Becoming a Specialist Nurse in Psychiatric Mental Health Care

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Abstract

Background

Specialist nurse students are upon graduation certified to have increased their professional competence to an advanced level. But how do specialist nurse students themselves experience and understand their professional competence and its development upon graduation? This is what this study aims at describing.

Method

This study has a phenomenographic approach. Data consists of student written narratives.

Results

The participants understood their professional competence developed in various degrees as a transformation in me and a transition in my encounter with the patient. Being able to integrate theory in practice was crucial for this competence to develop.

Conclusion

The specialist programme needs to support students in developing an alliance with the patient and promote patients' self-management, self-efficacy and promote students' possibility to integrate theoretical knowledge into practice. The result becomes an important input in the formulation of the assessment criteria for professional competence.

Keywords: Assessment, Specialist nursing students, Phenomenography, Education

1. Introduction

Specialist nurse students in the mental health care programme are upon graduation expected to have increased their professional competence within their specialist field to an advanced level. These students are, in different ways, supported throughout the programme to reach and fulfill the qualifications required for a specialist nurse in mental health care set in the "Qualifications ordinance for Higher Education "(1993:100). The faculty in the programme are throughout the programme assessing students' knowledge, skills and professional attitude in relation to the learning outcomes intended. Upon graduation the higher education institution certifies that students have reached the qualifications stipulated. However, we do not know how students themselves understand and assess their specialist competence or if they really have reached the required level of competence upon graduation of the two-year specialist nurse programme. This article adds knowledge about the specialist nurse students own understanding of their professional development during the specialist nurse programme in mental health nursing as it explores their own assessment of their professional competence.

2. Theoretical Framework

In this study competence is associated with and considered to be a result of learning. Competence is the body of knowledge, skills and attitude when these are intertwined and makes performance skillful (Driessen, Overeem & van Tartwijk, 2011). Competence is described by Dornan, Mann, Scherpbier and Spencer (2011) as having the ability to handle a complex professional task. It encompasses a holistic dimension and the desired outcome of learning, in a

way that makes knowledge useful (Illeris, 2006). Professional competence understood in this way is thus about how to learn and selecting what to learn (Mann, 2011). Learning closely interlinked with competence can be seen as having occurred when the learner has changed his or her way of seeing or understanding something (Biggs & Tang, 2011; Marton & Booth, 1997). For instance, when there is a need to adjust, modify or reconstruct practitioners' knowledge due to the immense production of knowledge that takes place in all fields (Scanlon, 2011). In healthcare professional competence has been defined by Epstein and Hundert (2002) as a common, sound judgment and a skillful way to communicate. It presupposes knowledge in the field (Epstein & Hundert, 2002; Holm, 2003, 2009), moral development (Epstein & Hundert, 2002; Holm 2003, 2009), empathy and affective sensitivity (Holm, 2003, 2009; Levett-Jones et al, 2010) practical skills, and ability of clinical reasoning (Epstein & Hundert, 2002; Levett-Jones et al, 2010; Tanner, 2006). All health care professionals should comprise a competence to work in interprofessional teams (Barr, Koppel, Reeves, Hammerick & Freeth, 2005; Wilhelmsson et al, 2012). Levett-Jones et al (2010) also emphasize the professionals' ability of, and competence in, complex thinking and reflection from a meta-cognitive perspective. Competence can also be viewed as a desired outcome in education, something that can be assessed and evaluated. For instance, in Sweden one competence requirement for a specialist nurse in mental health is to adopt a holistic perspective and as a result, see the whole patient. As a specialist nurse you should see the person behind the disease and be able to understand the patient's life situation as well as the next of kin's situation. The mental health nurse should also have the capacity to alleviate the psychiatric pain the patient expresses and support the patient to overcome this pain. Furthermore, the specialist nurse shall promote health and interact with the team around the patient and based on its expertise lead, guide and educate colleagues and other health care staff. In addition to this mental health nurses are to evaluate their professional competence in a critical way and continue to improve as well as develop their personal and professional competence (The Higher Education Ordinance Swedish Code of Statutes 1993:100 Annex 2 Qualifications ordinance).

No study, to our knowledge, have focused on how the specialist nurse students in the mental health care programme conceptualize this competence requirement upon graduation. To improve the quality of the specialist nurse programme in mental health care and thereby also improve the quality of the nursing care provided by the specialist nurses in psychiatric mental health we need this knowledge. With this knowledge we will be able to understand and better support students learning which ultimately will benefit the patient, the specialist nurse and the rest of the health care team.

3. Method

3.1 Research Design and Approach

This study had a qualitative, phenomenographic approach, since the main interest was to understand the individual rather than aiming at generalizations (Cohen, Manion & Morrison, 2011; Guba, 1981). A phenomenographic approach focus to describe *how* the participants experience a phenomenon (Larsson, 1986) compare and interpret these experiences (Dahlgren & Fallsberg, 1991; Marton & Boot, 1997). By applying this approach focus was to find what was meaning making for the individual participant and also about finding not only differences and variations but similarities in the phenomena found (Marton & Boot, 1997; Sjöström & Dahlberg, 2002; Åkerlind, 2007). Data in this study consists of student written narratives.

3.2 Setting, Participants and Data Collection

All students (N 23) in the last course in a specialist nurse programme in mental health care at a university in Sweden were invited to participate. The programme is given on halftime pace over two years and as a distance learning programme. Of invited students, 18 accepted participations in this study. They were asked to write a narrative as a part of a learning activity and examination at the end of the 4th and last semester in the specialist programme. In this examination paper the students were asked to, in writing, describe and reflect upon a recently experienced nursing situation that occurred in a psychiatric context. They were asked to put forth their feeling, thought and action in this situation. They were also asked to compare this situation with a similar learning activity made in the first semester in the specialist programme and assess strengths and further learning needs in the narrative. Of the 18 participants that took part in the study there was one man and 17 women between 30 and 56 years of age. The range of time as RN before starting the specialist education was 6 months to 16 years. All participants were working as general nurses in the psychiatric health care field simultaneously as they attend the specialist programme.

3.3 Ethical Considerations

Permission to conduct this study was obtained by director of the specialist nurse programme and written consent was obtained from each of the students who took part in this study. The participants were informed about the purpose of

this project and were given assurances that conditions of confidentiality would not be violated. They were also given information how collected data were to be used and presented. Since the participants in this study were students in a programme where the first author is one of the teachers, special emphasis was put on making it clear to students that a decision to participate or not to participate in this study would not influence the teachers' assessments of other courses in the program. It was also made clear that the first author would not take part in the students' grading in the programme.

3.4 Data Analysis

The analysis was based on a seven step analysis process described by Dahlgren and Fallsberg (1991). The analysis started with *familiarization*, reading through the data set, the 18 narratives, several times to get a grip of the content and the phenomena. Then *condensation* of data followed. The most significant and relevant phenomena for the aim and research questions in this project were identified and marked. The marking was done in a way that kept the meaning of the phenomena, statement, in its context. In the third step statements were *compared* to identify similarities and differences. Furthermore, patterns were searched for among the statements. Which meant to go back to the data set and confirm the individuals' statements. In the fourth step *grouping* of similar statements was made. The first four steps in the analysis were done by the first author (US). The fifth step, *articulation,* aimed to catch the essence of the similarities within each group. This was done by (US, JM). The sixth step in the process was to *label* the categories, which again required going back and forth between step four and six. The labeling process also required several discussions between all authors (US, CB, JM). The analysis and interpretation discerned the categories *Transformation in me* and *Transition in my encounter with the patient.* Within the categories hierarchies were discerned in the seventh and last step *contrasting,* where the categories obtained were compared with regard to similarities and differences concerning the levels of understanding expressed by the informants at a meta level. The categories were hierarchically ordered starting from the best understanding. This "negotiating consensus" is a process performed in the phenomenographic approach to replace an interjudge reliability test. The fact that hierarchies have been discerned is not indicating or to be understood as if some participants' understandings are better or more appropriate than others (Sandberg, 1997) but rather that the phenomena is perceived and/or expressed by the participants in different ways.

3.5 Trustworthiness

The confirmability aspect in a study's trustworthiness is about ensuring that the result truly is based on the data from informants and not on preferences of the researcher (Shenton, 2004). In this study we provide the reader with quotes to strengthen the confirmability. This can be reinforced by letting an independent researcher make a second analysis of the data set and compare the two results (Larsson, 1986). No second analysis has been made on the data material in this study, but there has been a continuously ongoing discussion and cooperation with the supervisors throughout the analysis process. Data consists of the participants own written texts, which strengthens the credibility in this study (Guba, 1981). Dependability focuses on the stability of data, about making the research process as transparent as possible and declare if any changes have been done during the study (Guba, 1981). The data collection in this project was not subject to any changes since all data was collected at one instance. By providing a description within which context this study took place together with clarity of the central assumptions in this study we hope to facilitate the reader's assessment whether results are transferable or not.

4. Results

The analysis and interpretation of the outcome space in this study reveals that what the specialist nurse students express as their professional development during the specialist nurse programme in mental health nursing can be grouped into two discerned categories: *transformation in me* and *transition in my encounter with the patient.* Moreover, it trifurcates each category into levels A, B, C. Level A represents the lowest level of understanding, B a more comprehensive understanding and C the most elaborated and most comprehensive understanding of the phenomena in each category.

4.1 Transformation in me

In this category the development of the professional competence perceived by the participants can be interpreted as an increase in emotional, cognitive and meta-cognitive competences that gives its expression in the specialist's professional encounter. The least elaborated understanding of the *transformation in me* (label A) participants perceives a change in their self-confidence and self-awareness and is expressed as trusting their knowledge and skills. The participants experience a change in their competence in the way that they feel more capable of handling new,

difficult and threatening situations due to theoretical knowledge and clinical experience. The self-confidence and self-awareness is also about being aware of one's own knowledge and trusting that knowledge.

I think I feel more secure in myself and through knowledge I feel safer. This applies not only to the patient encounter that I described, but in many other situations that previously was stressful for me. I am calmer now and try to use the knowledge I gained during the programme and experience I gained in my profession during the same time period and I feel confident in my profession (informant F).

Knowing that there will always be more to learn is expressed as a reassurance that no one knows everything and that this should not be seen as a shortcoming or failure but rather as comforting and a possibility. The need to continue the learning process after the specialist programme is now perceived as a driving force and as a positive and welcome challenge in the daily work. The increased self-confidence is experienced by participants as being able to and dare to give voice and argue for their own standpoint and opinion. They dare to discuss, question and challenge decisions made by the health care team when decisions, from the participant's view, seem to go against what's beneficial for the patient. Theoretical knowledge as knowing the physiological reason behind patients' behavior contributed to a complete change in thought and feelings towards patients due to an understanding of the cause and now having the tools to support and being able to help these patients. Moreover, the programme together with clinical practice and being able to directly integrate new theoretical knowledge in practice is perceived as having contributed to a major change.

With more knowledge, I feel safe and secure in my encounters and handle situations better now. I see that a positive transition has taken place in me as a nurse. The education, knowledge and experience provide security and confident in me. I have realized that it is impossible to know everything. In all the courses, I have applied the new knowledge in my work. Have more knowledge about diseases, symptoms and treatment. Know what is relevant in the situation to communicate with the patient. I learn something new every day (informant O).

The more elaborated understanding (label B) gives, besides what is included in level A, expression of the professional competence development as an ability of self-regulation. On this level the participants express an increased awareness about him- or herself and the ability to cope with their own feelings that occur in patient encounters. The change is in the behavior, particularly when coping with difficult and threatening situations. The change is experienced as being able to keep a distance and not to get too affected by the patient's behavior and doing this without being less emphatic, not to be provoked by the patient and show feelings like anger, powerlessness, and frustration, although this may be what the nurse feels.

I feel confident in the role. I have a different approach in difficult and uncomfortable situations. I can remain calm and be in control in threatening situations due to the knowledge I have gained (informant N).

The most elaborated level C in this category, *Transformation in me*, encompasses participants understanding of their professional development as being able to wait in many different situations. This waiting or awaiting allows the practitioner to think and reflect and is expressed as utilizing time in a different way. An inner reasoning is experienced and expressed, not acting too hasty but rather having the courage to wait and daring to be in the encounter without immediately taking action.

I was always in a hurry before and wanted to see immediate results, on that point I have changed and I do things more calmly now. Nursing care cannot be rushed. (Informant G).

The development of competence on this level is perceived as being more cautious, thoughtful and awaiting, for example before making a decision and taking action. The action or decision can be upon once own, patients' or colleagues' behavior or request.

I think more and am more prudent now and do reflect in the heat of the moment but especially after the encounter. I am also critical of my own actions but trust my knowledge and competence. I think critically and challenge existing methods (Informant R).

The competence is moreover understood as it is better to think over the purpose of an action before doing something. They were more inclined to quickly solve problems before the programme. This has now changed and developed into a long term problem solving attitude. Problems are also more often discussed with colleagues and the rest of the team and in counseling groups. Common assumptions are being challenged and an increased awareness of prejudices and using this in widening the perspectives and reach new understandings are included in the change.

I had previously, before the program, views about addicts that I have completely changed during the programme due to knowledge. I have now completely different thoughts and feelings. My attitude has also changed and I am no

longer frustrated in the meeting with addicts' when I know I can do something meaningful for these patients'. The program has made me confident in the specialist role. I feel as I am working as a specialist – I am working in a conscious way and think in a more critical way now (informant M).

4.2 Transition in My Encounter with the Patient

In this category the participants change is due to increased knowledge, skills, theories and new methods and how these are implemented in different ways to secure the patients safety and provide care with high quality. On level the change experienced by the participants concerns what they do and how, within the professional responsibility, to provide safe and high-quality patient care. On this level these tasks or interventions are expressed in a way that indicates the nurse as being active and the patient as passively receiving care. It is about the specialists' responsibility in making the environment safe for the patient and making interventions to protect the patient, supporting patients in vulnerable situations and alleviating patient suffering. It is furthermore about reducing coercive interventions and avoiding violence through/by prevention and violence management.

As a specialist nurse I can choose a health promoting approach rather than using coercion (informant C).

The experience is also about the ability and the courage to be more flexible and deviate from routines in order to protect a patient. And in some situations not to leave the decision to the patient in terms of basic needs when the patient's choice may lead to a deteriorated health situation. The quality of assessments has improved due to participants' changed approach and awareness in making more holistic and multifaceted assessments.

What is additionally included in the change on level B is the participants' experience of using theories as a natural part in the patient encounter and making more nuanced assessments and identifying patients' individual needs by using theories.

I now make more nuanced and multifaceted assessments of the patient. And I am interested in and my focus is on the patient instead of as before in the disease. This is due to the life-world perspective (informant K).

The use of theories about learning in psycho-pedagogical interventions, increased psychiatric knowledge is integrated into practice such that the environment is adjusted to fit the individual patient's health situation is also highlighted. Other theories mentioned as causing a change in patient encounters is knowledge about and use of a Trans theoretical Model.

Level C includes the experience to bond with the patient, making the patient an active partner in the encounter and in his/her own care. To cooperate with the patient and create an environment where both parties reciprocally listen to each other is part of this. The interdependence in the patient-nurse relation is put forth, together with the importance of having a relation that is characterized by trust between patient and nurse.

I feel that I am working as a specialist nurse due to knowledge, experience and being conscious and for example in making the patient involved in his/her own care. As an example I and the patient cooperate in deciding and planning nursing interventions (informant M).

4.3 Contrasting Analysis of the Outcome Space

In the category *transformation in me* participants give expression to a perceived development and an understanding about their own professional development in terms of a more internal, cognitive change on both a professional and personal level. It is about how they use this competence and see themselves as an instrument, one of the tools, to succeed in the professional encounter and not only in the encounter with the patient. The category *transition in my encounter with the patient* represents the participants experience and thoughts about their competence development in terms of what they now do differently in the patient encounter. In this category focus is on methods, nursing theories and ethical aspects that are tools or instruments used in the patient encounter. The change can be seen as signs as the participants have become more autonomous in their profession. The specialist nurse competence is in both categories perceived as having its origin in knowledge and clinical experience and by integration of new knowledge into encounters in the clinical praxis. On the third level in both categories there is openness from the specialist nurse for cooperation, mutuality and reciprocity.

5. Discussion

All research has limitations, one could argue that the sample is small and carried out at one university in Sweden. However, this study has a phenomenographic design which means that the variations in understandings are sought for. Also the data, the narratives, upon which the analysis and interpretation is conducted is the participants own thoughts and understanding. How something appears to them is not to be judge as true or false. The participants reflect the common student population at the University.

The result of the analysis and interpretation of the data set discerns that the participants experience a change in their competence. This is expected, as they are about to graduate from a specialist programme. The participants perceive the change in their competence as a combination of increased theoretical knowledge and skills and how these knowledge forms are being used and integrated in the participant's practice, sometimes also combined with reflection. The two-year specialist programme has contributed to a feeling of confidence**.** They dare to different degrees: remain in threatening situations, trust their knowledge and skills, show and tell when they do not know, admit that there will be more to learn and new knowledge to acquire, not act hastily but wait and be prudent, deviate from routines, face new situations without fear, challenge own prejudice and challenge decisions made by the health care team and argue their own standpoint. This courage can decrease or alleviate patient suffering as the specialist has an inner strength and a wider collection of methods when choosing nursing intervention. Particularly worrisome is that some participants only reach A-level in the categories and bonding and establishing an alliance with the patient was found only on the highest level in the category *transition in my encounter with the patient*. This needs to be considered in the specialist programme, especially as there is a call among the specialist nurses in mental health care to have a more distinct approach and focus on the patients' self-management (Farchaus Stein, 2014), support patients' recovery (Adams, 2015; Gaffey, Evans & Walsh, 2016), persons' wellness, early intervention and prevention (Adams, 2015).

Transformative learning is seen among the participants. Clear examples are those who experienced changes in the way they approach a certain group of patients or patients in special situations and also challenged their own preconceptions, as transformative learning is essentially a metacognitive process of *reassessing reasons* supporting our problematic meaning perspectives" (Merzirow, 2009 p 96).

One essential aspect put forth by the participants that enable the change is the possibility to try out and integrate newly constructed knowledge and skills in practice. By being able to integrate theory and practice, a so called vertical integration (Dahle et al, 2002), seems to have had a major impact on the students' learning and development of professional competence. The participants stress the necessity to continue their learning process and their professional development. This is very much in tune with Scanlon (2011) who point out that becoming a professional is a changing phenomenon never completely realized but always in the process of becoming, due to the great knowledge production in all fields. The professionals' CPD is an issue for the individual practitioner, the professional association, employers to promote and statutory organisations to control.

The difficulty of assessing students' professional competence and personal development is well known (Kane, 1992; Rees & Knight, 2007; Van der Vleuten, 1996). Assessment criteria need to be specified and clear both to students and teachers to support students in achieving goals of the curricula (Harden, Crosby & Davis, 1999; Ramsden, 2003). Through this study we can refine the assessment criteria of students' professional competence. More specifically, it is the levels A, B, C of the two categories (*transformation in me* and *transformation in my encounter with the patient*) that is to be an input, used for this purpose.

6. Conclusion and Implications

This study adds the participants' own understanding of their professional competence as an important input in the formulation of the assessment criteria for professional competence. Much of the professional competence the participants experience and give voice for upon graduation corresponds to the intended outcomes in the specialist programme. But looking at the levels discerned in the categories and the fact that some participants only reach the lowest level cannot be considered satisfactory and enough to graduate as a specialist in this field.

What the programme needs to consider is to have a more distinct focus on the cooperation and interdependence between nurse and patient to improve quality of nursing care, safeguarding students' possibility to integrate theory into practice and use the participants' own understanding of their professional competence in this study as an important input in the formulation of assessment criteria for professional competence.

We should though remember that this study has a phenomenographic design and the data set, the narratives, upon which analysis and interpretation is made are the participants' thoughts, understandings and assessments, how something appears to them. It should be regarded as such and not to be judged as true or false (Baker, 1997; Johansson, 2009; Larsson, 1986).

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Conflict of interest

The authors declare that there is no conflict of interest.

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