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UNIVERSITY OF THE PHILIPPINES INTERNATIONAL NURSING AND HEALTHCARE FORUM (UPINHF INC)
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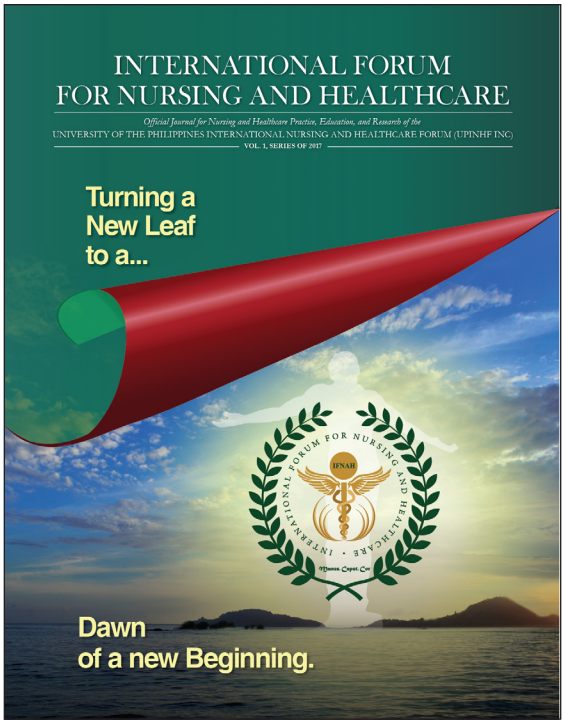
Turning a New Leaf to a...

Dawn of a new Beginning.

OUR COVER

By Nelson C. Borrero, UP Law '73
Editorial Consultant



The Cover Page of the ***UPINHF INC's International Journal for Nursing and Healthcare*** is reflective of the transition the publication is making from the former ***"The Nursing Journal"*** to a more comprehensive periodical. For years "*The Nursing Journal*" focused on everything "Nursing," viz. nursing education, nursing research, nursing care, etc. This time, the Editorial Board supported by an emerging organization (UPINHF INC) advocated a more holistic approach. Rather than limiting the content and context to a specific aspect, the editorial board favorably welcomes studies, research, and evidence-based articles and others that are interconnected or interrelated to a person's fitness and health. The novel concept is certainly turning a new leaf that hopefully will advance not only the nursing profession but also the healthcare practice and ultimately patient care as a whole. This is a bright light in the horizon, indeed a dawn of a new beginning. NCB

ACKNOWLEDGMENT

The International Forum for Nursing and Healthcare (IFNAH) profoundly acknowledges this edition's writers of thought-provoking research and studies. We also acknowledge the tireless and hardworking cooperation of the editorial staff and the wisdom and support of peer reviewers and IFNAH advisors who shared their valuable time in order to produce a very professional publication.

To our typist, layout artists, and printers from The Little Copy Shop and many others who contributed to this valuable publication, our deep appreciation.

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FEATURES

13

18

22

33

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The International Forum for Nursing and Healthcare (IFNAH) is the official journal for nursing practice, education, and research of the University of the Philippines International Nursing and Healthcare Forum (UPINHF INC). This peer–reviewed journal, formerly called The Nursing Journal, is published annually.

EDITORIAL

Moving Forward

The exciting thing about being involved in the fields of nursing and healthcare is that they are ever moving forward. Someone once said that *"Moving on is a process, moving forward is a choice. There's a slight difference between the two. Moving on is letting things happen; moving forward is making things happen."* With this editorial, it is our joy and privilege to introduce you to some major changes to the journal. The Editorial Board has made a bold choice to move forward and make things happen by changing the title of The Nursing Journal, whose maiden issue was published in August 2001, and to subsequently make relevant structural and strategic changes to better serve the twenty-first century nursing and healthcare communities. The new title of this peer-reviewed journal is the *International Forum for Nursing and Healthcare (IFNAH)*.

In the highly competitive world of academic publishing, the IFNAH Editorial Board will strive to provide the best possible service and to make a significant difference in people's lives. The new title will make the journal more identifiable in the global healthcare arena and improve the journal's competitiveness internationally. The Editorial Board aims to improve global recruitment of scholarly works or articles to the journal and increase the healthcare community's perception of the IFNAH as an international forum for nursing and healthcare practices, education, and research.

The IFNAH Editorial Board will change the current publishing mode and convert the journal into a modern online publication—the IFNAH journal will follow the publishing trend in the digital age. This change will improve the journal's environmental footprint and will support shortened publication time. The new electronic platform of the International Forum for Nursing and Healthcare will be launched in January 2018. Changes to the journal and its implications upon the submission of new manuscripts to the journal will be published on the new journal's website, www.ifnah.org, which is currently under construction.

The Editorial Board is convinced that the title change and the structural and strategic changes to the journal will improve its competitiveness and its global scope in ensuing years as well as pave the way for a brighter future for the journal as it positions itself for optimal impact in the international arena of nursing and healthcare.

On behalf of the IFNAH's Editorial Board, Editors, Advisory Board, and Editorial Consultant, we cordially welcome you to

the maiden issue of the International Forum for Nursing and Healthcare. It is published by the University of the Philippines International Nursing and Healthcare Forum (UPINHF INC), a non-stock, non-profit corporation founded in 2017; incorporated on June 1, 2017; is registered under the laws of the State of California, USA; and is organized as a public benefit, educational, and charitable corporation within the purview of the Internal Revenue Code of 1986, Section 501(c)(3), or corresponding sections of other Federal Laws.

The University of the Philippines International Nursing and Healthcare Forum is an accredited provider of Continuing Education by the California Board of Registered Nursing (CE Provider Number 16871). The mission of this health-centered international nonprofit corporation is focused on transforming healthcare by fostering inter-professional and multi-sectoral dialogue and collaboration in the advancement of professional practices, services, education, and research.

The Editorial Board wishes to congratulate the University of the Philippines International Nursing and Healthcare Forum on its inauguration and launching ceremony on August 5, 2017 in Glendale, California that was witnessed by the organization's three advisors: Dr. Lourdes Marie Tejero, Dean of the University of the Philippines Manila College of Nursing (2013-2017), Dr. Josefina Angeles Tuazon, UPCN Dean (2004-2010), and Dr. Emerlinda Ramos Roman, President of the University of the Philippines System (2005-2011). Dr. Roman led the induction of the Board of Directors. Its 2017 theme is "Moving Forward."

Quoted below is the organization's preamble.

"*We, the Founding Members and all members of the UPINHF INC, guided by our faith and profound fervor of fealty to our alma mater and by a common passion for charity towards mankind, envision an entity that is founded on loyalty, unity, amity, a caring spirit, and mutual respect, an entity that embodies our gratitude for what we have achieved, and our fervent hopes and dreams to leave a legacy that others can emulate, do hereby ordain and establish this organization.*"

We also wish to congratulate Dr. Lourdes Marie Tejero, the recipient of UPINHF's 2017 International Nurse Award "for her leadership and dedication in forging linkages between the U. P. Manila College of Nursing and nursing institutions of other countries to advance nursing education and healthcare." Dr. Tejero is highly deserving of this award, which was presented to her on August 5, 2017 during the UPINHF's breakfast seminar and gala night in Glendale, California.

In this 2017 maiden issue of the International Forum for Nursing and Healthcare (IFNAH), we applaud the professional and academic expertise of all of our contributors and thank them for their highly informative manuscripts. We also wish to thank all of you for your kind support of IFNAH and UPINHF.

Sincerely,

Jesusa Santa Barbara Czach

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BSN, RN/CCRN
Editor-in-Chief

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Chairman, Editorial Board

Call For Manuscripts

Submission Deadline: April 15, 2018

The INTERNATIONAL FORUM FOR NURSING AND HEALTHCARE (IFNAH), a peer-reviewed publication, is the official journal for nursing and healthcare practice, education, and research of the UNIVERSITY OF THE PHILIPPINES INTERNATIONAL NURSING AND HEALTHCARE FORUM (UPINHF INC). The IFNAH Editorial Board is currently accepting manuscript submissions. All submitted articles must be original, not under consideration for publication elsewhere, and have not been published before.

Please e-mail your queries regarding the manuscript submission guidelines to ifnahjournal@gmail.com; include your full name in the subject line and your phone number in the body of your e-mail.

Manuscripts MUST be submitted electronically as an e-mail attached MS-Word compatible document to Jesusa Santa Barbara Czach, Editor-in-Chief (E-mail Address: ifnahjournal@gmail.com) and Magdalena Laparan Ongkiko, Chairman, Editorial Board (E-mail Address: mlongkiko73@yahoo.com).

The Lived Experience of Nursing Faculty in Transitioning to a Concept-Based Curriculum

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Abstract

The purpose of this phenomenological study is to describe the lived experience of nursing faculty in a large baccalaureate prelicensure nursing program as they transitioned from a content-based to a concept-based curriculum. Qualitative data were obtained by face-to-face audio-recorded interviews with nine full time faculty members who were involved in the planning and implementation of the concept-based curriculum. Colaizzi's procedural steps were used in data analysis. Three major themes emerged: the faculty needs expert assistance in transitioning to a concept-based curriculum from the beginning through the implementation of the curriculum change; changing teaching strategies affects both faculty and students; and transitioning to new beginnings with a connection to past familiar practices can help in the transition process. The Bridges model of transition was the framework of this research study. Future research recommendation is to explore the experience of students during the process of curriculum change and transition in the nursing program.

Introduction

The call to reform nursing education from a highly structured, content-laden curriculum to a more innovative curriculum based on the changes in healthcare and nursing practice was published as early as 2003 in a position statement from the National League for Nursing (NLN, August 2003). In that statement, it was clarified that innovation meant not just adding or rearranging content, but creating a "paradigm-shift" in nursing curriculum. Nurse educators noted that the nature and amount of information and skills that new graduate nurses must have to practice safely and provide quality care could no longer be provided by the traditional content-based curriculum within the same instructional time frame (Giddens & Brady, 2007; Benner et al., 2010; Hickey, Forbes, & Greenfield, 2010). New competencies recommended for integration into the innovative nursing curriculum included competencies from the 1999 Institute of Medicine landmark statement (IOM, 1999; Hickey et al., 2010), i.e., care of the older adult (AACN, 2010), quality and safety education for nurses (QSEN, 2014), and cultural competency (AACN, 2008). These new competencies could add to content saturation (Giddens & Brady, 2007), that is "too much content" for students to learn (Diekelman, 2002), unless nursing faculty adopted an innovative curriculum.

Nurse educators cannot continue to merely expand the curriculum with additional content in response to calls for nursing reform based on the new healthcare complexities including technology, treatment modalities, and cultural competence. A paradigm shift needs to occur. Nursing faculty will need to drop the familiar teacher-focused learning activities, such as lecturing, and employ more student-centered learning activities. When faculty make a drastic and innovative change in the curriculum, they face a transition that has been described as an internal psychological process (Kupperschmidt & Burns, 1997; Deane & Asselin, 2015). Nursing faculty will experience the process of transition as it relates to how they evaluate themselves in relation to innovative, instructional change.

The change and transition from the familiar practice of teaching and learning nursing in a content-based curriculum to the new process of implementing a curriculum based on concepts can be challenging to both faculty and students. The process of transition, if not properly managed, can bring on responses such as anxiety, confusion, anger, high stress, and conflict among individuals affected by the change (Kupperschmidt & Burns, 1997; Bridges, 2004; Bridges, 2009). The effect of poorly managed transition can include poor educational outcomes as a result of misdirected energy and continuing conflict within and among individuals undergoing the transition (Bridges, 2009).

Purpose Statement

The purpose of this phenomenological study is to describe the lived experiences of nursing faculty during their transition from using a content-based curriculum to a concept-based curriculum.

Research Question

What is the lived experience of faculty in transitioning from a content-based curriculum to a concept-based curriculum?

Definitions of Terms

Content-based curriculum.

The conceptual definition of a content-based curriculum is based on the four-part, R.W. Tyler model of curriculum—defining the objectives of the learning experience, identifying the learning experience to meet the defined objective, organizing the learning activities to meet the objectives, and assessing and evaluating the learning objectives (Tyler, 1949, p.1; NLN, 2003). Operational definition of a content-based curriculum is the arrangement of courses that is content-laden, highly structured, and specialty and disease focused.

Concept-based curriculum.

Concept-based curriculum is defined conceptually as a paradigm for learning that classifies essential content into categories that have common relevant features, reinforces those concepts by teaching exemplars, and then encourages learners to determine whether each concept does or does not apply to a given situation" (North Carolina Concept-based Learning Editorial Board, 2011, p. xv).Operational definition of a concept-based curriculum is

the identification of concepts that is used as a framework through which the topics and most prevalent disease conditions are used as exemplars to best represent the concept.

Assumptions

Change is situational and external and it can be planned or unplanned. Curriculum revision involves planned change by the faculty of a school that may take months or years to be accomplished. Transition enables one to deal with the process and the outcomes of change. Managing transition well during a curriculum change will assist the faculty adapt to the change.

Literature Review

Giddens and Morton (2010) conducted a study on the implementation of formative and summative evaluation plans of a concept-based curriculum at the University of New Mexico pre-licensure undergraduate nursing program. The students were post–high-school, second-degree in the RN/BSN completion program students. The evaluation plan included measures for formative evaluation, such as course assessment, student survey, student focus groups, concept assessments, and standardized examinations. Two years after curriculum implementation, summative evaluation measures were studied, including faculty surveys, graduation rate, NCLEX pass rate, exit surveys, alumni surveys, and employer surveys. The NCLEX first-time pass rate initially dropped from 90% to 83%, which was expected during a major curriculum revision. Two years after the implementation of the concept-based curriculum, the first-time pass rate rose to 89%. This program used feedback from students and faculty in the earlier study to improve the implementation of the concept-based curriculum.

McGrath (2015) conducted a survey and qualitative study of 86 first-year students in a three-year,bachelor of nursing (BN) program in Whitireia, New Zealand. The purpose was to describe the transformational effect of using concept-based learning approaches as part of an integrated curriculum framework. The curriculum framework used the Oregon Consortium of Nursing Education clinical education model and the NCCLEB information. At the end of the year, the students were asked to complete an on-line questionnaire. Forty-five of the 86 students completed the questionnaire. Ninety-three percent of the respondents agreed or strongly agreed that the use of concepts was an effective way to learn. A qualitative method of evaluation on a second group of first-year students also had positive results. The teaching staff was queried during "evaluation conversations" at their annual, course-review, faculty meetings. The feedback from faculty was extremely positive. The study did not include objective measures of program outcomes, which could have made the study stronger.

Colley (2012) conducted a qualitative study to explore the experiences of faculty when the school of nursing changed to a learner-centered teaching philosophy. A purposive sample of nine eligible faculty members agreed to participate in the study. Interviews, both electronic and face-to-face, were conducted over 3 months. Data collection and analysis were rigorous. Twenty outcomes within five categories emerged including understanding of the teaching philosophy, teaching approaches, responses from students, factors affecting implementation, and perception of the current state. The findings indicated that a key factor in participants' willingness to change was the belief in the benefits of the learner-centered teaching philosophy. This willingness allowed participants to accept their new teaching role as learner-centered facilitators and not merely instillers of medical content.

The Bridges' model of change and transition (Bridges, 2004; Kupperschmidt & Burns, 1997; Deane & Asselin, 2015) was suggested by experts to assist nursing faculty during curriculum change and transition from currently used pedagogies to concept-based teaching. The Bridges' model (Bridges, 2004) categorizes the process of transition into three phases: letting go, neutral zone, and new beginnings. Bridges describes the first phase as an ending to something known and familiar. Letting go is followed by a period of confusion and distress that then leads to a new beginning. Kupperschmidt & Burns (1997) explained that with Bridges' model of transition some people resist transition because they have difficulty letting go of their identity. These people who resist change cope with ambiguities in the neutral zone until they are able to accept the challenge of beginning again and developing a new self-definition. The authors highly recommended that more research should be conducted focused on the experiences of faculty and students during curriculum change and transition using this model.

In another study, the nursing faculty at a Wisconsin Technology Enhanced Collaborative Nursing Education initiative experienced change that involved participation in an educational development program on problem-based learning (PBL). A qualitative, interpretive, phenomenological study was conducted following the PBL development program (Paige &Smith, 2013). Eight faculty volunteers representing four different nursing programs were recruited. The outcomes that were examined in this study were: change in teacher-student relationship, struggle in letting go, uncertainty, and valuing PBL. The authors found that some faculty participants struggled with letting go and expressed the need to cover medical content in their classes. In their discussion, the authors recommended time for individual or group reflection by faculty during the change process.

In the review of literature, two studies examined the experiences of nurse faculty undergoing change and transition during curricular changes. However, there were no studies specifically on the experiences of faculty undergoing change and transition from a content-based to a concept-based nursing curriculum. Taking discrete curricular content that belonged in a course and integrating the content or exemplars into a new conceptual framework is a paradigm shift. There is a gap in the literature regarding experiences of faculty undergoing the transition from content-based curriculum to a concept-based curriculum. The lived experience of faculty undergoing this change and transition will contribute to the nursing education literature and help other faculty who are contemplating making this major shift.

Methodology and Implementation

Research Design

This phenomenological research describes the lived experiences of faculty in a large independent university in New Jersey, USA, who converted their traditional content-based curriculum into a concept-based curriculum. This study is based on the philosophy of Edmund Husserl, considered the father of modern phenomenology that a phenomenon occurs when there is a person who experiences it (Grove, Burns, & Gray, 2013). Husserl believed that to study a phenomenon, it

is possible to set aside personal biases or beliefs while studying the phenomenon. Bracketing was used to suspend preconceived beliefs about concept-based curriculum during this study (Grove et al., 2013. A reflexive log on related biases, preconceptions, and preferences was kept to explore personal feelings that may influence the study (Polit and Beck, 2017).

Sampling Method

Purposive sampling strategy was employed for this study. Study participants were chosen from a list of faculty in the undergraduate nursing program who participated in the planning and implementation of the concept-based curriculum. Snowballing sampling was also employed when additional participants were recruited based on the recommendations of interviewed participants. Inclusion criteria were the variation in the years of teaching experience and the areas of teaching and clinical expertise, such as Foundations of Nursing, Medical-Surgical Nursing, Psychiatric-Mental Health Nursing, Maternal and Child Health, and Community Health Nursing.

Description of the Setting

The study was conducted in the faculty offices of an undergraduate BSN program of a large independent university located in New Jersey, USA.

Institutional Review Board Approval

The university's Institutional Review Board (IRB) approved the project.

Data Collection

A preliminary letter was sent to each faculty's office e-mail address to introduce purpose of the study. Anonymity was maintained by the use of code names for each participant and that study participants can remove themselves from the study at any time.

The interviews took place in individual faculty offices for privacy. One interview was conducted in a private place away from the university. With permission from the participants, the face-to-face interviews were audio-taped. Before the interviews, the participants were asked to sign written consent forms for participation in this study. At the start of the interviews, participants were asked to complete the demographic data sheet. The code names, not their real names, were on the demographic sheet. Semi-structured, audio-recorded, face-to-face interviews were conducted for 15-40 minutes over a period of 4 weeks. The semi-structured interviews included the following questions:

- Can you describe a situation that reflects your experience in transitioning to a concept-based curriculum?
- What did you understand was required in the change?
- What support did you require during the transition?

The interview recordings were supplemented with written notes in the event of equipment malfunction. Each interview was started by asking prepared questions. Triangulation was employed by asking the same question of the participant at different times during the interview (Polit & Beck, 2017). Further use of triangulation was done by validating the transcription of the recorded interview with the participants. Interviews were done until saturation was reached when informants began to repeat themselves.

All documents and recordings are kept locked in an office, which is away from the setting of the study. The computer and software used to store or process the audio files and written documents are secured with passwords.

Data Interpretation and Analysis

The audio files from the audio-taping were saved in individual electronic folders labeled with the participants' codes and folder numbers, and they are stored in a password protected computer. The recordings were listened to several times to identify patterns before the verbatim transcriptions were received. Themes that were common to participants and themes that were unique to certain participants were noted. The recordings were again reviewed after the transcriptions were received.

The audio files were transmitted electronically on the day of the interviews to a transcription service that required a password protected account. Each audio file was transcribed by the transcription service into a word document and sent within 1 to 5 days in a secure electronic mail. These transcribed individual files were uploaded to a secure computer-assisted qualitative data analysis software (CAQDAS), Dedoose™. Using the software functions, a few codes were entered based on significant words or phrases from the interview recordings related to the study phenomena. Dedoose assisted in the analysis of the data by organizing key words and phrases.

The Colaizzi's procedural steps in phenomenological data analysis (Polit & Beck, 2017) were used for this study, which insured a rigorous and auditable process. The process involved seven steps in the data analysis, including reading and rereading participants' verbatim transcripts of the phenomenon of study, extracting significant statements that pertain directly

to the research phenomenon, formulating meanings from the significant statements, formulating meanings arranged into cluster themes and referred back to the original protocols for validation, incorporating results into comprehensive descriptions of the phenomenon under study, returning the description to participants for validation, and incorporating new or pertinent data obtained from participants' validation (Polit & Beck, 2017; Colaizzi as quoted by Kornhaber, Wilson, Abu-Qamar, McLean, & Vandervord, 2015). The analysis using the Colaizzi method was executed using the guide adapted from an article by Shosha (2012).

Results

Demographics.

Nine full-time faculty members participated in this study. All participants were female and mean age range was 50–59 years. Four participants had their pre licensure nursing education in a diploma nursing program, one had ADN, two came from a BSN program, and one had a Master's degree pre licensure education. One did not indicate her basic nursing preparation. Four have the doctoral degree as their highest educational preparation and five have Master of Science in nursing degrees. The average years of nursing experience was 29. The mean years of experience in nursing education was 16 years. All areas of nursing clinical practice were represented.

Description of themes.

Data was collected until themes were redundant and saturation was reached. The total number of significant statements extracted from the transcripts was 81. The initial codes formulated from the transcribed files were 40. These codes were further collapsed to 13 to avoid redundancy and to remove codes that were not applicable. The records were reviewed again manually and compared to the electronic data gathered. Three major themes emerged from the data. As part of the Colaizzi's procedural steps in analysis, each participant's transcribed statement was reviewed by the participant along with the study's findings and formulated themes. The participants' individual comments and validations were integrated into the final result.

The responses of the participants and the themes that emerged will be illustrated in the participants' statements and then discussed.

Theme 1.

The faculty needs expert assistance in transitioning to a concept-based curriculum from the start of and through the implementation of the change.

This was a consistent theme voiced by those who have experienced teaching the new curriculum and those who are anxious about implementing the change into concept-based teaching in their course in the coming semester. M, a participant, (all initials of names used in this study are fictitious) described how change was initiated:

"I feel like we've been working on the transition for the last couple years, laying the groundwork, discussing it, discussing what it means, what the changes would mean for our students, analyzing our current curriculum, and what it would need to make the change into a conceptual-based curriculum, and then probably in the last two years or so, it became more tangible where we actually had a more established, laid-out groundwork…"

In the summer session of 2016, the first class in the concept-based curriculum was introduced to the students. V stated that expert guidance during the transition would have been helpful. She further stated that although experienced in teaching, some of them still needed guidance in implementing a new way of educating students:

"…it's very difficult to do that unless you have actual templates and you have the support, you have a consultant, or you have someone who's an expert in curriculum. We are highly educated people, but it doesn't mean that we can do it all or that we are able to just take a curriculum and change it overnight."

J clarified some of the difficulties with changing curricula related to the introduction of electronic books:

"…the faculty itself was not familiar with viewing the books electronically. So, looking for the exemplars on the electronic version took a little time…some faculty members are more computer savvy than others, so those that are more computer savvy helped the others, so that was a good thing."

N stated that:

"it took me a long time to figure out how to prepare my syllabus. I went and looked on-line to see if I could find other syllabi and I actually just, you know, searched through their Excel (data base program), they have pages and pages and pages of Excel online, to try and see how the content of what I was teaching would match the concept, and I have no idea what I'm doing, first of all, because I wasn't trained. For the next course, I actually will list my concepts and then on the next page you'll see how I set up the syllabus. Many, many, many, many, many, many, many, many hours of work."

The need for assistance during this transition was expressed even by those who have some experience in concept-based teaching.

M, a faculty member who had experience with using active- learning strategies in her classes stated that:

"I think having an outside consultant would've been nice. It would've made things a little bit easier, but we didn't have an outside consultant. Like I said, we worked in subcommittees as faculty. I think having someone—a fresh set of eyes on a situationis always a good thing."

N prefers assistance:

"someone who has taught concepts before and someone who can guide you as to what you should put on your syllabus. I actually found the syllabus, and for me, to be the easier part to do compared to the actual teaching, that's another whole thing." "… and not a textbook company because they don't even understand nursing, they just develop it but they don't truly understand nursing curriculum."

M, who was scheduled to teach her course in the fall of 2016, stated that she prepared for the course during the summer, but when the time came for her to teach her course in the fall, she looked for assistance, guidance, and validation of what she was doing:

"Well, I couldn't implement it with my understanding of what we were supposed to be doing, which was vague because the textbooks aren't concept-based. I had never sat in a classroom where it was concept-based so I didn't even have past experiences to draw from, and I didn't know what it is that we're supposed to be doing. So I did my best—floundering. I felt like that first semester was just a lot of floundering. Another instructor and I went through all the syllabi to figure out who was doing what, when, where, and we just recently identified where the overlaps are. That was helpful."

E, another participant, agreed that the change was not easy. She observed that the faculty and the students were having

a difficult time in the transition. She commented that:

"The first semester was very difficult for both the students and the instructor. But they got through that, and then they went into the next course. The instructor is still giving it her best shot. That's basically how it started."

Theme 2.

Changing teaching strategies affects both faculty and students. There are two subthemes: the effect of changing curricula on the faculty and the responses to changing curricula by the students.

Conceptual teaching focuses on learner-centered teaching techniques and moves away from teacher-centered pedagogy (Hardin & Richardson, 2012; Giddens & Brady, 2007). The change in teaching strategies affects the faculty as much as it affects the student. M stated:

"Oh, so my understanding was that there would be no more lecturing, and there would be no more Power Points at all. We were to present three exemplars exclusively, and the learning was to be about that, which was impossible…and when we actually started teaching, the students were like, uh, no. Not interested in doing that. If a student's not going to cooperate, he's not going to cooperate. And if you have a whole class [who are] not going to cooperate, it's like okay, try something different. And so that's what I encountered that first semester."

L, who was one of the first to implement the changes, felt that too many changes at the same time will overwhelm students:
"Well, there are two things that are being initiated at once, the concept-based curriculum and the flipped classroom. I don't think they're 100 percent together. I think they are two different concepts. So doing the flipped classroom is a little more difficult for the students to accept."

The students' behavioral response was more evident in the learning activities in the classroom than in the clinical setting. The students' behavior did not demonstrably change in the clinical according to M:
"Our clinicals are still pretty traditionally based…we're not doing a type of clinical where they're doing a little bit of peds, a little bit of med/surg, a little bit of OB in one semester."

Without being directly asked a question related to student responses to the new curriculum, the study participants discussed how students are responding to the new teaching/learning strategies. S stated:

"That's what they're saying, '…for the betterment of the students.' So, here we are. We're being encouraged to do active-learning exercises, and here is the other end saying, 'No, don't stop Power Points'. They want the lecture. So, there's a dichotomy there."

N, stated that when she introduced concept-based teaching the students "*were not happy with it. They said it was confusing at first. I ran into all the original first problems because nobody else taught concepts in the summer. For instance, a lot of them had trouble with maneuvering through the program so I had to teach them all – I mean the company came in but they still were having problems. A lot of them tried downloading the textbooks to their computers and three of the computers crashed. So now I had angry students with crashed computers in an acceleratedone-year nursing course with me."*

Another participant, A, observed that:

"So again, like I said, we need to find out how to reach this population because they have outgrown the technology of Power Points or putting things on the computer. They have outgrown it. So, I don't know what is happening. So, that's a huge challenge for educators that I've seen."

In trying to decide on what to do during the transition, M stated that *"I'm leaning more towards active learning instead of straight lectures."* When asked how it is working, she added:

"I think the students are responding to it very well. What I've been doing in my class and — I think it's worked nicely — is I pick my exemplars for the week for whatever topic we're discussing and then I ask the students go into small groups, two or three, and I assign exemplars to them. So, usually two or three groups have the same exemplar, and I give them a blank concept map, and they spend the first half-hour of class going through their text and their online book and whatever resources they have and they fill in their concept map".

She further stated that she did minimal me time when she first introduced active learning in which students did almost all classroom activities. The students did not do well in their tests. She explained that the next time, she will still have students do the active learning strategies:

"…but, I made very sure that I knew what key points I needed to drive home in the discussion and I made sure I didn't miss those and the test grades improved. So, the students need to do active learning. They learn better from that, but they still need a teacher."

Although not completely sure of how her students will respond to a change in teaching methods as part of the transition to concept-based teaching, M incorporated active-learning strategies in her class and asked students for feedback. She stated:

"I would informally ask students if we can make a change along the way, which is my MO because I don't want to know at the end of the semester that that didn't work at all. So, was that a valuable learning experience? And if I hear 'No' then we stop. If I hear 'Yes' from some and 'No' from others, then I would say okay, tell me more about that. This is to try to come toan agreement on how we could do it differently the next time."

Some of the reactions of the students to the change to learner-centered teaching were hurtful to N:

"this is their exact words, even on the evaluations, and from their mouths and also in their evaluations, that I am the expert and I should be teaching them through PowerPoint and that they shouldn't have to come into class prepared. 'She doesn't know what she's doing. Shedoesn't have the knowledge, she can't teach this to us because she is not teaching it. She has usdoing the work and being prepared to come in' and that's all the negatives that I received from the students."

Theme 3.

Transitioning to new beginnings with a connection to past familiar practices can help in the transition process.

Although the initial implementation of the concept-based curriculum by the faculty was difficult, there were some hopeful moments that some are looking forward to. When the students are engaged in their own learning and the faculty moves away from lecture and other traditional delivery of class material, both sides are experiencing the transition process. Janet, who team-taught with another faculty member, laughingly stated:

"…we assigned exercises, and we would discuss. They were engaged, nobody was asleep in class, everybody was included, and as a result we got to learn everybody's names, so that's a good thing."

Although intellectually the faculty sees a new beginning, the transition can

be facilitated for both faculty and students with an occasional reach back to the familiar, according to E:

"The adult learners are used to the traditional way of teaching. They respond better to that. So, when the instructor switches back and forth to a kind of a combination, test scores came up and they do much better"

One of the study participants' statements is reflective of looking to new beginnings:

"Well, now I'm really teaching concepts. That's my next step—to really have a strong, conceptually-based class moving into the summer because this is the first time I'm going to have students who will have the whole bundle. My current students have only one textbookand appropriately utilize the resources that they have to make sure that they are understanding the topic at the level that they need."

With the challenging use of technology, such as electronic books to help search and sort the vast amount of information, nursing faculty and students move with the times. M still prefers print textbooks, but saw the advantages of electronic resources to use with concept-based teaching:

"I like to highlight it (print textbooks). You can highlight in the online textbooks, and I do make it a point to explain the benefits of the online textbook. One can download books to up to five devices. It updates automatically—if the author updates something in the book, it updates in the software. There is also a social aspect to using electronic resources. If the students link to each other, they can have a study group. I tell students that you and your three friends are really good studying together."

A summarizes the process that the faculty and students are engaged in:

"I am going to be honest with you. The more we proceed with education, the more changes we will see."

Discussion

Transitioning from the comfortable, content-based curriculum with its familiar teaching strategies and course delineation to a concept-based curriculum where the learning and application of concepts have no boundary and where the students take on an active-learning role, is challenging to both faculty and students. The themes that emerged from the analysis of the data indicate a need for guidance for faculty through all phases of transition. These data suggest that the faculty are aware that change is occurring. They were willing to try new strategies and were flexible in response to students' behaviors. Some faculty used familiar teaching and learning techniques to gradually move through the transition. As nurse educators, they acknowledge that change and transition affect their students as much as themselves. For some faculty, the challenges herald new beginnings; but, for most, adequate and appropriate guidance is essential for a successful transition.

The main limitation of this study was that it was conducted before the first student cohort completed the new curriculum. Perhaps the faculty would have a different perspective at the completion of the curriculum by the first cohort of students.

This study adds to the literature on curriculum change and the lived experience of faculty undergoing change and transition from a content-based, traditionally taught curriculum to a concept-based, student-centered curriculum. Transition is a difficult time for faculty. Based on the study results, there is a need for expert assistance especially during the transition period. The use of some of the familiar teaching strategies will help faculty adjust to the new situation. Support needs to be provided for the faculty who have accepted the change and are transitioning well to the next phase.

References

American Association of Colleges of Nursing. (2010). Recommended baccalaureate competencies and curricular guidelines for the care of the older adults. Retrieved from ***www.aacn.nche.edu***

American Association of Colleges of Nursing. (2008). Cultural competencies in baccalaureate nursing education. Retrieved from ***www.aacn.nche.edu***

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). ***Educating nurses: A call for radical transformation***. San Francisco, CA: Jossey-Bass.

Bridges, W. (2004). ***Transitions, making sense of life's changes (2nd ed)***. New York, NY: Perseus Book Group.

Bridges, W. (2009). ***Managing transitions: making the most of change***. New York, NY: Perseus Book Group.

Colley, S.L. (2012). Implementing a change to a learner-centered philosophy in a school of nursing: faculty perceptions. ***Nursing Education Perspectives***, 33(4), 229-233.

Deane, W., & Asselin, M. (2015). Transitioning to concept-based teaching: A discussion ofstrategies andthe use of Bridges change model. ***Journal of Education and Practice***, 5(10), 52–59.

Diekelmann, N. (2002). "Too much content…." Epistemologies grasp and nursing education. ***The Journal of Nursing Education***, 41(11), 469–470.

Giddens, J., & Brady, D. (2007). Rescuing nursing education from content saturation: The case for a concept-based curriculum. ***Journal of Nursing Education***, 46(2), 65–69.

Giddens, J., Caputi, L., & Rodgers, B. (2015). ***Mastering concept-based teaching, a guide for nurse educators. St. Louis, MO***: Elsevier.

Giddens J., & Morton, N. (2010). Report card: An evaluation of a concept-based curriculum. ***Nursing Education Perspectives,*** 31(6), 372–377.

Grove, S., Burns, N., & Gray, J. (2013). ***The practice of nursing research, appraisal, synthesis, and generation of evidence***. St. Louis, MO: Elsevier.

Hickey, M., Forbes, M., & Greenfield, S. (2010). Integrating the Institute of Medicine competencies in a baccalaureate curricular revision: Process and strategies. ***Journal of Professional Nursing***, 26(4), 214–222.

Institute of Medicine. (1999). To err is human. Washington, DC: National Academies Press.

Kupperschmidt, B., & Burns, P. (1997). Curriculum revision isn't just change: It's transition! ***Journal of Professional Nursing***, 13(2), 90–98.

McGrath, B. (2015). The development of a concept-based learning approach as part of an integrative nursing curriculum. ***Whitireia Nursing & Health Journal***, 22, 11–17.

National League for Nursing. (2003). Innovation in nursing education: A call for reform. Retrieved from http://www.nln.org/docs/defailt-source/about/archived-position-statements/innovation-in-nursing-education-a-call-to-reform

National League for Nursing. (2014). Number of basic RN programs, total, and by program types, 2005-2014. Retrieved from http://www.nln.org/docs/default-source/newsroom/nursing-education-statistics/number-of-basic-rn-programs-total-and-by-program-type-2005-to-2014.pdf?sfvrsn=0

North Carolina Concept-based Learning Education Board. (2011). ***Nursing: A concept-based approach to learning***. Boston, MA: Pearson

Paige, J.,& Smith, R. (2013). Nurse faculty experiences in problem-based learning: An interpretive phenomenological analysis. ***Nursing Education Perspectives***,34(4), 233–239.

Polit, D.,& Beck, C. (2017). ***Nursing research, generating and assessing evidence for nursing practice***. Philadelphia, PA: Wolters Kluwer.

QSEN Institute. (2014). The evolution of the quality and safety education for nurses (QSEN) initiative. Retrieved from http://www.qsen.org/about-qsen/project-overview/

Shosha, G. A. (2012). Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. ***European Scientific Journal***, 8(27).

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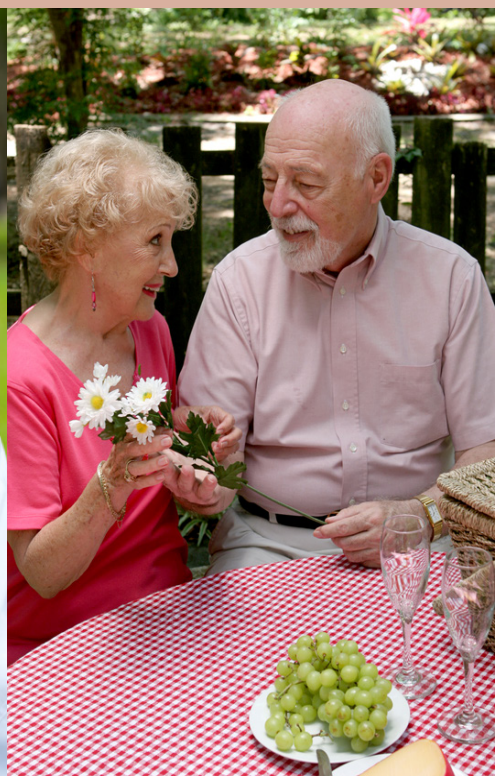

Integrating Education and Practice: A Grounded Theory on the Competency Acquisition of Advanced Practice Nurses in the United States

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Abstract

Advanced practice nurses' competency acquisition is a theory about how competency of advanced practice nurses in the United States is attained. This study presents an understanding of how APRNs acquire competency through semi-structured videotaped interviews of APRNs with at least three years of experience as APRN in diverse practice settings. A mixed Classic Glaserian and Straussian grounded theory approaches guided data collection and analysis. Open coding, constant comparative analysis, theoretical sampling, and data saturation generated a middle range grounded theory: advanced practice nurses competency acquisition. The overarching category that emerged from data was integrating education and practice, which were two lifelong processes integral to all APRNs professional journey. Additionally, three subcategories evolved, a) enabling self-advancement which described the circumstances that nurtured and advanced self-worth among APRNs, b) expanding area of influence, were circumstances that described the rippling effect of networking and collaborative practices cradled by supportive environment, c) paying forward were circumstances supporting legacy building for the advancement of nursing science. There were implications for nursing leadership and education in the U.S, where the advanced practice role was born and took roots.

Keywords: Competency, Advanced Practice Nursing, Grounded Theory

Background

Advanced practice registered nurses (APRNs) are nurses who function at an advanced level of practice that requires licensure, accreditation, certification, education at the master's level at a minimum, advanced clinical skills that focus on direct care of individuals (Bryant-Lukosius, D., DiCenso, A., Browne, G., Pinelli, J., 2004, Thomas, 2014). Further, in the United Sates (US) APRNs are nurses whose practice build on the competencies of registered nurses (RNs) and have obtained a license to practice as an APRN in one of the four Advanced Practice Nursing (APN) roles: certified nurse anesthetist (CRNA), certified nurse midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioners (CNP). The APRN role was first established in the US and eventually rippled in North America, Europe, Australia and Asia.

Competencies are behaviors that APRNs, must demonstrate regardless of specialty or practice setting. They are about skills, knowledge and characteristics that draw the line between excellence and mediocrity. Competency is important because nurses deal with human lives and incompetence could spell the difference between life and death. In skills acquisition, Stuart Dreyfus, a mathematician, and his brother Hubert, a philosopher (Dreyfus & Dreyfus, 1980) posited that any skill training procedure must be based on some model of skill acquisition through instruction and experience. In their skill acquisition model, the student normally passes through five developmental stages designated as: novice, competence, proficiency, expertise and mastery. According to their theory, as the student became skilled, dependence on abstract principles decreased while dependence on concrete experience increased (Dreyfus & Dreyfus, 1980).

Benner (1984) applied the Dreyfus Model of Skill Acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice, research, and education from an analysis of practice exemplars in the workplace. Benner advanced the view that goals and processes of nursing changed depending on the level of nurses' experience. In Benner's Model, From Novice to Expert, the novice and advanced beginner's perspectives were strictly characterized by adherence to rules; whereas the competent and proficient nurses had the capability of modifying plans when situations changed, Benner's competent nurse had the ability to perform a task with desired outcomes under varied circumstances of everyday life. The nurse who had confidence performing in the same or similar situations for two or three year's demonstrated competence. Further, the nurse was able to demonstrate efficiency and coordination, and had confidence in his/her actions. Benner's expert nurse had extensive clinical knowledge and experience that underpinned intuitive judgment. Benner advanced the primacy of experience and emphasized that experience-based skill acquisition was still safer and more efficient only when it rested on a strong theoretical foundation. By systematically recording what nurses learned from their own experience, Benner (1984) concluded that nurses' phenomenological experience and the expert nurses' technical and theoretical knowledge could expand and advance nursing.

Despite the numerous literature documenting the successful role enactment and proliferation of titles related to the APRN role, there was still paucity on the investigations of circumstances that were perceived useful by APRNs in the United States that related to their competency acquisition as healthcare providers. This study aimed to explore the different circumstances or experiences that APRNs in the US considered helpful in making them feel qualified or confident to do their job as healthcare providers through the

different stages of competency acquisition.

Methodology

A grounded theory methodology was used in this inquiry since it had the capability of identifying how participants experienced a phenomenon, what they found challenging about that experience, and to generate an initial theory about it (Glaser, 1978). Participants were chosen by purposive sampling because knowledgeable APRN experts from the United States, who experienced the phenomenon, were needed to provide a rich description about competency acquisition. The inclusion criteria were: (a) currently practicing in one of the four APRN roles for a minimum of two years, (b) a minimum of Master's degree in Nursing, (c) working in various specialty groups, (d) willing to sign an informed consent form (ICF), (e) willing to be interviewed in English and to be video- or audio-recorded during the interview.

A recruitment packet that included an invitation letter, ICF, and a demographics form were emailed to the prospective participants. The researcher followed up each email with phone calls to further explain study objective, confidentiality measures and to answer any questions from the prospective participants. After receiving the signed ICFs and the completed demographic form, a web-based interview was scheduled. To protect privacy and maintain confidentiality of the participants, the researcher was alone in a closed room while conducting the interview. Actual sample size was determined only after data saturation—a phenomenon that occurred when no more new information, and there was a redundancy of previously collected data— had been reached (Burns and Grove, 2011).

Using a semi-structured open-ended interview guide (Corbin and Strauss, 2008), all interview sessions were videotaped, lasted an average of 45 minutes, and were conducted at a mutually convenient time considering the time zone variations between the US cities and Manila, Philippines. Each participant's response the four general questions determined the direction of the following dialogue: a) what circumstances or experiences would you consider helpful in making you feel qualified or unqualified to do your job? Describe the feeling of being qualified and being unqualified, b) in your practice as APRN, at what stage of the Novice to Expert do you recall feeling accomplished?

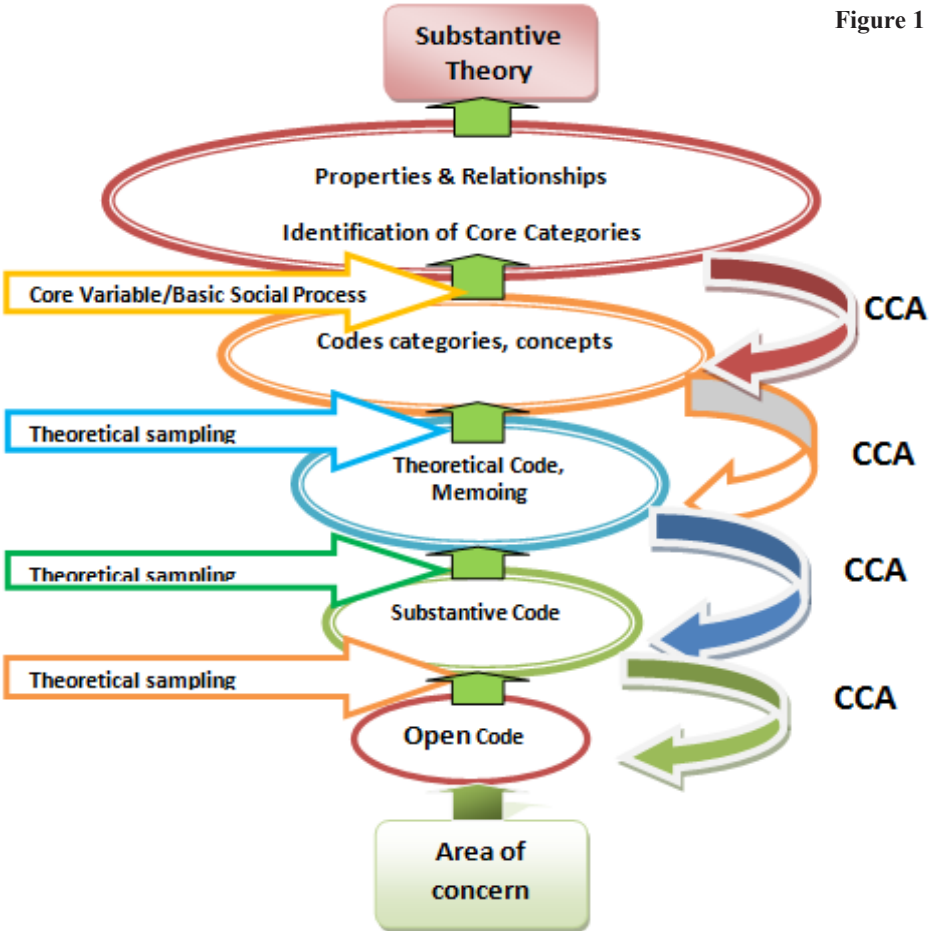


Figure 1

c) What instances would you like to share wherein you were facing an unfamiliar situation and how did you handle them? d) What circumstances helped you feel capable, or in control?

At the end of each interview session, the researcher transcribed the recorded interview verbatim while information was still relatively fresh. Faithful to theoretical sampling of the Classic GT as a process of data generation, the researcher collected coded and analyzed data simultaneously (Glaser & Straus, 1967). To guide the analysis of qualitative data, the author adapted a model of a substantive theory generation from Glaser and Strauss (1967) and Andersen (2008), as depicted in Figure 1.

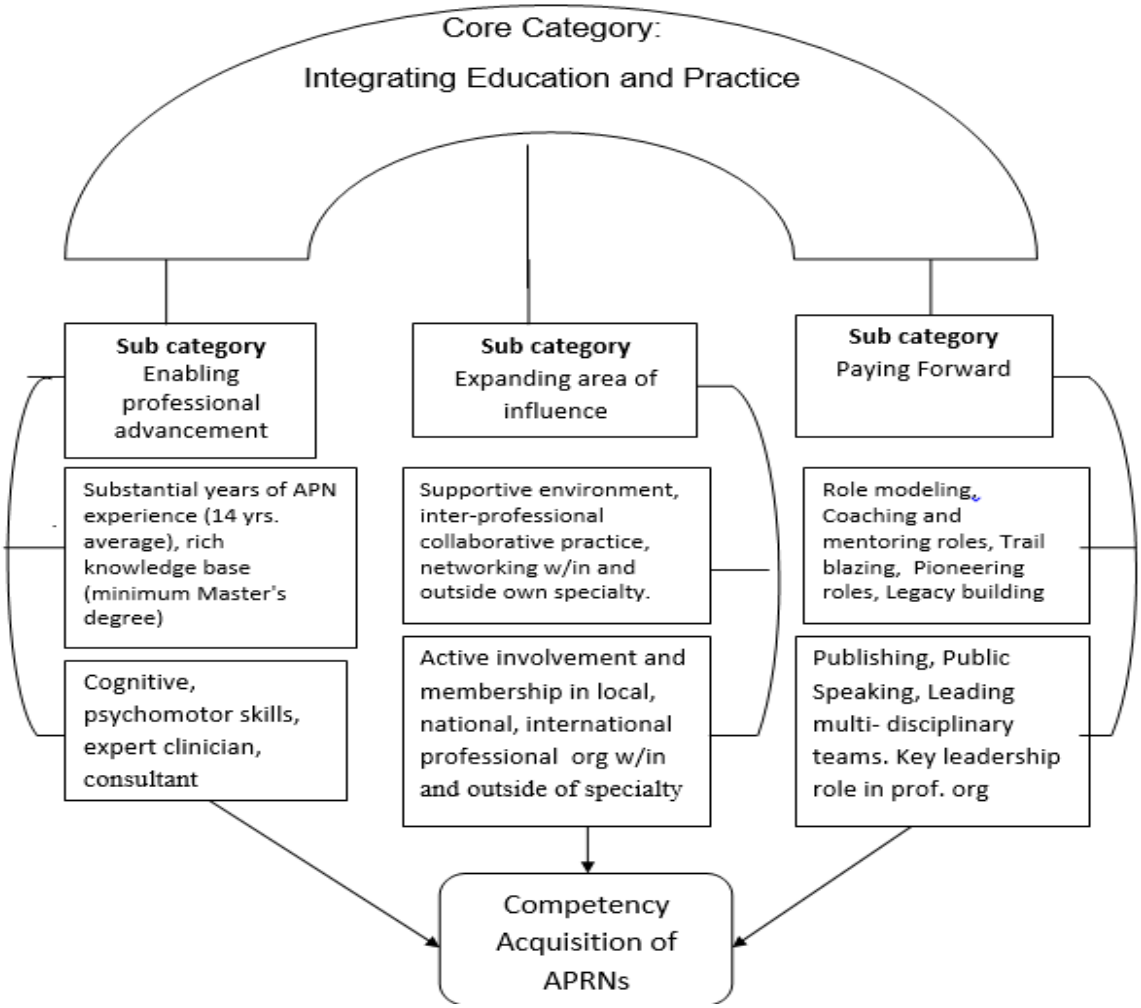
Figure 1. A Model of Substantive Theory Generation. Adapted from Glaser and Strauss (1967) and Andersen (2008).
* CCA – constant comparative analysis

In the analysis of data, the process commenced with an area of interest/ concern rather than a preconceived hypothesis (Glaser, 1998). During the first level coding, referred to as open or in vivo coding, the researcher read the transcribed interview texts several times in order to gain an overall impression of the material. With the study objective in mind, the researcher underlined and/or encircled relevant words, phrases, and themes in the transcript and made annotations within the transcript. Open codes have the smallest conceptual portion in the study as depicted by the smallest circles in the model (Glaser, 1978).

The next levels are series of theoretical sampling and iterative process of constant comparative analysis where data pool and the level of conceptualization and abstraction increased. During substantive and theoretical coding (Beck, 1999), the researcher used words or phrases from the verbatim transcripts, comparing these words with other codes and data, and clustering those with similar meanings into initial codes categories (Beck, 1999).

Constant comparisons among concepts, categories, and data helped identify relevant connections, contextual conditions, sorted categories by similarities and differences, examined relationships among substantive codes to elevate them to a conceptual level, identifying core categories and eventually a substantive theory is reached (Glaser, 1978). This process of theoretical sampling

Figure 2



and CCA continues until data saturation is reached.

To address credibility and validity, findings in this study were derived from verbatim narratives on the experiences of APRNs who lived the phenomenon and were corroborated by member checking. This was accomplished by returning for second interviews with some participants who confirmed the findings as their personal narratives Additionally, credibility was strengthened by the researcher's more than a decade of NP practice and documented prolonged engagement with APN competency, Furthermore, a faculty mentor experienced in grounded theory was consulted "to review and explore various aspects of the inquiry" (Polit & Hungler, 1999, p. 429).

The conduct of this study has been reviewed and approved by the UP Manila Research Ethics Board.

Results

The study participants (n=5) were APRNs who had prior RN experience ranging from five (5) to twenty (20) years and an average of twelve and a half (12.5) years. Additionally, the participants' APRN experience ranged from eight (8) to twenty (20) twenty years with an average of fourteen (14) years. They were all working full-time in specialty services of various institutions such as: Cardiac surgery (in-patient); Neuro-vascular (in/outpatient); Geriatrics (in/out patient); Oncology (outpatient), Dermatology (in/out patient). Most of them were females (80%), had a Master of Science in Nursing (40%). Sixty percent (60%) had doctoral degrees (DNP or PhD). The age of participants ranged from 36 to 58 years old with an average of forty-seven (47) years old. Forty percent (40%) worked in the Eastern US (New Jersey, Massachusetts) and sixty percent (60%) worked in Southern California area (Los Angeles and San Diego).

The core category that emerged from the data was integrating education and practice, which described how APRNs experienced competency acquisition. The coding scheme and relationships drawn from the narratives are shown in Figure 2.

Core Category: Integrating Education and Practice. The overarching category or the basic social process related to the APRN's competency acquisition as perceived by the participants were circumstances integrating education and practice. This amplified Benner's expert nurse who had extensive clinical knowledge and experience that underpinned intuitive judgment. Benner advanced the primacy of experience and argued that experience-based skill acquisition was still safer and more efficient only when it rested on a strong theoretical foundation. Participants described these two concepts as life-long processes integral to every APRN's professional journey.

Figure 2. Core and sub-categories generated by the coding scheme on the Competency Acquisition of APRNs.

Sub-Category: Enabling Professional Advancement. For this category, the participants articulated those circumstances that nurtured self-worth as fundamental constructs. This was backed by substantial years of APN experience, at an average of fourteen (14) years. Further, rich knowledge base, cognitive and psychomotor skills were supported by the participants' educational background where the majority (60%) had doctoral preparation (PhD and DNP).

Data from interview showed that all participants talked about enabling factors like advanced degree, length of APRN experience in varied settings, being experts, and breadth and depth of cognitive skills. As one participant expressed:

"I consider now myself in the work that I do as an expert, especially now that I finished my Doctorate in Nursing Practice. I mean, my ... you know ... the knowledge base and the principles of research and evidence-based. The transformational research is more ... I think, it's much stronger having completed the doctoral program." –Emily, CNS

Another participant believed that her work in varied settings strengthened her clinical and leadership skills:

"I worked in oncology and in critical care, as a staff nurse, nurse manager and later as an administrator and the different types of situations made me an astute clinician and consultant." –Bertha, NP

Sub-Category: Expanding Area of Influence. The APRN participants defined this sub-category as circumstances that described the rippling effects of best practices to inform clinical decisions or reaching out to and impacting other disciplines. Expanding area of influence is powered by a nurturing environment, collaborative practice, networking within and outside own specialty and complemented by active involvement and membership in local, national, international professional organizations. This subcategory is exemplified by this narrative:

"I started as a novice APRN and with the support of the people that I have been working since 1993 when I became an APRN, and the opportunities available in my work environment, I developed my skill from a novice to become very proficient and became an expert as an APRN... having been asked to lead the multidisciplinary teams, being consulted by fellows and residents, leading the multi-center Nursing Research group, etc." Emily, CNS

Another APRN recalled his experiences with his mentors:

"And then when we faced her staff, she would always introduce me as, "This is Mario. He's from UCLA. And he's really a smart kid. You have to listen to what he's got to say about breast cancer." – Mario, CNS

Mario also talked about his mentor with both an MD and a PhD:

"(He) is a very supportive physician, a one of a kind. He's very supportive of me as a nurse, and, in fact, this MD said, "I'm very busy with the clinic, very busy with the Lab, as a nurse I need you to handle all the symptoms and quality of life issues". – Mario, CNSa neuro-cardiovascular APRN discussed a patient care scenario she experienced:

"Since I was in CAT scan, there were two techs that are licensed in imaging – one of them is the supervisor, the nurse from ED, patient care assistant from ER. The supervisor tech said, we do not need a neurologist, all we need is you Bertha, you manage the patient by yourself". – Bertha, NP

Sub-Category: Paying Forward. In this sub-category, the APRN participants shared circumstances describing activities that support legacy building through publishing, trail blazing, coaching/ mentoring, public speaking and leading multi-disciplinary teams, among others. Mario reflected on how he first published, and the impact rippled and influenced more nurses when he became an Associate Editor of the Clinical Journal of Oncology Nursing, and currently, as an editor of what would be one of oncology books on Core Curriculum published in 2015. Bertha reflected from a clinical perspective:

"the training, experience, seminars, conferences outside your specialty that you attend, networking with other professional organizations strengthens you professionally and hence enables you to share your expertise with confidence. To me, it is when you are able to share that expertise to be considered competent as a professional" – Bertha, NP

On the other hand, an APRN saw this in the lens of the academe, through lectures and team conferences, where she brought up something "that no one thought about":

"Last week, for example, a psychologist from another Veterans Hospital in New York State called me to consult about a patient care issue that was related to my lecture on capacity of older adult, that the slides were posted at a VA website. So we discussed about an hour. It was really good. Or when people called me and asked questions I felt that I was paying forward" – Jessica, NP

Discussion

The different circumstances that APRNs in the US considered helpful in making them feel qualified and confident to do their job as healthcare providers in their specific area of specialization and practice settings presented insights on the primacy of clinical experiences. These findings within the social context of practice could be an impetus for the development of a beginner to expert APRN, which is similar to previous studies (Alber, Augustus, Hahn, Penkert, Sauer, & DeSocio, 2009; Benner, 1984). This study advanced what Dreyfus and Dreyfus (1980) posited that skill acquisition was strengthened through instruction and experience and amplified that Benner's expert nurse. Benner, (1984) also explicated that experience-based skill acquisition was still safer and more efficient only when it rested on a strong theoretical foundation.

This middle range substantive theory supported by data from interviews has several contributions to the nursing knowledge. First, it documented the circumstances or experiences that APRNs perceived as helpful in their competency acquisition as healthcare providers. The core and subcategories that emerged explicated how data were integrated during the different stages of APRNs competency acquisition in the US. Second, the study amplified that substantial years of APRN experience, in this case, an average of 14 years, rich knowledge base (participants were all educated at the Master's level, at a minimum and cognitive, psychomotor skills, being an expert clinician and consultant, are requisites in advancing the profession. Lastly, this study confirmed the fact that to acquire competence, an APRN must thrive in a supportive environment consisting of inter-professional collaborative practice, and networking within and outside of own specialty. Additionally, the APRN should be actively involved and maintained membership in local, national, international professional organization.

Furthermore, this research revealed circumstances pointing to legacy building involving a wider reach. These are

publishing, role modeling, coaching and mentoring, trail blazing, activities that "pay forward" and perpetuate competency acquisition among APRNs. There are several implications to nursing education in the US based on the findings of this study, specifically on customizing the role- or setting-specific continuing education offerings for APRNs with different levels of competency. For nursing leadership, this study supports the provision of APRNs with opportunities to perpetuate the core category and the subcategories that emerged.

The study with all its novel findings has limitations that needed to be addressed. For example, the findings lack generalizability because the study was limited to APRN experts who experienced the phenomenon to provide rich description about competency acquisition. Another limitation is the homogenous nature of the sample because all participants are of Filipino descent. Lastly, the study could use additional questions related to competency acquisition at different stages of APRNs' professional journey.

Conclusion and Recommendations

This study produced a middle range theory on Advanced Practice Nurses Competency Acquisition as independent healthcare providers in the United States. The research magnifies the role of nursing education departments in US hospitals by customizing continuing education offerings for APRNs with different levels of competency. Further, nursing leadership and collaborating healthcare professionals can provide APRNs with an environment that is conducive to produce the best practices, and learning opportunities that will empower professional advancement, support activities that will expand area of influence, and ultimately to perpetuate nursing knowledge through legacy building.

Further studies of APRN competency acquisition should be encouraged taking into consideration the limitations noted in this study. Specifically, participants from different ethnic groups should be considered for their contribution to cultural diversity. Further, there is a need for additional questions addressing issues specific to the different stages of competency acquisition as advanced by Dreyfus and Dreyfus (1980) and Benner (1964).

References

Alber, L., Augustus, L., Hahn, S., Penkert, J., Sauer, R., & Desocio, J. (2009). Applying Benner's model to psychiatric mental health nurse practitioner self-ratings of role competence. ***Journal of American Psychiatry Nurses Association*** 15(2), 126-137.

Andersen, P. (2008) Determining competency for entry to nursing practice: A grounded theory study. PhD Thesis, Victoria University of Wellington, Wellington, New Zealand.

Beck, C. T. (1999). Grounded theory research. In J. A. Fain (Ed.), Reading, understanding, and applying nursing research (pp. 205-225). Philadelphia: F. A. Davis.

Benner, P (1984). Using the Dreyfus Model of Skill Acquisition to Describe and Interpret Skill Acquisition and Clinical Judgment in Nursing Practice and Education. ***Bulletin of Science Technology Society*** 2004; 24; 188 -199

Bryant-Lukosius, D., Dicenso, A., Brown, D., Pinelli, J (2004) Advanced practice nursing roles: development, implementation and evaluation. ***Journal of Advanced Nursing*** 48(5)

Corbin, J., and Strauss, A. (2008) Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory (3rd ed.; Los Angeles, CA: Sage Inc.

Dreyfus, H., & Dreyfus, E. (1980) A Five-stage model of mental activities involved in direct skill acquisition. Retrieved from https://www.cmqcc.org/resources/1072/download

Glaser, BG., Strauss, AL., (1967). The Discovery of grounded theory: Strategies for qualitative research. Chicago, IL. Aldine Publishing Company.

Glaser, B. G. (1978). Theoretical sensitivity: advances in the methodology of grounded theory. Mill Valley, CA: Sociology Press.

Glaser, B.G. (1998). Doing grounded theory: Issues and discussions. Mill, CA: Sociology Press.

Polit, D.F., Hungler, B.P. (1999) Nursing Research. Principles and Methods. sixth. J.B. Lippincott Company, Philadelphia, New York, Baltimore; 1999

Thomas, A. (2014). NONPF Nurse Practitioner Core Competencies Content2014. ***National Organization of Nurse Practitioner Faculties.***

Nurse Practitioner Facilitated Hypertension Medication Adherence Improvement for African Americans: A Literature Review

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Abstract

Hypertension is a major health problem affecting more than 75 million Americans, and in approximately one half of adults it is uncontrolled (Yoon, Fryar, & Carroll, 2015). Worldwide prevalence estimates for hypertension may be as much as 1 billion individuals, and results in approximately 9.7 million deaths per year (Lim et al., 2012). Meanwhile, African Americans (AA) are among population groups with the highest rates of hypertension in the world, at nearly 45% for males and 46% for females (Mozaffarian et al., 2015). AA have disturbingly higher rates of cardiovascular mortality, stroke, hypertension-related heart disease, hypertensive nephropathy, congestive heart failure and end stage renal disease. The goal of management of hypertension is to achieve and maintain a blood pressure that will optimally reduce cardiovascular and renal morbidity and mortality. Some of the most prevalent barriers to hypertension control in African Americans include poor knowledge about hypertension and its consequence, poor adherence to drug therapy, and failure of physicians to emphasize therapeutic lifestyle changes (Odedosu, Schoenthaler, Vieira, Agyemang, & Ogedebge, 2012). Nurse practitioners (NPs) can provide care that leads to increased patient satisfaction and better health outcomes since they are at the forefront of preventative care. The purpose of this review is to provide an overview of the role NPs in facilitating improved medication adherence among AA, thereby reducing the enormous burden of this problem for this group.

Introduction

Hypertension is a serious health problem, affecting 25% of the United States adult population (Hartley & Repede, 2011). Uncontrolled hypertension is associated with increased cardiovascular morbidity and mortality and an increased use of health care resources, with approximately $49 billion spent annually in direct and indirect medical expenses (Merai et al., 2016). This disease leads to major complications, including heart disease, stroke, and kidney failure (Bell & Kravitz, 2008). Meanwhile, this major contributor to the global disease burden is also one of the leading preventable causes of premature death worldwide (Bromfield & Muntner, in press). Approximately one of three U.S. adults with hypertension is on medication, but only a half has their blood pressure (BP) under control (Centers for Disease Control and Prevention [CDC], 2017).

This lack of adequate BP control in treated patients may be a result of nonadherence or an inadequate treatment plan. Nonadherence to a prescribed therapy is a serious problem in the United States, resulting in significant consequences including unnecessary disease progression, disease complications, reduced functional abilities, a lower quality of life, and even death (National Council on Patient Information and Education [NCPIE], 2013). Among the 35 million people with uncontrolled hypertension, 33% (11.5 million people) are not aware of their diagnosis, 20% (7 million people) are aware of their diagnosis but not being treated for it, and approximately 47% (16.1 million people) are aware of their diagnosis and being treated for it, but treatment is not effectively controlling their blood pressure (Merai et al., 2016).

Background and Problem

Several studies have documented racial disparities in adherence to prescribed antihypertensive medications among patients with hypertension (Lewis, Ogedegbe, & Ogedegbe, 2012). AAhave been shown to have the highest prevalence of hypertension as well as poor and uncontrolled hypertension control (Merai et al., 2016; Schoenthaler et al., 2009;Middleton, 2009). These two factors combine to make hypertension a major risk factor for cardiovascular heart disease (CHD), stroke, and kidney failure among AA(American Heart Association [AHA], 2011).

In the Cohort Study of Medication Adherence among Older Adults (CoSMO) antihypertensive medication adherence was assessed telephonically using the 8-question Morisky Medication Adherence Scale (MMAS) and the Medication Possession Ratio (MPR) which uses prescription claims data to monitor a patient's supply of their prescribed antihypertensive medications. Low adherence was defined as a MMAS score <6 and non-persistent MPR was defined as <0.80 (Krousel-Wood et al., 2010)

The results showed that AA participants had lower adherence levels compared to whites with a MMAS of 18% versus 12% and an MPR score of 39% versus 22%, respectively. Furthermore, AA participants had a higher prevalence of uncontrolled blood pressure compared to their white counterparts; 38% versus 32% (Krousel-Wood, Muntner, Islam, Morisky, & Webber, 2009).

With the recognition that nonadherence with preventive and therapeutic recommendations is far more prevalent, especially among AA; more effective interventions are needed to reduce risk and improve patient outcomes. Studies show that using consistent education that increases patient awareness of choices, builds a partnership between the provider and patient, and allows for patient involvement is associated with better hypertension control (Naik, Kallen, Walder, & Street, 2008). Another study reports that more time spent on patient instruction can enhance patient understanding of prescribed medication, and correlates with greater intention to adhere to a prescribed regimen (Gilbert & Hayes, 2009). Other studies point out that medication adherence will be greatest

when patients understand the health consequences of uncontrolled hypertension and believe their BP medications constitute an effective response to this threat (Bell & Kravitz, 2008).

Review of the Literature

An exhaustive review of literature was performed using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PubMed databases to establish the need for this project. Search terms included African Americans, "medication adherence, and hypertensive compliance." A synthesis of major emerging themes relative to this project is presented here.

Hypertensive Medication Adherence among African Americans

The literature review suggests that the lower rates of adherence to hypertensive medication among AA may be the result of lay beliefs of the causes and treatment of hypertension that are divergent from medical understanding (Pettey et al., 2016; Middleton, 2009; Webb & Gonzalez, 2006; Ogedegbe, Harrison, Robbins, Mancuso, & Allegrante, 2004; Wilson et al., 2002;). Furthermore, Middleton's study (2009) shows that inaccurate lay public understanding of hypertensive illness and its consequences contributes to decreased perceived severity and susceptibility to hypertension. This in turn may result in poor hypertensive control and medication adherence. According to a report issued by the New England Healthcare Institute (NEHI), other reasons for not following proper medication regimen include: unpleasant side effects, confusion, forgetfulness, language barriers, and feeling "too good" to need medicine (Dolan, 2009). The report also points out at those with chronic conditions like diabetes and high blood pressure are among the groups that are less likely to follow their medication regimen (Dolan, 2009).

Multiple studies have examined the factors that contribute to the discrepancy between the levels of hypertensive control among AA and their white counterparts. However, there is a lack of evidenced based studies facilitated by NPs aimed at improving adherence among this at risk population.

Impact of Poor Adherence

On a worldwide basis, it is estimated that in developed countries about 50% of patients with chronic diseases do not take their medication as prescribed (AlHewiti, 2014). In the United States anywhere from one-third to more than one-half of adult patients do not take their medications as prescribed (Dolan, 2009; Zullig, Granger, & Bosworth, 2016). Not taking the medication on time, in the proper doses, or at all are just some examples of poor patient medication adherence (Dolan, 2009). Poor medication adherence leads to increasingly poor health outcomes for patients and has a significant negative economic impact on healthcare resources. Lack of medication adherence leads to poor outcomes such as unnecessary disease progression, disease complications, reduced functional abilities, a lower quality of life and even death (NCPIE, 2013). The NCPIE reports that the economic impact of nonadherence to medications and other associated factors is as much as $290 billion annually in increased medical costs (NCPIE, 2013).

Communications and Medication Adherence

Several studies show that patient–physician trust is linked to higher medication adherence, while on the other hand, patients are more likely to forego the use of medications when their trust level with the healthcare provider is low (Gabay, 2015; Schoenthaler et al., 2014; Piette, Heisler, Krein, & Kerr, 2005). In general, provider-patient communication has been shown to be linked to patient satisfaction, adherence, and health outcomes (Zullig et al., 2015; Ha & Longnecker, 2010; Betancourt, Green, Carrillo, & Park, 2005). Furthermore, race ethnicity and cultural barriers may impede effective provider-patient communication and thus lead to poorer adherence to treatment (Rocque & Leanza, 2015).

Studies show that the issue of communication may play an even larger role in multicultural and ethnic minority populations. For instance, miscommunication and less patient participation are particularly relevant between ethnic minorities and their healthcare providers resulting in lower satisfaction with care (Schinkle, Schouten, Street, Van den Putte, & Van Weert, 2016; Rocque & Leanza, 2015). In the United States, AA patients have reported lower levels of trust of physicians and tend to follow physician instructions on how to take medications less frequently than white patients (Zullig et al., 2015).

Reviews of more than 300 studies have shown that often health information cannot be understood by many patients (Ngoh, 2009). This communication mismatch has been associated with patients being less knowledgeable about their diseases, more

likely to have poorer health outcomes and more likely to be hospitalized (Ngoh, 2009). However, use of consistent education and more time spent on patient instruction have been shown to build a partnership between the provider and patient, increases patient awareness and understanding, and result in better hypertension control and medication adherence (Rocque & Leanza, 2015; Naik et al., 2008; Gilbert & Hayes, 2009).

Urgent Need for Hypertension Medication Adherence Improvement Interventions

Lack of and poor adherence with medication regimens has reached crisis proportions around the world prompting the World Health Organization (WHO) to declare poor adherence rates a worldwide problem of striking magnitude, and publish an evidence-based guide for health care providers, health care managers, and policymakers to improve strategies of medication adherence ((Vrijens, Antoniou, Burnier, De la Sierra, & Volpe, 2017; Osterberg & Blaschke, 2005). Worldwide, only about 50 percent or less of patients typically take their medicines as prescribed (AlHewiti, 2014; Brown & Bussell, 2011). In the United States, several health organizations including the NCPIE, National Institutes of Health (NIH) have recognized the need for intervention approaches to improved medication adherence and issued reports of findings addressing the key factors contributing to poor adherence and the importance of adherence for successful treatment (NCPIE, 2013; NCPIE, 2007). To further underscoring the need for action, the WHO has called for an initiative to improve worldwide rates of adherence to therapies commonly used in treating chronic conditions, including asthma, diabetes, and hypertension (World Health Organization [WHO], 2003).

Unfortunately, in spite of these calls for action rates of medicine adherence have not improved. The pervasiveness of non-adherence demands for urgent action to be taken to reduce the adverse health and economic consequences associated with this problem. As reports of the NCPIE points out, while no single strategy will guarantee that patients will fill their prescriptions and take their medicines as prescribed, elevating adherence as a priority issue and promoting best practices, behaviors, and technologies may significantly improve medication adherence in the United States (NCPIE, 2007; NCPIE, 2013). While the ultimate responsibility to fill prescriptions and take medications as prescribed rests with the patient, improved adherence requires the successful partnership between the patient and health care practitioners such as NPs who manage the patient's care.

Nurse Practitioners as Facilitators of Medication Adherence Improvement

Primary care practitioners including Nurse Practitioners (NPs) typically provide health care for a large percentage of the population and have the ability to follow-up with patients over time. In addition, many primary care practitioners have established relationships with patients, which may enhance the delivery and receptivity of recommended interventions and lifestyle changes.

Unfortunately, Nurse practitioners (NPs) represent often an overlooked yet ideal health professionals to implement and facilitate interventions in primary care. There are currently over 234,000 certified registered NPs in the United States, majority of whom (approximately 89%) are certified in family or adult/gerontology specialties (American Academy of Nurse Practitioners [AANP], 2017). NPs are at the forefront of managed care due to their expertise in counseling, health education, and case management. Research shows that NPs spend approximately two thirds of patient-encounter clinical time in direct patient contact or intrapersonal communication (Berry, 2009; Dahrouge et al., 2014). Several studies show that this approach is the cornerstone to building patient trust, which is more likely to lead to adherence to the treatment plan and therefore better BP control (Hayes, 2007; Brown & Bussell, 2011; Zullig et al., 2015).

Furthermore, NP-led hypertension intervention programs have been shown to result in greater rates of hypertension control rather than those achieved with standard care (Clark, Smith, Taylor, & Campbell, 2010). For instance, in the Community Outreach and Cardiovascular Health (COACH) study (N=525), aimed at comprehensive management of cardiovascular risk factors, a randomized controlled trial of patients in federally-qualified community health centers were either assigned to a NP/Community Health Worker (CHW) team or an enhanced standard care control group for one year. The NP/CHW group resulted in a greater improvement in systolic blood pressure by -6.2 mm Hg and a diastolic by -3.1 mm Hg (Allen, Himmelfarb, Szanton, Bone, Hill and Levine, 2011). Another study entitled Underserved Urban African American Men: Hypertension Trial Outcomes and Mortality During 5 Years (N=309), evaluated the effectiveness in controlling hypertension in a NP-led team focused on comprehensive interventions which included educational, behavioral and pharmacological management versus a standard less intensive group which only included educational and referral resources. The ranges of mean annual systolic BP/diastolic BP change from the baseline to each year were −3.7 to −10.1/−4.9 to −12.3 mm Hg for the NP-led team and +3.4 to −3.0/−1.8 to −8.7 mm Hg for the less intensive group. Furthermore, the prevalence of left ventricle hypertrophy (LVH) in the more intensive NP group was lower compared to the less intensive group at 37% v 56% respectively (Dennison et al, 2007).

The urgent need to improve the ability of patients to adhere to their therapy regimens necessitates an expanded role for NPs, who are among the most accessible members of the health care team. NPs are well positioned by academic preparation and expertise to implement intervention programs to help at risk patients (such as AA) for hypertension and medication nonadherence improve adherence.

Conclusion

The urgent need to address the pressing health concern of higher prevalence of hypertension and medication nonadherence particularly among AA has been well studied and documented in health literature. However, the pervasiveness and escalating rates of nonadherence demands for urgent action to be taken to reduce the adverse health and other consequences associated with this problem. This review supports the view that NPs can play effective roles in facilitating interventions to improve medication adherence in all population groups including AA. Additionally, the review underscores the value of NPs as key providers of patient counseling and education in correcting poor patient adherence. The goal of NP facilitated interventions is to help hypertensive patients, in this case, AA make substantial and sustained improvements in medication adherence. The successful implementation of such interventions resulting in improved medication adherence with an associated

reduction in levels of BP and LDL-C could lead to meaningful improvements in health outcomes. Furthermore, the success of NP facilitated hypertension adherence could serve as a catalyst for a greater emphasis within the health care delivery systems and policy organizations on the development and promotion of interventions to enhance medication adherence particularly among the at-risk AA population.

References

AlHewiti, A. (2014). Adherence to long-term therapies and beliefs about medications. ***International Journal of Family Medicine***, 2014, 1-8. http://dx.doi.org/10.1155/2014/479596

American Academy of Nurse Practitioners. (2017). About NPs: NP fact sheet. Retrieved July 10, 2017, from https://www.aanp.org/all-about-nps/np-fact-sheet

American Heart Association. (2011). Heart disease and stroke statistics - 2011 update: A Report from the American Heart Association. ***Circulation***, 123, e18-e209. doi: 10.1161/CIR.0b013e3182009701articles/PMC3699411/

Bell, R. A., & Kravitz, R. (2008, July). Physician counseling for hypertension: What do doctors really do? ***Patient Education and Counseling***, 72(1), 115-121. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18328663

Berry, J. (2009, July/August). Nurse practitioner/patient communication styles in clinical practice. ***The Journal for Nurse Practitioners***, 5(7), 508-515. Retrieved from http://download.journals.elsevierhealth.com/pdfs/journals/1555-4155/PIIS1555415509001408.pdf

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. ***Health Affairs***, 24(2), 499-505. doi: 10.1377/hlthaff.24.2.499

Brown, M. T., & Bussell, J. K. (2011, April). Medication adherence: WHO cares? ***Mayo Clinic Proceedings***, 86(4), 304–314. http://dx.doi.org/10.4065/mcp.2010.0575

Centers for Disease Control and Prevention. (2017). High blood pressure. Retrieved July 4, 2017, from https://www.cdc.gov/bloodpressure/index.htm

Clark, C. E., Smith, L. F., Taylor, R. S., & Campbell, J. L. (2010). Nurse led interventions to improve control of blood pressure in people with hypertension: systematic review and meta-analysis. ***BMJ***, 341. http://dx.doi.org/10.1136/bmj.c3995

Dahrouge, S., Muldoon, L., Ward, N., Hogg, W., Russell, G., & Taylor-Sussex, R. (2014, November). Roles of nurse practitioners and family physicians in community health centres. ***Canadian Family Physician,*** 60, 1020-1027. Retrieved from https://pdfs.semanticscholar.org/6d3b/222beab92d8446cb7beca999750e1bb119e1.pdf

Dennison, C. R., Post, W. S., Kim, M. T., Bone, L. R., Cohen, D., Blumenthal, R. S., ... Hill, M. N. (2007). Underserved urban African American men: Hypertension trial outcomes and mortality during 5 years. ***American Journal of Hypertension,*** 20(2), 164-171. http://dx.doi.org/10.1016/j.amjhyper.2006.08.003

Dolan, B. (2009, August 15). Poor medication adherence costs $290 billion a year. ***MobiHealthNews*** . Retrieved from http://mobihealthnews.com/3901/poor-medication-adherence-costs-290-billion-a-year/

Gabay, G. (2015, December). Perceived control over health, communication and patient–physician trust. ***Patient Education and Counseling,*** 98(12), 1550-1557. http://dx.doi.org/10.1016/j.pec.2015.06.019

Gilbert, D. A., & Hayes, E. (2009, July-August). Communication and outcomes of visits between older patients and nurse practitioners. ***Nursing Research***, 584(4), 283-293. doi: 10.1097/NNR.0b013e3181ac1413

Ha, J. F., & Longnecker, N. (2010, Spring). Doctor-patient communication: A review. ***The Ochsner Journal***, 10(1), 38-43. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/

Harmon, G., Lefante, J., & Krousel-Wood, M. (2006, July). Overcoming barriers: The role of providers in improving patient adherence to antihypertensive medications. ***Current Opinion in Cardiology***, 21(4), 310-315. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16755199?dopt=Abstract

Hartley, M., & Repede, E. (2011, September). Nurse Practitioner communication and treatment adherence in hypertensive patients. ***The Journal for Nurse Practitioners***, 7(8), 654-659. doi: 10.1016/j.nurpra.2011.04.017

Hayes, E. (2007, August). Nurse practitioners and managed care: Patient satisfaction and intention to adhere to nurse practitioner plan of care. ***Journal of the American Academy of Nurse Practitioners***, 19(8), 418-426. http://dx.doi.org/10.1111/j.1745-7599.2007.00245.x

Krousel-Wood, M. A., Muntner, P., Islam, T., Morisky, D. E., & Webber, L. S. (2009, May). Barriers to and determinants of medication adherence in hypertension management: Perspective of the Cohort Study of Medication Adherence Among Older Adults. ***Medical Clinics of North America***, 93(3), 753-769. http://dx.doi.org/10.1016/j.mcna.2009.02.007

Krousel-Wood, M., Muntner, P., Joyce, C. J., Islam, T., Stanley, E., Holt, E. W., ... Webber, L. S. (2010, January 4). Adverse effects of complementary and alternative medicine on antihypertensive medication adherence: findings from the Cohort Study of Medication Adherence Among Older Adults. ***Journal of the American Geriatrics Society***, 58(1), 54-61. http://dx.doi.org/10.1111/j.1532-5415.2009.02639.x

Lewis, L. M., Ogedegbe, C., & Ogedegbe, G. (2012, November 2012). Enhancing adherence of antihypertensive regimens in hypertensive African–Americans: Current and future prospects. ***Expert Review of Cardiovascular Therapy***, 10, 1375-1380. http://dx.doi.org/10.1586/erc.12.138

Lim, S. S., Vos, T., Flaxman, A. D., Danaei, G., Shibuya, K., Adair-Rohani, H., ... Ezzati, M. (2012, December 15, 2012). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. ***The Lancet***, 380, 2224-2260. http://dx.doi.org/10.1016/S0140-6736(12)61766-8

Merai, R., Seigel, C., Rakotza, M., Basch, P., Wright, J., Wong, B., & Thorpe, P. (2016). CDC Grand Rounds: A Public Health Approach to Detect and Control Hypertension. Retrieved from https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6545a3.pdf

Middleton, J. L. (2009, January). A proposed new model of hypertensive treatment behavior in African Americans. ***Journal of the National Medical Association,*** 10(1), 12-17. Retrieved from http://findarticles.com/p/articles/mi_7640/is_200901/ai_n32313162/

Mozaffarian, D., Benjamin, E. J., Go, A. S., Arnett, D. K., Blaha, M. J., Cushman, M., ... Turner, M. B. (2015, December 16). Heart disease and stroke statistics - 2016 update: A report from the American Heart Association. ***Circulation***, 1-11. http://dx.doi.org/10.1161/CIR.0000000000000350

Naik, A. D., Kallen, M. A., Walder, A., & Street, R. L. (2008). Improving hypertension control in diabetes mellitus: The effects of collaborative and proactive health communication. ***Circulation***, 117, 1361-1368. doi: 10.1161/CIRCULATIONAHA.107.724005

National Council on Patient Information and Education. (2007). ***Enhancing prescription medicine adherence***: A national action plan. Bethesda, MD: National Council on Patient Information and Education.

National Council on Patient Information and Education. (2013). ***Accelerating progress in prescription medicine adherence: The adherence action agenda***. Rockville, MD: National Council on Patient Information and Education.

Ngoh, L. N. (2009, August). Health literacy: A barrier to pharmacist–patient communication and medication adherence. ***Pharmacy Today***, 15(8), 45-57. Retrieved from http://courses.washington.edu/pharm585/literacy%20CE.pdf

Odedosu, T., Schoenthaler, A., Vieira, D. L., Agyemang, C., & Ogedebge, G. (2012, January 2012). Overcoming barriers to hypertension control in African Americans. ***Cleveland Clinic Journal of Medicine***, 79(1), 46-56. http://dx.doi.org/10.3949/ccjm.79a.11068

Ogedegbe, O. G., Harrison, M., Robbins, L., Mancuso, C. A., & Allegrante, J. P. (2004, Winter). Barriers and facilitators of medication adherence in hypertensive African Americans: A qualitative study. ***Ethnicity & Disease***, 14(1), 3-12. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15002917

Osterberg, L., & Blaschke, T. (2005, August 4). Adherence to medication. ***The New England Journal of Medicine***, 353(5), 487-497. Retrieved from http://www.nclnet.org/sosrx/membersonly/sept21/adherenceNEJM08042005.pdf

Pettey, C. M., McSweeney, J. C., Stewart, K. E., Cleves, M. A., Price, E. T., Heo, S., & Souder, E.

(continued on page 38)

Integration of Palliative and End-Of-Life Care Content to Strengthen the Undergraduate Nursing Curriculum: A Literature Review

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Abstract

Nurses play a crucial role in palliative and end-of-life (EOL) care. They assess and manage complicated diseases, monitor multiple technologies, and orchestrate respectfully culturally competent care with the inter-professional team when caring for seriously ill patients (Institute of Medicine, 2015). Studies indicate that nurses spend more time with patients at EOL than any other health care discipline, so it is vital that nurses be educated so they can provide high-quality palliative and EOL care (Foley &Gelband, 2003). Traditionally, nurses have not received extensive education on how to care for dying patients and their families. This lack of education is reflected in the level and quality of EOL care provided to patients. Nursing school's undergraduate curricula have been lacking both in palliative and EOLdidactic education and clinical experiences (Mallory, 2003).The objective of this review is to report on the importance of palliative and end-of-life care and its integration into the undergraduate nursing curriculum

Introduction

Nurses play a pivotal role in caring for patients with serious illness in today's complex health care system. This demands that nurses and members of the inter-professional team be educated in palliative and EOL care (IOM, 2015). Of all health professionals, nurses are in the most immediate position to provide care, comfort, and counsel near the end of life for patients and families, either in a hospital or in a hospice setting (Mitka, 2000) .In nursing schools, more attention is given to death and dying, yet the amount of content that deals with the wide range of end of life issues continues to be minimal (Walsh & Hogan, 2003). Therefore it is imperative that future nurses be prepared with the knowledge and skills to meet the needs of patients and families across the lifespan, the illness trajectory, and health care settings (Coyle, 2015).

Background and Significance

One of the earliest responsibilities of the professional nurse was care of the dying. Nurses have a long history of leading the efforts of developing policies and guidelines regarding palliative and EOL care. Dame Cicely Saunders began her career as a nurse and founded the first free standing hospice, St. Christopher's Hospice in 1967 in London, England. Florence Wald, former Dean at Yale School of Nursing, funded the first hospice in the United States in 1974.

Historically, there has been a lack of palliative and EOL care content in nursing textbooks, as well as very few nursing faculty with palliative and EOL education. Several studies have analyzed EOL content in nursing textbooks which revealed that only 2% overall content was related to EOL care. Nurse educators are challenged to select effective teaching strategies to prepare graduates to care for the dying since EOL care competes with other nursing content for a place in the curriculum. This was the initiation by Ferrell and colleagues to collaborate with the National Council of State Boards of Nursing (NCSBN) to improve the EOL content in the national nursing licensure examination for registered nurses (NCLEX-RN).Beginning with the April 2001 examination, EOL content was increased in the NCLEX by incorporating the 15 competencies set forth by the Peaceful Death document. This was a significant force in increasing EOL content in the nursing curriculum (Malloy, 2015).

Nursing faculty, continuing education providers, and staff development educators have to be educated so that they can teach the next generation and practicing nurses about this vital care. This also led to the development of the national project, the End-of-Life Nursing Education Consortium (ELNEC), originally funded by the Robert Wood Johnson Foundation (RWIF) in 2000. The ELNEC-Core Curriculum consists of nine modules: nursing care at the end-of-life, pain management, symptom management, ethical/legal issues, cultural considerations, communication, grief/loss/bereavement, achieving quality care, and care at the time of death.

They identified 15 core competencies with the purpose of assisting nurse educators in incorporating end-of-life content into nursing curricula. The mission of the consortium is to prepare specially trained nurse educators to provide end-of-life education for nursing students and practicing nurses, as well as to provide resources to facilitate that instruction (AACN, 2010). The "train-the -trainer" model continues to be used today, as attendees learn about the up-to-date palliative care, constructed on evidence-based practice. This is in concert with the IOM report (2010), The Future of Nursing: Leading Change: Advancing Health "to respond to the need to assess and transform the nursing profession." According to this IOM report, schools of nursing must provide more opportunities for students to expand their clinical experiences in primary care, long-term care, and public health. Instead of having students memorize various tasks, fundamental concepts need to be taught and higher level of competencies introduced, which revolve around knowledge and decision-making that can be applied across all clinical settings and various diseases (Malloy, 2015).

Review of the Literature

An extensive search of the literature was done using several databases such as CINAHL, Medline, Cochrane, Scopus, Proquest, and PubMed. Key search terms used were "undergraduate nursing education", "palliative care", end-of-life care", and "competencies". A majority of themes emerged which are summarized

below.

End-of-Life and Palliative care issues in nursing schools

Research suggests that nursing students have anxieties about and difficulty dealing with death and dying. Students are not ready to cope with issues related to death and dying and feel unprepared to care for these patients. These findings indicate that undergraduate nursing programs are not adequately preparing nursing students to care for people at the EOL (Mallory, 2003)

Dickinson (2007) study on EOL and palliative care issues in medical and nursing schools current offerings on death education revealed that there was a limited emphasis on EOL care. Data was gathered using a mailed survey from 122 medical schools in 2005 and 580 baccalaureate nursing programs in 2006 with return rates of 81% and 71% respectively. Both schools reported offering something on death and dying, with over 90% of student participation. The average number of hours offered in both professional programs was less than 15. Nursing programs relied solely on nurses for end of life course provisions. Students were exposed to the issues but on a limited basis and not an in-depth way.The study also revealed that it would be helpful to know which books, journal articles, and other materials are used in end-of-life and palliative care offerings to evaluate these topics for inclusion or expansion in the curriculum. This would give an overall profile of the current state of such offerings in nursing schools and future research could prove beneficial in planning future course provisions.

Dickinson, et al (2008) conducted a research study to determine the current status of palliative and end of life issues in UK undergraduate nursing programs. A mailed survey in 2006, sent to 66 undergraduate nursing programs in the UK with a return rate of 79% revealed that palliative and end of life care played a significant role in these programs. Forty-five hours on average was devoted to these topics. All of the schools had some provision on palliative and EOL care, and over 95% of students' participation in these courses. A nurse was usually the primary instructor, although non-nurses were sometimes used. Attitudes toward dying and death and communicating with terminally-ill patients and their family members were emphasized. By highlighting dying and death in the curricula, nursing schools appeared to be giving nursing students an opportunity to face the issue of death, thus helping them to be better prepared to help their patient and their families to do so.At the end of nursing school, if students feel comfortable educating the patient and family about the dying process, are ready to respond to patients who request assistance in dying, are ready to break bad news to a patient and family, then nursing programs will have done their part in educating about EOL issues.

Ramjan et al (2010) described how palliative care content was embedded throughout the three-year undergraduate nursing program at the University of Notre Dame in Australia.The University is committed to ensuring that students graduate with the capabilities to deliver appropriate care to people requiring EOL care. Regardless of whether a death occurs in acute care, hospice, residential aged care or community settings, nurses are the health professionals that will spend the largest

proportion of time with the patient who has a terminal illness and their families. This reality makes the integration of palliative care content into the undergraduate nursing curricula an important priority. The palliative care curricula for undergraduate program offers engaging palliative case studies and scenarios for academics to utilize. Adopting an iterative approach ensured that palliative care content was integrated across multiple units beginning in the first semester, repeated, expanded and spiraled through to their last semester, which consolidated their palliative learning experiences. Their next step is to evaluate the palliative care capabilities of the nursing graduates.

Students' knowledge, attitudes, and perceptions of EOL care

Wallace et al (2008) conducted a project to provide a current state of end-of-life nursing education in the literature and to report on the EOL knowledge and experiences of two groups of on nursing students in one small Liberal Arts University. A total of 111 undergraduate students (61 sophomores and 50 seniors) were administered a 50-item, multiple-choice test to determine their baseline knowledge about end-of-life care. Baseline analysis of quantitative data indicated that although EOL knowledge increased throughout the curriculum from sophomore to senior level, undergraduate nursing students still approach their final Years with limited competence in palliative care. The results of this study indicate that students beginning their nursing educational program are at a grade level of "D," and this rises to a level of "B"as they begin their final year of nursing studies. There was a significant difference between sophomore and senior student groups on palliative care knowledge. The literature clearly reveals a substantial need to improve EOL nursing care services to patients. To improve nursing at EOL, improved palliative care nursing education is needed. Although the study was limited to a small, homogeneous sample and only one sampling site, it provides the impetus to all nursing educators to integrate EOL content throughout the curriculum. Creating knowledgeable clinicians and leaders in EOL nursing care is the responsibility of all nursing educators.

A quantitative, quasi-experimental study using a longitudinal design with pretest, intervention and posttest (4 weeks post intervention) was conducted by Mallory in 2003. She addressed four research questions; first was to see if there was a significant difference in attitudes toward care of the dying in nursing students who participated in didactic and experiential education and those who did not. The second was to see if there is a change in attitudes toward care of the dying in nursing students who participated in the palliative care educational component. The third was to see if there is a relationship between nursing students' attitudes toward care of the dying and their previous education on death and dying. The fourth was to see if there is a difference in attitudes towards care of the dying in nursing students comparing post-test to post-post-test. The intervention was a 6 week palliative care educational component of didactic and clinical experiences with a control group that had no treatment. The ELNEC content was used which consisted of lectures and discussions on palliative care, death and dying and pain management, small group discussions and role play in a seminar format, visiting anatomy cadaver lab, visit to funeral home to learn about post mortem care, burial options and bereavement services, spending a day at a hospice unit observing hospice nurses, the interdisciplinary team and patients. Findings revealed that there was a significant relationship between previous death education and attitudes towards care of the dying. There was also a significant positive increase in the attitudes of nursing students' towards care of the dying when compared to the control group. Some of the limitations were asking students on pretest about attitudes toward caring for dying patients could affect attitudes on posttest, and the researcher as instructor could have introduced bias (Mallory, 2003).

Dobbins (2011) conducted a study to evaluate the impact of an elective nursing course incorporating the ELNEC curriculum on the attitudes of associate degree nursing students towards death and caring for the dying. A secondary purpose was to evaluate the effect of and end-of-life module embedded in a larger course on the attitudes of a similar group of students. She measured the student attitudes toward caring for dying patients using a demographic questionnaire and the Frommelt Attitude Toward Care of the Dying Scale (FATCOD) for nurses in addition to watching the film, Wit used by educators of health professionals to illustrate the complex issues faced by some patients at the end of life. Students participating in the study were enrolled in either a one-credit nursing elective, nursing care at the end-of-life (intervention group), or a three-credit required advanced medical-surgical course, nursing process 111(the control group). Participating students completed all three study instruments during the first and last weeks of class (Week 1 and Week 14), allowing for a pre-test-posttest comparison of data. The results of the study suggested that an ELNEC curriculum-based elective course, which included lecture/discussion, field trips, and the viewing of Wit, significantly decreased aspects of death anxiety and improved the attitudes of nursing students toward caring for dying patients. Study recommendations included continuing efforts to incorporate ELNEC-based programs using larger sample sizes and different populations, and longitudinal studies to determine the duration of effect of educational programs.

Barrere and colleagues (2008) conducted a pretest-posttest study to evaluate the influence of integration of the ELNEC curriculum into a baccalaureate nursing program on students' attitudes toward care of the dying. The Frommelt Attitudes toward Care of the Dying Scale for Nurses (FATCOD) was administered to traditional and accelerated baccalaureate students before and after exposure to a nursing curriculum that integrated essential ELNEC elements. Multiple regression analyses indicated that no previous experience with death and an age of 18-22 accounted for the most variance in attitude change. The findings suggest that integrating the ELNEC curriculum throughout a baccalaureate program positively affects the attitudes of nursing students towards the care of patients who are dying.

Competencies and Recommendations for educating undergraduate nursing students

The CARES document: Competencies and Recommendations for educating nursing students preparing nurses to care for the seriously ill and their families were developed to guide undergraduate nursing education in preparing future nurses to help patients attain a "peaceful death." The document emphasizes the essential role of the nurse in providing compassionate, evidence-based palliative care at the highest level of the registered nurses' scope of practice (ANA, 2010, IOM, 2015). The purpose of the competency statements is

to assist nurse educators in incorporating palliative care content into their existing curricula. There are 17 competencies that new nurses need to have completed by the end of their undergraduate nursing education which are in sync with the AACN baccalaureate essentials. These competencies can be threaded throughout the curriculum as content areas or in courses where various aspects of palliative care can be included. Example of content that can be included in the Fundamentals course which is usually taught in the first semester are: Principles of hospice and palliative care, Self-care for the professional caregiver, Basic communication skills, Comfort, including management of pain and suffering, Cultural and spiritual considerations in serious illness and Care of the imminently dying patient and the family. This introduction can lay the groundwork for further discussion of palliative care concepts in other courses (AACN, 2016).

Conclusion

Palliative and end-of-life care is an important theme in nursing. It is important for nurses or student nurses to be adequately trained at all levels of nursing education. Research has shown that nursing education has not prepared nurses to provide optimum EOL care; and yet, care of patients at the EOL is dependent on adequate educational preparation of nurses. Based on the AACN Peaceful Death document and the IOM report on Dying in America, it is imperative that nursing education is transformed in meeting the complex needs of patients and changing healthcare systems.

Older Americans, 65 years and older, will make up almost 20% (72 million) of the US population by 2030(NIH, 2012). The current US healthcare system and nursing curricula focus on assessing and managing acute illnesses. The Centers for Disease Control (CDC) reported 2,468,435 deaths in the United States in 2010, with the majority of those deaths (67%) occurring from chronic illnesses, such as heart failure, cancer, chronic respiratory disease, stroke, Alzheimer's, and diabetes (CDC, 2013). A drastic change in curricula must take place in order to meet the needs of older adults, many who have complex, chronic comorbidities. There are over 3 million nurses in the United States, no other health care professional spends more time with patients than the nurse as they assess and manage care (IOM, 2010). The complexity of care for those with chronic illness, including palliative and end-of-life care, require nurse to have the education and training to take care of this population. Nurse educators must be challenged to select effective teaching strategies to prepare graduate nurses to care for dying patients.

References

American Association of Colleges of Nursing (AACN).(2005). Peaceful death. Recommended competencies and curricular guidelines for end-of-life nursing care. ***http://www.aacn.nche.edu/education/deathfin.htm***. Accessed April 15, 2017.

American Association of Colleges of Nursing (AACN). (2016). CARES: Competencies and Recommendations for Educating Undergraduate Nursing Students Preparing Nurses To Care For The Seriously Ill And Their Families. ***Journal of Professional Nursing***, 32 (2):78-84.

American Nurses Association (2010). ***Position statement. Registered Nurses' Roles and Responsibilities in Providing Expert Care and Counseling at the End of Life*** .http://www.nursing world.org/ mainmenucategories/ ethicsstandards/ethics-position statements/ etpain14426.pdf. Accessed March 15, 2017.

Barrere, C., Durkin, A., & LaCoursiere. (2008). The Influence of End-of-Life Education on Attitudes of Nursing. ***International Journal of Nursing education Scholarship*** ,5(1): 3-15.

Centers for Disease Control (CDC) (2013). Leading Causes of Death. ***http://www.cdc.gov/nchs/fastats/icod.htm***. Accessed April 15, 2017

Coyle, N. (2015). Introduction to palliative nursing care. In Ferrell, B.R., Coyle, N., &Paice, J. ***Oxford Textbook of Palliative Nursing***. 4th ed., p. 3-10. New York, NY: Oxford University Press.

Dickinson, G.E. (2007). End-of-Life and Palliative Care issues in Medical and Nursing Schools in the United States. ***Death Studies***, 31(8), 713-723

Dobbins, E.H. (2011).The impact of end-of-life curriculum content on the attitudes of associate degree nursing students toward death and care of the dying. ***Teaching and Learning in Nursing***, (6):159-166.

Foley, K.M. &Gelband, H. (2003).Improving palliative care, a report on end-of-life care in nursing homes. ***Issues in Law and Medicine***, 19, 1-23. Washington, DC: National Academy Press.

Institute of Medicine (IOM) (2010). The Future of Nursing: Leading Change, Advancing Health. Retrieved from ***http://www.iom.edu/Reports/2010*** on April 10, 2017.

Institute of Medicine (IOM) (2015). ***Dying in America: Improving quality and honoring individual preferences near the end of life.*** Washington, DC: The National Academies Press.

Mallory, J.L. (2003). The impact of a palliative care educational component on attitudes toward care of the dying in undergraduate nursing students. ***Journal of Professional Nursing***, 19 (5), 305-312.

Malloy, P .(2015). Nursing Education. In Ferrell, B.R., Coyle, N., & Paice, J. ***Oxford Textbook of Palliative Nursing***. 4th ed., p. 1012-1013. New York, NY: Oxford University Press.

Mitka, M. (2000).Suggestions for help when the end is near. ***Journal of the American Medical Association***, 284, 2441-2442.

National Institute of Health (NIH). (2012). Federal Report Details Health, Economic Status of Older Americans. ***http://www.nih.gov/news/health/aug2012/nia-16.htm***. Accessed April 15, 2017.

Ramjan, J.M., Costa, C.M., Hickman, L.D., et al (2010). Integrating palliative care content into a new undergraduate nursing curriculum: The University of Notre-Dame, Australia-Sydney experience. ***Collegian***.(17): 85-91.

Wallace, M., Grossman, S., Campbell, S., et al (2009). Integration of End-of-Life Care Content in Undergraduate Nursing Curricula: Student Knowledge and Perceptions. ***Journal of Professional Nursing***,25 (1), 50-56.

Walsh, S.M.& Hogan, N.S. (2003). Oncology nursing education: Nursing students' commitment of "presence" with the dying patient and the family. ***Nursing Education Perspectives***, 24, 86-91.

Transforming Passive Students Into Active Learners Through the Flipped Classroom

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Abstract

The purpose of this evidence-based project was to describe the role of flipped learning pedagogy in increasing active learning and clinical decision-making in students in a Bachelor of Science in Nursing (BSN) program. A convenience sample of 42 students in a medical-surgical I course participated in this study. A participation checklist created and validated by two nursing faculty members was used to document active learning through the students' participation in unfolding case studies, virtual simulations, and answering practice questions for the National Council of State Boards of Nursing licensure examination (NCLEX-RN). The students' answers to the practice questions were evaluated with the use of i-clickers.

Two teaching strategies were compared in this project: flipped pedagogy starting from week 8 and the traditional teaching method (lecture and discussion). Using a checklist developed for this project, students who were in the flipped learning group showed increased participation in active classroom activities from week 8 (83%) to week 13 (100%). Students who were taught using the traditional teaching methods were not observed participating in class on week 8 and week 14. Clinical Decision Making Nursing Scale (CDMNS) scores between week 8 and week 14 were examined for both groups. A longitudinal analysis indicated that the flipped group improved significantly ($t = –5.2$, 95% CI: –14.1, –6.2, $p = 0.001$), while there was no significant change for the traditional group ($t = –0.93$, $p = 0.37$).

Introduction

Most nursing students are not prepared to meet the complex needs of patients in the health care system today. The majority of the students today are millennials, who were brought up to use advanced technological devices such as smartphones, laptops, and tablets. Millennials have replaced traditional forms of communication with email, texting, and social networks. As a result, face-to-face communication and interactions with others may be challenging for them (Towle & Breda, 2014).

Millennials (born in the late 1970s to the late 1990s) have different learning preferences than their predecessors. They are described as team-oriented and generally optimistic (Billings & Halstead, 2016). Their attention spans may be short, but they multi task and are able to respond to text messages, Twitter, and Snapchat.) On the other hand, some of their teachers in nursing are part of the Baby Boomer generation (born 1946-1964) who often lack technological savviness and some faculty members are from Generation X (born between 1965 and 1976) who are often amenable to technology and change (Billings & Halstead, 2016).

The traditional lecture method currently used in most nursing programs encourages passive learning, an indolent transfer of knowledge from instructor to student (Tedesco-Schneck, 2013). Coupled with the use of PowerPoint slides, information is delivered passively to students with little time for active engagement. The Carnegie Foundation National Study of Nursing Education (2009) noted that nursing education may not prepare students adequately to function in the contemporary health care environment (Benner, 2010). The Institute of Medicine (IOM) report, The Future of Nursing: Leading Change, Advancing Health (2011), emphasized that it is necessary to change 21st-century nursing education from passive to active participation of students in the teaching-learning process.

Background of the Problem

Nursing education has changed little since the days of Florence Nightingale. Students are still being educated as their faculty had been educated, and the medical model of education (body systems approach) has been used for decades. However, increases in technology, research, the complexity of diseases, and the rising responsibilities of nurses necessitates that nurse educators rethink the learning environment. As a result, educators have been adding a tremendous amount of content to the curriculum while finding it difficult to update their clinical skills, pedagogical skills, and competencies to teach effectively (Benner, 2012). The National League for Nursing (NLN, 2012) has identified nurse educator competencies to include: facilitating learning effectively, facilitating learner development, assessing and evaluating teaching strategies. and participating in curriculum design and program evaluation. The Carnegie Foundation National Nursing Education Study (2007) reported gaps in knowledge among faculty about how to answer clinical questions utilizing resources such as information systems and databases and obtaining assistance from other disciplines. The study noted that faculty and students did not feel that students were prepared adequately to care for the aging patient with complex health problems they encounter in the healthcare system today and that nursing education needs to be redesigned and reorganized to integrate clinical situations into classroom activities (Benner, Sutphen, Leonard, & Day,2010).

There have been changes in nursing responsibilities over the past 60 years (Benner et al., 2010). Nurses are functioning in a more independent role. The contemporary nurse must be able to identify early changes in a patient's condition and intervene rapidly. Nurses are expected to apply, analyze, and synthesize previously learned knowledge and skills in this rapidly changing health care environment. In education, there is a disconnect between the classroom and clinical practice (Benner,

2012). Students may have find difficulty applying what they learned in theory to clinical situations. Nurses need to be able to integrate problem solving and interpersonal processes (Benner et al., 2010). One change resulting from health care reform is the transfer of resources to provide more community health care. Inpatient stays in hospitals have been reduced by insurance companies, and patients are often sent to short-term rehabilitation centers or home care for additional treatments. The resulting increased acuity of patients in the hospital (Aiken et al., 2014) requires nurses to think critically and make sound clinical decisions in order to increase the likelihood of positive patient outcomes.

Significance of the Problem

Nurse staffing, work environments, and nurse educational levels have been associated with patient mortality (Cho et. al., 2015). Mortality and morbidity rates have been shown to decrease in patients who have nurses who are effective in making good clinical decisions, which is associated with nurses who are at least baccalaureate prepared.

Lucerno, Lake, and Aiken (2010) concluded that nursing care quality is significantly associated with adverse events in U.S. hospitals. Nurses reported that frequent adverse events were in: medication errors, 15%; patient falls with injury, 20%; and nosocomial infections, 31%. Del Bueno (2005) reported that 70% of nurses who graduated in the United States scored at an unsafe level on the Performance Based Development System (PBDS), a valid and reliable competency assessment system. The PBDS has been used in 350 health care agencies in 46 states to assess competence in critical thinking and interpersonal skills. Aggregated data indicate that nurses' knowledge of skills was satisfactory, but their clinical reasoning skills were below par in critical situations. Nurses are required to use effective clinical reasoning skills in order to have a positive impact on patient outcomes.

By 2022, the number of job vacancies for registered nurses due to growth and replacements is estimated to be 1.05 million (U.S. Bureau of Labor, 2014). Nursing faculty need to prepare students to fill these job vacancies. Positive patient outcomes will be maximized by increasing the quality of nursing education. Today's dynamic health care environment requires that nurses use sound clinical reasoning as patients' conditions change.

Clinical Question

Does implementing flipped learning pedagogy increase active learning and clinical decision-making in students of an undergraduate medical-surgical I baccalaureate nursing course?

Definition of Concepts

Active Learning

Conceptual Definition. Active learning is defined as the integration of student-centered interactive learning techniques that foster critical thinking during the pre-licensure academic career (Freire, 2010). Ultimately, the outcome is to be able to transfer clinical reasoning skills into nursing practice (Billings & Halstead, 2016).

Operational Definition. Students will

come to class having already reviewed the PowerPoints and doing the prerequisite readings for the lessons of the day. They will be prepared for weekly quizzes. Students will participate in and discuss case studies, virtual simulations, and test-enhancement activities (NCLEX-RN type questions). Students will participate in at least 75% of group work and/or answer questions from faculty and peers. This will be documented in the student participation checklist.

Clinical Decision-Making.

Conceptual Definition. Clinical decision-making is the ability to make appropriate decisions about a clinical situation in a timely manner. It is a process in which nurses are able to gather clues, process information, comprehend the problem, plan, intervene, and evaluate outcomes promptly (Hoffman, Aitken, & Duffield, 2009).

Operational Definition. The operational definition of clinical decision-making is the score on the CDMNS (Jenkins, 2001). The tool is a self-report measure used to assess how students perceive themselves making clinical decisions.

Flipped Learning.

Conceptual Definition. Flipped learning is a student-centered pedagogical approach in which direct content instruction shifts away from group learning into individual learning (Flipped Learning Network, 2014). Direct content instruction is done individually outside of class. Group learning is transformed into an interactive learning environment where the educator acts as facilitator to apply learned concepts. The four pillars of flipped learning are: a flexible environment where learning occurs, a learning culture that is student focused, intentional content that maximizes classroom learning, and a professional educator who provides feedback and acts as facilitator (Flipped Learning Network, 2014).

Operational Definition. Students in the flipped classroom are expected to view assigned PowerPoints and complete assigned readings prior to class. They are expected to work in groups in class on case studies, critical thinking exercises, and answer NCLEX-RN type questions using i-clickers.

Theoretical Framework

Flipped learning incorporates the four components of the How People Learn Theory (HPL), which is learner-centered, knowledge-centered, assessment centered, and community-centered. The HPL theory (Bransford, Brown, & Cocking, 2000) recognizes that students possess previous knowledge and experiences. Building on their knowledge, conceptually and culturally, information is arranged to lead to better comprehension and enable students to transfer knowledge. The teacher helps students identify what they know and what they do not know. The ongoing feedback from the instructor allows students to revise their thinking. In-class learning is linked to the professional community via realistic patient situations (Bransford et al., 2000).

Literature Review

A quasi-experimental study on students' impressions of improved learning through active learning reflected by improved test scores was conducted by Everly (2013). Convenience samples were used. Students in the spring 2010 control group (n = 44) received the traditional lecture in the classroom. In fall 2010, students (n = 95) received lecture content via prerecorded software (Tegrity or Adobe Breeze). Both classes were taught by the same faculty member, used the same syllabus, textbook, and course outline, and covered the same material. A maternity class was used for this study. A voluntary midsemester survey for student acceptance of the flipped classroom was conducted; 82% of students surveyed reported learning more from having discussions and having active learning in the classroom than from lecture alone. Both groups took the Assessment Technology, Inc. (ATI) standardized maternal exam; a Mann-Whitney U test was used to compare ATI exam scores with a medium effect size (d = 0.5). Scores were significantly higher in the flipped classroom ($z = -2.084$, $p < 0.05$). Validity and reliability of the maternal ATI exam were not presented.

Della Ratta (2015) conducted a quasi-experimental research study on flipping the classroom with team-based learning in undergraduate baccalaureate nursing education in a fundamentals nursing course. The study focused on the effects of a flipped classroom on nursing student performance and satisfaction. The sample consisted of a convenience sample of 80 students in the first semester and the same 80 students enrolled in two sections of the same course during the second semester. The flipped component was added in the second semester (5 of 12 three-hour lectures). Students were randomly assigned to work in teams in order to evenly distribute the diverse student population according to grade point average (GPA), ethnicity, age, and gender. Student test scores in the standardized fundamentals test were higher in the flipped classroom (the specific type of standardized test was not mentioned). Course evaluations in the first semester in the Della Ratta (2015) study were not as positive as evaluations from the second semester. Students in the flipped classroom highly valued the voice-over PowerPoint lectures and team-based learning. While a limitation of the study was that the flipped classroom was not carried out for the entire second semester, the findings imply that the flipped classroom and team-based learning can assist in transforming nursing education.

A quasi-experimental study was conducted by Missildine, Fountain, Summers, and Gosselin (2013) to explore flipping the classroom to improve student performance and satisfaction in an adult health nursing course. A convenience sample of 589 students was used over a period of three semesters; randomization was not discussed. In fall 2009, lecture only (LO) was used by faculty. In spring 2010, lecture plus lecture capture classroom (LLC) was used. Lecture capture allowed the updating of content. In fall of 2010, lecture plus innovation (LCI) (flipped classroom approach) was used. There were no classroom lectures in the flipped approach. Comparable examinations were used from previous semesters to ensure consistency, but reliability coefficients and validity of the exams were not addressed. A power analysis (power 0.80) for a one-way ANOVA for the three groups was used and a moderate effect size of 0.25 was noted.

Findings from the Missildine et al. (2013) study revealed that the average examination scores were significantly higher for students in the LCI group ($M = 81.89$, $SD = 5.02$) than the LLC group ($M = 80.70$, $SD = 4.25$, $p = 0.003$) and the LO group ($M = 79.79$, $SD = 4.51$, $p < 0.001$). Confidence intervals were not given in the statistical analysis. Students reported that the LCI entailed more work and that they did not value interactive learning strategies.

Geist, Larimore, Rawiszer, and Sager (2015) conducted a quasi-experimental study on the flipped versus traditional instruction and achievement in baccalaureate nursing in a state university in

Tennessee. The setting was a pharmacology II nursing course. Convenience samples were used for both the control group (n = 40) and the treatment group (n = 46). Participants had GPAs greater than 3.7 with a mid-curricular HESI score average of 911 for the treatment group and 965 for the control group. ANOVA was uses for statistical analysis. The F-value for the method (flipped or traditional) for the first test was F (1,86) = 90.50, p = 000, n = 52; the second test results were F (1,86) = 90.50, p = .000, n = 52; the third test results were F (1,86) = 43.59, p = 000, n = 34. All three exams demonstrated variance in performance and high association with the teaching method. Identical unit tests and the comprehensive final examination were used to reduce bias. Reliability and validity of the exams were not addressed, and confounding variables and confidence intervals were not mentioned. While the final exam did not show significant difference between the methods, results of the three unit exams supported the flipped method for knowledge acquisition. It is important to note that Geist et al. (2015) measured knowledge acquisition but did not mention knowledge application. The study implies that the flipped classroom model provides a learning environment that allows a better understanding of nursing concepts.

Simpson and Richards (2015) conducted a nonexperimental, descriptive, exploratory study on flipping the classroom to teach population health. The authors clearly addressed the need for the flipped classroom to revise the curriculum and to better address the needs of learners. Convenience sampling was used; 64 third-year public health students were enrolled in the traditional lecture, and 93 second-year students were enrolled in the flipped classroom. Voice-over PowerPoints, teaching videos, and interactive online modules were implemented in the flipped classroom, and online quizzes were administered prior to the start of each class. No statistical significant difference in course evaluations between the flipped and the traditional course was found. Statistical analysis was not clearly explained; t-tests of course evaluations were conducted but no significant differences were found. Reliability and validity were not addressed for the university-based course evaluations. Limitations were the small sample of traditional students from one geographic area of the country; students were not representative of overall undergraduate nursing students. Further, there was a higher in-class evaluation return as compared to online evaluations. Simpson and Richards (2015) recommended including the evaluation of content retention and the critical application of applying content. Students in the flipped classroom group were found to have increased levels of engagement and took ownership of their learning.

A systematic review was conducted by Betihavas, Bridgman, Kornhaber, and Cross (2016) using the databases PubMed, Embase, CINAHL, Eric, and Scopis. Search terms included: nurse flip, active learning, blended learning, problem-based learning, and teaching and education. Search strategy was limited to English. Studies were found with a total of 934 subjects. Five studies met the inclusion criteria; these studies were conducted in the United States between 2013 and 2015. Each study lasted for one semester. They were not randomized control trials; two studies used quantitative approaches and three used a mixed design. Geist et al. (2015) found no differences in final exam scores between the flipped and traditional classrooms. Missildine et al. (2013) revealed that students in the flipped classroom achieved higher exam scores than students in the traditional classroom. Harrington et al. (2015) concluded that both the flipped and traditional classroom were equally effective. Critz and Knight (2013) reported a greater than 75% satisfaction rating, quiz difficulty, case scenarios, prerecorded lectures, and quantity of assignments. Simpson and Richards (2015) found no difference between the flipped and traditional classroom in a customized survey. Validity of each study was not addressed. Methods of analysis were given for each study. Level of significance was noted for most of the quantitative studies but confidence intervals were not addressed.

The results of the systematic review by Betihavas et al. (2016) support the potential to transform nursing education to one that is student centered and to better prepare students for practice. The findings showed no evidence that the flipped classroom offers increased chances for developing critical thinking skills. Studies reviewed were heterogeneous, and studies from other countries were included. The number of studies was small, and the authors noted that some relevant studies may have been omitted.

Methodology and Implementation

Project Design

An Evidence-Based Practice (EBP) pilot design was used for this project. Two groups of students were compared from week 8 to week 14 during the semester. One group received the flipped pedagogy and one group received the traditional lecture discussion teaching strategy.

Flipped pedagogy consisting of case studies adopted from *Brunner and Suddarth's Textbook of Medical-Surgical Nursing* (13th edition) (Hinkle & Cheever), virtual simulations (Wolters Kluwer Health/Lippincott Williams & Wilkins), unfolding reasoning case study exercises, and NCLEX-RN type questions were used during class time (flipped classroom) starting on week 8 of a 15-week semester. The unfolding case studies were realistic scenarios that prepared students for professional practice through clinical decision-making by providing opportunities to assess a situation and develop nursing diagnoses to meet the needs of patients. I-clickers were used to document student participation when answering practice NCLEX-RN questions. Students were placed into small groups of five and worked collaboratively through the case studies with guidance from faculty. Prior to class students viewed PowerPoints (entire semester) and completed assigned readings, which were placed on Blackboard in the Web Campus.

The Clinical Decision Making in Nursing Scale (CDMNS) was administered to the students in the flipped classroom and to students who were taught using the lecture discussion teaching strategy on week 8 and week 14. A short quiz was given at the beginning of each class for students enrolled in the flipped classroom to ensure that students completed the pre-class assignments. A student participation checklist that was validated by a medical-surgical full time faculty member and i-clickers were used to monitor student participation in class activities.

Implementation Model

The John Hopkins Evidence Based Practice Model was used to guide this project (Dearholt & Dang, 2012). Permission to use this model was obtained. The EBP process follows three criteria: Practice Question, Evidence, and Translation (PET).

Precipitated by the need to transform

Table 1. Demographics

	No flipped class (n=9)	Flipped class (n=33)	Total (n=42)
Gender			
Male	4 (44.4%)	6 (18.2%)	10 (23.8%)
Female	5 (55.6%)	27 (81.8%)	32 (76.1%)
Educational Level			
High School	_	23 (69.7%)	23 (54.7%)
Associate	_	10 (30.3)	10 (23.8%)
Bachelor	6 (66.7%)	_	6 (14.2%)
Master's	3 (33.3%)	_	3 (7.1%)
Age (M±SD)	28.5±4.5	22.96±4	24.1±4.7
CDMNS Score Pre (M±SD)	126.5±16.05	126.4±10.76	
CDMNS Score Post (M±SD)	131.5±8.5	136.6±13.4	

the delivery of nursing education and the ongoing challenge to narrow the education-practice gap, a burning clinical question was formulated. A critical appraisal of the evidence was conducted. Based on the critical appraisal, a recommendation for an evidence- based practice project was warranted (translation). An educational intervention was recommended using the flipped learning pedagogy to increase active learning and clinical decision-making in an undergraduate medical-surgical I baccalaureate nursing course.

Student Role. Students took responsibility for their own learning andclassroom learning was student centered. Students were required to view the PowerPoints and complete readings in a specified time frame, with the majority of preparation done outside the classroom. The PowerPoint slides were made available to students on the Web Campus on the first day of class. The model allowed students to remediate and clarify any misunderstandings. Class time was reserved as a learning vehicle experience for students (Bergman & Sams, 2012).

A quiz was given at the beginning of each class in theory to ensure that students completed the prerequisite requirements. It consisted of approximately 10 multiple-choice or true/false questions (15 minutes). Students were placed into groups of five and worked collaboratively through case studies and virtual simulations adopted from Hinkle & Cheever's *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*, 13th edition, starting on week 8 in the flipped class (compatible with required textbook). Virtual simulations and unfolding case studies were incorporated into class sessions and students worked collaboratively with input from faculty. Students in the flipped class participated in concept mapping during the first 7 weeks of class. Students in the flipped class participated in test enhancement activities for selected classes.

Faculty Role. Questions on the quiz were at the remembering and understanding levels of Bloom's Taxonomy. The quizzes served as a check to see if students completed their prerequisite assignments. After the students took the quiz, the instructor highlighted the key features of the readings and PowerPoints, giving students the opportunity to ask questions and clarify any misunderstandings about the prerequisite work. Faculty were able to immediately assess if students were experiencing difficulty and provide feedback.

The teaching strategies used enabled students to use information rather than memorize content. Through case studies, critical thinking exercises, and NCLEX-RN preparatory questions, connections were made to clinical practice (Geist, Larimore, Rawiszer, & Al Sager, 2015). Instant feedback was given to students as they participated in active learning, making clinical decisions that impacted patient outcomes.

Sample and Sampling.

A convenience sample of 42 students enrolled in two sections of Medical-Surgical Nursing-I course participated in the project in fall 2016. One section/group received the flipped pedagogy (n = 33). These were traditional four-year students who entered from high school. The other section/group was taught using thetraditional lecture with discussion teaching strategy n = 9). These students were holders of baccalaureate or higher degrees other than nursing.

Setting.

The setting for this pilot project was a northern New Jersey university school of nursing and allied health BSN program.

Institutional Review Board and Protection of Human Subjects

An exempt permission from the university's Institutional Review Board (IRB) was granted. A student information sheet regarding the project was given to all participants. Demographic information was obtained from participants. Data with personal information were placed in a locked safe and will be destroyed once the study has been officially concluded. Information about this study was given and explained to students in both classes. Students were asked to use the last four digits of their student identification to link to the tool used for evaluation.

Implementation

Data Collection and Analysis.

Instruments Used: The Clinical Decision Making Nursing Scale (CDMNS) developed by Dr. Helen Jenkins. and a Checklist for Participation developed by

the PI. The CDMNS has a Cronbach's alpha of 0.83. Content validity was based on the literature of normative decision making, preliminary testing, and a panel of five nurse experts teaching in a baccalaureate program. The CDMNS is in the public domain and is available through this site https://www.amazon / Measurement-Nursing-Outcomes-Measuring-Performance. The Checklist for Participation was developed by the PI and validated by faculty teaching the Medical- Surgical Nursing course.

Participating students attended their 15-week medical-surgical nursing I theory class. The Monday class participated in the flipped pedagogy class while the Tuesday class participated in the class using the current teaching methodology (traditional lecture). The PI collected all data on both classes. There were no students who refused to participate. The Clinical Decision Making Nursing Scale (CDMNS) was administered to the students of the flipped learning pedagogy and the traditional lecture on week 8 and week 14. The CDMNS has a Cronbach's alpha of 0.83. Content validity was based on the literature of normative decision making, preliminary testing, and a panel of five nurse experts teaching in a baccalaureate program.

Descriptive analysis of the sample was reported in percentage for categorical variables and in mean and standard deviation for continuous variables. The differences for the CDMNS scores between week 8 and week 14 were calculated using Analysis of Variance (ANOVA) with the significance level set at 0.05. Data were analyzed using SPSS version 23.

A checklist was used to monitor active participation. Active learning was observed by the PI as well as the faculty member in the flipped classroom. Students were observed for participation within each group during virtual simulations and by calculating the number of students polled while using i-clickers during NCLEX-RN test preparatory questions. The PI and faculty member ensured participation of each student by facilitating discussion with each group.

Results

Demographics

The total sample of 42 participants consisted of 10 males and 32 females ages 20 to 35. More than half of the sample (69.7%) were high school graduates. The others held baccalaureate or higher non-nursing degrees. The demographic characteristics of the participants in this study are reported in **Table 1.**

Outcomes

Descriptive analysis of the sample was reported in percentage for categorical variables and in mean and standard deviation for continuous variables. The differences between CDMNS for week 8 and week 14 were calculated using Analysis of Variance (ANOVA) with the significance level set at 0.05. Data were analyzed using SPSS version 23. A checklist was used to describe student participation; this was reported in percentages.

Results of CDMNS Scores

On week 8 and week 14, there were no significant differences between the mean CDMNS scores between the groups ($t = 0.01$, $p = 0.98$). However, there was a significant effect of time for CDMNS scores ($F = 10.9$, $p = 0.002$) for both groups. When comparing scores from week 8 and week 14 there was no significant difference between groups ($F = 0.39$, $p = 0.5$). Further analysis of CDMNS scores for each group indicated that the flipped group significantly improved over time, CDMNS scores ($t = –5.2$, 95% CI: –14.1, –6.2, $p = 0.001$); there was no significant change for the traditional group ($t = –0.93$, $p = 0.37$).

Results of Active Learning.

Since quizzes were administered at the beginning of each class, students had to take responsibility to complete all prerequisite assignments (e.g., readings, PowerPoints). A checklist was used to document if students participated or not. The PI and faculty member were able to facilitate discussion to develop clinical reasoning skills. Participation was documented on week 8 as 83% and at week 13 as 100% indicating a 17% increase in student participation with a mean participation rate of 95%. Students who were taught in the traditional teaching method were not observed participating in class on weeks 8 and 14.

Discussion

Although the results did not show a significant difference between the flipped and traditional classes, there was a significant difference in time in the CDMNS mean scores for the flipped group. The checklist showed an increase in participation from 83% to 100% over time.

This evidence-based project supports the use of the flipped classroom pedagogy and its ability to transform nursing education over time. Students were able to apply what they learned in relevant case studies, virtual simulations, previously viewed PowerPoints, and practice NCLEX-RN-type questions. There was increased time in the classroom to foster the development of clinical reasoning skills. This DNP candidate and the faculty member were able to intervene early with students who needed clarification of course content. The faculty member noted that the students had become more actively engaged when compared to the beginning of the semester. Students became partners in their own learning. Simpson and Richards (2015) found that with the flipped classroom, students had an increased level of engagement and took ownership of learning.

Clinical decision-making increased significantly over time in the class that used the flipped pedagogy.CDMNS mean scores for students taught using the flipped pedagogy were $t = –5.2$, 95% CI: –14.1, –6.2, $p = 0.001$; in contrast, there was no significant change for the traditional group (traditional lecture method with discussion) $t = –0.93$, $p = 0.37$.

Limitations

This evidence-based practice project had limitations, including a small sample size of students followed for half of a semester. Students who received the traditional teaching method were a smaller sample size than those who received the flipped methodology. A convenience sample was used for this EBP project. Clinical decision-making was self-reported by the students. The results may have been more valid and reliable if the flipped classroom with enhanced active learning activities were used for 15 weeks instead of starting at week 8.

Recommendations and Implications

The use of the flipped pedagogy allows faculty to reconsider the learning environment. This approach addresses the various learning styles of students (Simpson & Richards, 2015). It is the responsibility of faculty to assess our students' educational outcomes. The dependence on the exclusive use of lecture alone no longer meets the needs of contemporary nursing students

(Billings & Halstead, 2016). Our students need to be prepared to make sound clinical nursing decisions in this complex health care environment. The clinical decisions they make when they practice nursing will directly impact patient outcomes.

Future studies are warranted to assess the educational outcomes of the flipped classroom. Larger sample sizes, longitudinal studies, a longer implementation period and a more rigorous design is recommended by this DNP candidate. Variables such as age, culture, and confidence level may also impact clinical decision-making and student participation

References

Baxter, P.E., and Boblin, S. (2008). Decision making by baccalaureate nursing students in the clinical setting. ***Journal of Nursing Education***, 47(8), 345-350.

Benner, P. (2012). Educating nurses: A call for radical transformation. How far have we come?

Journal of Nursing Education, 51(4), 183-184. Doi: 103928/01484834-20120402-01.

Benner, P., Sutphen, M., Day, L., Leonard, V.W. Sullivan, W. & Carnegie Scholars. (2007). The Carnegie Foundation National Nursing Education Study AACN March 18, 2007. Retrieved from www.aacn.nche.eduBenner.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). Educating nurses: A call for radical transformation. Stanford, CA: Jossey-Bass.

Bergmann, J., & Sams, A. (2012). Flip your classroom. Reach every student in every class every day. Eugene, OR: ISTE.ASCD.

Bernard, J.S. (2015). The flipped classroom: Fertile ground for nursing education research.

International Journal of Nursing Education and Scholarship, 12(1), 99-109.

Betihavas, V., Bridgman, H., Kornhaber, R, & Cross, M. (2016). The evidence for flipping out: A systematic review of the flipped classroom in nursing education. ***Nurse Educator Today***, 38, 15-21. doi: 10.10.16/j.nedt. 2015.Epub2015Dec22

Billings, D.M., & Halstead, J.A. (5th Ed.). (2016). ***Teaching in nursing: A guide for faculty***. St. Louis, MO: Saunders Elsevier.

Boctor, L. (2013). Active-learning strategies: The use of a game to reinforce learning in nursing education. A case study. ***Nurse Education in Practice***, 13, 96-100.

Bransford, J., Brown, A., & Cocking. R. (2000). ***How people learn: Brain, mind, experience, and school.*** Washington D.C: National Academies Press.

Centers for Disease Prevention and Health Promotion. (2016). Chronic disease prevention and health promotion. U.S. Department of Health & Human Services.

Cho, E., Sloane, D.M., Kim, E.Y. Kim, S., Choi, M., Yoo, Y. & Aiken, L.H. (2015). Effects of nurses, staffing, work environments, and education on patient mortality: An observational study. ***International Journal of Nursing Studies***, 87(12), 1438-1443. doi: 10.13.13189/nh.2014.020601.

Crabtree, B.F., & Miller, W.L. (1999). Using codes and code manuals: A template organizing style of interpretation. In B.F. Crabtree & W.L. Miller (Eds.)., ***Doing qualitative research*** (2nd) ed., pp.163-178). Thousand Oaks: Sage.

Critical Appraisal Sills Programme (CASP). (2013). ***Making sense of evidence***. Retrieved from www.casp-uk.net

Critz, C.M., & Knight, D. (2013). Using the flipped classroom in graduate nursing education. ***Nurse Educator***, 38(5), 210-213.

Dearholt, S. L. & Dang, D. (Eds.). (2012). John Hopkins nursing practice: ***Model and guidelines*** (2nd ed.). Indianapolis, IN: Sigma Theta Tau International.

Del Bueno, D. (2005). A crisis in critical thinking. ***Nursing Education Perspectives***, 26(5), 278-283.

Della Ratta, C.B. (2015). Flipping the classroom with team-based learning in undergraduate nursing education. ***Nurse Educator***, 40(2), 71-74.

Everly, M.C. (2013). Are students' impressions of improved learning through active learning

methods reflected by improved test scores? ***Nurse Education Today***, 33, 148-151.

Flipped Learning Network. (2014). ***The four pillars of F-L-I-P***. Retrieved from www.flippedlearning.org/definition.

Freire, P. (2010). ***Pedagogy of the oppressed*** (3rd ed.). New York, NY: Continuum.

Geist, M. J., Larimore, D., Rawiszer, H., & Al Sager, A. (2015). Flipped versus traditional instruction in a baccalaureate nursing pharmacology course. ***Nursing Education Perspectives***, 6(2), 114-115.

Harrington, S.A., Bosch, M.V., Schoofs, N., Beel-Bates, C., & Anderson, K. (2015. Quantitative outcomes for nursing students in a flipped classroom. ***Nursing Education Perspectives***, 36(3), 179-181.

Hinkle, J.L., & Cheever, K.H. (2014). Case studies. Medical Nursing. Philadelphia, PA: Wolters Kluwerb Health/Lippincott Williams & Wilkins.

Hinkle, J.L., & Cheever, K.H. (2014). Virtual Simulations. Medical Nursing. Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Hoffman, K.A., Aitken, L.M. & Duffield, C. (2009). A comparison of novice and expert nurses' cue collection during clinical decision-making: verbal protocol analysis. ***International Journal of Nursing Studies***, 46(10), 1335-1344.

Institute of Johns Hopkins Nursing. (2012). ***JHNEBP research evidence appraisal***. Retrieved from: www.nursing world.org/nursing practice.

Institute of Medicine. (2011). ***The future of nursing***: Leading change, advancing health.

Washington, DC: National Academies Press.

Jenkins, H. M. (2001). Clinical Decision Making in Nursing Scale. In Waltz, C.F. & L.S. Jenkins, (2nd Ed.) ***Measurement of Nursing Outcomes Volume 1: Measuring Nursing Performance in Practice, Education, and Research***. New York: Springer Publisher Company.

Lucero, R.J., Lake, E.T., & Aiken, L.H. (2010). Nursing care quality and adverse events in US hospitals. ***Journal of Clinical Nursing***, 19, 2185-2195. doi: 10.1111/j.1365-

Missildine, K., Fountain, R., Summers, L., & Gosselin, K. (2013). Flipping the classroom to improve student performance. ***Journal of Nursing Education***, 52(10). 597-599.

National League for Nursing. (2012). ***The scope of practice for academic educators*** (Rev. ed.). New York, NY: National League for Nursing.

Post, J.L., Deal, B., & Hermanns, M. (2015). Implementation of a flipped classroom: Nursing students' perspectives. ***Journal of Nursing Education and Practice***, 5(6), 25-30.

Pretz, J., & Folse, V. (2011). Nursing experience and preference for intuition in decision making. ***Journal of Clinical Nursing***, 20, 2878-2889.

Schwartz, T.A. (2014). Flipping the statistics classroom in nursing education. ***Journal of Nursing Education***, 53(4), 199-206.

Simpson, V. & Richards, E. (2015). Flipping the classroom to teach population health: Increasing the relevance. ***Nurse Education in Practice***, 15, 162-167.

Stubbings, L., Chaboyer, W., & McMurray. (2012). Nurses' use of situation awareness in

decision-making: An integrative review. ***Journal of Advanced Nursing***, 68(7), 1443-1453.

Tedesco-Schneck, M. (2013). Active learning as a path to critical thinking: Are competencies a roadblock. ***Nursing Education in Practice***,13, 58-60.

Thompson, C., & Stapley, S. (2011). Do educational interventions improve clinical-decision making and judgement? A systematic review. ***International Journal of Nursing Studies***, 48(7), 881-893.

Towle, A. & Breda, K. (2014). Teaching the millennial nursing student: Using a flipping the classroom model. ***Nursing and Health***, 2(3), 107-114.

U.S. Bureau of Labor Statistics. (2014). Bureau of labor statistics employment projections 2014-2024. Retrieved from https://www.bls.gov/emp/

Waltz, C.F., Jenkins, L.S., & Han, N. (2014). The use and effectiveness of active learning

methods in nursing and health professions education: A literature review. ***Nursing Education Perspectives***: 35(6), 392.

Wonder, A.H., & Otte, S.L. (2015). Active learning strategies to teach undergraduate statistics. Connecting class to practice. ***Sigma Theta Tau International***, 122, 126-127.

Yoder, S.L., & Terhorst, R. (2012). Beam me up, Scotty: Designing the future of nursing professional development. ***Journal of Continuing Education Nursing***, 43(10), 456-62. doi: 10.3928/00220124-20120904-78.

Lateral Violence: Perceptions of Psychiatric Nurses

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Lateral violence, a pattern and process of persistent, confrontational behaviors that are intentionally applied in the workplace, is a concern among nurses in the psychiatric setting. Also referred to in the literature as horizontal violence, workplace incivility, workplace aggression, harassment, and bullying; lateral violence is an expression which describes and quantifies a series of rude, disrespectful and demeaning behaviors demonstrated in the workplace by nurses towards peers and colleagues (Corney, 2008; Rainford, Wood, McMullen, and Philipsen, 2015). The presence of lateral violence among nurses in the workplace is a paradox since the nursing discipline is one of caring. The inherent nurturing qualities and associated behaviors of nursing, so essential to the care of the ill and fragile, are predisposed towards demonstrating non-assertive behaviors in the workplace thus setting the stage for lateral violence. Frustration and work-related conflicts result in low self-esteem of nurses and can be reasonably considered as the origin of lateral violence and interpersonal conflict. It is inherent for nurses to demonstrate caring behaviors in all interactions; but all too often nurses do not demonstrate caring for themselves or each other. Incidences of lateral violence among nurses are at epidemic proportions and so prevalent among nursing that at some point in every nurse's career s/he will experience its effects (Dzurec and Bromley, 2012; Dzurec, 2013; Hutchinson, 2010a, 2010b, 2013; Spence-Laschinger, Leiter, Day, Gilin, 2009; Spence-Laschinger and Frida, 2014). The purpose of this qualitative descriptive study was to describe through an anonymous, voluntary online survey, the perceptions of psychiatric nurses, a group well versed in addressing patient-oriented violence with lateral violence

Background of the Problem

Lateral violence exists among nurses as an insidious concept adversely influencing interpersonal relationships, patient safety, and clinical outcomes. Behaviors demonstrative of lateral violence are subtle covert nonverbal exchanges (Dzurec, 2012; Antoniazzi, 2011; Croft and Cash, 2012; Lee, Bernstein, Lee and Nokes, 2014) as well as overt verbal expressions.

The cycle of lateral violence within nursing is representative of a culture of incivility, insidious and covert, debasing and demeaning interactions between nurses (Cutliffe and Travale, 2013). Disrespectful behaviors including poor conflict resolution erode productivity, adversely influencing interpersonal relationships, safety, and clinical outcomes and are representative of as well as contributory to the phenomenon. Additional causal factors include work overload, inadequate staffing, time constraints, ineffective leadership style, impaired locus of control, poor group cohesion, oppression, ever-increasing patient acuity, personal and professional health risks, sleep deprivation, role ambiguity, lack of workplace and or social supports culminate in aberrant behaviors among co-workers, (ANA, 2015; APNA, 2008; CDC/NIOSH, 2015; Papa and Venella, 2013; Spence-Laschinger, Leiter, Day, Gilin, 2009; Spence-Lashinger, Leiter, Gilin-Oore, and MacKinnon, 2012; Wilson, Phelps, Diedrich, and Choi, 2011). Each factor, separately and collectively, has a role, which sustains lateral violence. Information sharing, a cornerstone of interpersonal relationships and a separate concept, is at best inadequate, and at worst, absent. The American Nursing Association (2008, 2015), American Psychiatric Nursing Association (2008) and U.S Department of Labor (2015) identify impaired staff relations, poor group cohesion, ineffective leadership, and lack of administrative and peer support as issues of concern that may lead to lateral violence. However, they do not offer recommendations or plans for resolution.

Brothers, et.al. (2010) reported over fifty percent of those nurses who experienced lateral violence, acknowledge lost work time as secondary to anxiety and stress, while more than twenty-five percent of those who described themselves as targets of lateral violence reduced their work endeavors. Loss of morale and confidence, sense of powerlessness, and low self-esteem are symptomatic and fuel for lateral violence among nurses in the workplace; its effects seen in loss of revenue associated with extensive use of benefit time, orienting and training staff to replace those who resign. For each percentage point of the nursing workforce lost to attrition, health care organizations lose an estimated three-hundred thousand to four million dollars when one considers the cost of recruitment, hiring, training, and retaining nurses (Price Waterhouse Coopers' Health Research Institute, 2007; Duffield, Roche, Homer, Buchan, and Dimitrelis, 2014). The loss of one nurse will cost the health care organization over twice the nurse's salary; the cost to train a new registered nurse is estimated at over ninety to one hundred thousand dollars per individual nurse (Antoniazzi, 2011; Lee, et.al.; 2014, Rainford, et.al. 2015), a huge expense in an era of cost containment and minimal reimbursement.

Antoniazzi (2011) approached lateral violence via Kantian ethics studying the means by which nurses communicate with each other alluding to the need for respect for oneself and peers. Using a hermeneutic qualitatitve descriptive approach, N =5, the author noted that communication and associated prosody; what was said; how it was stated; and what was not shared were signifcant. The conclusion was barriers to clear communication set forth and reinforce the foundation for lateral violence. Lack of awareness and impaired trust as evidenced poor communication affirm a workplace culture condusive to lateral violence via disrespect and incivility.

Lateral violence was explored by Stagg and Sheridan (2010) using the term workplace bullying. The authors conducted a quasi-experimental study, N = 62, among

nurses concluding that cognitive rehearsal offered a viable and proactive framework for organizations to address and prevent lateral violence. The findings noted the complexity and scope of the concept in the workplace as well as the absence of standards for identifying, measuring, and managing the problem; the latter makes recognizing and comparing programs challenging.

Van Bogaert, et.al, (2013) explored the relationship of workplace culture on burnout, workload, emotional exhaustion, decision - making skills, and depersonalization. A cross sectional study of psychiatric nurses, N = 357, was completed with the results alluding to lateral violence. The authors used the *Maslach Burnout Inventory Human Service Survey* and found the existence of burnout and depersonalization among the subjects. The results validated the perception that lateral violence is supported by a culture that promotes and nurtures the concept thus adversely affecting confidence and decision-making skills. The results indicated a civil workplace directly correlated with trust in administration and personal and professional confidence. This study was the only study to explore the experiences of lateral violence among psychiatric nurses.

Spence-Lashinger and Fida (2014) conducted a two-wave survey of nurses, N = 205, assessing lateral violence via burnout, a concept which can be the etiology of as well as the experience(s) of lateral violence. The authors noted the detrimental effects of burnout on new nurses' health and the role of health care leadership. The new nurses' perceptions of proactive and caring healthcare leadership increased self-esteem, confidence and self-care.

The validity of a workplace intervention was the intent of Spence-Lashinger, et.al. (2012) who conducted a quasi-experimental study of nurses, N = 755; Time -1 and N = 573; Time - 2. This study identified the only proactive intervention to address the experiences of lateral violence and confidence, the *Civility, Respect, and Engagement in the Workplace (CREW)* theme. Issues assessed were empowerment, co-worker incivility, and perceptions of health care administration. The authors implemented *Civility, Respect, and Engagement in the Workplace (CREW)*. The conclusion was the nurses who participated in the study reported increased empowerment, reduced perceptions of health care administration incivility and increased trust confidence in self, peers, and management. The instrument *(CREW)* offers great potential as an intervention and educational resource to promote a healthy workplace culture thereby preventing lateral violence as well as promoting nurse retention.

Ceravelo, et.al. (2012) conducted a two-part quality improvement project, N = 703 and N = 485, with the intent of creating a respectful workplace culture that reduced lateral violence via a series of workshops. The authors sought to raise awareness of lateral violence as well as improve communication skills among nurses with the goal of reducing attrition. The respondents reported peer-attributed verbal abuse as adversely influencing their morale and productivity, and increasing their risk for medical errors. Of note was the results did not vary significantly from the start of the workshops to their conclusion indicating a growing awareness of lateral violence in the workplace. The respondents who reported high self-esteem at the start of the workshops reported low self-esteem at the conclusion indicative of increased awareness of lateral violence as an issue of concern but possibility highlighting personal inadequacies surrounding confidence. Lack of confidence is an attribute of lateral violence for the recipient as well as the perpetrator. The authors concluded their results corroborated previous studies of lateral violence among nurses; nurses have to take ownership of behaviors deemed unsafe and/or inappropriate, that health care administration has to take a proactive role and raise awareness of lateral violence in their respective workplace cultures.

A qualitative study, N = 1118, using groups of twenty to twenty-four, Croft and Cash (2012) conducted a study of lateral violence expressed as bullying among psychiatric nurses. The purpose was to review the lived experiences of respondents and the role of health care administration relative to enforcing institutional conduct oriented policies. The conclusion was lateral violence identified as workplace bullying, was embedded in the workplace culture implying the associated behaviors are condoned by health care administration. Emphasis was on peer-based interpersonal skills as contributing to lateral violence but not necessarily the causative factor. The authors alluded to the nursing code of ethics (ANA, 2015; APNA, 2008) while suggesting nurses reflect on their experiences.

Hutchinson et.al. (2010a) conducted a sequential mixed study, N = 370, of lateral violence expressed as horizontal violence and workplace bullying among nurses. This was the first study to note that individual characteristics of nursing staff might not be the core-contributing factor to horizontal violence and workplace bullying. The authors focused on healthcare organization qualities that contribute to the growth of the concepts and the role of leadership; the likelihood of underreporting incidents of horizontal violence and workplace bullying on the part of the nurses as well as administration.

A qualitative analysis, N = 24, was performed as a follow-up to the previous 2010 study by Hutchinson, et.al. (2010b) looking at lateral violence through workplace bullying and horizontal violence among nurses. The intent was to explore the context of workplace bullying and is the first study to define the characteristics of workplace bullying among nurses. The study identified three forms of workplace bullying among nurses: personal attack, erosion of professional competency and reputation, and attack through work roles and tasks. All three allude to intimidation and the loss of self-esteem and confidence concluding that workplace bullying is an escalated form of interpersonal conflict.

Lateral violence as workplace aggression among nurses was explored by Farrell and Shafei (2012), N = 1495, from the perspective of patient/family on nurse as well as nurse on nurse violence. The results indicated the respondents were more concerned about peer originating and directed violence than they were of patient/family aggression. The respondents remarked they wanted and needed 'realistic training' alluding to cognitive rehearsal. Fear such as the respondents described is indicative of intimidation and avoidance.

Methods

The question of this study was: What are the perceptions of psychiatric nurses with lateral violence? To answer the question, the study used a qualitative - descriptive design. An anonymous, online survey was distributed via Survey Monkey (2014), a software program that allows the researcher to create and design an electronic assessment. Survey Monkey (2014) is a cloud-based program that provides researchers the means to develop an easily customized survey. The program includes data analysis, sample selection, if desired, bias elimination and data representation. The online survey helped identify if the sample participants have experienced lateral violence during his/her career as a psychiatric nurse. Survey Monkey (Survey Monkey, 2014) permits distribution of survey material to potential subjects and sends an online reminder to those who have not yet responded to the original invitation.

Instrument

The primary author developed the online survey, Lateral Violence among Nurses Query (LVANQ). Content validity was ascertained via soliciting the opinions of and pretesting the instrument with several registered nurses, each having over ten years of experience within inpatient psychiatric nursing, regarding the understandability of the terminology incorporated in the instrument to ensure content validity and reduce bias (Polit and Beck, 2014).

Data Collection and Analysis

The local health care workers' union was provided with postcards detailing the researcher's contact information, title of and link to the survey, and a request to participate. The union distributed postcards to the entire population of 250 member psychiatric registered nurses via standard mail, at the request of union administration, to control access to their database. Participation in the online survey was voluntary; participants could withdraw from the study at any time. Respondent anonymity was maintained by disabling the IP address and email tracking within the Survey Monkey program, prior to distribution of the survey.

The survey was made available for four weeks, an extension of the original two weeks, due to poor response. An email was also sent by the administrators of the local health care worker union to member psychiatric nurses in an effort to encourage participation. At the end of four weeks, the data was collected and analyzed using Survey Monkey's Portable Document Format (PDF) Exports (Survey Monkey, 2014) program.

The data from the online survey were analyzed using the Survey Monkey's Portable Document Format (PDF) Exports (Survey Monkey, 2014) program. The responses were categorized in themes using Rayner and Hoel's (1997) five categories of behaviors consistent with incivility, bullying, and lateral violence to establish rigor and creditability. The following are the five categories of themes (Raynor and Hoel, 1997): threat to one's professional status through belittling, humiliation, and/or accusations; threat to one's personal standing such as name-calling, insults, and/or teasing; isolation such as withholding information; overwork; and destabilization.

Results

The online survey was gender, age, education, and ethnicity neutral. A convenience sample of fifteen (N=15) respondents from a pool of 250 registered psychiatric nurses responded to the online survey. The average number of years each of the fifteen respondents has been employed as a registered nurse was 22.8 years; range of less than one year to 47 years. The average number of years each of the respondents has been employed as a psychiatric registered nurse was 16.66 years; range of less than one year to 29 years.

Five of the fifteen respondents completed the online survey in its entirety. Ten respondents submitted varying degrees of incomplete surveys where the survey queried the respondent about seeking assistance and confidence relative to decision-making skills. One respondent with less than 12 months of time working as both a registered nurse and as a psychiatric nurse did not answer any of the queries which followed length of work experience. Five of the fifteen respondents who submitted complete surveys reported reaching out to friends or ancillary health care workers for assistance with their experience (s) vs. reaching out to registered nurse peers. These same respondents reported confidence with their decision-making skills, a concept that correlated with healthy self-esteem.

The online survey questions, responses, and themes are listed as follows and are reflective of the research question; "What are the perceptions of psychiatric nurses with lateral violence?"

The results were correlated with Rayner and Hoel's (1997) five categories of behaviors consistent with lateral violence, incivility, and bullying and summarized in Table 1:

Theme 1: Threat to one's professional status through belittling, humiliation, and/or accusations. RN's 1, 2, 5, 6, 7, 8, 10, 11, 12 and 15 reported colleagues, peers, staff, administration, and coworkers as the origin of threat to their perception of competence and self-esteem.

Theme 2: Threat to one's personal standing such as name-calling, insults, and/or teasing. RN's 1, 2, 5, 6, 7, 8, 10, 11, 12, and 15 reported perceptions of intimidation adversely influencing one's self-esteem using the terms and phrases of 'harassment, violence transferred to others, being caught up in a violent episode where I am not the intended target, coworkers angrily and verbally bashing the lesser, charge nurse reprimanding another, bullying by a coworker in charge and bullying between colleagues'. Of interest were the respondents' perceptions and observations of lateral violence directed towards another vs. towards oneself as evidenced by the absence of descriptions using first-person tense.

Theme 3: Isolation such as withholding information. RN 2, 4, 13, 14, and 15 indicate themes of intimidation, control, and avoidance as noted in remarks 'being passive-aggressive with another such as giving an incomplete report' or 'I don't know' relative to the theme of isolation. RN 4 and 13 respectively had 24 and 29 years of experience as a psychiatric nurse implying loss of confidence due to experiences with lateral violence.

Theme 4: Overwork. None of the respondents' comments directly indicated a sense of being overextended or overburdened in the work setting.

Theme 5: Destabilization. The

Table 1

Summary of Results

RN number of years/ RN number of years as a Psychiatric RN	Responses: Personal definition of Lateral Violence	Responses: Reaching out for assistance/ relationship of the contact person	Concepts / Themes	Rayner and Hoel (1997) 5 Categories of Behavior Consistent with Lateral Violence
RN # 1 35/15	"Harassment by co-workers."	"Non-nurse friends."	Intimidation Avoidance	1,2
RN # 2 15/8	"When peers intimidate, control, mock one another. Lateral violence is being passive –aggressive with another coworker e.g. not giving a complete report."	*	Avoidance Intimidation	1,2,3
RN # 3 <1/<1	*	*	Avoidance	3,5
RN # 4 24/24	'Don't know."	"Nursing assistant/ staff."	Avoidance Impaired interpersonal relationships Intimidation	3,5
RN # 5 5/5	"Violence transferred to another."	*	Avoidance Intimidation	1,2,5
RN # 6 47/26	"Being caught up in a violent episode where I am not the intended target."	*	Avoidance Intimidation	1,2,5
RN # 7 24/23	"Coworkers angrily and verbally bashing the lesser making it harder for them to stay working there."	*	Avoidance Intimidation	1,2,5
RN # 8 24/23	"Charge nurse reprimanding a coworker."	*	Avoidance Intimidation	1,2,5
RN # 9 42/25	*	*	Avoidance Intimidation	3.5
RN # 10 16/3	"When get bullying by a coworker who is in charge."	"Another nurse."	Avoidance Impaired interpersonal relationships Intimidation	1,2,5
RN # 11 15/16	'Bullying between peers."	No	Avoidance Impaired interpersonal relationships Intimidation	1,2,5
RN # 12 5/5	"Violence directed towards someone by another staff usually the violence is not physical but sometimes through verbal."	No	Avoidance Impaired interpersonal relationships Intimidation	1,2,5
RN # 13 30/29	"I don't know."	*	Avoidance Intimidation	3,5
RN # 14 25/23	*	*	Avoidance Intimidation	3,5
RN # 15 25/23	"Lateral violence refers to bullying between colleagues."	*	Avoidance Intimidation	1,2,3,5

Note: Key: * survey question left unanswered.
Average # years as a Registered Nurse = 22.8 years. Range < 1 year to 47 years.
Average # years as a Psychiatric RN = 16.66 years. Range < 1 year to 29 years.

perception of confidence belies disruptions and permits the nurse to move forward. The perception of destabilization alludes to the absence of a collegial work environment and peer support, which would erode self-esteem and confidence. All are symptomatic of as well as the outcome of experiences with lateral violence.

The respondents reported their perceptions and experiences from the point of view of an observer vs. citing direct experience. None of the respondents reported proactive measures consistent with empathy and caring, a foundation of nursing, ethics, and the nursing oath.

Discussion

Lateral violence is worthy of study because of the absence of literature relative to the presence and lived experiences of the concept as perceived by psychiatric nurses. The loss of registered nurses, including psychiatric nurses, to other occupational fields and the ever-increasing expenditures by health care organizations to deal with the exodus, warranted this study. In spite of the challenges, much was learned about the presence and perception of support, decision-making skills and self-esteem as related to lateral violence among psychiatric nurses.

Data gleaned from the online survey wasanalyzed using themes from Rayner and Hoel (2007) and validated using the quantitative descriptive research criteria established by Lincoln and Guba (1994), Sandelowski (2000), and Tracy (2010). A culture of lateral violence exists within psychiatry, but it is overshadowed by the acuity of the aberrant behavior (s) seen among inpatient psychiatric patient population. Psychiatric nurses work with a variety of conduct aberrations including overt and covert expressions of violence and thus are skilled at interpreting the subtle nuances of verbal and non-verbal behaviors (Croft and Cash, 2012; Madanthil et.al. 2014; Van Bogaert, et.al. 2012). Psychiatric nurses are representative of a number of cultures and a variety of personalities, each bringing to the table a set of diverse and individually driven interpretations of how to conduct therapeutic interactions. Such variety and change can be threatening to the routine and internal structure of the inpatient psychiatric unit and by default, to the clinical staff. Power and control are central themes within inpatient psychiatric nursing as it is within lateral violence (Antoniazzi, 2011; Dzurec and Kennison, 2014; Hutchinson, 2010a, 2010b; Spence-Lashinger, et.al. 2012). Monitoring oneself, the patients and the environment is/are priorities within psychiatric nursing; the principal goal is to maintain and sustain a safe, therapeutic milieu. Psychiatric nurses are at greater risk for experiencing lateral violence when control leads to hypervigilance; uncompromising ideology and unwillingness to explore new ideas associated with change (Croft and Cash, 2012; Madanthil et.al. 2014; Van Bogaert et.al. 2012). Continuous exposure to stressors and the constant need for essential alertness to behavioral shifts indicative of increasing patient acuity will heighten anxiety thereby increasing the risk for experiencing lateral violence.

Limitations

Limitations of the study were the small sample size, the union administration controlling the nurse member mailing list and contact information, the subjective nature of the concept and the structured self-report design of the online survey. A survey is easy to ignore hence the rationale for inviting the entire population of psychiatric nurses from the union registry to participate.

Recommendations

Themes identified in this study can and should be investigated across all areas of nursing. The absence of reporting experiences with lateral violence in the first-person indicates the need to revise the survey towards querying not only an intimate and individualized experience but also validating therespondents'awareness of the concept occurring around them in the psychiatric work setting. Lincoln and Guba ((1994) recommend researchers provide sufficient descriptive data so future investigators can reach their own conclusions. Further study on lateral violence among psychiatric nurses is indicated with emphasis on structured focus groups via an online discussion board or blog to explore the dichotomous thinking and emotional distancing of this population. The ability to maintain an anonymous online profile will likely promote discussion of the subject. The respondents' reluctance to join a focus group where the foundation of the group is to share and explore solutions, validates the loss of confidence and self-esteem further substantiating the sense of intimidation associated with existence of lateral violence among psychiatric nurses.

References

American Nurses Association. (2015). Code of ethics for nurses with interpretative statements. Silver Spring, MD: Nursesbooks.org.

American Nurses Association. (2008). Position Statement: Lateral violence and bullying in the workplace. Silver Springs: Center for American Nurses.

American Psychiatric Nurses Association. (2008). Position statement: workplace violence.

Antoniazzi, C.D. (2011). Respect as experienced by registered nurses. ***Western Journal of Nursing*** Research. 33 6: 745-66.

Brothers, D., Condon, E., Cross, B., Lewis, E. (2010 – 2011). Taming the beast of lateral violence among nurses. Virginia Nurses Today. 18 (4): 7-11. Retrieved from http://www.virginianurses.com12/03/2013.

Centers for Disease Control and Prevention/ NIOSH. (2015). Violence: Occupational hazards in hospitals (No. 2002-101): ***CDC: National Institute for Occupational Safety and Health***.

Ceravalo, D.J., Schwartz, D.G., Foltz-Ramos, K.M. and Castner, J. (2012). Strengthening communication to overcome lateral violence. ***Journal of Nursing Management***. 20: 599-606.

Corney, B. (2008). Aggression in the workplace: A study of Heideggerian hermeneutic phenomenology. ***Journal of Health Organization and Management***, 22 (2): 164-77.

Croft, R.K. and Cash, P.A. (2012). Deconstructing contributing factors to bullying and lateral violence in nursing using a postcolonial feminist lens. ***Contemporary Nurse***. 42 (2): 226-42.

Cutliffe, J. R. and Travale, R. (2013). Respect in mental health: Reconciling the rhetorical hyperbole with the practical reality. ***Nursing Ethics.*** 20 (3):273-84.

Duffield, C.M., Roche, M.A., Homer, C., Buchan, J., and Dimitrelis, S. (2014). A comparative review of nurse turnover rates and costs across countries. ***Journal of Advanced Nursing***. 70 (12): 2703-12.

Dzurec, L and Bromley, G. (2012). Speaking of workplace bullying. ***Journal of Professional Nursing.*** 28 (4): 247-54.

Dzurec, (2013). Status limbo: Analysis of nurse faculty member reports of administrator. Response to workplace bullying complaints. ***Journal of Professional Nursing*** 29:e1 e9.

Farrell, G. and Shafei, T. (2012). Workplace aggression, including bullying in nursing andmidwifery: a descriptive survey (the SWAB study). ***International Journal of Nursing Studies***. 49: 1423-31.

Hutchinson, M., Wilkes, L., Jackson, D., and Vickers, M.H. (2010). Integrating individual, work group and organizational factors: Testing a multidimensional model of bullying in the nursing workplace. ***Journal of Nursing Management***. 18: 173-81.

Hutchinson, M., Vickers, M.H., Wilkes, L., and Jackson, D. (2010). A typology of bullying behaviours: The experience of Australian nurses. ***Journal of Clinical Nursing***. 19: 2319-28.

Hutchinson, M. (2013). Bullying as workgroup manipulation; a model for understanding patterns victimization and contagion

within the workgroup. Doi:10.1111/j.1365-2834.2012.01390.x

Lee, Y.J., Bernstein, K., Lee, M., and Nokes, K.M. (2014). Bullying in the nursing workplace: Applying evidence using a conceptual framework. ***Nursing Economics***. 32 (5): 255-57.

Lincoln, Y. and Guba, E.G. (1994). Competing paradigms in Qualitative Research. In Denzin, N.K and Lincoln, Y.S. (Ed.). 105-117. ***Handbook of Qualitative Research.*** (Thousand Oaks, CA, USA: Sage Publications.

Madanthil, R., Heck, N.C., Schuldberg, D. (2014). Burnout in psychiatric nursing: Examining the interplay of autonomy, leadership style, and depressive symptoms. ***Archives of Psychiatric Nursing.*** 28: 160-66.

Papa, A.M. and Venella, J. (2013). Workplace violence in healthcare: Strategies for Advocacy. ***The Online Journal of Issues in Nursing.*** 18 (1). Retrieved on 03/12/2016 from http://www.nursing world.org/.

Polit, D. F. and Beck, C.T. (2014). Qualitative Research. ***In Essentials of Nursing Research: Appraising the Evidence for Nursing Practice. Part Four***. 8th Ed. New York. USA: Wolters, Kluver, Health. Lippincott, Williams and Wilkins.

Price Waterhouse Coopers' Health Research Institute. (2007). What works: Healing the health care staffing shortage. Retrieved from http://www.wiche.edu/info/agendaBook/nov07/presentations/Carparelli.pdf. on 3/14/2016.

Rainford, W.C., Wood, S., McMullen, P.C., and Philipsen, N.D. (2015). The disruptive force of lateral violence in the health care setting. ***The Journal for Nurse Practitioners***. 11 (2): 157-164.

Rayner, C. and Hoel, H. (1997). A summary review of literature relating to workplace bullying. ***Journal of Community and Applied Social Psychology***. 7: 181-91.

Spence-Laschinger, H.K., Leiter, M., Day, A., Gilin, D. (2009). Workplace empowerment, incivility, and burnout: impact on staff nurse recruitment and retention outcomes. ***Journal of Nursing Management***. 17: 302-11.

Spence-Lashinger, H.K., Leiter, M.P, Day, A., Gilin-Oore, D., MacKinnon, S.P. (2012). Building empowering work environments that foster civility and organizational trust. ***Nursing Research.*** 61 (5): 316-25.

Spence-Lashinger, H.K. and Fida, R. (2014). New nurses' burnout and workplace wellbeing: The influence of authentic leadership and psychological capital. ***Burnout Research***. 1: 19-28.

Stagg, S.J. and Sheridan D. (2010). Effectiveness of bullying and violence prevention programs: A systematic review. ***American Association of Occupational Health Nurses.*** 58 (10): 419-24.

Survey Monkey. (2014, September 22). Survey Monkey: Free online survey software and questionnaire tool. Retrieved from Survey Monkey: ***https://www.surveymonkey.com***

U.S. Department of Labor, Occupational Safety and Health Administration. (2015). ***Guidelines for preventing workplace violence for healthcare and social service workers*** (OSHA publication No. 3148-04R).

Van Bogaert, P., Clarke, S., Wouters, K., Franck, E., Willems, R., and Mondelaers, M. (2012). Impacts of unit-level nurse practice environment, workload and burnout on nurse – reported outcomes in psychiatric hospitals: A multilevel modelling approach. ***International Journal of Nursing Studies***. 50: 357-65.

Wilson, B.L., Diedrich, A., Phelps, C.L., and Choi, A. (2011). Bullies at work: The impact of horizontal hostility in the hospital setting and intent to leave. ***Journal of Nursing Administration***. 41. (11): 453-58.

(continued from page 21)

(2016, January-March). African Americans' perceptions of adherence to medications and lifestyle changes prescribed to treat hypertension. ***Sage Open***, 6(1), 1-12. http://dx.doi.org/10.1177/2158244015623595

Piette, J. D., Heisler, M., Krein, S., & Kerr, E. A. (2005). The role patientpPhysician trust in moderating medication non-adherence due to cost pressures. ***Archives of Internal Medicine,*** 165(15), 1749-1755. Retrieved from http://archinte.ama-assn.org/cgi/reprint/165/15/1749.pdf

Qureshi, N. N., Hatcher, J., Chaturvedi, N., & Jafar, T. H. (2007, November 17). Effect of general practitioner education on adherence to antihypertensive drugs: Cluster randomised controlled trial. ***British Medical Journal,*** 335(7628), 1030-1033. doi: 10.1136/bmj.39360.617986.AE

Rocque, R., & Leanza, Y. (2015, October 6). A systematic review of patients' experiences in communicating with primary care physicians: Intercultural encounters and a balance between vulnerability and integrity. ***PLoS ONE***, 10(10), 1-31. http://dx.doi.org/10.1371/journal.pone.0139577

Rosamond, W., Flegel, K., Friday, G., Furie, K., Go, A., Greenlund, K...., & Hong, Y. (2007). Heart disease and stroke statistics - 2007 update: A report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. ***Circulation***, 115, e69-e171. doi: 10.1161/CIRCULATIONAHA.106.179918

Schinkle, S., Schouten, B. C., Street, Jr., R. L., Van den Putte, B., & Van Weert, J. C. (2016). Enhancing health communication outcomes among ethnic minority patients: The effects of the match between participation preferences and perceptions and doctor–patient concordance. ***Journal of Health Communication*** , 12(12), 1251-1259. http://dx.doi.org/10.1080/10810730.2016.1240269

Schoenthaler, A., Chaplin, W. F., Allegrante, J. P., Fernandez, S., Diaz-Gloster, M., Tobin, J. N., & Ogedegbe, G. (2009, May). Provider communication effects medication adherence in hypertensive African Americans. ***Patient Education Counseling,*** 75(2), 185-191. doi: 10.1016/j.pec.2008.09.018

Schoenthaler, A., Montague, E., Manwell, L. B., Brown, R., Schwartz, M. D., & Linzer, M. (2014). Patient–physician racial/ethnic concordance and blood pressure control: the role of trust and medication adherence. ***Ethnicity & Health,*** 19(5), 565-578. http://dx.doi.org/10.1080/13557858.2013.857764

Vrijens, B., Antoniou, S., Burnier, M., De la Sierra, A., & Volpe, M. (2017, March). Current situation of medicationadherence in hypertension. ***Frontiers in Pharmacology***, 8(100), 1-8. http://dx.doi.org/10.3389/fphar.2017.00100

Webb, M. S., & Gonzalez, L. O. (2006). The burden of hypertension: Mental representation of African American women. ***Issues in Mental Health Nursing***, 27(3), 249-271. doi: 10.1080/01612840500502742

Wilson, R. P., Freeman, A., Kazda, M. J., Andrews, T. C., Barry, L., Vaeth, P. A., & Victo, R. G. (2002, January). Lay beliefs about high blood pressure in a low- to middle-income urban African-American community: An opportunity for improving hypertension control. ***The American Journal of Medicine,*** 112(1), 26-30. Retrieved from http://www.amjmed.com/article/S0002-9343(01)01049-X/abstract

World Health Organization. (2003). ***Adherence to long-term therapies***: Evidence for action. Retrieved from http://whqlibdoc.who.int/publications/2003/9241545992.pdf

Yoon, S. S., Fryar, C. D., & Carroll, M. D. (2015). Hypertension prevalence and control among adults: United States, 2011-2014. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db220.pdf

Zullig, L. L., Granger, B. B., & Bosworth, H. B. (2016, July 7). A renewed Medication Adherence Alliance call to action: Harnessing momentum to address medication nonadherence in the United States. ***Patient Preference and Adherence***, 10, 1189-1195. http://dx.doi.org/10.2147/PPA.S100844

Zullig, L. L., Shaw, R. J., Shah, B. R., Peterson, E. D., Lindquist, J. H., Crowley, M. J., ... Bosworth, H. B. (2015). Patient–provider communication, self-reported medication adherence, and race in a postmyocardial infarction population. ***Patient Preference and Adherence,*** 9(), 311-318. http://dx.doi.org/10.2147/PPA.S75393

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