and 53% of pupil nurses responded to this question, making constructive suggestions. The responses were as follows:-

	mentioned
Pupils - 8 responded	
'More clinical teachers'	4
'More trained staff on wards'	2
'Better balance of clinical experience'	1
'More time in school'	1
'More written work between blocks'	1
'Small group teaching'	1
Students - 14 responded	
'More clinical teaching'	11
'More understanding of trainee's needs'	3
'Correlation of theory with practice'	2
'Ward staff with up to date knowledge'	2
'More study days'	2
'More theoretical instruction'	1
'Planned programmes of instruction for each ward'	1
'Continuous assessment'	1

CONCLUSION

The findings on effective teaching behaviours are reviewed in more depth in section two of this chapter. It is probably relevant to conclude this section, however, with three statements made by trainees which seemed to summarise all their views on what makes a good ward 'teacher':

> 'That's what it is, the sister getting out of the office and communicating'.
>
> 'That's the main thing. If a teacher's approachable she doesn't have to be a great expert as long as you can ask questions and she tells you what she knows'.
>
> 'If something came up, little points, not big teaching sessions necessarily, she would talk through, when she had chance, why we had done this or that. She just seemed to have time for you ... It was no big lecture thing but she was a very helpful person'.

SUMMARY OF FINDINGS - interviews with trainees

The information obtained from the interviews met the objectives of Phase 1. The main findings are as follows:-

1. Trainees are more likely to enjoy work experience: when the level of stimulation is high and they feel active and involved; when relationships on the ward are satisfying and they feel accepted as part of the ward team; when they feel they are being 'taught'; when nursing patient groups for whom they have a high level of empathy.
2. Task allocation was the most common practice of work management experienced by trainees at the time of the interviews (1977-78).
3. Induction routines concentrate on introducing trainees to the physical environment and to patients and colleagues. Some wards have a typed handout available for trainees; these list a nursing experience available and/or procedures to be taught rather than objectives (goals) to be achieved. It was not customary for sisters to discuss learning needs and objectives in depth with trainees during the induction interview at that time (1977-78).
4. Active teaching during slack periods was experienced by 24% of trainees; 19% reported carrying out cleaning tasks during slack periods.
5. Trainees expressed satisfaction at the level of support and supervision given for technical nursing tasks.
6. Sister is the key figure for theoretical teaching i.e. teaching of nursing knowledge. Sisters share equally with State Enrolled nurses and staff nurses in the teaching of nursing skills.

67% of trainees reported being reluctant to discuss problems of an emotional nature with ward staff.

sition of knowledge by 37% of trainees. A few trainees saw learning in terms of the acquisition of new skills and behaviours. Similarly the majority (37%) saw teaching in terms of passing on information; (13%) defined teaching in terms of helping learning take place.

8. There was 90% agreement that practical skills are more meaningful and realistic when taught and learned on the ward. Less support was expressed, however, for the view that nursing skills should be practised as taught in theory; 17% only felt that they should, 69% expressed the view that although that was the ideal it was not a practical reality.

9. The teaching role of qualified nurses is clearly recognised by trainees. 37% saw teaching in the service area as the responsibility of all qualified nurses. 33% saw the prime responsibility resting with sisters and charge nurses, 17% clinical teachers (mainly pupils). Of the remainder, one trainee specified 'staff nurses', one 'anyone more experienced', and one saw the responsibility resting with the trainee.

10. 37% of trainees felt they needed more help with theory or help in relating theory with practice. 10% felt they would have liked more help and support in the early days of ward experience.

11. Significant learning i.e. learning which is meaningful to the learner, more pervasive and lasting, is more likely to occur when:-

    11.1 the whole person is involved i.e. feelings as well as intellect.

    11.2 when emotional support is available and threat to 'self' is low.

    11.3 when the learner has to confront a practical, social or ethical problem and apply a solution.

11.4 theory is directly related to practice, i.e. the learner sees theory as having relevance for his own purpose.

11.5 when there is 'readiness' to learn in terms of background knowledge and experience. New ideas and information can only be learned to the extent that they are related to concepts already acquired which act as anchors.

11.6 in the case of learning from role models, the modeller is esteemed by the learner.

11.7 when the learner is helped to organise newly learned concepts, i.e. the 'teacher' gives tips and hints that aid learning. This applied to the learning of both the theory and practice of nursing.

12. Learning is inhibited:-

12.1 when physical and emotional factors interfere i.e. the learner is too anxious, too threatened, too bored, too tired, feels unappreciated i.e. feels trained staff are not interested in them.

12.2 when the learner lacks relevant background knowledge and skills on which to anchor newly learned material.

12.3 when there is insufficient time to follow up and evaluate a new experience.

13. Behavioural characteristics of effective ward teachers (49 in all) have been identified (see Appendix C page XXV). The characteristics relate to four areas of competence, that is, professional, managerial,empathic,and instructional competencies, and personality traits.

14. The ward sister is the predominant figure in ward teaching, being named by 58% of trainees as the best teacher for them.

15. More clinical teaching and/or teachers was suggested by 50% of trainees when asked for 'ways of improving nurse training'.

INTERVIEW FINDINGS - sisters

Twenty-one sisters out of the twenty-two initially selected were interviewed. All were in charge of teaching wards covering general medicine and surgery and a range of specialities (see page 59).

The first three questions asked for biographical information: the type of ward and number of beds, sex and social background of the patients and the type of nursing and medical problems most frequently encountered. This gave the sister time to relax from ward duties and settle in to the interview. The wards concerned carried a range of nursing activities coming under the broad headings, curative, caring, rehabilitative, basic and technical nursing.

Trainee allocation

The number of trainees on the wards at time of interview ranged from 0 to 10; the mode was 4. Fluctuations within this range were reported by most sisters. This was considered at the time to be due to a computerised allocation system.* The sisters in charge of general, medical and surgical wards reported a predominance of first year trainees in their allocation, the orthopaedic ward a predominance of third year nurses. Two sisters felt too many trainees on the ward made it difficult to meet training needs, particularly if they were at the same stage of training.

Trainees spent a period of from six to eight weeks on each ward, the exceptions being a sixteen week stay on a geriatric unit and a one week stay on a geriatric day ward. All the sisters felt an eight week stay was an adequate training period providing trainees did not go on night duty too soon, that is, after one or two weeks on the ward.

A stay of less than four weeks was felt to be inadequate; longer off duty periods sometimes resulted in trainee and sister not meeting,

*Since changed to a manual system.

in some instances, for as long as two weeks; difficulties then arose when assessment time came around. Two sisters, one on the Accident and Emergency department and one on the Ear, Nose and Throat ward, felt time allocated for their speciality was not long enough.

Trained staff

There were a total of 105 trained staff for 21 wards (76 full-time, 29 part-time). The length of stay of trained staff ranged from three months to five years, with an eighteen month stay being the most frequently reported.

Work routines

The most predominant work routine is task allocation, that is, trainees are allocated tasks to carry out baths, temperatures, for example, rather than individual patients to care for.

Work routine	No. responding
Task allocation	17
Team nursing	1 - (a geriatric unit)
Total patient care	3 - (2 medical & 1 surgical ward)

The sisters practising total patient care were highly satisfied with the system. Of those who were reported using job allocation, four had tried total patient care but given it up. All four were on surgical wards. The reasons given were:-

'Not enough trained staff'

'Not enough equipment'

'Not practical'

One sister expressed a desire to practise total patient care, but felt she didn't know enough about it.

Most sisters planned and allocated the work routines themselves with the exception of those practising total patient care; in this case nurses were responsible for planning their own work routines. Some ward sisters had a written work list, others relied on the Kardex and verbal instructions.

Slack periods

A period in the afternoon when staff overlapped was reported by 11 sisters as the quietest time. The remaining sisters reported either no slack periods or too few or too random to be used systematically. Six of the sisters reporting slack periods stated these were used for study - 28% of the total sample. One sister allowed trainees to study when routine tasks were finished. On one ward, cleaning tasks were done in slack periods. On a geriatric ward, nurses were encouraged to play games with or talk to patients.

Study periods

When questioned further on what was actually done in study periods this was found to include:

Self-directed study

e.g. 'Reading case notes'

'Studying text books' (ward library or trainees own)

'Writing case studies'

Study involving trained staff

e.g. 'Lectures'

'Case discussions'

'Quizzes and questions'

Subjects covered in lectures included:-

'Cardiac arrest'

'Drugs'

'Family planning'

'Ear, Nose and Throat' (set course of lectures given by ENT sister which included use of models)

Case discussions tended to centre on patients with rare or interesting conditions rather than the more common conditions.

Teaching and learning on the ward

The remainder of the interview (sections B & C) concentrated on perceptions about and methods of teaching and learning in the ward environment.

Learning Definitions

Most sisters found it difficult to say what they meant when they used the word learning. Of the 11 sisters attempting a definition, the majority saw learning in terms of gaining knowledge. One geriatric ward sister defined it as a change in attitude. In the discussion that followed the question 'What do you mean when you talk about learning?' the following comments emerged:-

8 saw learning as a continuous and universal process:

'We are all learning all the time'

3 mentioned that learning is a two-way process:

'We learn from the trainees'.

How much is to be learned?

The responses to the question 'How much can nurses learn on your ward?' were as follows:-

'Very much'	5
'A lot'	10
'Quite a lot'	4
'Too much'	1

learned depended on the initiative of the trainees.

What is to be learned?

The question 'Can you tell me of at least six important things you expect all nurses to learn on your ward?' produced a variety of responses.

Nine sisters listed specific nursing tasks when asked this question, these sisters working on acute medical and surgical wards.

Surgical ward sisters - the list included

aseptic technique

fluid balance

pre-operative and

post-operative care

intubation

care following specific conditions e.g.

mastectomy, prostatectomy

Medical ward sisters - the list included

basic nursing care

care of coronary patients

assisting medical staff

A number of sisters stressed the importance of 'treating the patient as an individual', when listing things important to learn. When questioned further, however, the sisters were unable to describe how they would recognise this in terms of observed behaviour.

Three sisters saw changing attitudes as most important. These were sisters in charge of geriatric wards. Specific nursing tasks were not mentioned by any of these sisters.

Geriatric ward sisters - the list included

respect for the patient as an individual

getting the patient's confidence

encouraging independence

communicating with the elderly

coping with incontinence

learning to work in a multi-disciplinary team

Two sisters included understanding the psycho-social background of the patient in their list; these were a nurse in charge of an Accident and Emergency Unit and a Gynaecological ward sister.

Other responses were as follows:-

Accident and Emergency - list included

resuscitation and maintenance of airway

Ear, Nose and Throat - list included

administration of nasal drops

bandaging

care of tonsillectomy patients

tracheostomy

use of drugs in ENT cocaine for example

Gynaecology - list included

write a report

vulval swabbing

taking a high vaginal swab

None of the following was mentioned as being an important thing to learn while on the ward, with the exception of the one listed above.

Communicating with patients, relatives and staff

Decision making, team building or allied nursing management skills

Legal/ethical implications of nursing practice

Which nursing skills were considered important depended on the individual sister's values and beliefs about nursing and nurse training. This in turn depended on the type of nursing carried out i.e. curative or caring. Those sisters on acute wards with a high patient turnover rated the ability to carry out technical nursing skills as important. Sisters on longer term caring wards valued attitudes more highly.

Assessing learning

The responses to the question 'do nurses learn these important things?' were as follows:-

'Majority do'	(9)
'Think/hope so'	(3)
'Not always'	(2)
'Reasonably competent'	(1)
'It's up to them'	(1)

The majority of ward sisters, then, are reasonably confident that trainee nurses were learning what they wanted them to learn from ward experience.

With regard to how assessment was carried out, no clear pattern emerged. Two ward sisters had a written programme listing experiences available. Trainees were interviewed pre, during, and at the end of ward experience, initialling on the list those experiences or procedures completed. A sister on a geriatric ward had a similar system using a wall chart and different coloured pins to indicate levels of proficiency. Other responses to the question 'How is learning assessed?' included:-

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*NB The nursing process was only just beginning to make an impact in 1978.

'I discuss it with the trained staff'

'By working with the trainee'

'By the final interview'

'It's a gut feeling'

None of the ward sisters interviewed used objective measures for assessing learning, relying in the main on subjective impressions. Where experiences available were specified, no criteria for standards to be reached was included.

Learning difficulties

Question 4 asked the sisters for nursing skills and/or knowledge trainees had difficulty in mastering, possible reasons for the failure to learn and suggestions for helping trainees learn more effectively. This question produced a variety of responses, some of which were conflicting. (See table overleaf)

Learning difficulties - sisters' responses

Learning problem	Reason	Possible solution
Patients' names & diagnoses	quicker turnover of patients	more time to spend with trainee
Medical terminology (x3) Medical tests and investigations (x3)	advances in medicine	
Drugs	advances in pharmacology	
Mechanics of skeletal traction	emotional block	
Fluid balance (x2)	not seeing relevance	
Welfare & Social aspects of patient care (A&E)	new experience	
Observations e.g. TPR	familiarity obscures importance	more time to explain
Wanting to go too deeply into medical treatment		more guidance from tutors
How to encourage independence in the elderly	lack of understanding of aims of geriatric care	
Communications		total patient care
Passing a Ryles tube		
Developing right professional attitudes		

Sisters were quite specific in answering this question. Trainees, when asked a similar question, that is 'What would you like more help with?' tended to give more generalised answers. 'Help with theory' or 'Relation of theory to practice', for example, rather than mentioning specific difficulties.

Learning difficulties - trainees' responses

Number responding	Learning Problem
5	Needed help with theory
4	Needed help with application of theory to practice
1	Needed more feedback on progress
8	Can't think of anything

It is difficult to draw any inferences from this finding. It could be that trainees are unaware of their personal weaknesses or had interpreted the question differently from the sisters?

Whom do trainees go to?

The responses to this question were in line with the trainees responses:-

Subject	Whom they go to	Number responding
Theory	Sister or staff nurse	9
Practical	Sister/staff nurse	6
	Any member of trained staff	8
	SEN	7
Personal/ interpersonal problem	Sister	2
	SEN	2

Sisters were, in the main, unable to say to whom trainees go with personal or interpersonal problems. Three sisters were aware that trainees were reluctant to approach anyone on the ward with

such problems:-

'They don't seem to ask anyone'

'I often find these things out by chance from a third person'

'I seem to get those (personal/interpersonal problems) second hand'

One sister denied having interpersonal problems on her ward:-

'I don't have any of those types of problems on here'

Best Teacher

When the sisters were asked to name a member of their staff particularly good at helping trainees, 13 named a State Enrolled nurse, 4 a staff nurse, and 2 a charge nurse. The remaining sisters responded:'All my trained staff are good at teaching'.

When asked to say why they felt the person named was so good at teaching, answers were as follows*:-

Quality	Times mentioned	Quality	Times mentioned
'Excellent nurse'	x 5	'Quiet & reserved'	x 2
'Understanding'	x 5	'Kind'	x 2
'Motherly'	x 4	'Good at explaining'	x 2
'Professional'	x 3	'Sympathetic'	x 1
'Very experienced'	x 3	'Likes teaching'	x 1
'Friendly and approachable'	x 2		

These findings correlated with those of the trainees with the exception that more sisters selected an SEN, when asked to name a person particularly good at teaching on the ward, than did the trainees (62% of sisters as opposed to 19% of trainees).

*Data from interviews with sisters and trainees have been combined for analytical purposes. (See Appendix C page XXV)

It is probably better to resist the temptation to read too much into this finding. It may, however, be an indicator of the power and influence of the ward sister role. A trainee will be more likely to be impressed if a ward sister has shown an interest in his/her progress and equate this with teaching.

What factors help trainees learn on the job?

Sixteen sisters felt that good relationships on the ward, that is, a good team spirit, was the most important factor. This factor was also noted by trainees. The next most important factor was having sufficient experienced trained staff willing and able to support trainees, mentioned by five of the sisters.

Other factors rated as important included 'getting them involved', four, 'good communications' three, 'a well run ward' three.

Summary of all responses

Factors helping trainees learn	No. responding	%
Good relationships/atmosphere/ team work	16	76
Sufficient experienced trained staff willing and able to support trainee	5	23
Getting trainees involved	4	19
A well run ward	3	14
Good communication	3	14
Good standards of nursing	2	9
Encouraging them to ask questions	1	5
Practising total patient care	1	5

While it would be unwise to draw any conclusions from such a small study, this particular finding has paralleled that in the Orton and Fretwell studies.

> 'The hallmark of a high student orientation ward was the combination of teamwork, consultation and ward sister awareness of the needs of subordinates ... in contrast, low student orientation wards presented the opposite side of the coin. Teamwork, consultation and ward sister awareness of need were either absent or deficient'. (Orton, 1979, page 144)

Ward sisters taking part in this particular study would appear to be well aware of at least one of the factors that help trainee nurses to learn in the ward environment, that of good team relationships.

Which trainees are rewarding to teach

Trainees who are interested in what is going on and who ask questions were found to be the most rewarding to teach. Other factors mentioned included:-

'Able to accept criticism in the right spirit'	x 1
'Responsive trainees who give feedback'	x 1
'Those who fit in'	x 1
'Well mannered' (I'm old fashioned)	x 1
'Those who have failed once' (a challenge)	x 1

Those sisters who gave the responses 'Well mannered' and 'Able to accept criticism in the right spirit' were of the older age group. They were well aware that their attitudes may be considered 'old fashioned' today, but both expressed some regret at what they saw as the changed attitudes in present-day nursing students.

Teaching (section C)

This section of the interview concerned the teaching responsibilities of sisters and charge nurses viz their role as ward managers, the means by which their teaching function is fulfilled, and preparation given for this function.

Most important activities

When asked what they saw as their most important activities as a ward sister, 15 (71%) included 'organising safe patient care', 'teaching trainees' was mentioned by eight sisters, (38%),all except one placing it second in importance to other duties. Less frequently mentioned were 'maintaining good communications' four,'building a team', and 'co-ordinating care' (one sister in charge of a geriatric day centre).

Administrative work, filling in forms, making and taking telephone calls,for example, although not rated as important, was seen by 81% of the sisters as taking up the most of their time. Many expressed resentment at the amount of time they had to spend on paper work,feeling it kept them from the patients. It would seem that these particular sisters see themselves as nurses first and managers second.

Whose responsibility is it to teach on the wards?

12 sisters responded 'Myself' when asked 'Who should have the major responsibility for seeing that nurses learn on the ward?'. For some this was seen as the ideal,but not always feasible in reality e.g.

> 'Ideally the sister, she knows what's best and what matters, it's a question of overcoming the problem of time'

> 'The sisters,really, the students expect it of you'

A further seven saw it as a joint responsibility, that is, shared between service and tutorial staff. One sister saw it as the responsibility of all trained staff and one put the responsibility for learning firmly on the trainee.

The teaching of practical nursing skills

The view of the majority of the sisters was that practical nursing skills are best taught on the wards. The reason given for this point

of view included:-

> 'It is so artificial in school, you bath a dummy and its leg falls off'

> 'It's more difficult on the ward when they are dealing with the real thing,but more realistic'

13 felt practical skills were best taught in the training school

> 'Initially in school; they don't seem to get the practice of basic things in school today'

Should procedures be practised in the ward as taught in school?

Sisters were more emphatic than trainees in their responses to this question. 12 gave an unqualified 'yes' stressing that it was important. A further 4 gave a qualified 'yes' response e.g.

> 'Yes, I think they have improved the procedures but it is difficult to stick rigidly to the book'

The remaining 5 were not asked this question due to shortage of time.

What cannot be taught on the wards

Four sisters felt it would be difficult to teach theory on the ward due to lack of time or their own feelings of inadequacy in this area.

> 'I wouldn't like to go deeply into theory,It is a while since I did any'

One sister felt that some 'things' do get left out

> 'Talking to bereaved relatives,for instance,you have to learn it by experience.There are no set rules'

The remainder felt most things could be taught on the ward given sufficient time and staff with expertise.

The next few questions were designed to elicit which routines were used to introduce new trainees to the ward, and the measures taken to assess the trainees' pre-knowledge and skills.

Previous knowledge and experience

Of the twelve sisters* who were asked this question, all attempted some form of assessment of previous experience, usually at the first interview. This took the form of asking a trainee what wards had been worked on and what procedures had been done. The impression given was that this preliminary interview is a superficial one; in some instances assumptions are made about a trainee's previous experience and standard of expertise -

e.g. 'If they have been on a surgical ward we know pretty well what they should know'.

Induction routines

The induction routine followed a standard pattern. New trainees were interviewed by sister, usually on the first day, who explained ward routines and her expectations of the trainee. A conducted tour of the ward, either with sister or another member of the trained staff, followed the interviews. It was frequent practice for the trainee to be put to work with one particular member of the permanent staff until 'settled' in, the settling in period varying from one or two days to a week. There were variations to this routine, two sisters preferring to interview trainees after the settling period; that is, after the first week. The geriatric day hospital sister approach was less formal, trainees joining staff over a cup of coffee on the first morning. There is an apparent discrepancy between trainee's and sister's accounts of induction procedures, that is, 12% of trainees reported being set straight into work without a formal introduction during their last ward experience. This could in part be accounted for by absence of the sister on holiday, sick leave or leave of absence.

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*NB In some interviews questions had to be omitted due to shortage of time.

Questioning by sisters

Most sisters (61%) reported asking trainees questions i.e.

When working with trainee	6
During reports	2
During drug rounds	2
At end of period on ward	2
During slack periods	1

Questions asked related to topics such as:-

Nursing care

Patients' names and diagnoses

Drugs: actions and side effects

Diagnostic tests

What to do in emergencies

One charge nurse disliked formal questioning, encouraging trainees to formulate their own questions, then find out the answers for themselves from a file of reading materials kept in the office. The materials were off-prints of articles from nursing journals, typed hand-outs and diagrams. Two sisters gave trainees essays to write and one had compiled a set of multi-choice questions.

Sisters reported doing more teaching to students who were actively interested and those who were approaching examinations.

Time for teaching

Five out of the eighteen sisters answering this question (27%) reported having little time for teaching; these were sisters from 'acute' wards i.e. medical, surgical, orthopaedic and accident and emergency unit.

A further four (22%) felt that plenty of time could be found for teaching if trained staff were interested; two of these sisters were

on acute wards and two on geriatric wards. Three sisters (16.6%) took a much broader view of teaching and learning, emphasising that it was going on all the time; by example, 'by doing' and during activities like report sessions. The question 'If you had more time what would you do that you don't do now?' brought a variety of responses:-

Go over things in more detail	4
More case discussions with trainees	3
Carry out more nursing care with individuals	3
Prepare visual aids	2
Give trainees projects to do	1
Ask more questions	1
Personal study	1
Not asked	5

Value of doctors' rounds/ward reports

There was general agreement that the value of doctors' rounds depended on the doctor. Some doctors were excellent teachers, knew what the nurses wanted, others went too deeply. Surgical ward rounds were frequently stated to be too hurried to be of value. Ward reports were considered invaluable for teaching purposes.*

Best ways of teaching on the ward

Eight sisters felt they had nothing to add to what they had already said, when asked this question.

Those who did respond answered in the following way:-

Demonstration and practice	3
Teaching by example	3
Involving trainees	2

*For further discussion of the value of ward reports see page 146.

Support from trained staff	1
Total patient care	1
Make them seek knowledge	1
Lectures	1
Nothing to add	8

Training for the teaching role

Training and teaching methods is a topic often included in first line management courses and six sisters had experienced such training. Ten had attended an 'art of examining' course.

One sister had attended a short seminar on teaching techniques, two had no training at all. For the remainder the interview had to be concluded before this question was reached.

Six of the sisters (28.5%) were assessors for the General Nursing Council's ward based practical examinations.

Development courses

Of the sisters responding to this question seven (one third of the sample) felt a need for more 'clinical updating' courses; reading nursing journals was not considered sufficient. One sister only expressed a wish for a course to develop her teaching role.

Satisfaction with present system of training

Of the eleven sisters answering this question two only expressed satisfaction, the remainder feeling there was a need for improvement. Some specific criticisms were:-

'I don't think they get sufficient support in the school. We have more failures now'

'The theory should be more related to practice'

'The discipline has gone now'

'The students are apathetic, they need spoon feeding today'

'There are too many distractions. Many of them are married nowadays'

Suggestions for improvements included:-

'More tutors on the ward/more clinical teaching'

'Modular system and study days'

'More trained staff to support trainees'

The last question asked the sisters how long they had been a sister. The responses varied from eighteen months to sixteen years, four years being the mode.

SUMMARY OF FINDINGS - interviews with sisters

The main findings were as follows:-

1. Ward allocations - periods of less than four weeks were considered useless for training purposes: eight weeks was considered the optimum.
2. Task allocation is the most common practice; 81% of sisters interviewed practised job allocation, team nursing 5%, total patient care 14%.
3. Study in slack periods - 52% of sisters reported a slack period during the afternoon.
4. Study activities encouraged by sisters in slack periods included reading case notes/text books, writing nursing care studies, case discussions, quizzes and questions, lectures by trained staff.
5. Learning - eleven sisters attempted to define teaching and learning; of these 52% saw learning in terms of 'gaining knowledge', one associated learning with a 'change in attitude'.

52% saw learning as a continuous and universal process. 14% saw it as a two way process. All sisters felt there was much to

learn on their particular ward, one expressed it as 'too much'.

6. What is to be learned - 43% of sisters listed specific nursing tasks as important things to learn. 14% mentioned changing attitudes (all on geriatric wards). 43% included treating the patient as an individual in their list. 10% included understanding the psycho-social background of the patient.

7. Assessment of learning - 62% of sisters were reasonably satisfied that nurses did learn what they wanted to learn on their ward; 10% reported nurses as failing to learn at times. Assessment of learning was mainly by subjective impressions, no objective measures were used.

8. Learning difficulties. Sisters were much more specific about learning difficulties than the trainees, naming particular topics or skills e.g. passing a Ryles tube, medical terminology and drugs, as being difficult to learn.

9. Whom do trainees go to with questions and problems? Sisters reported themselves as the key figure approached to answer theoretical questions.

   Practical nursing queries - sister, staff and SENs have equal shares.

   Interpersonal problems - sister 13%, an SEN 13%. Most sisters were aware that trainees are reluctant to approach anyone on the ward with interpersonal/personal problems.

10. Best teacher - the findings here correlate with those of the trainees.

11. Factors that help trainees learn on the job. 76% of sisters considered good staff relationships on the ward as the most important factor, 23% having sufficient trained staff willing and able to

support trainees; other factors included good communications 19%, getting trainees involved 14%, a well run ward 14%.

12. Trainees who are rewarding to teach. 38% found trainees who are interested and ask questions as the most rewarding to teach.

13. Role and responsibilities - most important duties; organising safe patient care was seen by 71% of sisters as their most important duty.

Teaching trainees mentioned by 38%, all but one sister placing it second in importance.

14. Whose responsibility is it to teach on the ward?

Sister	59%
Joint school/ward staff	29%
All trained staff	6%
Trainee's own responsibility	6%

15. Where should practical nursing skills be taught?

Wards	85%
Training schools	15%

16. Should nursing procedures be practised as taught in school?

57% gave an unqualified yes

19% gave a qualified yes response, relating some of the difficulties e.g. shortage of time and equipment.

17. What cannot be taught on the ward?

Theory 19%. Lack of time and inadequacy of knowledge were mentioned as deterring factors.

Communicating with patients and relatives. It was considered that this skill could be learned by experience only.

18. Assessing a trainee's previous skills and knowledge.

This is assessed mainly by interview i.e. 57% of sisters reported asking trainee what wards had been worked on; no further probing appeared to be done.

19. Induction routines. A set pattern is followed, that is,an interview with sister, then a tour of ward, trainee then attached to a permanent member of staff for the rest of the day or longer in some cases.

20. Questioning practices. 61% of sisters reported asking trainees theoretical questions, mainly when working with trainees (47%).

21. Time for teaching

'Little time'	27%	(all on acute wards)
'Plenty of time if you want to teach'	22%	(11% on geriatric wards) (11% on acute wards)
'Going on all the time'	16%	

22. Training for the teaching role

52% had attended an art of examining course

24% had had instruction in training techniques in a first line management course.

28% of sisters were General Nursing Council assessors.

23. Staff development courses - one third of the sisters interviewed felt a need for clinical updating courses. One sister only expressed a desire for more training in training techniques.

24. Satisfaction with present system for training nurses - 18% only were satisfied with present system, remainder felt improvements were needed. Suggestions for improvements were:-

'More tutors on the ward'

'More trained staff to support trainees'.

EFFECTIVE 'TEACHING' BEHAVIOURS - analysis of questionnaire

Data from the interviews suggested that the teaching and learning of nursing is a complex process in which the human factor plays a very important part. The quality of the interpersonal relationship formed between learners and those who support and train them in the clinical area would seem to be a significant factor in learning.

Verbal descriptions

The purpose of this study is to identify the behavioural characteristics of effective ward teachers. Forty-nine statements describing characteristics were collected during interviews; some were mentioned more frequently than others (see Appendix C page XXV). The characteristics were found in all grades of staff: sisters, charge nurses, State Enrolled nurses and other trainees; whoever the trainees chose to describe as the nurse from whom they had 'learned the most' in the ward situation (see table on page 85). It will be seen from the table that more ward sisters were nominated than other grades of staff: an indication of the nature, power and influence of the ward sister role (a phenomenon also noted by Dodd (1973)).

The most frequently mentioned characteristic was: the 'good teacher' took up all opportunities for teaching. For example:-

'She would explain everything you wanted to know'

'Every opportunity she would take me and show me'

'She seems a person who really wants a trainee to achieve a high standard'

'He took every new nurse to work with him personally for a week'.

In other words the person described was interested in teaching the trainee and sharing knowledge.

Ranking second after 'interest in training' was nursing competence.

'She was such a good nurse'

'She instilled confidence'

'She was very professional'

'She kept good standards of nursing'

'She knew her job inside out'

'She was conscientious'

The clinical practioner who is valued as a teacher is also perceived as caring for patients: e.g.

'His patients were his prime concern'

'She was interested in the welfare of the patients'

'You feel more confident with a sister who cares for her patients'

and as a competent manager -

'The ward ran like clockwork'

'He organised the work well'

'She had things under control, the ward ran the same whether she was on or not'

The professional image projected by a potential teacher would appear to be a very important factor in the teaching and learning of nursing.

While trainees like a respectful distance between themselves and those who teach them, it must be a gap that can be bridged.

'She isn't stiff and starchy but she commands respect'

'She didn't make you feel she was the sister and you were only a pupil'

'She treated you as more as an equal'

They also need to feel valued and of worth to the ward team.

'You feel as though you are wanted on there'

'She made you feel part of the ward team'

Characteristics which indicate a high level of empathy in the individual were also frequently mentioned e.g.

'She understood how I felt'

'She knew what it was like to be new'

'She could always recognise a situation where you weren't learning, she was magic. She knew when you weren't taking something in she was explaining'

Communication skills are also important.

'She checked you had understood'

'Other sisters haven't explained as well as he does, they go too deep'

'She is able to put things in words I understand'

Personality attributes were mentioned,but less frequently than other factors; patience, kindness and a sense of humour were the attributes mentioned more than once. Also a happy and lively or calm and unhurried personality.

Consistency, openness and approachability are important, as is sensitivity to a trainee's feelings.

'You knew where you stood with her'	(consistency)
'She would tell me her feelings about a patient and I found I felt the same way'	(openness)
'You could tell her if you didn't understand whereas you daren't do that to some people'	(approachability)
'If anyone does anything wrong she corrects them in a nice way'	(sensitivity)
'She didn't bear grudges'	(emotional maturity)

Skills which could be considered as formal teaching skills were mentioned,but less frequently than either professional or human relationship skills e.g.

'She puts things over in an interesting way'

'She gives you the main points of patient care right back to outpatients so when you write an essay you can remember the main points and fill it in'

'If you know why you are doing something you are more likely to learn, some (sisters) are good at showing you how but not telling you why'

'He asked me questions to find out what I already knew'

The forty-nine statements, then, covered four areas of human competence, that is, some concerned general professional conduct, others described personality attributes and a third group could be loosely termed human relationships skills. The remainder were descriptive of behaviours that could be classed as instructional skills.

It appeared from the raw data that these four factors underlie effective ward teaching behaviour as perceived by trainee nurses. It is unwise to make generalisations from such a small sample, however analysis of data from the questionnaires (ninety-six subjects) did seem to support the findings.

QUESTIONNAIRE FINDINGS

Positive statements

Analysis showed that twelve of the characteristics described in the questionnaire were considered to be strongly related to good teaching by more than 70% of the respondents. Five of the twelve produced a response rate of over 80%. That is:

2/1* 'Sets a good example at all times'

2/14 'Displays high standards'

4/4 'Shows care and concern for patients' needs'

17/31 'Always has time for trainees'

42/22 'Gives hints and tips to help learning'
(see Appendix C page XXXI fig.1)

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*number of interview statement/number of questionnaire statement. The questionnaire is in Appendix B pages XIII to XVII, interview statements are given in Table I Appendix C page XXV.

Slightly fewer respondents rated the following characteristics strongly related to good teaching.

7/39 'Capable and competent'

8/48 'Always there when help is needed'

9/64 'Gives correction quietly and in private when needed'

13/49 'Is able to explain things simply'

21/42 'Is respected by staff and patients'

22/57 'Is knowledgeable about nursing'

44/26 'Enjoys his/her work'

(see Appendix C page XXXIII fig. 2)

These figures agree reasonably well with the interview findings. The characteristics mentioned more frequently in the interviews were ticked as strongly related by a larger number of respondents. There were a few exceptions: number 42, 'Gives hints and tips to aid learning' was mentioned less frequently at interview but was considered to be strongly related by 80% of respondents on the questionnaire. Similarly, statement number 44 - 'Enjoys his/her work' was put into words by only one interviewee but rated highly by 74% of the respondents on the questionnaire. It was obvious from the verbal descriptions that 'good teachers' transmit their enjoyment of nursing, even if this was not actually put into words by the interviewee. Conversely some characteristics mentioned frequently at interview were lower down the scale when rated on the questionnaire.

1/52 'Takes every opportunity to tell and show'

the most frequently mentioned characteristic at interview was rated 'strongly related' by only 45% of questionnaire respondents.

There was also less polarisation on factors that could be categorised as personality traits or human relationship skills.

15/17 'Is a motherly/fatherly sort of person'

45/65 'Is quiet and reserved'

3/54 'Communicates person to person'

Linked statements, that is, numbers 11 and 53, also showed a similar response rate.

It would seem that individual preferences for particular personality traits or interpersonal behavioural styles are operating here. Responses to statements indicative of an open non-directive style of interpersonal behaviour were also less discriminative.

*47/10 'Is open about his/her feelings'

* 25 'Encourages trainee to express his/her own opinions and ideas'

24 'Conveys that he/she has trust and confidence in trainee'

(see Appendix C page XXXVI Fig. 3)

Of particular interest is the pattern of responses to characteristics which could be considered related to instructional skills.

19/47 'Gives feedback on progress'

20/36 'Gets trainees to work things out for herself'

26/18 'Sets goals for trainee to achieve'

27/9 'Prepares and uses teaching aids'

Behaviours that nurse educators would probably consider as strongly related to good teaching practice are considered less so by trainees. The exception was with statements concerning the relation of theory to practice.

11 'Teaches the "why" of nursing care as well as the "how" '

NB *Responses to these two statements, which were additions to the original forty-nine, may be an indicator of the hierarchical nature of nursing. This is discussed more fully in the section on conclusions and recommendations.

29/34 'Relates teaching to real life experience'
(see Appendix C page XXVIII Fig. 4).

Theory becomes more meaningful when linked to real life work experience.

Negative statements

Responses to the negative statements included in the questionnaire tended to be less discriminative. This was probably due to variations in interpretations of the meaning of the statements.

Those that showed a tendency to polarisation were:-

- 12 'Stays in the office and allows staff to get on with their work'

*+ 12/40 'Takes all opportunities to work with trainees'

- 61 'Does not carry out basic nursing care'

*+ 31/27 'Carries out basic nursing care when necessary'

- 33 'Corrects trainee immediately wherever and whenever a mistake is made'

*+ 9/64 'Gives correction quietly and in private when needed'

(See Appendix C page XXXIX fig. 5)

Trained nurses perceived as good teachers are those who work with trainees when opportunities arise and are seen to be involved in giving basic as well as technical nursing care.

Analysis of total score

The statements were rearranged using a total entropy score. Entropy being a measure of uncertainty, the lower the score the more certainty is being expressed about a particular statement. Using the entropy score, the statements were re-ranked (see Appendix C page XLII).

The characteristics ranking the lowest on entropy (that is, expressing less uncertainty) are those concerned with professional

*Positive statements collected at interview.

image and a general care and concern for others.

e.g. 'Good nurse with high standards

'Cares about patients'

'Always has time for trainees'

'Capable and competent'

These characteristics were also the most frequently quoted in the interviews. It would seem that the 'role model' presented to trainees is an important factor in the teaching and learning of nursing, as is skill in handling interpersonal relationships.

Differences between groups

Entropy scores enable differences between the groups of learners to be identified. First year students and pupils show a similar pattern of entropy scores on certain factors i.e. professional characteristics, human relationships and teaching competencies. (See Appendix C page XL figure 6.) The entropy scores were lower for first year trainees on characteristics 18, 21 and 23 and 43, all relating to professional image:-

e.g. 'Very professional'

'Respected by staff and patients'

This may indicate that learners are more strongly influenced by the 'professional' role model in their first year. Entropy scores on personality characteristics did not show so much variation, first year students showing a lower score here. Scores on human relationship factors were also lower for first year nurses e.g. characteristics numbers 8 and 17 'always there when help is needed'/'always has time for trainees' and 37 'ensures trainees feel part of ward team'. This response pattern may be indicative of a greater need for personal support in the first year.

When we look at responses to characteristics linked to teaching

competence, entropy scores of first year nurses again tended to be lower than those of second or third year trainees

No. 1 'Takes every opportunity to tell, teach, show'

No. 13 'Explains things simply'

No. 25 'Asks relevant and stimulating questions'

No. 28 'Checks for understanding'

and on numbers 40, 41 and 42, characteristics linked to formal teaching skills.

There is an obvious need for more formal teaching, simplification and clarification in the first year of training. Some differences were noted in the entropy scores of third year student nurses. The scores for this group of learners tending to line up with first year nurses on professional and human relationship characteristics, rather than second years. Entropy scores were low for this group on the following:-

No. 4 'Cares about patients'

No. 22 'Knowledgeable about nursing'

No. 7 'Capable and competent'

No. 8/17 'Always there when needed'/'always has time for trainees'

No. 9 'Gives correction appropriately'

No. 13 'Explains things simply'

This pattern of responses may indicate a returning need for support and identification with a role model in preparation for assuming the responsibilities of a trained nurse.

The statements were re-ranked and classified into the four category areas discussed previously, that is, professional competence, personality traits, human relationship skills and instructional competence(App.C page XLIV). The profile that emerged was a subjective view

drawn from examining the raw data. However, in order to produce more reliability and to reduce the number of variables, the responses to the 70 items on the questionnaire were factor analysed.

FACTOR ANALYSIS

The first step in the process was the computation of a correlation matrix for all 70 variables; the following items were noted to produce the highest number of correlations or clustering:- (see Appendix C page XLVI Fig. 7)

No. 31 'Always makes time to answer questions'

No. 46 'Gives responsibility of a degree trainee can cope with'

No. 48 'Is always ready to offer help when needed'

No. 70 'Checks that information absorbed is understood'

The 70 items were then analysed using principal factors followed by a Varimax rotated factor matrix. Three factors were identified, not four as was anticipated from the raw data (see App.C page XLVIII table.3).

As some of the correlations were low the data were re-analysed using an oblique solution*. The second run produced higher correlations and two factors were identified. Factor one concerns general values and attitudes to learners and factor two the personality characteristics of effective teachers. (Appendix C pages L - LI).

It would seem from this statistical analysis of the data that effective ward teaching, from the learners' perspective, is a global concept. What a trained nurse is is as important as what she does in the sphere of ward teaching and learning.

We can assume from this more rigorous analysis that nurses perceived by trainees to be effective teachers, are caring, competent nurses and skilled team leaders. They are sensitive to learners'

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* An oblique solution is preferable when factors are correlated, an orthogonal solution when factors are uncorrelated or independent of each other.

needs, make efforts to motivate and involve them and give feedback on progress when needed. They are skilled at interpersonal communications and in total would appear to be acting out of a personal value system of care and concern for others.

Good teacher profile

To conclude this section on the characteristics of effective teachers I would like to summarise a finding of Dodd, in her study of the phenomenon known as the 'nursing problem' (Dodd, 1973). In her interviews with trainees experiencing an ideal/real conflict in a particular hospital, Dodd noted trainees making repeated references to a particular ward, the key to which was the sister. Working on that particular ward was described as rewarding and sister's relationships with all ranks stated as satisfactory. An interview with the sister revealed she had a strong religious faith and acted out of personal concern for those she came in contact with. Team work was emphasised and the ward was patient oriented; relationships with doctors were cool and limited to business. The sister understood what teaching meant and practised continuous feedback to trainees. Standards of nursing care were explicit and the ward was well run, with a stable, predictable environment. Dodd's finding are paralleled in this study.

It has been argued in Chapter IV (page 50) that it makes sense to consider what a 'teacher' does in addition to making generalisations about a teacher's personality. With this in mind the factor-analysed data from the questionnaires have been refined and an attempt made to express the good teacher characteristics in behavioural terms. In doing this the researcher has tried to keep the statements as near as possible to the context of the original statements collected at interview. (see table page 126-128).

THE FACILITATION OF LEARNING - from the learner's perspective

EFFECTIVE BEHAVIOUR	INEFFECTIVE BEHAVIOUR
1. Asks stimulating and relevant questions to aid and to assess learning	Rarely asks questions; questions when asked are irrelevant or unchallenging
2. Checks that trainees have understood instructions and takes measures to clarify communications given	Rarely tests for understanding of communications given
3. Encourages trainees to express personal feelings, ideas and opinions and listens in a supportive and non-judgemental manner	Displays no interest in trainees' opinions, ideas or feelings
4. Communicates person to person in interactions with trainees	Uses a condescending manner when communicating with trainees
5. Gives hints and tips to help trainees assimilate new skills and knowledge	Takes no actions aimed at helping trainees assimilate new knowledge
6. Makes efforts to ensure trainees feel needed and part of the ward team	Is insensitive to trainees' acceptance needs
7. Is supportive and ready to give help when needed	Unsupportive and rarely offers help to trainees
8. Takes an interest in trainees' questions and ensures these are answered either personally or by directing them to relevant sources	Unwilling or unable to deal with trainees' questions and makes no effort to direct them to appropriate sources for answers
9. Takes up available opportunities to teach, tell, show and work with trainees	Does not utilise learning opportunities and tends to avoid interaction with trainees
10. Explains <u>why</u> things are done	Rarely gives reasons for nursing or medical actions
11. Commends effort and gives regular feedback on progress made	Rarely gives praise and information on progress
12. Ascertains trainees' feelings and capabilities before increasing responsibilities	Fails to find out trainees' capabilities or limitations

EFFECTIVE BEHAVIOUR	INEFFECTIVE BEHAVIOUR
13. Ensures permanent staff are supportive and aware of trainees' learning needs	Takes no measures aimed at developing teaching skills in other members of the trained staff
14. Takes responsibility for stimulating trainees' interest in work experience and draws attention to relevant learning opportunities	Tends to blame trainees for lack of interest and motivation
15. Maintains consistently high standards of nursing care	Appears unconcerned about standards
16. Informs and instructs in a clear and logical way, in language suited to trainees' level of understanding	Gives ambiguous instructions and makes no effort to use terms appropriate to trainees' level of knowledge and experience
17. Assists trainees apply theory to real life work experience	Makes no effort to apply theory to practice
18. Helps trainees set specific objectives (goals) to be achieved from work experience	Unable or unwilling to help trainees formulate objectives
19. Shows kindness and patience in dealings with trainees	Is impatient and over-critical with trainees
20. Well organised and competent worker	Allows work situation to get out of control
21. Remains calm and in control in crisis/conflict situation, not easily upset	Lacks control in crisis/conflict situation
22. Disciplines when needed in a quiet,dignified and constructive manner	Disciplines in an insensitive manner
23. Does not bear grudges following interpersonal conflicts	Is unable to resolve interpersonal conflicts satisfactorily
24. Has a sense of humour/enjoys fun when appropriate	Unable to relax and enjoy a humorous situation
25. Takes steps to ascertain trainees' individual needs	Insensitive to trainees' needs
26. Friendly and approachable in relations with trainees and puts them at ease	Unapproachable and distant in relations with trainees

EFFECTIVE BEHAVIOUR	INEFFECTIVE BEHAVIOUR
27. Is genuine and real in dealings with trainees	Hides real self behind professional facade
28. Recognises and shares own feelings with trainees when appropriate	Rarely shares personal feelings and ideas with trainees

Phase two was concerned with the qualities of effective teaching behaviour. Phase three, findings of which are discussed in the next section, could be considered to be more in the light of a quantitative study. Verbal communications between trained nurses and trainees were observed, categorised and analysed over a four week period. This produced a total of 22 hours, in all, of analysed conversations.

NURSES AS COMMUNICATORS - observations of trained nurses - trainee verbal interactions

Analysis of data collected in phases 1 and 2 highlighted the power and influence of the role model and the importance of interpersonal relationships in the teaching and learning of nursing. Thus, teaching can be viewed as in part a covert activity as well as a series of overt acts. In other words what we 'are' is as important as what we 'know' or 'do' as teachers of nursing. The third phase of the study set out to observe and analyse the overt aspect of ward teaching, that of verbal communications between trained nurses and trainees.

ANALYSIS OF VERBAL INTERACTIONS

General Impression

The overall impression gained was that communications between trained nurses and trainees followed a one-way pattern on all four wards.* There were one or two exceptions to this general pattern, however, and these findings are discussed more fully in the section on individual wards and differences.

The pattern of communication is an autocratic one, trained nurses doing a lot of telling and proportionately little asking. Approximately 70% of all trained staff verbal exchanges with trainees came in the giving information category i.e. giving instructions, opinions or explanations. Seeking information and clarifying behaviours, that is, testing, understanding and summarising, accounted for only 14% of interactions.

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*There is much research to show that one-way communication is fast but rather inefficient, as far as learning is concerned (Bligh, 1971).

It is to be expected that trainees will pursue more seeking and clarifying behaviours by virtue of their position as learners and 'junior' workers. Seeking and clarifying behaviours of trainees accounted for 29% of interactions, giving information for 46% (see App. D p. LII Fig. 8). What are termed reacting behaviours, that is, remarks that are supportive, open, defensive or attacking in response to others, accounted for the remainder of verbal interactions.

Trainees involved were asked at the post-observation interview if they felt that the presence of the researcher had in any way affected verbal communications between themselves and trained nurses. After a period of reflection the response in every case was 'No'.

INDIVIDUAL WARDS

Ward 1

This ward was a busy female surgical ward. Permanent staff consisted of a sister, three staff nurses and three State Enrolled nurses. Learners in the team were two student nurses and two pupils -

i.e. 1 2nd year student - a Registered Sick Children's Nurse - 3rd week on ward - had previously worked as a sister on a paediatric ward

1 1st year student - 9 months into training - third ward

1 2nd year pupil nurse - trained orthopaedic nurse

1 1st year pupil nurse - on first ward

There was an extremely pleasant, supportive atmosphere between nursing, medical staff and patients. All members of the nursing team were involved in all aspects of nursing care, both basic and technical. Nursing care was given on a task allocation basis.

Verbal interactions

A total of seventeen interactions were observed during a three day span; these were days in the working week when trainees were on duty. The following interactive situations were monitored:

Ward report sessions	-	x 6
Drug administration	-	x 3
Dressing rounds	-	x 2
Bladder washout	-	x 1
Inhalations	-	x 1
Bed bathing) Bed making)	-	x 3
Induction round	-	x 1

The time span varied from five minutes for the shortest interaction, to forty-minutes for the longest.

General pattern

All verbal behaviours recorded on Ward I were categorised as follows.

Trained staff		Trainees
Proposing	2.0%	5.0%
Giving information	69.5%	47.8%
Seeking information	8.5% (0.8% theory)	21.8% (3.1% theory)
Clarifying (i.e. testing understanding and summarising)	5.2%	9.1%
Reacting	13.5%	16.1%

74.6% of the verbal interactions monitored and recorded were from trained staff; trainees were responsible for 25.4%. In other words trained staff do most of the talking. The sister was the initiator of most of the seeking theoretical information behaviour i.e. 1.8% of the sister's interac-

of the permanent staff. The sister was responsible for 40% of the interactions, an average of fifty-seven minutes per day. Calculated on this basis, the sister on this particular ward spent 11.8% of her time in a (40 hour) working week interacting with trainees.

Specific interactions

Ward reports - The six report sessions observed were mainly one-way interactions - to impart information; this was probably due to the heavy work load and shortage of time. Approximately 80% of the interactions came in the 'giving information' category. Trainee participation was low, accounting for 3% of interactions. However, a third of these came in the 'seeking information/theory' category.

Nursing procedures

Most of the overt teaching was seen to be done during nursing activities. The sister was involved in carrying out dressings with trainees on two occasions, and doing a great deal of teaching by exposition. The ratio of 'giving information' was high: 88% on one occasion, 81% on the other. Some differences were noted when State Enrolled nurses were monitored carrying out both basic and technical nursing procedures with trainees. The ratio of giving information was lower, averaging 48% giving information to 24% seeking information, this coming in the 'job related' category, that is, the State Enrolled nurses were asking more questions on how a job is done, the sister giving more facts and opinions when carrying out nursing tasks.

Learners' impressions of Ward I

All learners were very happy on this ward, felt they were welcomed and made to feel part of the team.

'There is a lovely atmosphere'

'I am really enjoying it, it's fun to work on here'

Trained staff were seen to be approachable and willing to help. The sister was named as the one most able to answer theoretical questions. The ward was considered well run with high standards and nursing procedures were carried out according to the procedure book. The sister was described as being sensitive to patients' and trainees' needs and firmly in control.

e.g. 'Sister gives you praise when something has been done well and that makes you feel good'.

Researcher's impressions

The ward was geared to supporting and teaching learners. The sister was active in providing learning opportunities and trainees appreciated this and felt they had learned. To give an example, during the period that the research assistant was present on the ward arrangements were made for a pupil nurse to visit the operating theatre to follow a patient through all stages of surgery. The pupil was asked to present a case study on the experience for sister's approval. Nursing textbooks were available and easily accessible, and trainees did not have to disturb the sister to get them. A notice board was available with articles and diagrams pinned on, trainees being encouraged to put up their own material. The sister was observed as doing most of the teaching of theory mainly by exposition. State Enrolled nurses taught practical nursing skills. Trainees, one pupil nurse in particular, were observed to engage in marginally more seeking and clarifying behaviours than on other wards (see App. D page LII figure 8).

Ward 2

This was a mixed, that is, both male and female patients, medical high dependency ward. Two sisters, one senior, one junior, two staff

permanent staff. Four learners completed the team.

1 - 2nd year student nurse with orthopaedic training

1 - 2nd year student nurse

1 - 2nd year pupil nurse - also orthopaedic trained

1 - 1st year pupil nurse - first ward, also trained orthopaedic nurse.

The ward was running below full capacity owing to an industrial dispute affecting the hospital laundry service. As with Ward 1 a pleasant atmosphere with good relationships between staff and patients was noted. All nursing staff were involved with both basic and technical nursing care with the exception of the senior sister who worked mainly in an administrative capacity. This tended to make the senior sister appear less approachable than the rest of the trained staff. Nursing care was delivered on a task allocation basis.

Verbal interactions

The observations spanned a three day period and a total of 16 interactions were observed i.e.

Ward report sessions	x 6
Drug rounds	x 2
Bed making	x 3
Bed bathing	x 2
Admitting patients	x 2
Serving lunch	x 1

Time spans of the interactions varied from five to forty minutes.

General communication pattern

To reiterate, the pattern of communication was markedly similar in all four wards, that is, trained nurses giving much information and seeking relatively little. Ward 2 was no exception. Analysis of the

	Trained Staff	Trainees
Proposing	2.0%	5.7%
Giving Information	70.5%	54.3%
Seeking Information	10.5% (2.2% theory)	14.8% (2.7% theory)
Clarifying	3.5%	4.2%
Reacting	11.5%	21.72%

Permanent staff accounted for 76% of all interactions, trainees 24% Trainees were observed to do less seeking of information on this ward. Most of the trained staff seeking information behaviours (theory related) were attributable to one individual, an SEN who was nominated by all trainees as the most active teacher. The sisters on this ward spent less time interacting with trainees than the sister on Ward 1. Approximately 5% of the senior sister's time was spent with trainees.

Specific interactions

The six report sessions observed were delivered speedily and contained much medical information e.g. tests, diagnoses and treatments and nursing care instructions. Giving information averaged 77% for most reports, 'seeking information' behaviours 10%.

Trainee participation for report sessions, that is, trainee interactions, averaged 11%, which is slightly higher than on Ward 1. There was one exception to this pattern, a ward report session conducted by the State Enrolled nurse where the seeking of 'theory related information' accounted for 11% of interactions (the mean of seeking information in other report sessions was 2%, all job related).

This finding was repeated whenever an interaction involving the State Enrolled nurse and a trainee was monitored; the proportion of seeking behaviour was noted to be higher than with other individuals

(see Appendix D page LIII figure 9). This finding was found to be significant at the 0.001 level chi-square.

Learners' impressions of Ward 2

The ward was described as a supportive one. Relationships were good and trainees felt they had settled in quickly. All trainees had had a formal introduction to the ward. Trained staff were seen as approachable and trainees stated they were encouraged to ask questions. The sister was seen as responsible for teaching by two of the trainees, one saw it as shared by all trained staff. One trainee felt the sister probably was responsible for teaching but felt she was too busy.

The State Enrolled nurse was singled out by all trainees in some capacity - as being very helpful, approachable or teaching a great deal. She was described as a

> 'Natural born teacher,' 'speaking the same language', 'having a sense of humour','pleasant personality', 'speaking person to person', as helping trainees 'find the answer' rather than just telling them.

These remarks were volunteered spontaneously. The State Enrolled nurse on ward 2 was the only trained nurse to be singled out in this particular way on all four wards. She was noted to be involved in 43% of the interactions observed.

All trainees felt they had learned a lot on this ward.

Researcher's impression

Learners engaged in less seeking and clarifying behaviours than on Ward 1, with relatively more giving information. This could be accounted for by the relatively higher ratio of seeking behaviour on the part of the State Enrolled nurse. Overt teaching was seen to go on during nursing activities, this being very necessary owing to the dependent nature of the patients. The instruction given was related

to nursing procedures and medical information at a superficial level. No formal teaching sessions away from the bedside were observed during the three days in spite of the ward being described as quiet. The staff were seen as supporting and encouraging trainees, the State Enrolled nurse was seen to be the most active teacher of both theory and practice. Text books were available on the ward but were out of date.

Ward 3

This was an acute male medical ward; this ward was also described as 'quiet' due to the laundry dispute i.e. admissions were restricted. A pleasant atmosphere between staff and patients was evident. All grades of staff were involved in both technical and basic nursing care. Permanent staff consisted of a sister, two staff nurses (one full-time, one part-time) and a State Enrolled nurse. There were four learners:

1 - 2nd year student, just completed first year; two days on the ward

2 - 1st year students, four months into their training; on second ward

1 - 1st year pupil nurse on first ward

As with other wards, nursing care was delivered on a task allocation basis rather than as individualised patient care.

Verbal interactions

Observations covered a three day period and a total of twenty interactions were observed. These covered:-

Ward report sessions	x 6
Bathing patients	x 7
Drug rounds	x 4
Admitting patients	x 1
Pleural aspiration	x 1

Time spans varied from five to forty minutes. Permanent staff were responsible for 72% of the interactions, trainees 28%.

General Communication pattern (all interactions)

The findings were similar on this ward as on the others, trained staff doing much giving of information and relatively little seeking. Analysis of total interactions:

	Trained staff	Trainees
Proposing	6.3%	6.8%
Giving information	69.0%	44.3%
Seeking information	8.9% (3.42 theory)	24.5% (11.7 theory)
Clarifying	3.9%	5.4%
Reacting	14.4%	19.0%

Approximately 50% of the 'seeking information/theory' behaviours were attributable to one first year student nurse.

The State Enrolled nurse was seen to be active in the teaching of practical nursing skills, engaging in more seeking information behaviours (job related) than other trained staff. This nurse was also noted to do more proposing than average e.g. 27% of her interactions were in the form of proposals. (Proposals are suggestions for a course of action that can be modified by others as opposed to directives that cannot be modified). The sister was involved in interactions with trainees for approximately 5% of her time.

Specific interactions

Ward reports - Overt teaching was observed during ward reports on this ward. The ratio of giving to seeking behaviours was somewhat lower i.e. 69% giving to 12% seeking. Approximately 3% of the 12% related to theoretical information. Student participation in ward

reports was also higher, i.e. 17%. Again the theoretical teaching was noted to be based on the medical model, that is, information on conditions, treatment and diagnostic tests etc. The most notable findings on this ward were the interactions involving the student just entering her second year. This student was seen to initiate more interaction when involved 'one to one' with trained nurses than other trainees, particularly in 'seeking information' and 'reacting' categories. Thirty-seven percent of all trainee seeking information behaviours, both job related and theory, were attributable to this particular learner.

Learner's impressions

Comments on staff relationships were favourable on the whole; one learner confessed she had had problems getting along with one member of staff. Trained staff were seen as approachable and trainees felt supported. The sister was perceived as having overall responsibility for teaching but as not 'putting herself out'. When approached, she would answer questions. Two trainees who had approached her, one with a question on insulin and one on cytotoxic drugs, had found her very knowledgeable and helpful; this was much appreciated. When asked if they had been encouraged to learn, two learners (one the pupil nurse) felt they had been encouraged. One student said she had been encouraged on occasions. The other said: 'You have to find things out for yourself.' This was, in fact, the trainee who engaged in more 'seeking information' behaviours. One trainee singled out the State Enrolled nurse as the most active teacher. Trainees on the whole felt they had increased their learning whilst on this ward.

Researcher's impressions

The sister was described as 'shy' and lacking in confidence. She found it difficult to put over the wealth of knowledge and experience she obviously had in the field of nursing patients with respiratory conditions. Trainees who were able to bridge the gap were appreciative of the fund of knowledge tapped. The sister described pupil nurses as being more interested in learning than were students. While relationships were described as 'easy' there was less of a 'team spirit' on this ward. The sister did not always appear to have the confidence of other trained nurses on the ward.

Although the ward was described as 'slack', no formal teaching sessions were observed during the period of observation. Much cleaning activity, damp dusting, cleaning cupboards and similar duties were done in quiet periods. Medical textbooks were available in sister's office but these were considered to be too advanced for learners.

Ward 4

This was a small (18 beds) female medical ward. This ward, as with the others, was described as quiet due to the industrial dispute. A shortage of permanent staff meant the trainees were frequently seen to be working alone. Permanent staff consisted of a sister, a staff nurse (temporarily on loan from another ward) a part-time State Enrolled nurse and two nursing auxiliaries. Learners making up the nursing team were:

1st year student nurse - 9 months into training

1st year student nurse - 4 months into training on second ward

1st year pupil nurse - in training for 12 weeks

2nd year pupil nurse - previously orthopaedic trained; on shortened training scheme

All staff with the exception of the sister were seen to be engaged in basic nursing care. There was a pleasant,relaxed atmosphere on the ward.

Verbal interactions

Fourteen interactions were monitored during a four day period. These were:

Ward report sessions	x 5
Introductory tour of ward	x 1
Catheterisation	x 1
Preparation of nebuliser	x 1
Preparation of IV infusion	x 1
Bed bathing	x 2
Drug rounds	x 3

Time spans varied from five to forty-five minutes. Trainees were responsible for 36% of interactions, permanent staff 64%. All interactions were examined with the following findings:

	Trained staff	Trainees
Proposing	1.9%	1.5%
Giving information	66.5%	48.2%
Seeking information	15.6% (5.4 theory)	24.1% (2.7 theory)
Clarifying	1.9%	4.9%
Reacting	14.0%	20.2%

Trained staff interactions with trainees were slightly lower in the 'giving information' categories on this ward and correspondingly higher in the 'seeking information' and 'reacting' categories. Sister on this ward spent 3.8% of her time interacting with trainees, less than sisters on other wards.

Specific interactions

Ward reports - These were observed to be mainly concerned with imparting information, with little exploration or discussion.

Giving information	72.9%	
Seeking information	11.5%	(all 'task' related)
Reactive	15.6%	

Trainees' interactions accounted for 17.2% of the total, these being largely in the 'giving information' and supporting categories. No theory related questions were asked.

Drug rounds

The sister was seen to confine her overt teaching to drug rounds; interactions observed were as follows:

Giving information	58.9%
Seeking information (theory)	19.6%
Seeking information (job related)	5.9%
Clarifying	1.9%
Other	15.6%

The part-time State Enrolled nurse was singled out as being helpful by one of the trainees. When analysed, this nurse was found to engage in more 'proposing' behaviour i.e. 2.5% as opposed to a mean of 0.9% for the rest of the permanent staff.

Learners' impressions of Ward 4

Learners on the whole were less satisfied with this ward; the pupils were more satisfied than the students. Three were enjoying the ward and finding relationships and the quiet pace easy. One student

nurse stated that the ward would be 'boring' for third year nurses as there was 'only basic nursing to do'. The second student was overtly dissatisfied, feeling that there was a barrier between trained staff and trainees.

All trainees saw the sister as responsible for teaching but only one pupil nurse reported being taught by sister on drug rounds. The remaining three felt sister was too busy to actually teach. Support was not so evident on this ward. Two learners had had no formal induction when starting work on the ward and one had had to assist with, and on one occasion carry out, technical nursing procedures without prior experience. This was probably due to the shortage of a stable,permanent staff.

Researcher's impressions

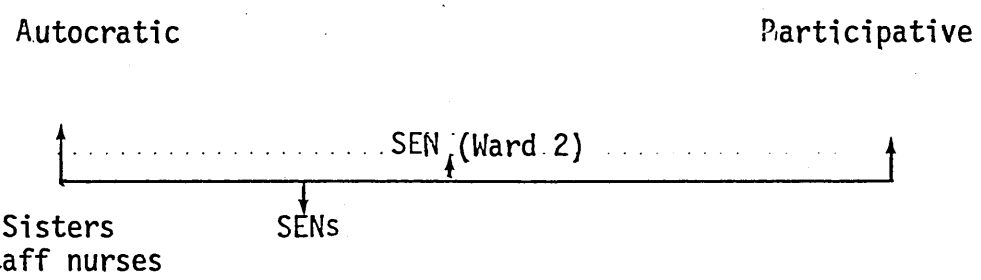
The ward was very quiet owing to the industrial dispute and therefore there was,in the main,only basic nursing care to carry out, with little that could be described as technical nursing care. A great deal of attention was paid to correct procedures for carrying out nursing care. The shortage of permanent staff meant trainees were seen frequently working alone. Trainees were expected to carry out routine domestic cleaning duties e.g. damp dusting and cleaning cupboards. The sister was described as 'shy' and seen to do the most teaching (by exposition) on drug rounds. The lack of patients meant that learning experiences were limited but no effort appeared to be made to provide opportunities for learning. The learners themselves stated that they felt more like 'workers on this ward'. The sister in the interview described herself as shy and confessed to feeling intimidated by groups of learners. She did, however, have the confidence to teach about 'drugs' and went out of her way to ensure this was done.

Discussion of Findings: interaction analysis

Communication styles could be viewed as a continuum from an autocratic to a participative pole. Individuals communicating in an autocratic style do lots of telling with proportionately little asking; they tend to communicate in the form of instructions or commands. There is a tendency to disagree with, or point out snags in, other people's suggestions. The participative person seeks other persons' opinions and ideas, asking lots of questions for clarification. They tend to support and develop other people's ideas rather than squash them.

Observations on the four wards indicate that, on the whole, trained nurses communicate with trainees in an autocratic style, sisters and staff nurses lying nearer the autocratic pole, State Enrolled nurses near the participative end, with one, the identified 'good teacher' on Ward 2, lying even nearer the participative pole (see Appendix C page LIII Fig. 10).

Communication Styles



Identified good teachers

Phase three set out to study the relationship between 'verbal behaviours' and 'good teaching'. Sister on Ward 1 and the State Enrolled nurse on Ward 2 were particularly singled out as good teachers. Two more State Enrolled nurses on Wards 3 and 4 were also identified as being helpful to trainees. These nurses were, however, mentioned once only; the State Enrolled nurse on

a good teacher. (See Appendix D page LIV Fig. 11).

The more participative style of State Enrolled nurses could perhaps be viewed in this context as arising out of a situation rather than the individuals, that is to say, involvement with patients in nursing tasks necessitates a more participative approach. When the interactive situations were analysed, however, it was seen that State Enrolled and State Registered nurses participated almost equally in both basic and technical nursing tasks. During the ward report sessions when patients were absent the same finding occurred, State Enrolled nurses using a more participative,State Registered nurses a more autocratic, communication style (this finding is significant at the 0.001 level, chi-square).

A word must be said here about ward reports as teaching sessions. Several of the ward sisters at interview described ward reports as invaluable for teaching purposes. The ward report sessions observed during the four week period, however, were concerned with imparting and receiving factual information, with little discussion of concepts, ideas or ethical issues. A little of this was witnessed to go on on Ward 3.

The sister on Ward 1, in contrast to the State Enrolled nurse (Ward 2), used a more 'autocratic' verbal communication style. It is probably true to say that the overriding factor here is the power and influence associated with the sister's role. The sister was perceived as a good nurse with high standards and as being firmly in control of the ward. Her orientation was 'learner' centred. Learners were quickly made to feel part of the ward team, learning opportunities were provided and all trained staff were active in supporting learners. The sister was actively involved in carrying out nursing care with trainees, teaching mainly by exposition.

No significant differences were observed between the sisters, all four operating near the autocratic pole in the verbal behaviours. The most notable finding concerned quantity. The sister on Ward 1 was involved in 40% of the interactions observed, the other three averaging 24%. This could perhaps be attributed to differences in the nature of the work on surgical, as opposed to medical, wards. This could only be verified by more observations using 'matched' wards.

Trainees on Ward 1 were noted to engage in more 'seeking' and clarifying behaviours than trainees on other wards (see Appendix D page LII Fig. 8). It would seem in the light of this small study that when an 'emotional climate for learning' is established on a ward or department learners are more stimulated, and feel free to ask questions and clarify their understanding.

Taking into account all the other factors investigated and discussed in this paper - the power of the role model; stimulus; the climate for learning - communication styles would also appear to have their influence. Those trained nurses with a more participative verbal communication style are perceived as helpful and/or good teachers. Generalisations could not be made from one subject, however; so a decision was taken to extend the study by carrying out further observations.

Non-verbal behaviours

While phase three concentrated on verbal behaviours, non-verbal behaviours could not be discounted. These may, indeed, have a powerful influence. While no quantitative assessment was made of non-verbal behaviours in the first study, a subjective impression was gained.

The sister on Ward 1 and the State Enrolled nurse on Ward 2 were noticed to stand physically closer to trainees when communicating with them, were heard to address trainees by name more frequently and maintained eye contact with trainees for longer periods than the other nurses observed.

Observations of nominated good teachers

In view of the rather inconclusive nature of the findings from phase three it was recommended that further observations be carried out. Limitations on time and the administrative problems of gaining access to wards for a second period, ruled out another large scale investigation. It was, therefore, decided to observe six nominated 'good teachers' for one full duty shift, to 'tighten up' the study.

Selection of good teachers

The ninety-six trainees who had taken part in completing the questionnaire were asked to name, in conditions of strict confidentiality, a trained nurse from whom they had learned a great deal. A total of forty names were collected. Again the list included all grades of trained staff and one nursing auxiliary.

Six nurses were selected, two sisters, a staff nurse and three State Enrolled nurses. Choice was on the grounds that these nurses were named more frequently than others. The procedure followed was as in the first study but with more attention paid to non-verbal behaviour.

Discussion of findings

Again it was found that the communication process was mainly one-way, with the exception of sister G (see App: D page LV Fig. 12). The State Enrolled nurses were marginally lower on giving information and slightly higher on seeking information and communication clarifying behaviours. These differences were not as marked as in

the first study, however.

During the period between the first and second set of observations the nursing process had been introduced experimentally. Sister G was in charge of one of these wards. It will be seen from the table that a more participative communication behaviour pattern is evident. Sister G admitted when questioned that this had been a difficult thing to do; to hold back from being directive and allow trainees time to work through nursing problems. In other words to 'listen rather than tell'. Sister G was also observed to use more open statements, to ask probing questions and to seek trainees' feelings and opinions on nursing issues (a behaviour not encountered in previous observations). Staff nurse D and sister H were noted to be much more directive in their approach.

The three State Enrolled nurses were mature and very experienced nurses working on geriatric wards. They personalised the care they gave to patients, bringing trainees into the relationship when carrying out nursing procedures with them. When interviewed, all three expressed care and concern for trainees and their problems, often ending with the remark -

'I have a daughter/s their age'

All nurses observed were very supportive of trainees and went out of their way to instruct and inform while working with them.

Non-verbal behaviour

Particular attention was paid to non-verbal signals in the extended study; it was not possible to carry out a quantitative analysis, however. A subjective assessment was recorded at the end of each observation period (see App.D page LVI Fig 13). Four of the trained nurses were observed to stand physically close to trainees, maintaining frequent eye contact when speaking. One State Enrolled nurse was

seen to smile frequently in interpersonal interaction. Two sisters addressed trainees by name more frequently than others observed. One sister in particular was noted to personalise information during ward report sessions. Nurses were addressed by name and their attention drawn to relevant facts in the report, for example -

'Nurse ... I would like you to make particular note of ... '

In this way the report session was a less passive experience than the majority observed.

In the absence of any quantitative data it may be tentatively assumed that non-verbal behaviours are as powerful as, if not more powerful than, verbal behaviours in interpersonal relationships.

Conclusions

It would seem from this small study that 'on the job' teaching of learners is a complex global act. To isolate one aspect is to lose sight of the whole. The role model presented to the trainee is a very powerful influence, as is a general attitude of care and concern for their welfare and professional development. While it cannot be said conclusively that a more participative verbal communication style is indicative of effective teaching behaviour, there are good grounds, both professional and educational, for trying to achieve that goal in developing communication skills in nurses.

CHAPTER VII

REFLECTIONS, IMPLICATIONS AND RECOMMENDATIONS

REVIEW OF THE FINDINGS

In this final chapter the main findings of the study will be reviewed, the practical implications discussed and recommendations made. Possible areas for further research will be suggested.

The intention of the study was to investigate the teaching skills of ward sisters. The motivation to carry out the investigation came from reading firmly expressed views in the nursing literature on the value of ward based learning. There was also research evidence to show much dissatisfaction with the quantity and quality of ward instruction; thus an ambiguous situation appeared to exist.

In view of the dearth of information on the process of ward teaching and learning, it was decided to approach the problem from several angles, to employ a variety of techniques, interview, questionnaire and direct observations, to throw more light on the problem, beginning with a wide angled view of the ward as a learning environment, moving in to assess behaviours critical to the teaching/learning transaction; ending with a close-up view of the communication process; and linking the whole with current theories of teaching and learning.

How do trainees learn? - a review of the major findings on the ward learning environment

The majority of trainees interviewed had a passive view of learning; only one or two saw learning as an internal or self-initiated activity. Trainees, on the whole, feel they have been taught when someone 'has told them'. When asked to describe a recent event that had

resulted in significant learning, however, few of the experiences recounted actually involved didactic instruction. The majority, that is 58%, could be described as self initiated or internal learning arising out of the experience itself rather than from someone's intention to teach.

Rogers (1969) takes the view that much significant learning is acquired by doing, by coming face to face with practical, social or personal problems, which have to be worked through. He also feels that self-initiated learning which involves the whole person, feelings as well as intellect, tends to be the more lasting and influential.

Most of the incidents described by trainee nurses came in these two categories. This view of learning must surely cause us to reconsider the present constructs of 'ward teaching'.

The factors reported to inhibit or interfere with learning were: personality issues, lack of interest on the part of trained staff and/or personality clashes, emotional stresses such as over-anxiety, boredom or overwork, lack of time to follow up a line of enquiry due to work pressure or a move off the ward, readiness to learn factors: some trainees reported a particular experience coming too soon to be assimilated or lacked the necessary background knowledge with which to relate a new experience.

To return to a view of teaching discussed in chapter IV (Models of Teaching p 48). It would seem important to ensure that any didactic teaching activity taking place on the job begins at a point where the learner can take on board the new information. It would also seem necessary to provide opportunities for discussions with learners to help them assimilate and integrate new learnings arising from work

experience. This should take place at regular intervals during the placement. Some sisters do in fact do this, but discussions described or observed during the research study tended to concern medical information or 'interesting cases'. Rarely were learners observed to be asked to utilise their own everyday nursing experience for learning purposes.

Another important finding was the lack of communication between trainees and ward sisters on the objectives and standards to be achieved from work experience*. The overall impression gained from the study is that the orientation interview is superficial and didactic in nature, with little investigation of learners' true needs. Trainees also reported receiving little constructive feedback on their progress during their stay on the ward and on the whole were unaware of or unable to verbalise their specific strengths and weaknesses. Even if able to do so, their position in the organisational hierarchy would in the majority of cases prevent them negotiating to fulfil learning needs.

Sisters were very conscious of their responsibilities in the training of future members of the nursing profession, but 'teaching' trainees came second after patient care. The comment: 'If I had wanted to teach I would have taken a tutor training' was frequently heard during the interviews. Although sisters were very aware of the conditions under which learning takes place on the ward, they, too, seemed to equate the word 'teaching' with 'didactic' instruction. Their construct of 'teaching' is probably based on their own experiences of being taught!

This would seem to suggest that the emphasis be shifted from teaching as a didactic activity and placed on learning as self development. Responsibility for learning would be placed on the learner and sisters would see themselves as helping trainees learn rather than

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*NB Some progress in setting objectives for work experience has been made in the two years since the interviews took place.

'teaching' them. That is, they would become facilitators of learning rather than teachers per se.

What sisters see as important to teach depends on their individual values and beliefs about nursing and nurse training. There was a tendency for sisters on acute wards to rate technical nursing competence as important, those on long term caring wards to rate changing attitudes as the most important goal.

Higher level skills inherent in the management of patient care, interpersonal, problem solving and decision making skills were rarely mentioned. It could be that sisters are in the main unaware that they have these skills in their own repertoire and need help to express these in behavioural terms.

Assessment of learning was mainly at the 'gut' feeling level, there was no evidence, at the time of the interviews, of outside criteria being applied by ward sisters to evaluate what a trainee had learned in their particular ward. According to Rowntree (1977)

> 'If we wish to discover the truth about an educational system, we must look into its assessment procedures. What student qualities and achievements are actively valued and rewarded by the system? How are its purposes and intentions realised? To what extent are the hopes and ideals, aims and objectives professed by the system ever truly perceived, valued and striven for by those who make their way within it? The answers to such questions are to be found in what the system requires students to do in order to survive and prosper. The spirit and style of student assessment defines the de facto curriculum'. (page 1)

It would seem that the further development and refinement of objectives, criteria and tools for the assessment of ward teaching will be an important step to take in the development of basic nurse education.

What makes a good teacher? - review of major findings from the good teacher questionnaire

The major findings to arise from the research into effective teaching behaviours is the learner's view of ward teaching as a global activity.

It is difficult to separate one discrete activity and say: 'This is teaching'. There are, however, important factors inherent in effective teaching behaviour that can be identified. These are: the power of the role model presented to the learner (we tend to want to emulate those who possess qualities we esteem and admire), skill in forming and managing interpersonal relationships and the art of being a good communicator. Any course aimed at developing ward teaching skills should take into account these three factors.*

To return to Rogers: he states that one of the most important conditions which facilitate learning is:

> 'the attitudinal quality of the interpersonal relationship between facilitator (teacher) and learner'.

Attitudes that facilitate learning are:-

> 'transparent realness in the facilitator, a willingness to be a person, to be and live the thoughts of the moment'
>
> 'a prizing, caring trust and respect for the learner'
>
> 'sensitive, accurate and empathic listening'

This theme is also emphasised in a World Health Organisation paper on educating the health professions:

> 'learning is facilitated when a teacher develops a high level of skills in questioning thoughtfully, listening perceptively and responding supportively'. (Miller and Fulop 1974 p63)

This research study has shown that these are some of the qualities that facilitate learning in trainee nurses. The personal attributes identified in the study would seem to create a freeing climate that stimulates self initiated learning and personal growth of the learner. True facilitators are more concerned with releasing the potential of their students than with their deficiencies.

This approach entails: a change of attitude for some trained nurses; sisters to see their responsibilities towards learners in terms of

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*An attempt has been made to draw up a model for designing a curriculum for such a course. The model is based on Rogers', Gagne and Bruner's work. (See Appendix D page LVII figure 14).

facilitating learning rather than 'teaching'; trainees shouldering more responsibility for their own learning and being given the tools and skills to do it; and qualified nurse teachers acting as analysts, catalysts and co-ordinators in both classroom and clinical situations.

Trained nurses as communicators - review of the observations of trained nurse/trainee verbal communications

The overall impression gained was of a one-way communication behaviour pattern - trained nurses doing a great deal of telling in their interactions with trainees and relatively little asking. It was also rare for them to use behaviours which were intended to clarify communications given. The one or two exceptions to this general rule have been discussed fully in the text.

The question must of necessity be asked: 'How effective is this mode of behaviour in facilitating the kinds of learning required by the nursing process?' In raising this question I am not suggesting that formal instruction has no place in ward teaching but rather questioning its efficiency as a general pattern of behaviour. Didactic teaching may not link in with a learner's, perceptions, previous knowledge or value system. It is also an ineffective medium for developing problem solving, decision making and communication skills.

To reiterate, phase three of the study did not show conclusively that effective teachers use a participative mode of verbal communication. The findings do, however, highlight the need for increased awareness of verbal behaviour patterns and their possible effects on the outcomes of person to person communications.

It would appear that non-verbal behaviours also have a powerful influence on the teaching/learning transaction. This inference is made tentatively, however. It was not possible to carry out a quanti-

tative analysis of both verbal and non-verbal behaviours at the same time. The following non-verbal behaviours were noted in identified good teachers:

They tend to stand physically closer to learners when communicating

Use frequent eye contact; personalise communications by using names.

With regard to the content of the theoretical instruction which was observed to go on, this, on the whole, was based on the medical model. The topics most frequently observed being taught were drugs- their action and side effects- and medical diagnostic test on medical wards, technical nursing skills on surgical wards*. On geriatric wards much more effort was put into teaching nursing as individualised care, that is, permanent staff were often observed drawing a learner's attention to a patient's individual needs, physical or psychological.

Relation of findings to other studies

Three other studies into ward teaching and learning have been published in the final stages of this research (Fretwell 1978, Ogier 1979, Orton 1979). Their findings, which appear to complement this study, will be discussed briefly.

Orton, in a study of student nurses' responses to the ward learning climate, identified teamwork, consultation and ward sister awareness of needs of subordinates as hallmarks of a good learning climate. Not only did students see their own physical and emotional needs as being met, but those of the patients also.

Fretwell, in her study of the socialisation of nurses in hospital wards, generated a list of characteristics of a ward atmosphere condu-

*At the time of the initial study the nursing process had not then been introduced into the service areas. In the extended study, the sister on the nursing process ward was observed to use a nursing rather than a medical model in her teaching.

cive to learning from which she concludes that the key factors are teamwork, negotiation and good communication.

It has not been possible to obtain the Ogier study in time for the completion of this thesis. Orton, writing on the Ogier study, states:-

> 'This research was aimed at studying the effects ward sisters have upon nurse learners (i.e. students and pupils) in the wards ...
> The first part of the study was designed to develop "Learning Opportunities" categories. Learners and trained nurses agreed on the definition of five categories of which the second, ward climate is most relevant to the present study (Orton's). Ward climate was described as an "atmosphere" where it is safe to ask questions'. (Orton 1979, page 150)

Orton goes on to summarise the second part of the study; the development of an 'ideal' and 'non ideal' ward sister profile based on verbal interactions of seven sisters recorded during duty spans. The interactions were analysed in terms of the five learning opportunities. To quote Orton again:

> 'The study revealed that the ideal ward sister was approachable, learner oriented and had sufficient directiveness for a particular work situation'. (Orton 1979, page 151)

There appears to be a common thread linking all three studies, each approached from different viewpoints. The theme is one of learner orientation springing from a general attitude of care and concern for the needs of others. A concomitant of this is skill in communication and team building.

Where does 'real' learning take place?

In the introductory chapter, 'Outline of Research', the issue of the quantity and quality of instruction 'on the job' was raised. This inevitably leads to the question whether or not it is possible to create an atmosphere which is conducive to learning in a clinical environment oriented to giving service? The apprenticeship system has many drawbacks and from time to time pressure to separate education from service arises. Any step which has the effect of widening the gulf between education and service may not be to the benefit of nurse education, particularly at this critical stage of development.

There is a swing in higher education, particularly in the professions, toward experiential learning, that is, involving the learner in real life experience (Sexton and Ungerer, 1975). There is a general consensus of opinion that it is in the real life situation that students should learn the skills of problem solving, planning, implementing and decision making. In the present system for training nurses we already have this advantage which could be developed more fully than at present.

Trainee nurses derive a great deal of stimulus and motivation from working as a member of the nursing team.

The Fretwell and Orton studies both emphasised the centrality of the ward sister's role (Orton 1979)

> 'whatever doubts may exist concerning the detail of ward learning climate there is no doubt that the ward sister's influence in determining the atmosphere of the ward is of the utmost importance'. (p152)

This study also has emphasised the power associated with the ward sister's role in the teaching situation. This finding, along with the

findings of Fretwell and Orton, indicate that a key figure in the development of nurse education is the ward sister. It is from this grade of nurse that change will come. Trained nurses therefore need to be informed of the ways in which their attitudes and behaviour influence nurse learners and be helped to change these to become more effective in facilitating learning. Findings from these studies are a base from which professional educational programmes, aimed at improving the learning climate in service areas, could be developed. An improved ward learning climate combined with the problem solving approach of the nursing process offer a means for improving the nurse education system. There is a need, however, to clarify goals.

What should be learned?

This study has been concerned with how trainee nurses learn in the service environment. The conclusion reached by the research worker after five years of study is that an equally if not more important question to ask is 'what' are they learning?

The main field work, that is, the interviews and observations, were conducted in 1977 and 1978. Since this time we have had the publication in 1977 of the General Nursing Council's Education Policy in which it is stated that:-

> 'The concept of the nursing process provides a unifying thread for the study of patient care and a helpful framework of nursing practice'.

Findings from this study confirm that the focus in the majority of wards is on 'nursing tasks' rather than on nursing as a holistic activity, as embodied in the nursing process. The General Nursing Council go on further to recommend that:-

> 'The aims (of a course of learning experience) should be defined in behavioural terms'.

The specification of learning objectives is a difficult and time consuming task, demanding analytical skills (Marson 1979). Research in other fields of education and training indicate that time invested in the effort is time well spent, in that, many of the ambiguities are removed from the teaching learning situation, assessment therefore becomes easier. There was little evidence of clinical learning experiences defined in behavioural terms available at the time of the main study. Some wards had made some progress in specifying the experiences available, which with some effort could be expressed in behavioural terms. In the main, the sisters interviewed found it very difficult to talk of nursing skills in terms of observed behaviours. It would seem worthwhile, therefore, to invest some time and effort in this exercise if we are to 'improve' teaching and learning in the ward situation.

With further regard to what is being taught, inherent in the nursing process are communication and decision making skills. Findings from the interviews indicate that trainees feel they have very little influence on decision making. Responses to the question in the post-observation interview question

> 'Do you feel you have been able to influence decisions on nursing care?'

were mainly in the negative. On wards 3 and 4 there was an emphatic No. Trainees on ward 2 were less emphatic; there was a generalised feeling that if they wanted to make a suggestion they may be listened to. Standards were considered so high on Ward 1 as not to merit changing.

The introduction of the 'nursing process' approach will necessitate the involvement of trainees in decision making. There will be an interim period, however, before this is fully established. Steps should be taken in this interim period to prepare ward sisters to take

a more 'participative' approach. That is, to involve trainees in the planning as well as delivery of nursing care.

A major behavioural study 'Mirrors for Behaviour', published in the United States, draws attention to deficiencies in the general school curriculum (Simon and Boyer, 1974).

> 'If the teacher consistently reserves the right to make decisions about procedures and standards, experience in decision making is denied to the student'. (page 17)

A similar problem could also be said to exist with regard to communication skills. The General Nursing Council educational policy document stresses the importance of communication skills. Nurses have a professional responsibility to communicate with patients, relatives and colleagues. The nursing process philosophy necessitates a participative rather than directive approach to the nursing care; and the patient, when able, being involved in planning and setting objectives for his care, there is, therefore, a need for nurses to be skilled communicators.

No overt attempts to teach communication skills were seen during the observation period. One could assume, then, that these are transmitted covertly in the clinical field. This was also the impression gained from the interviews, that is to say, that both trainees and sisters felt that interpersonal skills could only be 'caught', not taught. If this is so, then the findings from phase three, that is, the analysis of verbal behaviours, must be taken seriously. What is being 'learned' at present, perhaps unintentionally, is that trained nurses, particularly those who are State Registered, communicate with others in an autocratic style. The limitations of a one-way mode of communication have been discussed elsewhere in the thesis. It is probably pertinent to turn again to the Simon and Boyer study.

> 'It is entirely possible that autocratic teacher behaviour limits resources available because in this type of classroom the teacher is the only one who can legitimately provide inputs'. (page 17)

An autocratic environment is more likely to produce a safe practitioner within the system, thus preserving the status quo; a democratic environment a more 'thinking participant' from whom change may come.

In conclusion I would like to quote once more from Simon and Boyer.

> 'It could be said that teachers are teaching perhaps unintentionally but nonetheless in reality that exploration of one's own feelings and personal reactions has no place in the classroom scene'. (p VIII)

Data collected at the interviews indicate that this situation also exists in nursing. Trainees were rarely encouraged to explore deep feelings arising out of nursing situations; many such feelings were reveale to the researcher during the interviews. The tendency is to suppress or rationalise these. Before we can truly care for and support others there is a need to come to terms with our own deep feelings. This is an area in the nursing curriculum we are only just beginning to explore.

CONCLUSION AND SUGGESTIONS FOR FURTHER RESEARCH

The general conclusion to be drawn is that students can learn many things, right things, wrong things, irrelevant things as well as relevant things. The essential operation is to be clear about the kinds of behaviour, values and attitudes that are considered desirable for future nurses to possess. Bearing these conclusions in mind one must of necessity give attention to the nature and pattern of reinforcers in 'real' life work experience. The ward sister is a powerful influence in the socialisation of trainee nurses. What are her beliefs and attitudes, from what value system do they arise? What type of reinforcers does she use and what kind of behaviour is being reinforced?

Do these conflict with or support the expectations of nurse educators? These are important questions to raise at a time when curricular changes are in progress, and would be a fruitful area for further study.

The opportunities for further research into the communication process are also immense. Techniques for analysing behaviour in education and training settings are developing rapidly. The operationalisation of such projects is not easy, however. There is the problem of access to wards for observation purposes and the ethical implications arising out of an observer's presence. Observers also require intensive training in the techniques. In view of the findings from phase three of this small scale study and the current concern in the nursing profession with interpersonal skills, it would seem that analytical studies of the communication process should continue on a larger scale. Of particular interest is the finding on communication styles related to role behaviour, that is, the differences found between State Registered and State Enrolled nurses' verbal behaviour patterns. This finding would seem to merit further study.

RECOMMENDATIONS

This research was initiated in the hope that the results would have practical applications of value to the nursing profession. The following recommendations are made with this aim in view.

To improve the ward learning climate it would seem necessary to adopt the following measures:-

1. Specify in behavioural terms the objectives for clinical experience; these should reflect a nursing process approach.

   NB The research worker is aware that progress in this area is under way.

2. More time should be spent with the trainee at the commencement of the clinical experience assessing her needs and determining what she already can do. This should be more than a 15 minute interview. (The development of more precisely defined learning objectives would aid this process).

3. Attention should be paid to developing assessment tools to estimate progress. These could be in the form of self assessment check lists or rating scales or peer assessments.

   The development of assessment and diagnostic tools is easier when objectives are specified behaviourally.

4. Steps should be taken to give trainees more 'feedback' on their progress than is customary at present. Continuous feedback should be built into the learning process.

5. Training to prepare qualified nurses for their teaching role should concentrate on self development and on developing the skills of human relationships and communications, rather than instructional skills. The instructional skills that would be useful to the clinical practitioner are the art of stimulating interest in learning (particularly important in student nurses), of questioning to determine existing knowledge and skill and the use of reinforcement in the clinical area.

6. Much more attention needs to be paid to the emotional stresses inherent in nursing. The exploration of feelings tends, on the whole, not to be encouraged, trainees preferring to suppress these or talk it over with peers. This latter ploy was acknowledged by trainees themselves to be not always helpful. Trained staff need to develop sensitivity, empathy and counselling skills in order to aid trainees in their emotional development. (This fact has been recognised by other workers; Birch 1975, Stewart, 1975).

7. Trainees need to develop more efficient self study skills. New techniques have been developed in the last decade which could be applied to help trainee nurses learn more effectively from work experience. (Russell 1979).

8. Last, but not least, serious consideration should be given to the use of training materials of all kinds, relevant and up-to-date text books, programmed texts, tapes and slides, for example, in the service area. Much useful material is already available that could be adopted and adapted for ward use. This would relieve sisters from the chore of imparting factual information which can be acquired by means other than didactic teaching.

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APPENDIX A

Gagné's types and conditions of learning applied to nursing skills.

LEARNING TYPE	DEFINITION	EXAMPLES	PREREQUISITES/ CONDITIONS INTERNAL TO THE LEARNER
Signal	A signal involves a specific response to a specific stimulus	Responding to changes in a patient's skin condition	There must be a natural relex. The response can also be an emotional one e.g. fear, alarm, pleasures, willingness to attend etc.
Chain	A chain involves a fixed sequence of verbal or motor responses	Verbalising the causes of pressure sores - (verbal). Turning a helpless patient - (motor)	Each of the links or signals making up the chain must already have been aquired by the student
Multiple discrimination	A multiple discrimination involves distinguishing one category of phenomena from another	Recognizing on a helpless patient those points on the body most vulnerable to pressure	Each of the chains or signals making up the set to be discriminated between must already have been acquired by the student
Concept	A concept involves making a generaliz-ation about a whole class of related phenomena	Classifying or making generalizations about objects or events e.g. classifying local and general factors pre-disposing to the development of pressure sores	Each of the chains of signals making up the class or set to be generalized about must already have been acquired by the student

Principle/ Rule	A principle/ rule involves a chain of concepts e.g. if A then B	Fundamental truths or laws e.g. constant pressure obstructs the circulation; immobilised patients therefore need frequent turning	Each of the concepts making up the principle must already have been acquired by the student
Problem Solving	Application of rules to yield 'new' learning i.e. individual possesses a new capability	When nursing a patient at risk will utilise available resources and take constructive action to prevent break-down of the skin	Ability to recall relevant rules applicable to the problem

Adapted from 'Management of Learning' : I.K. Davies.
McGraw Hill, 1971, Fig. 6.1. Page 93.

S.N. Marson
Developing Individualised Instructional Units
Module 4 Analysis of Learning Structures

Trainee Nurses

Introduction

I am researching into how nurses learn in the ward situation and would appreciate the help that you can give from your own experience. The information obtained from this interview is strictly confidential. In no circumstances will any information be disclosed to any member of the hospital staff. No names will be used in any future publications and anonymity will be preserved in all circumstances.

Section A. Ward environment

Can you first of all give me some information about yourself and the ward you are working on/last worked on?

1. How long have you been in training?
2. What study blocks have you completed?
3. Have you had a GNC assessment - if so, which one?
4. Which wards have you worked on so far?
5. Which experience did you enjoy the most? - (explore)
6. Which did you like the least? - (explore)
7. Which ward are you working on at the present time?
8. What type of nursing - mainly basic, mainly technical, equal mix of basic and technical?
9. How many trained staff are there?
10. Did you feel there was much to learn there? - (explore)
11. Who allocates the work on that ward?
12. Is there a work plan to follow? - (explore)
13. Who is responsible for the work plan?
14. When are the busy periods on that ward?

15. When are the slack periods?

16. What do you do in the slack periods?

17. How were you introduced to your duties when you first joined the staff of this ward?

18. Does this happen on every ward?

19. Who supervises you when you carry out a 'new' nursing procedure?

20. Whom do you approach on the ward when you want to know:-

    a. Some aspect of a practical nursing skill

    b. Some theoretical point about your work

    c. How to deal with an interpersonal problem? - (explore)

SECTION B. Teaching and learning on the ward

The following questions concern learning on the ward.

1. Could you tell me first of all what you understand by learning?

2. What do you understand by teaching?

3. Where do you think practical nursing skills are best taught - in the school, on the ward, in school and ward? - (explore)

4. Should procedures practised in the ward be the same as those taught in the school? - (explore)

5. Are there any aspects of nursing that can't be taught on the ward? - (explore)

6. In your opinion who should be responsible for teaching in the wards? - (explore)

7. What aspects of nursing would you like more help with?

8. Can you think of the last time you were aware of learning something worthwhile/important, while working on a ward? (elaborate if necessary)

    a. Can you say who was involved?

c. Can you say why you felt this learning experience was particularly important?

9. Can you now describe a situation where a teaching opportunity was missed or mishandled? (elaborate if necessary)
   a. Who was involved?
   b. What was said/done?
   c. Why do you think this was a missed opportunity?
10. Can you recall the person from whom you feel you learned the most in any ward situation?
11. Can you give five characteristics that made this person a good teacher?
12. Can you think of a person from whom conversely you learned the least or very little?
13. Can you describe five characteristics of this person?
14. Lastly, can you think of ways of improving the education and training of nurses?

INTERVIEW SCHEDULE

Ward Sisters

Introduction

I am researching into how nurses learn in the ward situation and would appreciate the help that you can give from your own experience. The information obtained from this interview is strictly confidential. In no circumstances will any information be disclosed to any member of the hospital staff. No names will be used in any future publications and anonymity will be preserved in all circumstances.

Section A. Ward Environment

Can you first of all give me some information about your Ward/Unit?

1. What type of ward is it?
2. How many beds?
3. a. What illnesses do patients in your ward suffer from?
   b. What is the most common condition nursed?
4. How would you describe the type of nursing carried out on your ward?
   a. Mainly curative, mainly caring - equal mix of both?
   b. Mainly basic, mainly technical - equal mix of both?
5. How many learners do you have on your ward?
6. At what stages of training?
7. How many trained staff?
8. How long have the trained staff been with you?
9. How long do learners stay on your ward?

10. How would you describe the length of stay:-

    a. Too long, too short, about right - if not any of these please specify.

    b. Why do you say that?

11. Is there a routine for allocating work on your ward? - (explore)

12. Who plans the work routine?

13. Who allocates the work?

14. Is the work routine the same for every day?

15. a. Are there any slack periods?

    b. When are these?

    c. What do staff do during these slack periods?

Section B. Learning on the ward

This research concerns 'learning on the ward'.

1. Could you first of all tell me what <u>you</u> mean when you talk about learning?

2. a. How much can nurses learn on <u>your</u> ward:-

    - very much - quite a lot - a lot - very little

    b. Why do you say that?

3. a. Can you tell me of at least six <u>important</u> things that you expect <u>all</u> nurses to learn on your ward?

    b. Can nurses learn these six things anywhere else?

    c. Do <u>all</u> nurses learn <u>all</u> these six things?

    d. How do you know when they have learned them?

4. a. Are there activities on the ward which nurses fail to learn or have difficulty in learning?

    b. Is this related to any particular stage of training or does it apply to all stages?

c. Why do you think they have difficulty in learning that particular thing?

d. How do you think they could be helped to learn that better?

5. How do nurses get to know what they are expected to learn when they are working on your ward?

6. To your knowledge whom do nurses ask if they want to know the following:-

   a. Some practical aspect of a job they are performing.

      Have you been asked this type of question recently?

      Who asked, what was said, what did you reply? - (explore)

   b. Some theoretical point about a patient's condition -(explore)

   c. How do you deal with an interpersonal problem?

      e.g. handling a distressed relative - (explore)

7. How do other staff handle the above questions?

8. Is there one member of the trained staff particularly good at helping trainees learn?

   Why do you think he/she is better than other members of staff?

9. What factors do you think help trainees learn from ward experience?

10. a. Can you recall a trainee whom you found it particularly rewarding to teach?

    b. Can you describe the characteristics of this trainee that made her special?

Section C. Teaching on the ward

The following questions concern your role as a Ward Sister/Charge Nurse.

1. a. Can you tell me what your five most important activities are as a ward sister?

   b. Which of those duties takes up the most of your time?

Could we now look at your role in relation to trainee nurses on your ward?

2. Who do you think should have major responsibility for seeing that nurses learn on the ward? - (explore)
3. Where are practical nursing skills best taught and practiced, in school, in the ward, in school and ward? - (explore)
4. Should procedures practised in the ward be the same as taught in the school? - (explore)
5. Are there any aspects of nursing which cannot be taught on the wards?
6. Do you know which wards nurses have previously worked on?
7. How do you find out what previous teaching nurses have had in the wards?
8. Have you a routine for introducing 'new' staff members to their duties? - (explore)
9. Who usually carries out this duty?
10. Do you ask questions to assess a nurses knowledge?
11. Are there any nurses to whom you find you are teaching more to and why?
12. How much time and opportunity is there for you to pass on your knowledge and skills in the ward situation?
13. If you had more time whatwould you do that you don't do now?
14. What is your opinion of the value of doctors' ward rounds/report giving as a learning exercise for trainee nurses. Why do you say that?
15. What do you feel are the best ways of teaching nurses on the ward?
16. We talked a lot about learning and teaching. What do you mean by teaching?

17. Have you been on any courses which have included 'teaching' as a subject? - (explore)

18. What do you feel you need to know in order to help trainees learn more effectively in the ward situation?

19. Have you been on any courses on the art of examining/assesors course?

20. Are you an assessor or examiner for the GNC? - (explore)

21. Would you like opportunity to attend more courses? What subjects would you like to see covered?

22. How satisfied are you with the present system of training nurses? - (explore)

23. Finally, can you tell me how long you have been a Ward Sister/ Charge Nurse?

NHS LEARNING RESOURCES UNIT
55, Broomgrove Road
Sheffield S10 2NA

Telephone Sheffield (0742) 661862

Dear

I am carrying out research into how nurses learn in the ward situation. In particular, I wish to look in depth at person to person interaction between trainee and trained nurse. I also wish to determine the training needs of qualified nurses in regard to ward teaching methods; your help in these two matters would be most welcome. It is anticipated that your co-operation will help determine what sorts of behaviours turn the day to day work into a learning experience for trainee nurses.

Your participation in the project will involve you in a strictly confidential interview lasting approximately 45 minutes, in a place and at a time convenient to yourself. If you are willing to participate you need do nothing after receiving this letter, I will contact you in due course. If you feel you cannot take part I would appreciate it if you would ring the following number and leave a message to this effect - 0742-661862.

May I offer anticipatory thanks for your taking part in this research project, your experience will be invaluable to the study, and ultimately of benefit to nurse training as a whole.

Yours sincerely,

S.N. Marson (Miss) SRN RSCN SCM RNT
Unit Director
NHS Learning Resources Unit

WARD DIARY (NHS LRU Ward Teaching Research Project)

* Type of Ward (surgical, medical, paediatric) _____

* Grade of staff recording a 'learning/teaching' experience _____

Staff involved in the situation _____

_____

_____

In your opinion did the incident you are describing represent effective/ineffective teaching behaviour (delete whichever is not applicable).

What events led up to the incident?

_____

_____

What did the participants say/do?

_____

_____

_____

Give your reasons for thinking that the behaviours of the participants were examples of effective or ineffective teaching behaviour.

_____

_____

e.g. Medical staff, Senior Nursing Officer, Sister, staff nurse, 1st, 2nd, 3rd year nurse, pupil nurse, ancillary staff etc.

WARD TEACHING SURVEY

The left hand column of this questionnaire contains a list of statements about the characteristics, behaviour and personality of trained nurses working on wards and departments. Consider the statements carefully then put a X on an appropriate point in the scale in the right hand column, according to how well you think that characteristic applies to the person who is skilled at teaching in the ward. E.g. if you feel that 'setting a good example' is a marked characteristic of a good ward teacher put an X under the column marked strongly related. If you feel it helps if the good teacher sets a good example but is not essential put an X under moderately related and so on.

	Strongly related	moderately related	not related
1. Sets a good example at all times.			
2. Gives lectures frequently.			
3. Doesn't bear grudges.			
4. Shows care and concern for patients' needs.			
5. Is a strict disciplinarian.			
6. Is sympathetic to a trainee's problems.			
7. Gives trainee written work to do (e.g. case studies etc.)			
8. Treats trainee differently from trained staff.			
9. Prepares teaching material to use on ward/ department.			
10. Is open about his/ her feelings.			
11. Teaches the <u>why</u> of nursing care as well as the how.			
12. Stays in the office and allows the staff to get on with their work.			
13. Has a happy and lively personality.			
14. Displays high standards of nursing care			

	strongly related	moderately related	not related
15. Ensures Doctors' needs are attended to first.			
16. Makes sure all members of the ward team support trainees.			
17. Is a motherly/ fatherly person.			
18. Sets objectives (goals) for student to achieve during ward/ department experience.			
19. Makes routine nursing care interesting.			
20. Is down to earth.			
21. Behaves in a professional manner at all times.			
22. Gives hints and tips to help learning.			
23. Is dedicated to her work.			
24. Conveys that he/she has trust and confidence in trainee.			
25. Encourages trainee to express his/her own opinions and ideas.			
26. Enjoys his/her work.			
27. Carries out basic nursing care when necessary.			
28. Instils confidence in his/her abilities.			
29. Is able to delegate responsibility.			
30. Is conscientious.			
31. Always makes time to answer questions.			
32. Finds out what trainee knows before teaching something new.			

	strongly related	moderately related	not related
33. Corrects trainee immediately whenever and wherever a mistake is made, regardless of who is present.			
34. Relates teaching to 'real life' ward experience.			
35. Ensures that the ward routine runs smoothly.			
36. Gets trainee to work things out for him/herself.			
37. Ensures trainee feels part of ward team.			
38. Has a calm and unhurried manner.			
39. Is capable and competent.			
40. Takes all opportunities to work with trainees.			
41. Is sensitive to trainee's feelings.			
42. Is respected by staff and patients.			
43. Asks the trainee relevant questions to help learning.			
44. Puts the trainee at ease.			
45. Keeps her relationship with trainee on an impersonal basis.			
46. Gives responsibility of a degree the trainee can cope with.			
47. Lets trainee know how he/she is progressing at regular intervals.			
48. Is always ready to offer help when needed.			
49. Is able to explain things simply to trainee in a language he/she can understand.			

	strongly related	moderately related	not related
50. Is approachable and friendly.			
51. Is honest.			
52. Takes every opportunity to teach.			
53. Shows respect for trainee as a person in her own right.			
54. Communicates ' person to person' with trainee.			
55. Questions frequently to find out what trainee has learned.			
56. Is very experienced at his/her job.			
57.. Is knowledgeable about nursing.			
58. Is always patient.			
59. Works hard.			
60. Is able to teach in a logical way.			
61. Does not carry out basic nursing care her/himself.			
62. Has a kindly nature.			
63. Shares his/her ideas and feelings with the trainee.			
64. Gives correction quietly and in private when it is justified.			
65. Is quiet and reserved.			
66. Is interested in the trainee as a person.			
67. Has a sense of humour.			
68. Understands how trainee feels.			

	strongly related	moderately related	not related
69. Keeps a distance between him/herself and the trainee.			
70. Checks that information given is absorbed and understood.			

RACKHAM, N. Verbal Behaviour Categories - outline definition

Initiating Categories

Proposing - a behaviour which puts forward a new concept or suggestion for a course of action. Stated in a non-directive form e.g. *"can I suggest?"*

Building - a behaviour which extends or develops a proposal which has been made by another person. (follows immediately and is directly related to the proposal)

Reacting Categories

Supporting - a behaviour which involves a conscious and direct declaration of support of, or agreement with, another person or his ideas.

Disagreeing - disagreeing with or contradicting what another person has said e.g. *"I don't agree with that"*, *"No, that's not right"*, *"Jim said . . . "*.

Defending/ Attacking - a behaviour which attacks another person or defensively strengthens an individual's own position. Defending/ attacking behaviours usually involve overt value judgements and often contain emotional overtones.

Blocking (difficulty stating) - a behaviour which places a difficulty or block in the path of a proposal or point of view, without offering any alternative proposal and without offering a reasoned statement of disagreement. Blocking/difficulty stating behaviours therefore tend to be rather bald e.g. *"It won't work"* or *"We couldn't possibly accept that"*, cliches are an example of blocking behaviour.

Open - a behaviour which exposes the individual who makes it to risk, ridicule, or loss of status. This behaviour may be considered as the opposite of defending/attacking, included within this category are admissions of mistakes or inadequacies providing that these are made in a non-defensive manner.

Testing Understanding - a behaviour which seeks to establish whether or not an earlier contribution has, been understood.

Summarising - a behaviour which summarises or otherwise restates in a compact form, the content of previous discussion or considerations.

Giving Information - speaker gives facts, explanations or instructions, describes actions, gives opinions.

Seeking Information - a behaviour which seeks facts, opinions or clarification of another individual's contribution.

Bringing in - a behaviour which increases another individual's opportunity to participate, or invites a contribution from a specified individual.

Shutting out - a behaviour which decreases another individual's opportunity to participate and which, whether deliberate or otherwise, excludes another individual from making his contribution. Interrupting is the most commonly observed form of shutting out.

ACTIVITY - Ward Report

DURATION - 30 minutes

2nd year student

1st year pupil

NAMES		SEN	2nd yr. stud:	1st yr. pupil		Total
PROPOSING						
BUILDING						
SUPPORTING		III	II	II		7
DISAGREEING		II				2
BLOCKING/DIFFICULTY STATING						
DEFENDING/ATTACKING						
OPEN		III		I		4
TESTING UNDERSTANDING		IIIII III				8
SUMMARISING						
SEEKING INFORMATION	SOCIAL					
	JOB REL.	IIIII				5
	THEORY REL.	IIIII IIII	III			12
	THEORY IN DEPTH					
GIVING INFORMATION	OPINION	II				2
	INSTRUCTION	IIIII IIIII IIIII IIIII I				21
	EXPLANATION	IIIII IIIII IIIII IIIII IIIII IIIII	IIIII IIIII I	IIIII I		47
Total		83	16	9		108
			XX			

INTERVIEW SCHEDULE

Trainee Nurses

Post-observational period on the ward

Introduction

I am researching into how nurses learn in the ward situation and would appreciate the help that you can give from your own experience. The information obtained from this interview is strictly confidential. In on circumstances will any information be disclosed to any member of the hospital staff. No names will be used in any future publications and anonymity will be preserved in all circumstances.

Section A. Ward Environment

Can you first of all give me some information regarding yourself and your present ward experience.

1. How long have you been training?
2. What prior knowledge and experience did you have about this speciality before you came onto this ward?
3. Were you asked about this on your arrival onto this ward?
4. How were you first introduced to the ward?
5. How would you describe your feelings about working on this ward?
6. How do you get on with your fellow nursing colleagues?
7. How long did it take to form a relationship with the staff on this ward?
8. How easy was it?
9. Which would you say was the most important concern on this ward:-

a. patient care

b. completing tasks

c. fulfilling doctors orders?

10. Can you recall any incident which helped you form your opinion about that?

11. While working on the ward do you see yourself as a student or as a worker?

12. Were there any previous wards where you had the opposite feeling about yourself?

13. Why do you think this was so?

14. Whom do you approach on this ward for an answer to any questions you might have?

15. Is this because you feel that the person is the most able to answer or are there any other reasons?

16. Whom do you consider the most able person to answer your question?

17. Can you tell me what prevented you approaching that person?

18. Have been asked to do anything, on this ward, for which you felt you were inadequately prepared?

19. While you have been here have you helped a junior student or pupil nurse?

20. Were you asked to do this, or did you offer yourself?

21. Do you do this on this ward or on every ward?

Section B. Learning

1. What do you believe learning is?

2. What motivates you to learn?

3, How much do you feel you have learnt on this ward?

4. What has most helped you to learn?

5. Who has helped you the most?

6. Did she help you in practical nursing skills, theoretical concepts, interpersonal problems?

7. In which areas do you feel you have learnt the most:

   a. basic nursing care

   b. specialised technical care

   c. social interaction?

8. How well have you been able to relate the theory from the school to the practice on the ward?

9. Can you think of learning that you completed in the school but not had the opportunity to practice on the ward?

10. Who has helped you most in the adaptation from school to the ward situation?

11. Do you feel you have had any influence on, or made any contribution to, the type of nursing care a patient has received on this ward?

12. What and how do you feel this contributed?

13. Who do you feel is responsible, on this ward, for trainees' learning?

14. Is this the person who does the most teaching?

15. From whom do you feel you have learnt the most?

16. Can you name some of the characteristics which you feel made that person a good teacher?

17. Can you recall a person on this ward from whom you learnt the least?

18. Why do you think this was so?

19. Is there an adequate ward library?

20. Are you encouraged to use it?

21. Do you feel that it has been left up to you to seek knowledge or

has such knowledge been give without your prior inquiry?

22. Do you feel you have been encouraged to learn on this ward?
23. Have you experienced any strong feelings towards any patient on this ward?
24. Were you able to discuss this with anyone?
25. Why do you feel you approached this person?
26. Do you feel that the experience you have had on this ward has changed you in any way?
27. Can you recall any incidents when you were embarrassed by anyone on this ward?
28. Finally, can you think of any ways in which you might have been helped to learn more on this ward?
29. How has my presence on the ward affected interactions?

TABLE 1

APPENDIX C

Behavioural/personality characteristics of good ward teachers; statements collected from interviews with ward sisters and trainees.

Statement number		No.of times given
1.	Takes every opportunity to teach/tell/show	18
2.	Good nurse/high standards/good example	17
3.	Communicates person to person	16
4.	Cares about patients	15
5.	Approachable, friendly	
6.	Understands how trainee feels	14
7.	Capable/competent well organised	9
8.	Always there when help is needed	
9.	Gives correction appropriately	
10.	Puts trainee at ease	
11.	Interested in trainee	8
12.	Works with trainee	
13.	Explains things simply	
14.	Very experienced	
15.	Motherly	
16.	Patient	6
17.	Always has time for trainee	
18.	Very professional	5
19.	Gives feedback on progress	
20.	Gets trainee to work things out for herself	4
21.	Respected	
22.	Knowledgeable	
23.	Instils confidence	
24.	Sense of humour	3
25.	Asks relevant questions	
26.	Sets goals for trainee	
27.	Prepares teaching aids	
28.	Checks for understanding	3
29.	Relates teaching to real life	
30.	Gives responsibility in acceptable amounts	
31.	Carries out basic nursing care	
32.	Able to delegate	
33.	Calm, unhurried	
34.	Happy and lively	
35.	Kind	2
36.	Doesn't bear grudges	
37.	Makes trainee feel wanted	
38.	Hard working	
39.	Finds out what trainee knows	
40.	Gives hints and tips to aid learning	
41.	Makes things interesting	
42.	Teaches in a logical way	1
43.	Dedicated	
44.	Enjoys her work	
45.	Quiet and reserved	
46.	Sympathetic	
47.	Open about her feelings	
48.	Down to earth/honest	
49.	Conscientious	

TABLE 2

RAW DATA FROM GOOD TEACHER QUESTIONNAIRE

WARD TEACHING SURVEY

The left hand column of this questionnaire contains a list of statements about the characteristics, behaviour and personality of trained nurses working on wards and departments. Consider the statements carefully then put a X on an appropriate point in the scale in the right hand column, according to how well you think that characteristic applies to the person who is skilled at teaching in the ward. E.g. if you feel that 'setting a good example' is a marked characteristic of a good ward teacher put an X under the column marked strongly related. If you feel it helps if the good teacher sets a good example but is not essential put an X under moderately related and so on.

	Strongly related		moderately related		not related
1. Sets a good example at all times.	79	12	5	0	0
2. Gives lectures frequently.	17	11	60	5	3
3. Doesn't bear grudges.	58	12	23	2	1
4. Shows care and concern for patients' needs.	86	4	6	0	0
5. Is a strict disciplinarian.	11	9	49	11	15
6. Is sympathetic to a trainee's problems.	56	11	27	0	2
7. Gives trainee written work to do (e.g. case studies etc.)	10	5	42	16	23
8. Treats trainee differently from trained staff.	9	4	37	11	35
9. Prepares teaching material to use on ward/ department.	28	14	35	8	10
10. Is open about his/ her feelings.	19	9	42	5	21
11. Teaches the why of nursing care as well as the how.	82	10	4	0	0
12. Stays in the office and allows the staff to get on with their work.	3	2	20	13	58
13. Has a happy and lively personality.	3	13	44	2	6
14. Displays high standards of nursing care	88	3	5	0	0

	strongly related		moderately related		not relate
15. Ensures Doctors needs are attended to first.	9	2	41	18	22
16. Makes sure all members of the ward team support trainees.	63	7	22	1	2
17. Is a motherly/ fatherly person.	6	3	39	15	32
18. Sets objectives (goals) for student to achieve during ward/ department experience.	42	14	31	4	5
19. Makes routine nursing care interesting.	66	12	16	2	0
20. Is down to earth.	30	11	39	4	12
21. Behaves in a professional manner at all times.	51	13	30	1	1
22. Gives hints and tips to help learning.	77	8	9	2	0
23. Is dedicated to her work.	49	16	27	1	2
24. Conveys that he/she has trust and confidence in trainee.	62	17	15	0	2
25. Encourages trainee to express his/her own opinions and ideas.	54	13	24	1	4
26. Enjoys his/her work.	71	11	14	0	0
27. Carries out basic nursing care when necessary.	63	12	18	2	1
28. Instils confidence in his/her abilities.	65	17	13	0	1
29. Is able to delegate responsibility.	65	15	14	1	0
30. Is conscientious.	61	8	24	2	1
31. Always makes time to answer questions.	78	8	9	0	1
32. Finds out what trainee knows before teaching something new.	56	17	17	2	4

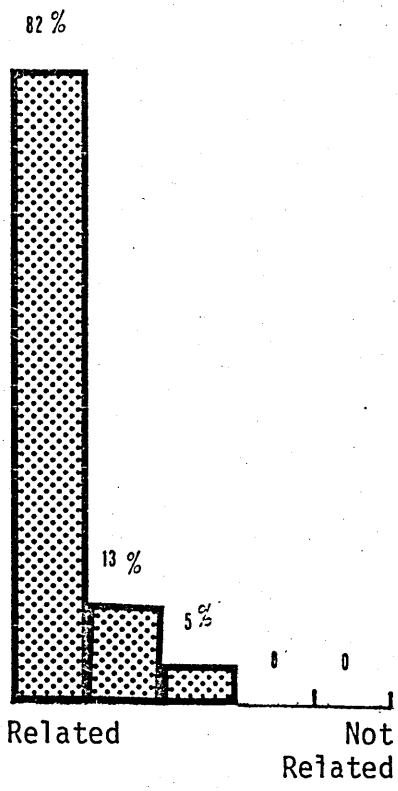
	strongly related		moderately related		not related
33. Corrects trainee immediately whenever and wherever a mistake is made, regardless of who is present.	14	6	21	16	39
34. Relates teaching to 'real life' ward experience.	58	14	24	0	0
35. Ensures that the ward routine runs smoothly.	51	14	29	2	0
36. Gets trainee to work things out for him/herself.	40	13	39	1	3
37. Ensures trainee feels part of ward team.	65	14	16	1	0
38. Has a calm and unhurried manner.	46	18	27	2	3
39. Is capable and competent.	73	11	12	0	0
40. Takes all opportunities to work with trainees.	52	9	34	0	1
41. Is sensitive to trainee's feelings.	33	18	36	4	5
42. Is respected by staff and patients.	68	9	18	1	0
43. Asks the trainee relevant questions to help learning.	60	16	18	2	0
44. Puts the trainee at ease.	53	13	27	1	1
45. Keeps her relationship with trainee on an impersonal basis.	15	6	46	9	20
46. Gives responsibility of a degree the trainee can cope with.	61	16	17	2	0
47. Lets trainee know how he/she is progressing at regular intervals.	38	23	20	6	9
48. Is always ready to offer help when needed.	68	14	14	0	0
49. Is able to explain things simply to trainee in a language he/she can understand.	75	11	10	0	0

	strongly related		moderately related		not related
50. Is approachable and friendly.	56	15	21	2	2
51. Is honest.	65	14	16	0	1
52. Takes every opportunity to teach.	44	21	26	2	3
53. Shows respect for trainee as a person in her own right.	55	13	25	0	3
54. Communicates ' person to person' with trainee.	40	21	32	1	2
55. Questions frequently to find out what trainee has learned.	39	15	33	5	3
56. Is very experienced at his/her job.	59	16	16	1	4
57.. Is knowledgeable about nursing.	74	11	9	1	1
58. Is always patient.	40	15	36	0	4
59. Works hard.	52	12	31	0	1
60. Is able to teach in a logical way.	57	16	21	1	1
61. Does not carry out basic nursing care her/himself.	6	6	14	8	62
62. Has a kindly nature.	28	16	43	4	2
63. Shares his/her ideas and feelings with the trainee.	18	13	36	8	21
64. Gives correction quietly and in private when it is justified.	70	4	16	3	3
65. Is quiet and reserved.	1	4	30	18	42
66. Is interested in the trainee as a person.	33	9	43	3	7
67. Has a sense of humour.	48	10	28	5	4
68. Understands how trainee feels.	49	13	28	3	3

	strongly related		moderately related		not related
69. Keeps a distance between him/herself and the trainee.	3	8	34	17	34
70. Checks that information given is absorbed and understood.	62	14	18	0	2

Figure 1 Figures 1 - 5 Responses to questionnaire expressed as percentages

2/1



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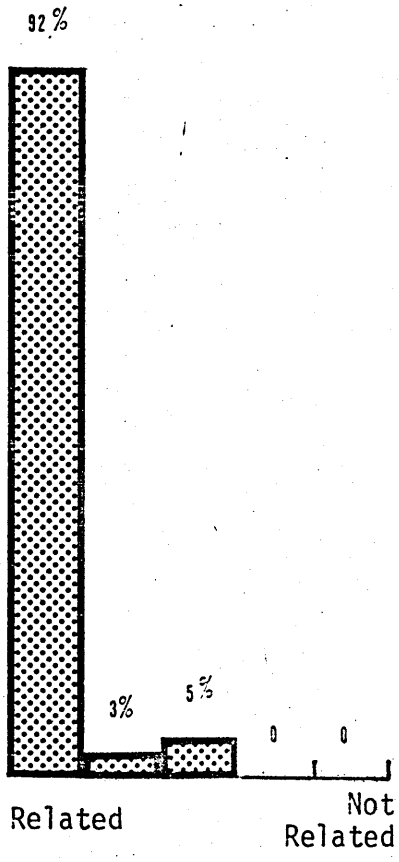

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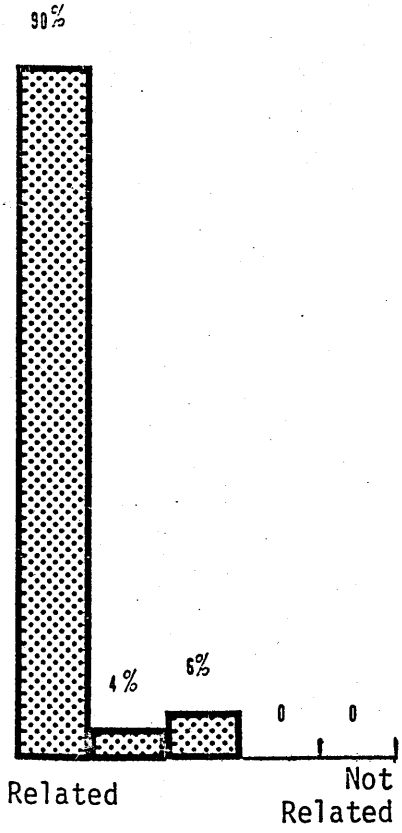

Figure 1 (cont.)

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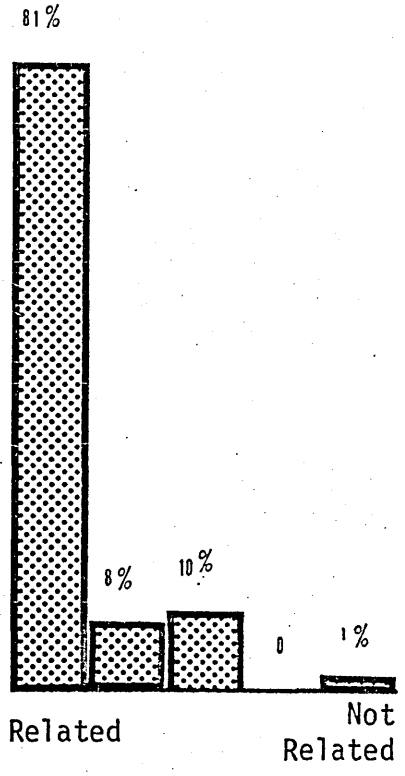

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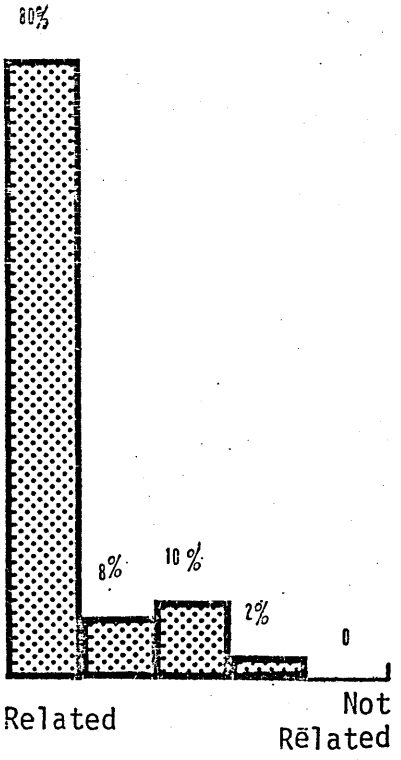


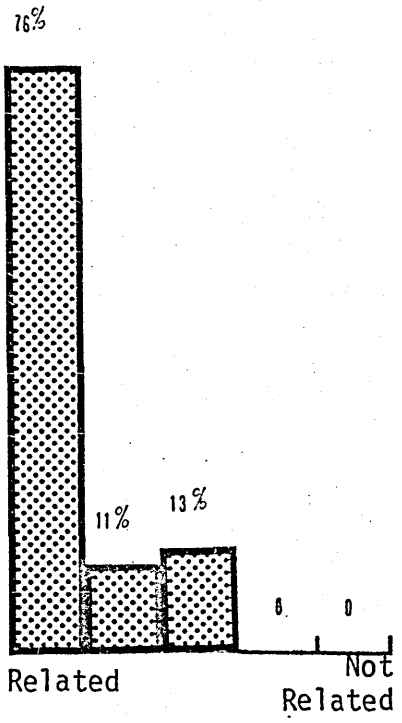
Key	INTERVIEW STATEMENTS (see table I page XXV)	
2	Sets a good example at all times/ high standards	Question 1 & 14 on questionnaire
4	Shows care and concern for patient's needs	Question 4 on questionnaire
17	Always has time for trainees	Question 31 on questionnaire
40	Gives hints and tips to help learning	Question 22 on questionnaire

Figure 2

Key

Interview Statement Number		Number on Questionnair
7	Capable and competent	39
8	Always there when help is needed	48
9	Gives correction quietly and in private when needed	64

7/39



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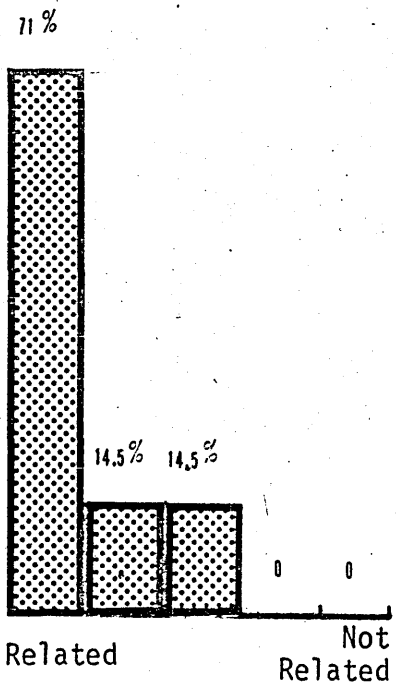

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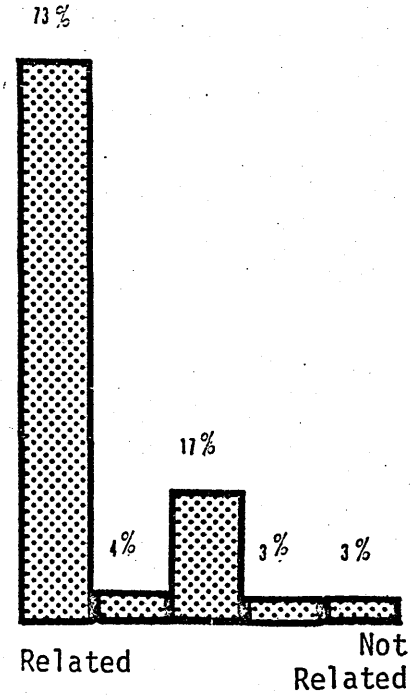
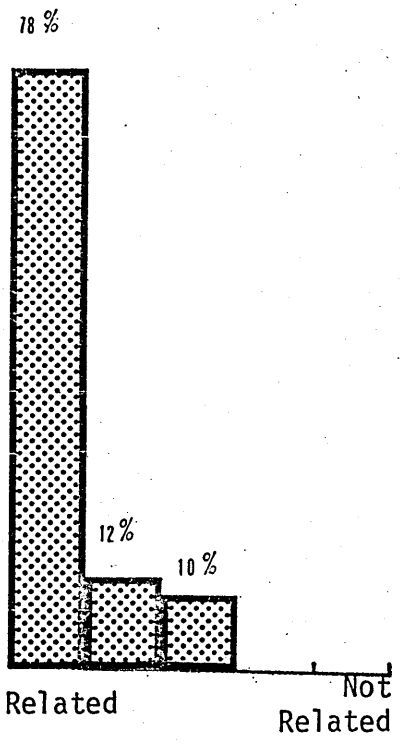


Key

Interview Statement Number		Number on Questionnaire
13	Is able to explain things simply	49
21	Is respected by staff and patients	42
22	Is knowledgeable about nursing	57

13/49



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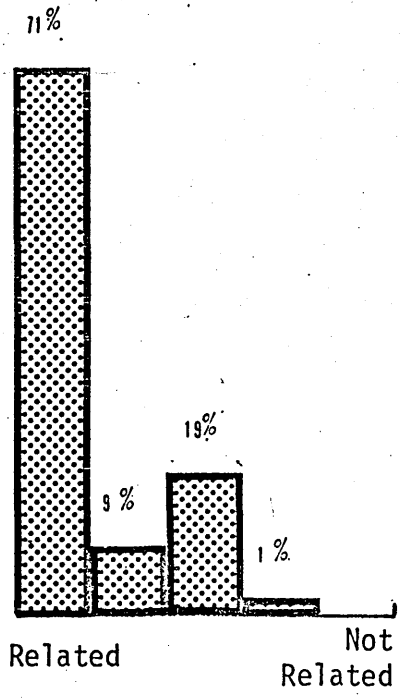

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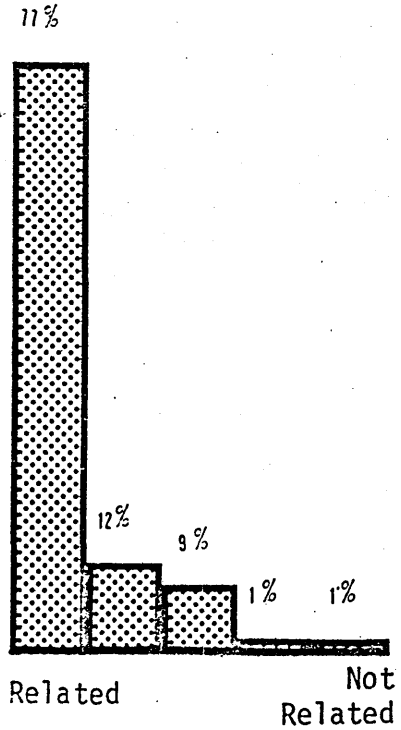

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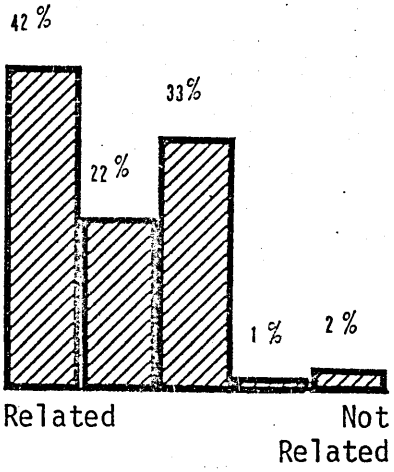
Key

Interview Statement Number		Number on Questionnai
3	Communicates person to person	54
15	Is a motherly/fatherly sort of person	17
45	Is quiet and reserved	65



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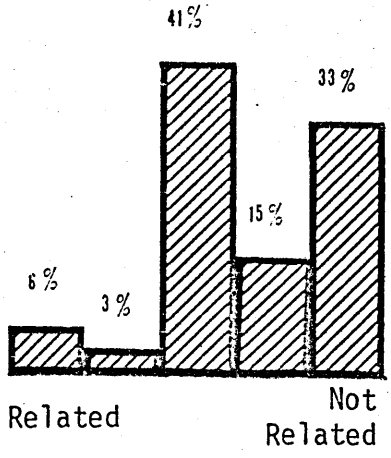


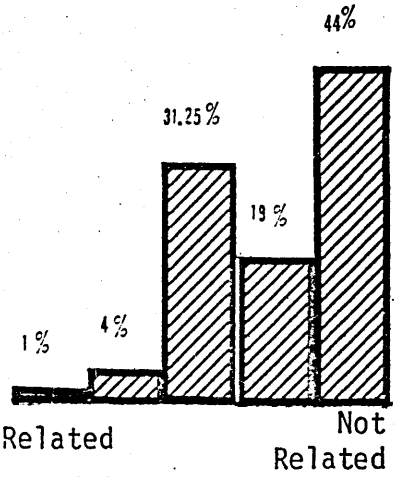
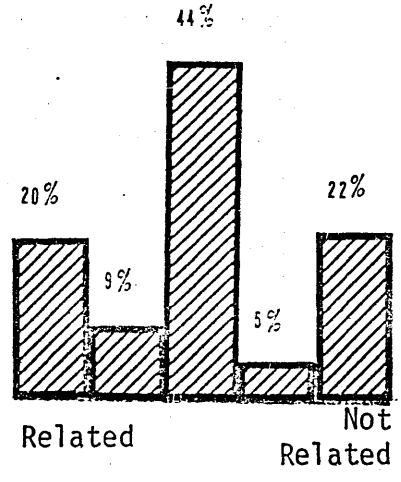


Figure 3 (cont.)

Key

Interview Statement Number		Number on Questionnaire
47	Is open about his/her feelings	10
	Encourages trainee to express his/her own opinions and ideas	25
	Conveys that he/she has trust and confidence in trainees	24



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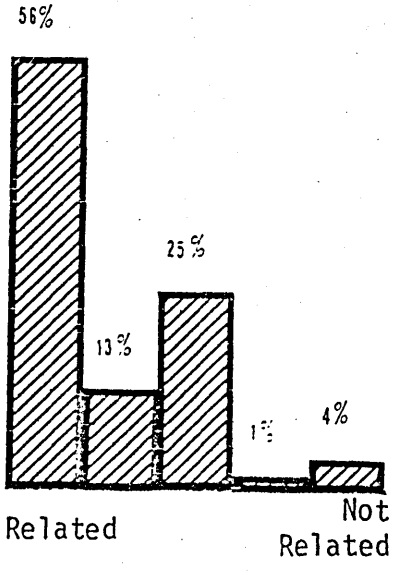


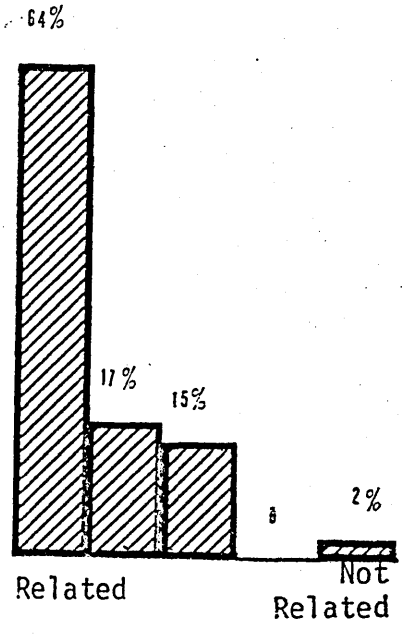
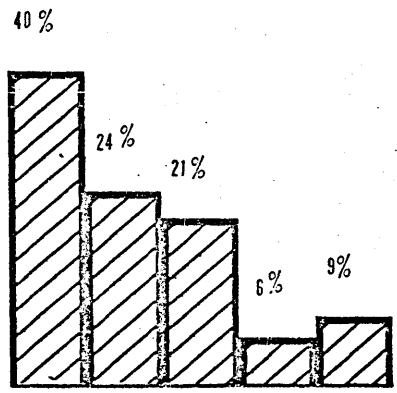


Figure 4

19/47

Key

Interview Statement Number		Number on Questionnair
19	Gives feedback on progress	47
20	Gets trainee to work things out for herself	36
26	Sets goals for trainee to achieve	18



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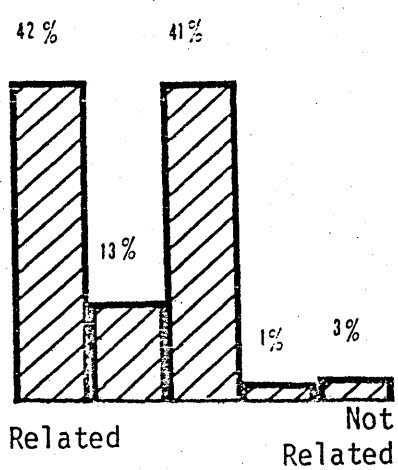


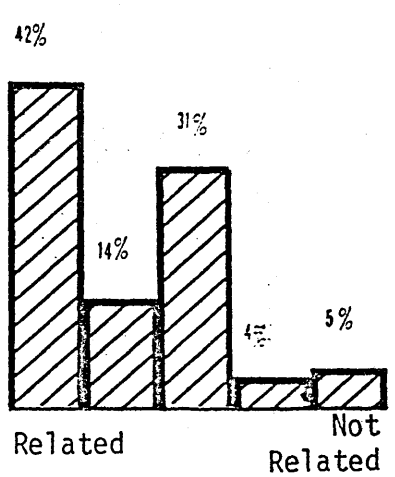
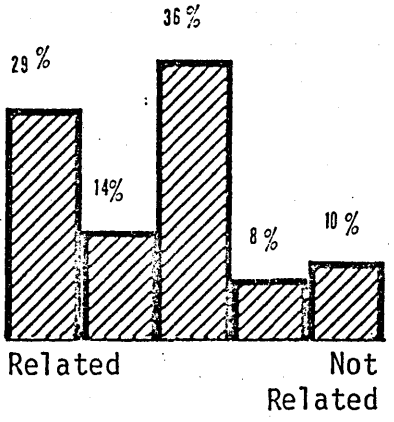


Figure [illegible]

Key

Interview Statement Number		Number on Questionnaire
27	Prepares and uses teaching aids	9
	Teaches the 'why' of nursing as well as the 'how'	11
29	Relates teaching to real life experience	34

27/9



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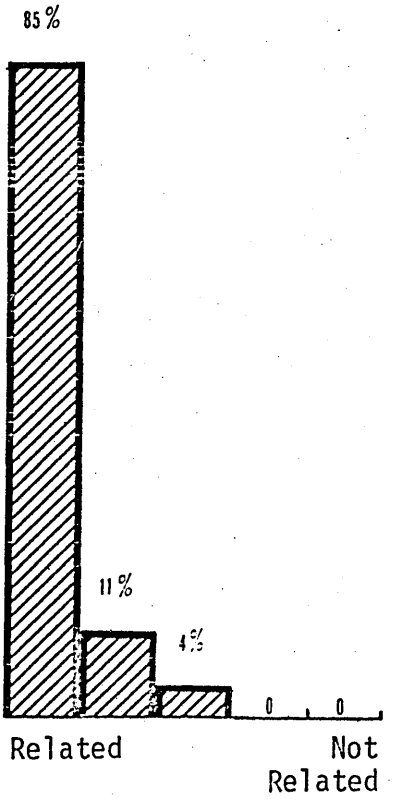
29/34



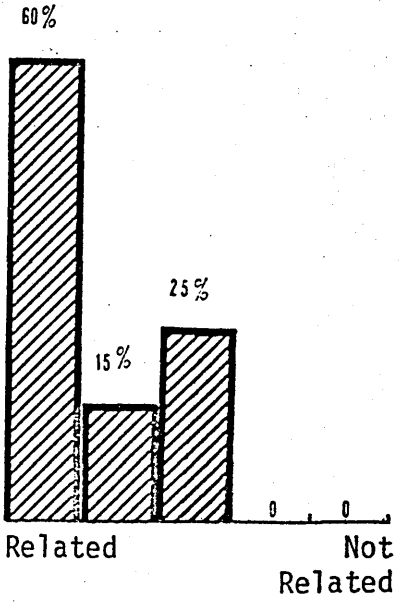
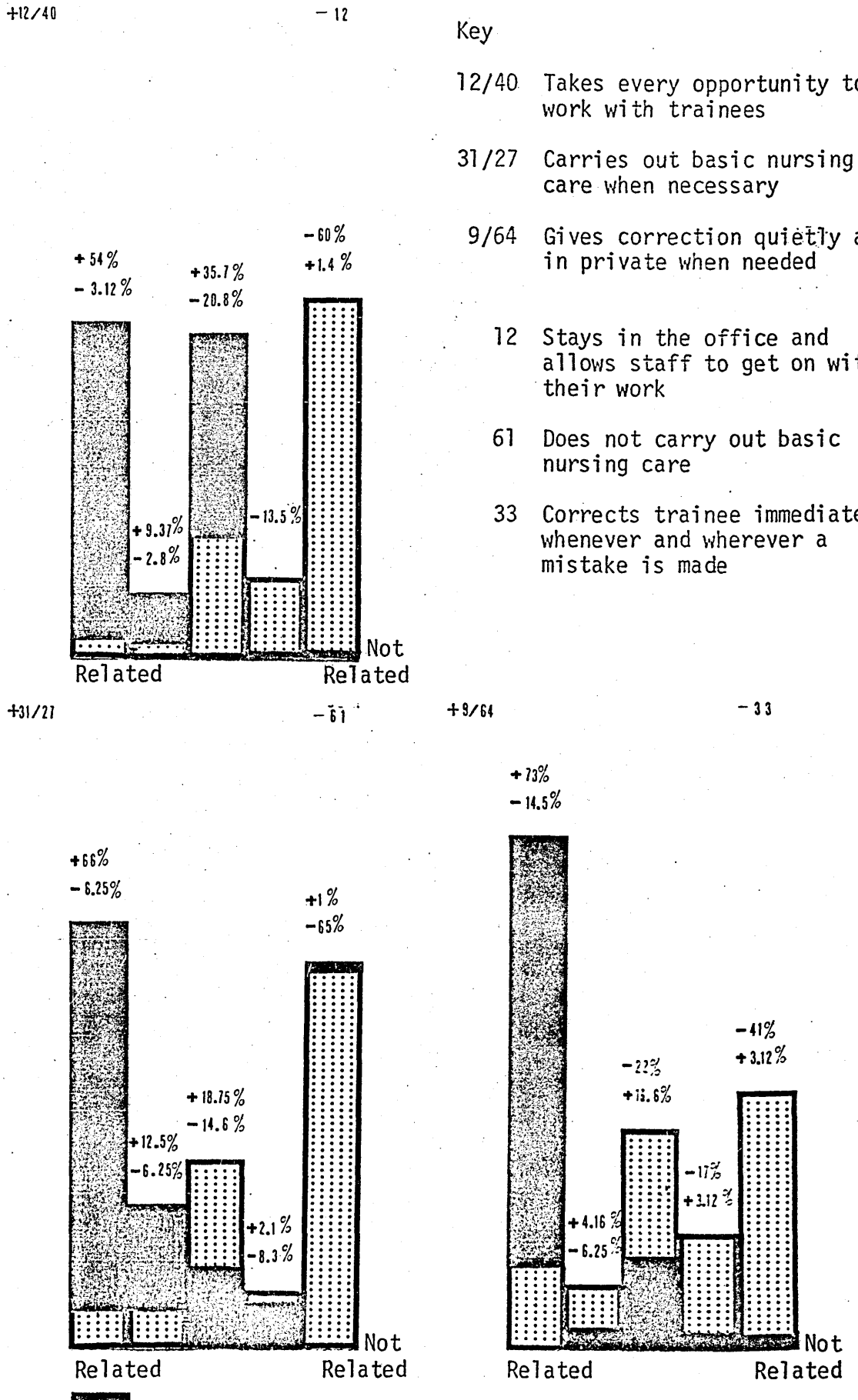


Figure 5 Responses to negative and positive statements on questionnaire



Key

12/40 Takes every opportunity to work with trainees

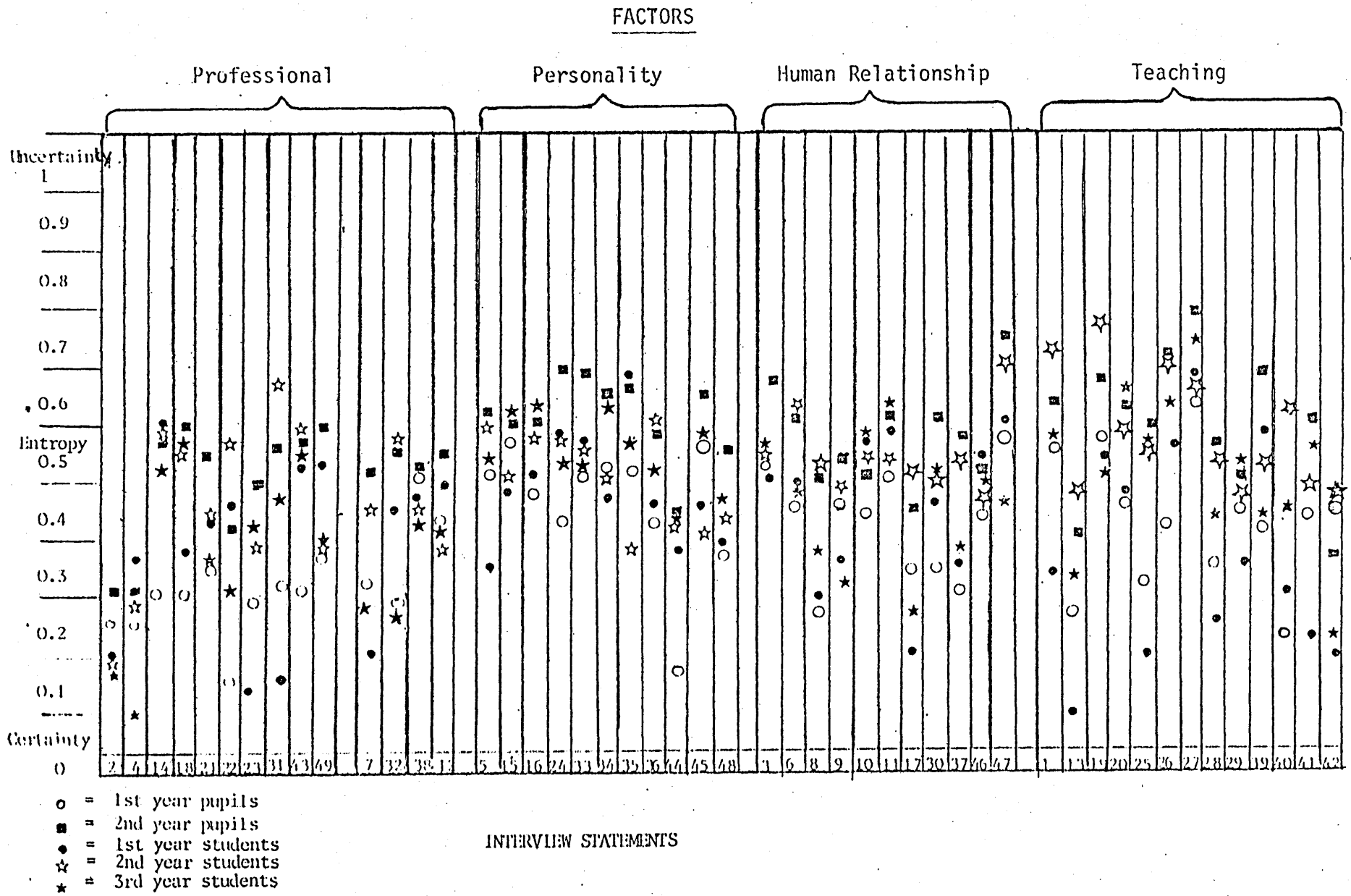
31/27 Carries out basic nursing care when necessary

9/64 Gives correction quietly and in private when needed

12 Stays in the office and allows staff to get on with their work

61 Does not carry out basic nursing care

33 Corrects trainee immediately whenever and wherever a mistake is made


FACTORS
Professional
Personality
Human Relationship
Teaching
Uncertainty
1
0.9
0.8
0.7
0.6
Entropy
0.5
0.4
0.3
0.2
0.1
Certainty
0
2 4 14 18 21 22 23 31 43 49 7 32 38 13 5 15 16 24 33 34 35 36 44 45 48 3 6 8 9 10 11 17 30 37 46 47 1 12 19 20 25 26 27 28 29 39 40 41 42
o = 1st year pupils
■ = 2nd year pupils
● = 1st year students
☆ = 2nd year students
★ = 3rd year students
INTERVIEW STATEMENTS

FORMULA FOR CALCULATING ENTROPY SCORES

$$\text{Entropy} = -\sum P \log P$$

$$= -(P_1 \log P_1 + P_2 \log P_2 + \ldots\ldots)$$

e.g. For questionnaire statement No. 14

$$\text{Entropy} = -(88/96 \times \log_{10} 88/96 + 3/96 \log_{10} 3/96 + 5/96 \times \log_{10} 5/96)$$

$$= -(-0.0346 - 0.0470 - 0.0668)$$

$$= 0.1484$$

$$\simeq 0.15$$

(If all the responses fall on one point, the entropy = 0. If the responses are evenly distributed (i.e. 20% of the responses fall at each of the five points) then entropy = 0.699.)

STATEMENTS RANKED ACCORDING TO ENTROPY SCORE

Questionnaire Number		Score	Rank
14	Good nurse with high standards	0.15	1
4	Cares about patients	0.17	2
31	Always has time for trainees	0.28	3
32	Gives hints and tips that aid learning	0.28	
49	Explains things simply	0.28	
39	Capable and competent	0.3	6
26	Enjoys his/her work	0.32	7
57	Knowledgeable about nursing	0.33	8
42	Respected by staff and patients	0.34	9
48	Always there when help is needed	0.34	
28	Instils confidence	0.38	11
29	Able to delegate	0.38	
37	Ensures trainee feels part of ward team	0.38	
64	Gives correction appropriately	0.38	
51	Down to earth/honest	0.38	
19	Makes work experience interesting	0.38	
34	Relates teaching to real life	0.4	17
70	Checks for understanding	0.41	18
27	Gets involved in carrying out basic nursing care	0.42	19
40	Works with trainee	0.42	
46	Gives responsibility in acceptable amounts	0.42	
43	Asks relevant and interesting questions	0.42	
30	Conscientious	0.42	
59	Hard working	0.43	24
6	Sympathetic to trainees' problems	0.43	

TABLE 2 (Cont.)

Questionnaire Number		Score	Rank
60	Teaches in a logical way	0.44	26
3	Doesn't bear grudges	0.44	
44	Puts trainee at ease	0.45	28
66	Interested in/has respect for trainee	0.45	
50	Approachable and friendly	0.46	30
21	Very professional	0.46	
56	Very experienced	0.46	
32	Takes trouble to find out what trainee knows	0.48	33
23	Dedicated nurse	0.49	34
58	Patient	0.5	35
54	Communicates person to person	0.5	
68	Understands how trainee feels	0.5	
36	Gets trainee to work things out for him/herself	0.5	
38	Calm and unhurried	0.52	39
62	Kind	0.53	40
65	Quiet and reserved	0.53	
67	Has a sense of humour	0.53	
52	Takes every opportunity to tell/teach/show	0.53	
13	Happy and lively personality	0.54	44
63	Open about feelings	0.55	45
17	Motherly	0.56	46
18	Sets goals for trainee to achieve	0.56	
47	Gives feedback on progress	0.62	48
9	Prepares and uses teaching aids	0.63	49

TABLE 2a

CATEGORISED STATEMENTS

Professional competence		Entropy Score
14 =	Good nurse with high standards	0.15
4 =	Cares about patients	0.17
39 =	Capable, competent, well organised	0.30
26 =	Enjoys his/her work	0.32
57 =	Knowledgeable about nursing	0.33
42 =	Respected by staff and patients	0.34
28 =	Instils confidence	0.38
29 =	Able to delegate	0.38
27 =	Gets involved in carrying out nursing care	0.42
40 =	Works with trainee	0.42
30 =	Conscientious	0.42
59 =	Hard working	0.43
56 =	Very experienced nurse	0.46
21 =	Very professional	0.46
23 =	Dedicated nurse	0.49
Personality traits		
51 =	Down to earth/honest	0.38
50 =	Approachable/friendly	0.46
58 =	Patient	0.50
38 =	Calm and unhurried	0.52
67 =	Has a sense of humour	0.53
62 =	Kind	0.53
65 =	Quiet and reserved	0.53
13 =	Happy and lively personality	0.54
17 =	Motherly	0.56

TABLE 2a cont.

Human relationship skills		Entropy Score
31 =	Always has time for trainees	0.28
48 =	Always there when help is needed	0.34
37 =	Ensures trainee feels part of ward team	0.38
64 =	Gives correction appropriately	0.38
46 =	Gives responsibility in acceptable amounts	0.42
6 =	Sympathetic to trainees' problems	0.43
3 =	Doesn't bear grudges	0.44
44 =	Puts trainee at ease	0.45
56 =	Interested in/shows respect for trainee as a person	0.45
54 =	Communicates person to person	0.50
68 =	Understands how trainees feel	0.50
63 =	Open about own feelings	0.55
Instructional competence		
22 =	Gives hints and tips which aid learning	0.28
49 =	Explains things simply	0.28
19 =	Makes work experience interesting	0.38
34 =	Relates teaching to real life	0.40
70 =	Checks for understanding	0.41
43 =	Asks relevant and interesting questions	0.42
60 =	Teaches in a logical way	0.44
32 =	Takes trouble to find out what trainee already knows	0.48
36 =	Gets trainee to work things out for him/herself	0.50
52 =	Takes every opportunity to tell/teach/show	0.53
18 =	Sets goals for trainee to achieve	0.56
47 =	Gives feedback on progress	0.62
9 =	Prepares and uses teaching aids	0.63

CORRELATION MATRIX

PRINCIPAL FACTORS

	11	14	18	22	24	25	31	32	34	37
11	1.0	0.39	0.44	0.33	0.21	0.14	0.24	0.16	0.24	0.32
14	0.39	1.0	0.35	0.35	0.36	0.21	0.37	0.41	0.4	0.31
18	0.44	0.35	1.0	0.32	0.06	0.15	0.24	0.26	0.21	0.23
22	0.33	0.35	0.32	1.0	0.28	0.31	0.3	0.17	0.29	0.25
24	0.21	0.36	0.06	0.28	1.0	0.3	0.26	0.17	0.19	0.26
25	0.14	0.21	0.15	0.31	0.3	1.0	0.4	0.21	0.38	0.38
31	0.24	0.37	0.24	0.3	0.26	0.45	1.0	0.32	0.42	0.54
32	0.16	0.4	0.26	0.17	0.17	0.21	0.32	1.0	0.4	0.41
34	0.24	0.4	0.21	0.29	0.19	0.38	0.42	0.4	1.0	0.39
37	0.32	0.31	0.23	0.25	0.26	0.31	0.54	0.41	0.39	1.0
39	0.43	0.16	0.08	0.26	0.27	0.16	0.44	0.05	0.24	0.41
40	0.2	0.24	0.25	0.26	0.08	0.31	0.4	0.32	0.37	0.41
43	0.51	0.3	0.38	0.51	0.28	0.4	0.42	0.25	0.3	0.47
46	0.42	0.28	0.17	0.33	0.28	0.26	0.31	0.2	0.35	0.54
47	0.3	0.15	0.24	0.45	0.17	0.28	0.29	0.2	0.26	0.47
48	0.32	0.28	0.28	0.41	0.23	0.39	0.6	0.29	0.41	0.36
49	0.45	0.16	0.21	0.4	0.08	0.42	0.36	0.17	0.4	0.24
54	0.28	0.22	0.14	0.21	0.07	0.15	0.24	0.28	0.43	0.37
64	0.3	0.31	0.11	0.26	0.19	0.34	0.51	0.13	0.37	0.25
63	0.15	0.1	0.31	0.27	0.05	0.34	0.46	0.18	0.26	0.33
70	0.59	0.4	0.38	0.38	0.25	0.24	0.45	0.25	0.41	0.43

Figure 7

CORRELATION MATRIX

PRINCIPAL FACTORS

39	40	43	46	47	48	49	54	64	68	70
0.43	0.20	0.51	0.42	0.3	0.32	0.45	0.28	0.30	0.29	0.59
0.16	0.24	0.3	0.28	0.15	0.28	0.16	0.22	0.31	0.1	0.4
0.08	0.25	0.38	0.17	0.24	0.28	0.21	0.14	0.11	0.31	0.38
0.26	0.26	0.51	0.33	0.45	0.41	0.4	0.21	0.26	0.27	0.38
0.27	0.08	0.28	0.28	0.01	0.23	0.08	0.07	0.19	0.05	0.25
0.16	0.31	0.4	0.26	0.28	0.39	0.42	0.15	0.34	0.34	0.24
0.44	0.4	0.43	0.31	0.29	0.6	0.36	0.24	0.51	0.46	0.45
0.05	0.32	0.25	0.2	0.2	0.29	0.17	0.28	0.13	0.18	0.25
0.24	0.37	0.3	0.35	0.26	0.41	0.4	0.43	0.37	0.26	0.41
0.41	0.41	0.47	0.54	0.47	0.36	0.24	0.37	0.25	0.33	0.43
1.0	0.27	0.36	0.57	0.33	0.36	0.4	0.21	0.5	0.33	0.42
0.27	1.0	0.41	0.35	0.34	0.37	0.39	0.33	0.32	0.34	0.41
0.36	0.41	1.0	0.51	0.33	0.54	0.43	0.35	0.32	0.29	0.54
0.57	0.35	0.51	1.0	0.48	0.29	0.33	0.39	0.34	0.25	0.53
0.33	0.34	0.33	0.48	1.0	0.26	0.35	0.34	0.23	0.22	0.33
0.36	0.37	0.54	0.29	0.26	1.0	0.57	0.25	0.48	0.44	0.52
0.4	0.39	0.43	0.33	0.35	0.57	1.0	0.21	0.42	0.29	0.49
0.21	0.33	0.35	0.39	0.34	0.25	0.21	1.0	0.23	0.29	0.37
0.5	0.32	0.32	0.34	0.23	0.48	0.42	0.23	1.0	0.47	0.55
0.33	0.34	0.20	0.25	0.22	0.44	0.29	0.29	0.47	1.0	0.39
0.42	0.41	0.54	0.23	0.33	0.52	0.49	0.37	0.37	0.55	1.0

Varimax Rotated Factor Matrix

FACTOR 1

S = statement number		Correlation Index
S43	Asks trainee relevant questions to aid learning.	0.66
S70	Checks that information absorbed is understood.	0.65
S22	Gives hints and tips to aid learning.	0.64
S55	Questions frequently to find out what trainee has learned.	0.62
S53	Shows respect for trainee as a person in his/her own right.	0.61
S11	Teaches the why of nursing care as well as the how.	0.58
S16	Makes sure all members of the team support trainee.	0.57
S52	Takes every opportunity to teach.	0.57
S14	Displays high standards of nursing care.	0.55
S18	Sets objectives for trainees to achieve during ward experience.	0.55
S47	Lets trainee know how he/she is progressing at regular intervals.	0.55
S48	Is always ready to offer help when needed.	0.54
S19	Makes routine nursing care interesting.	0.53
S31	Always makes time to answer questions.	0.52
S40	Takes all opportunities to work with trainee.	0.50
S49	Is able to explain things simply to trainee in a language he/she can understand.	0.49
S46	Gives responsibility of a degree trainee can cope with.	0.49
S34	Relates teaching to real life experience.	0.47
S9	Prepares teaching material for use on ward.	0.47
S2	Gives lectures frequently.	0.46
S60	Is able to teach in a logical way.	0.46
S25	Encourages trainee to express own ideas.	0.45

FACTOR 2

Varimax Rotated Factor Matrix

		Correlation Index
S68	Understands how trainee feels.	0.62
S13	Has a happy, lively personality.	0.61
S63	Shares ideas and feelings with trainee.	0.55
S62	Has a kindly nature.	0.53
S67	Has a sense of humour.	0.51
S50	Is approachable and friendly.	0.51
S66	Is interested in trainee as a person.	0.50
S58	Is always patient.	0.48

Factor 3

Varimax Rotated Factor Matrix

		Correlation Index
S57	Is knowledgeable about nursing.	0.64
S56	Is very experienced at his/her job.	0.61
S21	Behaves in a professional manner at all times.	0.46
S39	Is capable and competent.	0.46

Oblique Sol. Rotation Kaiser Normalisation

FACTOR 1

Attitudes to learners

		Correlation Index
S43	Asks trainee relevant questions to aid learning.	0.72
S70	Checks that information absorbed is understood.	0.71
S53	Shows respect for trainee as a person in her own right.	0.69
S22	Gives hints and tips to aid learning.	0.65
S55	Questions frequently to find out what trainee has learned.	0.65
S37	Ensures trainee feels part of ward team.	0.64
S48	Is always ready to offer help when needed.	0.63
S31	Always makes time to answer questions.	0.62
S52	Takes every opportunity to teach.	0.60
S11	Teaches the why of nursing care as well as the how.	0.59
S47	Lets trainee know how he/she is progressing at regular intervals.	0.59
S46	Gives responsibility of a degree trainee can cope with.	0.58
S16	Makes sure all members of the ward team support trainees.	0.57
S19	Makes routine nursing care interesting.	0.57
S14	Displays high standards of nursing care.	0.57
S49	Is able to explain things simply to trainee in a language he or she can understand.	0.56
S34	Relates teaching to real life experience.	0.55
S18	Sets objectives for trainees to achieve during ward experience.	0.55
S60	Is able to teach in a logical way.	0.55
S25	Encourages trainee to express his/her own opinions and ideas.	0.52

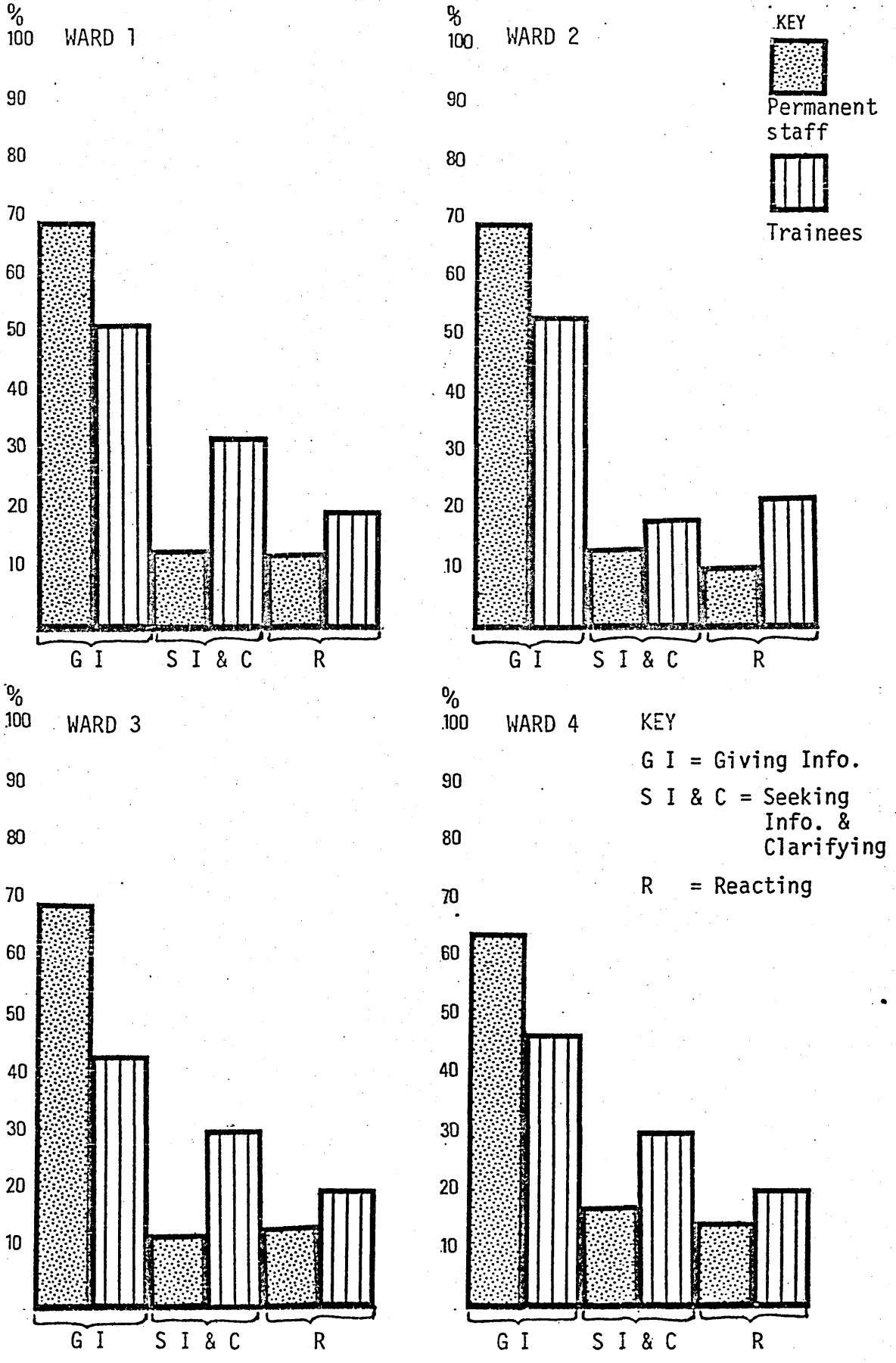
Oblique Sol. Rotation Kaiser Normalisation

FACTOR 2

Personality attributes

		Correlation Index
S62	Has a kindly nature.	0.74
S58	Is always patient.	0.64
S39	Is capable and competent.	0.62
S38	Has a calm, unhurried manner.	0.60
S3	Doesn't bear grudges.	0.59
S67	Has a sense of humour.	0.59
S41	Is sensitive to trainees feelings.	0.55
S50	Is approachable and friendly.	0.55
S66	Is interested in trainee as a person.	0.51
S44	Puts trainee at ease.	0.50

VERBAL INTERACTIONS - all wards



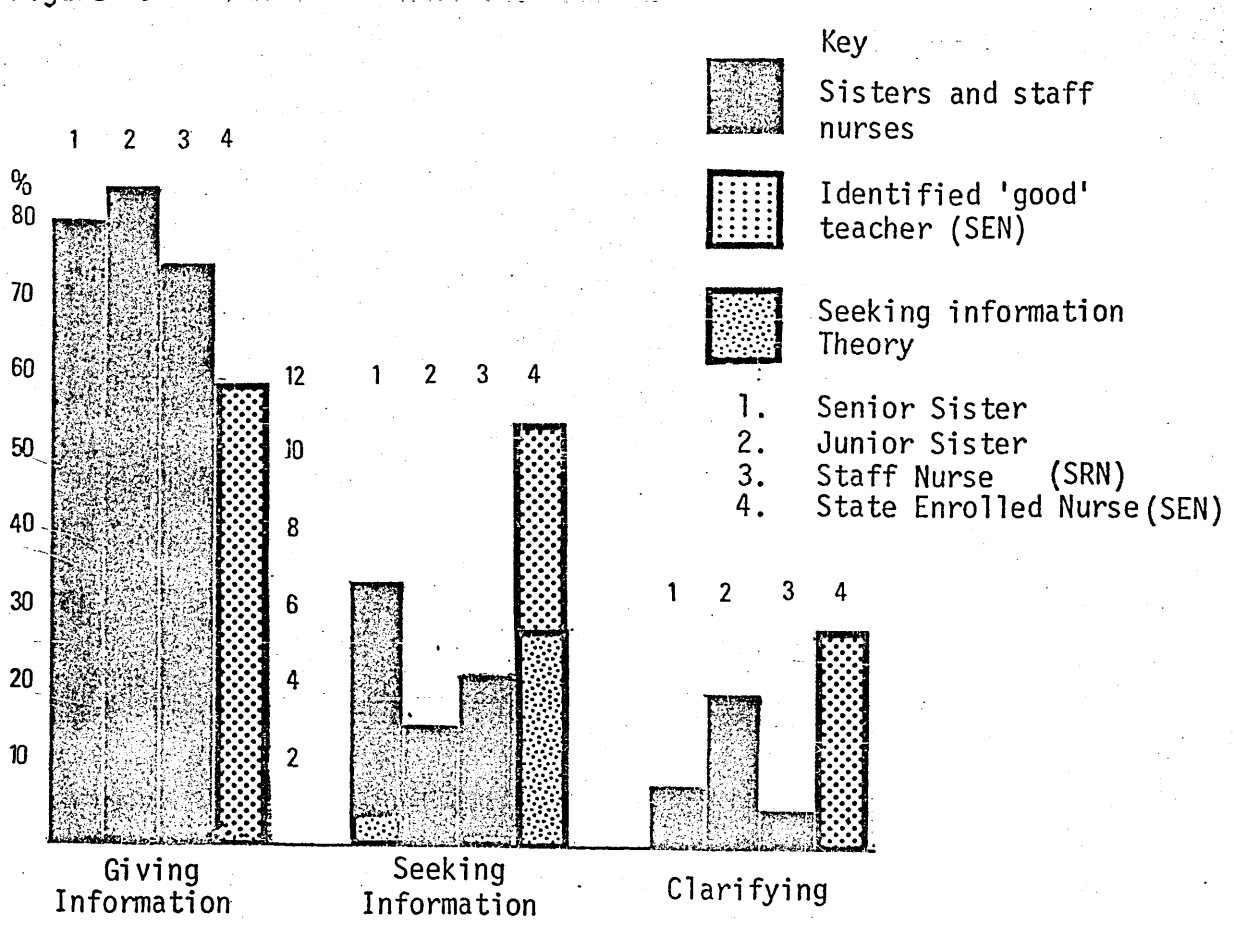


Figure 10 VERBAL INTERACTIONS - SRN's & SEN's

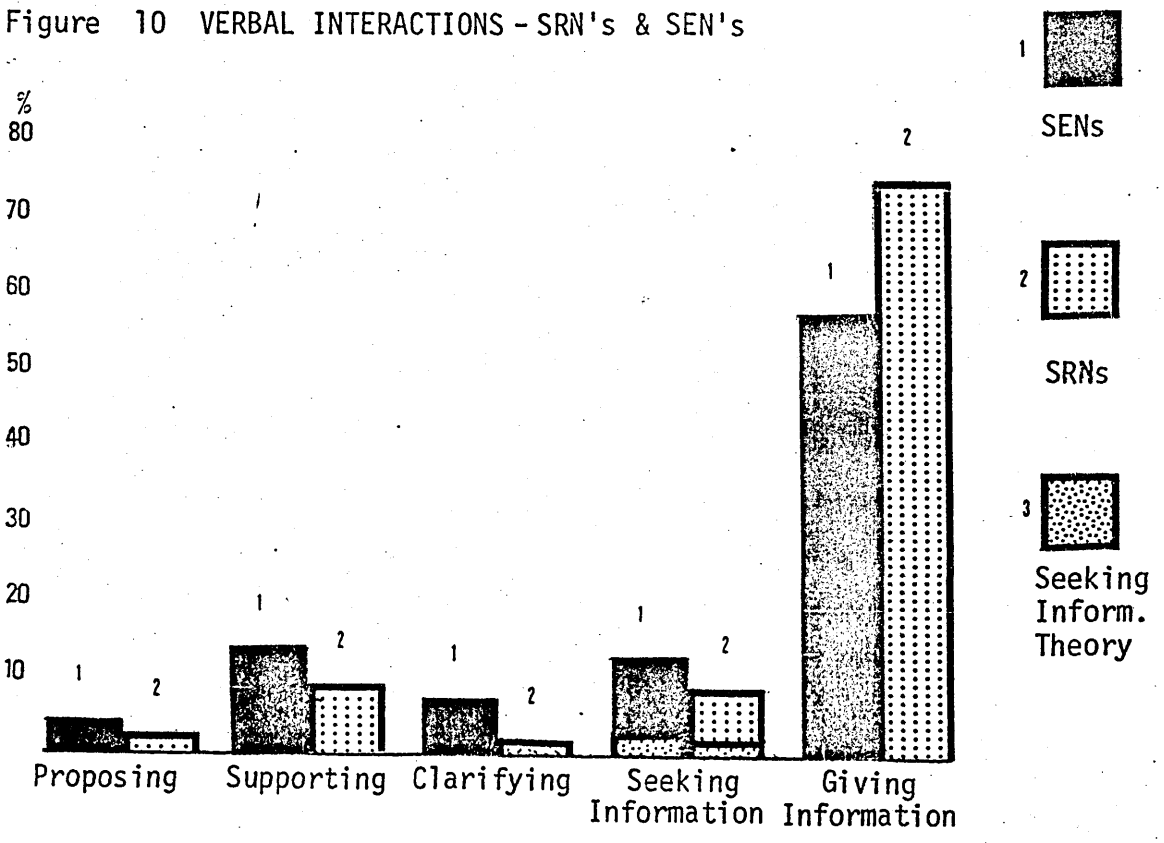


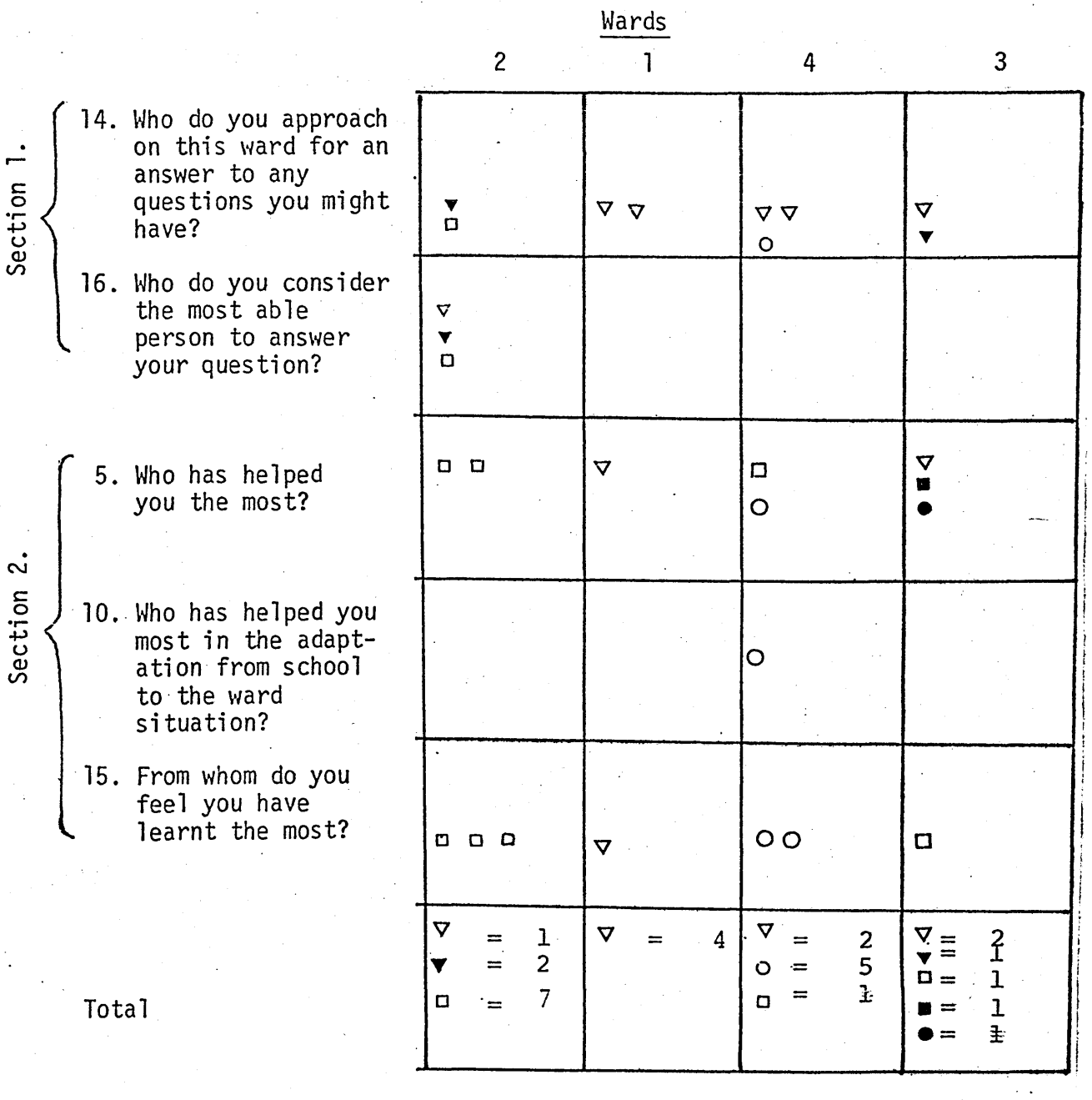
Figure 11

Responses to Post-Observation Interviews

Section 1. Question 14 and 16

Section 2. Question 5, 10 and 15

Questions

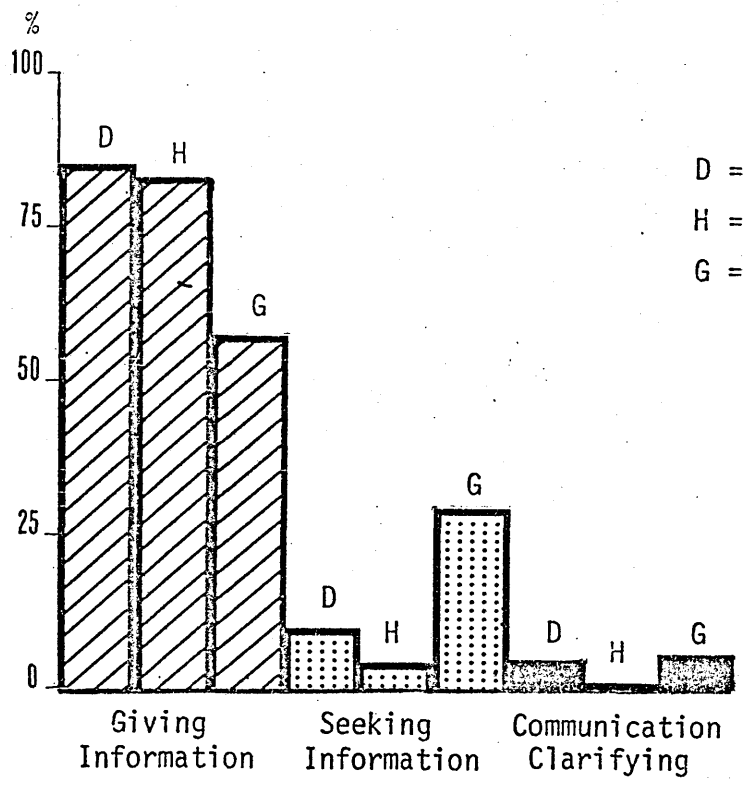


Key ▽ = Sister
▼ = Staff Nurse
□ = State Enrolled Nurse
■ = Nurse Auxiliary
c = Trainees
● = Doctor

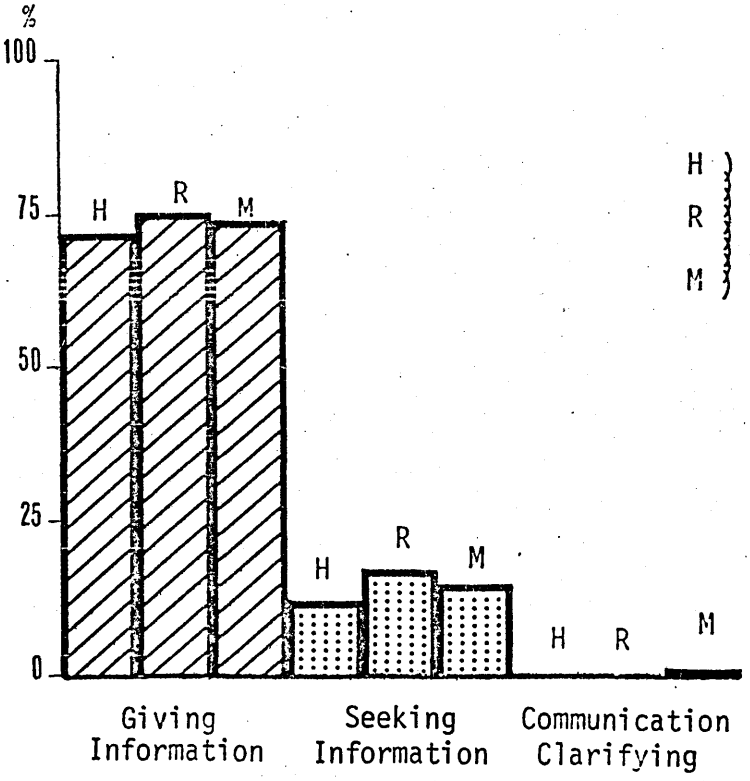
Figure 12

VERBAL BEHAVIOURS - EXTENDED STUDY

State Registered Nurses



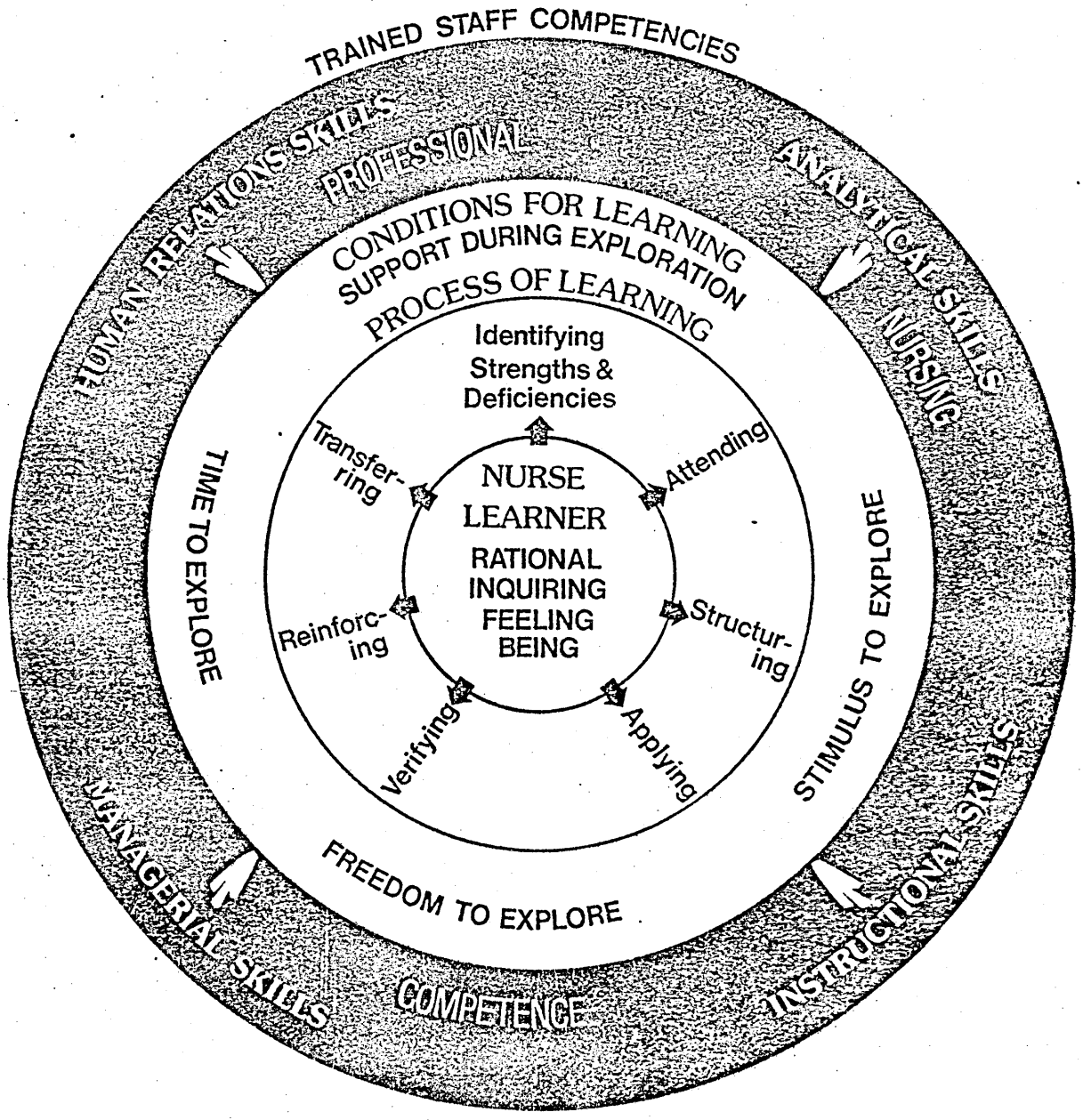
State Enrolled Nurses



NON VERBAL BEHAVIOURS

Teacher-initiated Behaviour Items	Frequently	Sometimes	Never	Comments
Physically close to student(s)				
Uses name(s) of student(s)				
Maintains eye contact with student(s)				
Personalizes remarks (e.g. I think, I feel,)				

Figure 14


TRAINED STAFF COMPETENCIES
HUMAN RELATIONS SKILLS
PROFESSIONAL
ANALYTICAL SKILLS
NURSING
CONDITIONS FOR LEARNING
SUPPORT DURING EXPLORATION
PROCESS OF LEARNING
Identifying Strengths & Deficiencies
Attending
Structur-ing
Applying
Verifying
Reinforc-ing
Transfer-ring
NURSE LEARNER
RATIONAL
INQUIRING
FEELING
BEING
TIME TO EXPLORE
STIMULUS TO EXPLORE
FREEDOM TO EXPLORE
MANAGERIAL SKILLS
COMPETENCE
INSTRUCTIONAL SKILLS