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NAVIGATING THE RULES OF CLINICAL PRACTICUM WORK:
AN INTERPRETIVE STUDY OF THE EXPERIENCES OF ASSOCIATE DEGREE
NURSING STUDENTS

by

Leonie L. Sutherland

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy in Nursing

University of San Diego

January 31, 2006

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NURSING STUDENTS

Abstract

Leonie L. Sutherland, RN, MSN

Responding to changes in technology, economics, and the demographics of society, nurse leaders incorporate new ideas and systems into clinical practice. Nurse educators are challenged to adopt these ideas and systems and make them part of the nursing curriculum. Educators develop tools and strategies to help students gain knowledge and skills to work with patients in the clinical setting. The ways in which students use these tools and perceive and manage their clinical work is not understood. The dearth of research related to what students actually do in clinical practicum settings provided the backdrop for this study.

This is a grounded theory of how student nurses through a second semester clinical practicum. Ethnographic methods of observation and interviews were used to collect data with four groups of student nurses. The analysis shows that embedded within the educational requirements of the clinical practicum are a set of rules guiding the work of student nurses.

The central perspective, how students navigate the rules of their clinical practicum work, describes a set of strategies that students employ to complete the clinical practicum. "Rules" and "work" emerged as the most salient dimensions in this study with students following the explicit and implicit rules to complete the work expectations of faculty, nursing staff and patients. The analysis further shows that a hierarchy of work

existed wherein faculty work and expectations influenced the ways in which student approached staff and patient work. At times the rules were not sufficient to manage contingencies that arose in the context of the clinical practicum and student nurses created new rules or modified the rules. Consequently, students came to view patients as objects to forward the educational requirement of the practicum and experienced tension and conflict in translating classroom learning to the care of patients on the actual clinical unit.

Nurse educators are challenged to prepare nursing graduates who are flexible, have the necessary skills for problem solving, and have the ability to advocate for patients. The results of this study help inform nurse educators about how students prioritize their learning activities in the clinical setting.

DEDICATION

This dissertation is dedicated to John and Loekie Blans, my parents, both of whom passed away during the final two years of my doctoral education. My dad always wanted to have a daughter who was a doctor, he now does. My mother always cheerfully supported me, even agreeing to read excerpts of my work. As she read she would ask me, “Did you really write this?” After I responded in the affirmative she would say, “Nou, ik snap er geen bal van”. The Dutch way of saying, “It looks like Greek to me”. An immigrant’s life can be difficult, especially the attempt to gain higher education. As immigrants to this country, we, as a family, never dreamed this achievement could be possible. But in the United States

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I would like to thank Paul Sutherland, my husband, for his love, patience and support throughout my doctoral education. He stood by me during the high and low points of this endeavor and never failed to doubt my abilities. This accomplishment is in part due to his steadfastness and unwavering conviction that success would be achieved. I would also like to thank my daughter Denise Brail for her belief in me and her not-stop encouragement of, "You can do it mom". My sisters, Kristine, Julie, and Phyllis, always lent a sympathetic ear as I tried to explain the complexities of grounded theory research. For my family I am ever so grateful.

I owe a debt of gratitude to Dr. Mary Rose Mueller for her continuous guidance and critique of my work. She unfailingly drew out the best from me, setting high standards and ensuring that the final product could uphold under scrutiny. Her firm yet gentle demeanor helped me to explore ideas and stretch my thinking to achieve new inspirations and ways of viewing the data. Dr. Anastasia Fisher, the second member of my committee, provided the creative support and the expertise for grounded theory. She guided me down the grounded theory highway and brought me to a better understanding of this research methodology. The third member of my committee, Dr. Susan Instone, was instrumental in asking the probing questions about the data analysis. Her keen thinking brought new perspectives to the analysis. This committee guided me through a difficult journey and I am indebted to them for their time, energy, and commitment to my endeavor.

Finally, I want to thank the faculty and students who so graciously allowed me to into their world of clinical nursing education. Their openness and willingness to share

their personal thoughts and experiences made this research possible. I was with them day after day and they continued to welcome me, answered my probing questions, and let me observe their daily activities. As a researcher I was so fortunate to have a group of professionals willing to support my efforts. I will fondly remember the field experiences as a time of exciting new discovery. My hope is that each of the students achieves their professional goals as they are now active members of the nursing profession.

TABLE OF CONTENTS

DEDICATION		ii
ACKNOWLEDGEMENT		iii
TABLE OF CONTENTS		v
LIST OF TABLES		ix
LIST OF FIGURES		x
 CHAPTER		
1. PHENOMENON OF INTEREST		1
Purpose of the Study		4
Significance of the Study		5
Work in Sociological Terms		5
Studies of Work in Nursing		7
Dirty work		8
Body work		9
Invisible work		10
Work of student nurses		11
The Interpretive Methodological Tradition and This Study		14
Summary		17
 2. REVIEW OF THE CARE PLANNING LITERATURE		 21
History of the Nursing Care Plan		22
Late 19 th and early twentieth century		22
Early 20 th century training schools		23
The National League for Nursing Education		24
The case and care study		25
The first plan of care		27
The post-war era		28
Development of the Nursing Process		30
Nursing care plans, nursing process in clinical practice		31
Nursing care plans, nursing process in academia		33
Linking Care Plans to Credentialing		35
How Students are Taught Care Planning		37
The Relationship of Care Planning to the Development of Nursing ..		39
Summary		40
 3. STUDY DESIGN, FIELD SITE, IRB, PARTICIPANTS, AND RESEARCH METHODS		 41
Study Design		41
Gaining Entry and Negotiating Access		42

Field Setting	45
IRB Approval	45
Recruitment of Participants	46
Data Collection Methods	48
Participant Observation	48
In-depth Interviewing	50
Presenting Myself, Gaining Trust, Establishing Rapport.	51
The Interviewing Process	52
Document Review	53
Participant Sample	54
Theoretical Sampling	56
Philosophical Underpinnings of Grounded Theory	59
Ethnography and Grounded Theory	60
The Analytic Journey of This Study	61
Summary	73
4. THE CONTEXTUAL BOUNDARIES OF THE CLINICAL PRACTICUM AND THE RULES AND WORK EXPECTATIONS FOR STUDENT NURSE WORK	74
Nursing Leadership and the Origin of Rules for Student Work	74
The Community College	76
The Nursing Program	77
The Nursing Program Curriculum	79
The Hospital and Clinical Environment	81
Orientation	82
The syllabus	83
Hospital forms	84
Medication administration rules	85
Care planning rules	86
The working care plan	87
The major and complete care plans	90
End-of-course evaluations	92
The Hospital Tour	93
The Clinical Units	95
Orthopedic Unit I physical layout	95
The nursing station	96
Medication carts	98
The controlled substance system	99
Auxiliary rooms	100
The patient rooms	101
Orthopedic Unit II physical layout	101
Composition of the nursing staff	103
The Conditions and Salient Dimensions	105
The Rules: What They Are and Who Sets Them	105
Nursing program rules	105
Individual faculty rules	106

	Hospital and unit rules	108
	Staff rules	108
	Self rules	108
	The Work: Faculty, Patient, Staff	109
	Faculty work	111
	Patient work.....	111
	Staff work	112
	Work Expectations	113
	Summary	115
5.	IMPLEMENTING THE RULES FOR FACULTY WORK	117
	Implementing the Rules	118
	Assigning Hierarchical Value to the Work	118
	Being on Stage	119
	Backstage Work	120
	Figuring it out	121
	Front Stage Work	124
	Performing work	125
	Managing medication administration	126
	Managing the care plans	129
	Validating Work	131
	Implementing the Rules for Faculty Work	133
	Summary	135
6.	IMPLEMENTING THE RULES FOR PATIENT WORK	136
	Work of Meeting Patient Expectation	138
	Entering Into the Patient's World	138
	It Makes Me Look Stupid	142
	Carrying Out the Rules for Patient Work	143
	Implementing the Faculty Rules for Patient Work	144
	Direct care rules	146
	Indirect care rules	146
	Summary	148
7.	IMPLEMENTING THE RULES FOR STAFF WORK	150
	Negotiating Their Role	151
	Negotiation With Staff Cooperation	152
	Negotiation Without Staff Cooperation	154
	Nursing Staff Response to Negotiation	156
	Negotiation With Nursing Assistants	157
	Caught in the Middle: Managing the In-between position	160
	Implementing the Rules	163
	Faculty Rules for Staff Work	164

	Staff Rules for Staff Work	164
	Summary	165
8.	CONSEQUENCES OF THE WORK	166
	Modifying the Rules	167
	Questioning Existing Rules	168
	When a Rule Does Not Exist	171
	Managing the Vague Rules	173
	Objectification of the Patient	174
	The Good Patient	175
	The busy patient	176
	The care plan patient	176
	The psychosocial patient	177
	The patient with a simple medication regime	178
	The Bad Patient	178
	The atheist	179
	The cardiac patient	180
	The young patient	180
	The chronic pain patient	181
	Tension, Conflict, and Disillusionment	181
	Faculty Contingencies	182
	Nursing Driven Contingencies	184
	Patient Contingencies	186
	Summary	187
9.	REFLEXIVITY	188
	Evaluating the Nursing Program	188
	Relationship with Nursing Students	190
	Loneliness as a Researcher	192
	What I Learned About Teaching	192
	Summary	193
10.	DISCUSSION AND IMPLICATIONS	194
	Navigating the Rules	195
	Student Work and Education	197
	Nurse-Patient Relationship	198
	The Good Patient – Bad Patient	199
	Student Work and Staff Nurse Relationships	201
	Nursing Work and the Work of Student Nurses	202
	Invisible and Visible Work	203
	Body Work	204
	Dirty Work	204
	Implications and Recommendations	205
	Strengths and Limitations	205
	Nursing Education	206

Nursing Administration and Practice	210
Future Research	212
Summary	213
References	215
Appendices	
A. Letter of Inquiry – Community College	228
B. Letter of Inquiry – Hospital	229
C. Follow-up Research Description – Hospital	230
D. Hospital Approval Letter	231
E. IRB Approval	232
F. Information Sheet – Faculty	233
G. Consent Form – Faculty	236
H. Information Sheet – Hospital Personnel.....	239
I. Information Sheet – Students	241
J. Consent Form – Students	244
K. Consent Form Hospital Personnel	247
L. Topical Guide First Student Interview	250
M. Topical Guide Faculty Interview	251
N. Document Summary Form	252

LIST OF TABLES

TABLE 1	
Demographic Description of Student Nurse Participants	56
TABLE 2	
The Good Patient	176
TABLE 3	
The Bad Patient	179

LIST OF FIGURES

FIGURE 1	
Planning for Care	63
FIGURE 2	
Planning for Care and Work	66
FIGURE 3	
Basic Core Process: The Work of Student Nurses	68
FIGURE 4	
Central Perspective: How student nurses navigate the rules of their work	72

CHAPTER I

Phenomenon of Interest

Nurse educators face formidable challenges in preparing graduates to function effectively in today's healthcare environment. Such challenges include emerging trends in health care management and interventions like advances in technology and genetics, increases in the aging population, the complexities of chronic illness, and health promotion. In addition, it is predicted that the U.S. population will continue to diversify along racial, ethnic, and socioeconomic lines (American Association of Colleges of Nursing, 1998). In light of these trends recent registered nurse graduates will need to be flexible in their thinking, have knowledge necessary for problem solving, and have to ability advocate for patients (Diede, McNish, & Coose, 2000; Ebright, Patterson, Chalko, & Render, 2003; McCannon & O'Neal, 2003; Nelson, Godfrey, & Purdy, 2004). Nurse educators must guide students in the development of a broad spectrum of skills necessary for providing safe, effective, and appropriate care (National League of Nursing, 2005).

Historically, nursing leaders from both the academic and practice settings have worked to bring about changes and improvements to the nursing profession. Major transformations for nursing have ranged from the implementation of registration laws in the early 1900s (Reverby, 1987) to the development of the "nursing process" in the 1970s (Yura & Walsh, 1973). More recently concepts like evidenced based practice and patient outcomes are at the forefront of nursing's vision (Dale, 2005, Turkel, Reidinger, Ferket, & Reno, 2005, Friese & Beck, 2004). As new ideas and systems are incorporated into

clinical nursing practice, nurse educators adopt these ideas and systems and make them part of the nursing curriculum. Nurse educators then develop tools and strategies to help students utilize these concepts and ideas with patients in the clinical setting.

The clinical arena is an area where classroom learning is put into practice. Every semester student nurses spend between 135 and 180 hours in the clinical setting. The nursing care plan is an educational strategy believed to facilitate this transformation of learning. The purpose of the nursing care plan is to document the problem-solving process, provide written guideline for patient care, and specify patient problems, goals and interventions (Craven & Hirnle, 2000; Potter & Perry, 2001; Taylor, Lillis, & LeMone, 2001). Widely used and accepted, teaching care plan development continues to be an integral component of the nursing curriculum (Lea, Anema, & Briscoe, 2001; Schuster, 2000; Welk, 2001).

Initially this study was designed to examine how Associate Degree nursing students in an orthopedic clinical practicum go about go planning for patient care. In spite of the fact that care plan use is so extensive, very little research had focused on how students approach the process during clinical practicums. Ethnographic methods of participant observation and interviews were deemed appropriate to collect data for this investigation since an aspect of planning for patient care occurred in a clinical setting, the patient care unit. While in the field it became clear that care plans were just one part of a number of other student related activities. Throughout the field observations and interviews, a broader phenomenon of interest was revealed, how students focus their efforts to get through the clinical practicum. After leaving the field, re-reading field data, and discussing the field data with my committee members, it became clear that students

get through the clinical practicum by completing various work activities. It also became clear that these work activities were guided by rules of conduct and requirements that have been set by faculty, nursing staff, and patients. Previous studies (Simpson, 1979; Melia, 1989) have shown that what student nurses do and how they work in clinical settings are shaped and influenced by faculty and nursing staff expectations for performance. As such, the focus of the analysis shifted from care plan development to Strauss, Fagerhaugh, Suczek, and Weiner's (1985) description of work as "a sequence of expected tasks, sometimes routinized but sometimes subject to unexpected contingencies" (p.29). Work then became the analytic framework for this study.

Thus, the data were analyzed to discover what students actually do during their clinical hours. While some research had explored student perceptions of clinical experiences there have been no reports of students' clinical activities using work as a guiding factor (Konrad, 2002; Letizia, 1996). An extensive gap in knowledge exists between how nursing faculty construct clinical expectations in line with the standards and regulations set by licensing and accrediting agencies and how nursing students deal with those expectations. Nursing educators generally agree that learning is a process that occurs over time and as such employ educational strategies to encourage the acquisition of knowledge. Clinical courses seek to expand the students' understanding through experiential activities such as application of concepts learned in the classroom to actual patient situations. Examining the end result of learning provides valuable insight to student knowledge acquisition. However, hearing the voices of students as they engage in the everyday clinical work adds an additional perspective into how students use the strategies and tools given them. Increasing the understanding of how students perceive

and manage their clinical work may be useful to the design and implementation of teaching strategies.

The discussion surrounding the work of student nurses illuminates the challenge and dilemmas of contemporary nursing education. The dearth of research related on what students actually do in clinical practice, in the context of these educational challenges and dilemmas, provides the backdrop for this exploration of the work of student nurses. This study provides an explanation of how students get through a clinical practicum and the strategies they use to do so.

Purpose of the Study

The initial purpose of this study was to gain an understanding of the processes student go through to develop a plan of care. The research questions that drove the initial inquiry were as follows:

- What process occurs when students go about planning care for their patients?
- What resources do students use to develop a plan of care?
- How do student nurses use the nursing process in planning for care?

However, as stated, the focus of the analysis was expanded to discover how student nurses in an Associate Degree program get through an orthopedic clinical rotation. As such, the data were reexamined with the following questions in mind.

- What process occurs when students go about their clinical work?
- How do students use and apply the rules of work during a clinical practicum?
- How do students manage work-related contingencies?
- How do student nurses negotiate their role in the clinical setting?
- What are the consequences of the work of student nurses?

This research has led to a substantive grounded theory that is an analysis of the work experiences of students enrolled in an Associate Degree Nursing program and how they get through a clinical practicum.

Significance of the Study

This study explored a phenomenon that has been not been addressed by researchers. Although the conceptualization of work and study of nursing work have been examined from different perspectives, the ways in which students get through a clinical practicum has not found its way into the nursing literature. The student nurse perspective of the clinical activities, conceptualized as work, has not been studied. A review of what has been done in the study of work and identification of the knowledge gap in this area demonstrates the significance of this research to nursing and nursing education. In order to understand the work of student nurses, it is important and useful to look at how “work” has been conceptualized.

Work in Sociological Terms

A generic definition of work is “exertion or effort directed to produce or accomplish something; labor; toil; productive or operative activity; employment” (Webster's Encyclopedic Dictionary, 1989). Sociologists however have studied work from a variety of perspectives. Not only have they looked at work as a tangible outcome, they have studied work from the social and personal experiences of those who engage in it. As such, the concept of work takes on a richer and expanded meaning when it incorporates the experiences and perspectives of the workers themselves.

The early social science studies of work dealt with occupational development, work site relationships, and work in organizations (Hughes, 1971a). Strauss relates how

he expanded this body of research by looking at the interactional processes of work, the articulation of work, types of work, and forms of work (Strauss, 1988; Strauss, 1993; Strauss, Fagerhaugh, Suczek, & Wiener, 1985). Through this expanded conceptualization of the phenomenon, researchers began to study work as a process and not just an outcome. It was through such studies of work as a social process that led to an awareness of the ways in which individuals construct meaning about their work.

Hughes began studying work in the late 1930's. Over the years, he and his students explored many aspects of work including comparisons between occupations, organizations in which workers enact their roles, common themes concerning work in different occupations, and the study of specific professions (Hughes, 1971a). Hughes also explored the work of nurses and maintained that in order to fully understand this work, it was necessary to look at the environment in which the work took place, that is, the hospital (Hughes, 1971b). He viewed hospital work and the division of labor as a prism for understanding how nursing was progressing as a profession. Hughes suggested that all professions have some elements of desirable and undesirable work. He may have been the first one to coin the phrase "dirty work".

Strauss, Fagerhaugh, Suczek, and Weiner (1985) maintain that health related occupations, because of the hierarchical organizational structure and overlap of work tasks, are ideal places in which to study work. While examining the sociological aspects of medical work, Strauss and his colleagues identified characteristics of work that captured the essence of what occurs in hospitals. They conceptualized chronic disease related hospital work as involving safety work, comfort work and sentimental work to name a few. This conceptualization provided additional dimensions to the earlier

concepts of work and as well as expanded viewpoints from which to study the phenomenon of work.

Smith (2003) broadens the work dialogue by including everyday activities in the conceptualization of work. She maintains that much of what people do, while not overtly described as work, actually constitutes work. Smith describes situations where simple daily tasks may involve complex thinking and classifies these thinking steps as work, even though most are not usually credited as such. Smith supports continuing the efforts to study work since work, both visible and invisible, makes up the realities of people's lives.

Studies of Work in Nursing

In a society where output and production is measured and quantified, many dimensions of work, and this includes nursing work, are not captured (Wadel, 1979). Liaschenko and Fisher (1999) make the case for theorizing nursing work in an effort to show that the intangible aspects of work are indeed integral to the management of the patient and the success of the organization. One of the compelling reasons to study nursing work has been the drive to demonstrate its value. In an effort to quantify work done by nurses, researchers and administrators looked at aspects of nursing care to identify those things that were not part of the measured work. Recently Liaschenko (2002) reviewed what has been researched in the area of nursing work. In response to an impending nursing labor strike, Liaschenko describes the various components of nursing work as she locates this discussion around the current state of the health care system. Of interest are the references to different types of work within nursing's domain of practice. Liaschenko identifies area of nursing work that have been conceptualized as "dirty"

work, “emotional” work, “body” work, “invisible” work and “in-between” work. Each one of these classifications of nursing work has a sociological foundation in that work is related to societal expectations and social transactions. A review of the nursing literature demonstrates how each one of these views about nursing work has been studied.

Dirty work. All occupations contain tasks that can be considered “dirty work” in some form or another. These tasks may include physically dirty work like managing garbage or morally dirty work such as interrogation activities (Hughes, 1994). Dirty work was first described by Hughes (1971b) to refer to generally unpleasant tasks. Nursing has identified what tasks constitute dirty work. Although he does not specify what dirty work is, Hughes brings forth the notion that dirty work is acceptable if it is “part of a good role” (p. 314). In the case of nursing, when dirty work results in positive praise from patients or families, then engagement of it is deemed tolerable.

Zane Wolf’s (1988) ethnographic account of nurses in an acute care hospital redefines dirty work as both sacred and profane. She suggests that work associated with bodily products, while deemed dirty by nurses, has sacred value. For example, bathing patients, removing dirt and cleansing can be seen as “symbolic purification” which nurses accept as their sole responsibility. Wolf discovered that although doing dirty work was one segment of a ritual of nursing, there were benefits and consequences that reached far beyond the physical tasks. She notes, “Nurses have extraordinary access to the sacred aspects of human existence. Few have such privilege as witnesses and participant-observers of the suffering, pain, and the dying of patients” (p.23).

Aiken and Sloane (1997) argue that another benefit of dirty work may be the organizational change that can result. These authors use the early AIDS epidemic to

demonstrate that when the dirty work of caring for these patients was shunned by prestigious health care professionals, nurses took the opportunity to assume that responsibility. A consequence of accepting the responsibility of dirty work was that specialized nurse-run AIDS care units were established, resulting in an enhanced status for the nursing profession. Although this research was not designed to study dirty work, it demonstrates that under certain circumstances this type of work can be beneficial for both nurses and patients.

In an opinion paper, Godin (2000) defines coercion as dirty work and persuasion as clean work. In an attempt to understand and explain the dilemma community mental health nurses face when medicating patients, Godin suggests that in order to achieve medication compliance, a concerted effort needs to be made to use persuasive strategies rather than coercive strategies. In the milieu of caring for difficult patients, the connotation of dirty work had no perceived benefits except for getting the work done.

Body work. Closely related to dirty work is the conceptualization of body work. Although limited in scope, the research concerning body works encompasses two main themes, caring for the body and focus on the body. Wolf (1999) maintains that body work, while not requiring advanced technical skills, is certainly not menial work. Similarly, Lawler (1993) suggests that body work is central to nursing activity. However, the body remains in a private space, a space entered into by nurses but not discussed outside of nursing. As such, Lawler contends that while nurses are completely engaged with the body and body work, there is a lack of theoretical development about the human experience of the body. She attributes this to the fact that in health care the emphasis is placed on scientific practice with positivistic underpinnings and that body work is hidden

from everyone except nurses. Lawler believes that nursing is uniquely positioned to build a theory of the body that would explain the human experience, expression, and personal identity. In this context, body work provides the time and space for the nurse to enter into to patient's world.

The second way that body work has been studied relates to focus on the body. Although the study of body work is not pervasive in the literature, two studies reveal that nurses practicing in hospitals focus primarily on the physical aspect of the body (Hardey, Payne, & Coleman, 2000; Heartfield, 1996). These researchers discovered that nurses place their primary focus on body work. As they investigated how nurses note and use change of shift information on scraps of paper, Hardey, Payne, & Coleman (2000) found that nurses utilize a body-centered approach to list the tasks that needed to be completed. Furthermore, the researchers noted that the physical aspect of body work received more attention than the psychosocial aspect. Similarly, Heartfield (1996) found that in documenting patient care and status, nurses focused on body systems and their function. While body work was not the primary objective of these two studies, these analyses uncovered aspects of nursing work that suggests that body work is a significant aspect of nursing work.

Invisible work. Research and commentary on the invisible work of nursing has probably received the most attention in the literature. In a society where work value is placed on measurable and tangible production, researchers argue that a significant portion of nursing work is invisible or hidden. Invisible work includes the efforts of emotional labor (Aldridge, 1994), relationship work (May, 1992; May & Purkis, 1995; Williams, 1998) and what Liaschenko (2002) terms in-between work, activities that are connected

with information exchange. This information exchange, crucial for the safe provision of health care, is carried out in the forms of “transferring patients from one place to another, explaining to a physician what a patient has said about the treatment, clarifying orders, talking with families, keeping supervisors informed”, (p. 69). The consequence of not acknowledging hidden work results in a devaluation of the nursing role, lack of recognition the true cost of nursing, and keeping nursing work implicit. These studies attempt to inform the profession that recognizing the hidden aspect of nursing can not only help make work explicit, it will “enable nurses to explain the less obvious but distinguishing and essential elements of their profession” (Wolf, 1999, p. 22)

Work of student nurses. The work of student nurses has not been studied in recent years. As funding for educational scholarship has declined, fewer researchers are attempting large-scale studies to explain the experiences of nursing students. Instead much of the research concerning nursing education has focused on the concept of critical thinking and clinical judgment (Benner, Tanner, & Chesla, 1996; Daly, 2001; Forneris, 2004; Vaughan-Vrobel, O'Sullivan, & Smith, 1997). An extensive review of the literature revealed that while several studies have been concerned about specific aspects of student work, such as care planning and quality of care (Brennan, 1992; Caldwell, 2000), there have been no recent published accounts detailing a more comprehensive explanation of student nurse activities.

In 1968, Oleson and Whittaker conducted a three-year field work study of nursing students and their professional socialization (Oleson & Whittaker, 1968). The researchers observed and interviewed students in the classroom, the clinical setting and multiple recreational events. During this time, the researchers gained a deep understanding of the

process of professional socialization. This seminal work provided an explanation of how student nurses actively influenced their own education. Since that time, few researchers have conducted extensive studies of student nurses in the field.

Simpson (1979) conducted a study of the professional socialization of students. Using student interviews and observations, both in the hospital and in the dormitory, Simpson developed a model of professional socialization. Although not directly centered on the work of student nurses, Simpson describes the transformation that student nurses experienced during the first year of nurses training. Simpson discovered that the focus for student nurses shifted from concern for the patient to a concern for the skills and knowledge they would need to satisfy faculty requirements. Described in the context of professional socialization, Simpson suggests that the educational focus of the nursing faculty shapes the ways in which students approach clinical. Simpson found that the work of student nurses in the earlier semesters of a nursing program was determined by the faculty member's emphasis on technical skill. Working within this model students felt they were not able to foster relationships with patients. Although my research does not describe the same phenomenon, it does highlight similarities in how faculty is instrumental in shaping the clinical focus for students, at times frustrating the student's attempts to carry out the nursing work they believe should comprise some of the clinical time.

Similarly, Melia (1989) explored how students learn and work in the clinical environment. Using ethnography and extensive interviewing, Melia conceptualized several aspects of student work. The research site was located in Great Britain, where students were enrolled in a traditional three-year diploma program. Although the research

describes how student nurses learn and work, the working and learning are focused on the nursing staff who were the primary educators in this type of nursing program. In describing the student nurses' experiences, Melia illustrates the social process that occurs as students become nurses. The ways in which students respond to nursing staff are similar to how the student nurses in this study managed the clinical work. This process will be further discussed in Chapters V through VII.

The Interpretive Methodological Tradition and This Study

Research methodologies have frequently been identified as either quantitative or qualitative. Lowenberg (1993) argues that many of the qualitative research approaches within the interpretive methodological tradition have been derived from the symbolic interactive perspective, including ethnography. She further maintains that grounded theory is an outgrowth of ethnographic thinking within the field of sociology. This study of how Associate Degree nursing students get through an orthopedic clinical practicum is situated within the interpretive methodological tradition of research. It utilizes the sociologically informed ethnographic and grounded theory approaches to research design and methods of data collection. In what follows, I present a brief discussion of the relationship between symbolic interaction, ethnography and grounded theory. I revisit some this discussion in Chapter III as well.

Symbolic Interactionism (SI) is a theoretical perspective that has its roots in American pragmatism. Based on the premise that human beings adapt to their environment the early pragmatists adhered to the ideas that all organisms play a part in shaping the environment with which they must cope (Manis & Meltzer, 1978). Although there were several contributors who built on pragmatist thinking, Baldwin, James,

Cooley, Dewey and Thomas, it was Mead who extended early pragmatist thinking on individual interests into the realm of identity and society.(Manis & Meltzer, 1978).

Blumer, a student of Mead's, further developed the perspectives into what is now called symbolic interactionism (Charron, 2001).

Blumer, (1969) maintains that SI is a theoretical perspective based on three premises:

- Human beings act toward things on the basis of the meanings that the things have for them
- The meaning is derived from the social interaction people have with one another.
- The meanings are managed through an interpretive process used by the person in dealing with the things he encounters (p. 2).

Manis (1978) elaborates on Blumer's writing and states that the central idea of SI is that "human behavior and interaction are carried out through the medium of symbols and their meaning" (p. 6). Rather than responding directly to stimuli, human beings assign meanings to the stimuli and act on the basis of that meaning. This results in human behavior that is distinctly different from other organisms.

An additional premise of SI is that individuals become humanized through interaction with others (Manis & Meltzer, 1978). In other words, it is through the interaction with others that human beings take on the unique human abilities to think, feel, and possess human nature. Symbolic interactionists maintain that people are not born human but become human and that society is conceived of people in interaction.

Individual behavior is shaped by interaction with others and individuals act on meanings and responses that others have.

The symbolic interactionism perspective holds that in order for the inquirer to understand the process of meaning making, the overt and covert behaviors, speech and circumstances of the settings must be carefully observed and taken into account (Schwandt, 2001). Ethnography, as a general approach to research, is a way of discovering the perspectives of individuals as they live in their world (Hammersley and Atkinson, 1995). For the grounded theory approach, the interaction between the participants and the researcher should result in shared meanings. The personal voice of the participants is a key characteristic for the development of grounded theory and as such provides the basis for variation in the data that reflect each participant's unique experience. The grounded theorist then constructs an image of reality based upon the symbolic meanings and interactions of those studied.

Glaser and Strauss (1967) first introduced grounded theory as an approach to design and analyze ethnographic data. Their position was that theory, in order to be understandable, must "fit the situation being researched and work when being used" (p. 3). Rather than using theories that are logically deduced from a priori assumptions, Glaser and Strauss stressed the point that sociologists must use theory that is specifically developed for the phenomenon under study. As a result, Glaser and Strauss maintained that by discovering the theory from the research data, the theory would meet the requirements of "fit" and "work". They also state that intimate linking of the data to the theory through inductive development can result in a theory that will endure over time.

Grounded theory methods use an inductive approach, working from the data of individual cases to a more general conclusion (Charmaz, 2001). A central characteristic to this analytic approach is the method of constant comparative analysis (Strauss & Corbin, 1998b). Although the procedures have been refined since the inception of grounded theory by Glaser and Strauss (1967), constant comparative analysis remains a central tenet of the methodology. As a result of this analytic technique, the theory is developed from data that is consistently revisited throughout the analysis. Additionally, theoretical sampling is a strategy consistent with constant comparative analysis. As the researcher analyzes the data, additional participants are interviewed until no more new information can be discovered. Called theoretical saturation, this step in the research process is key to the development of a substantive theory. Using an inductive approach is particularly appropriate for this study in that little is known about the work of student nurses. A discovery of how student nurses get through clinical practicum was made possible using grounded theory methodology. The substantive theory provides an explanation of the process that occurs as students navigate the rules of their work.

Charmaz and Mitchell (2001) support the use of ethnographic methods to generate a substantive theory. Combining grounded theory and ethnographic methods allows the researcher to experience the phenomena as it is experienced by the participants. Charmaz and Mitchell go on to suggest that while grounded theory methods can help focus ethnographic data analysis, ethnographic methods contribute to broaden the grounded theorists perspective, enabling the researcher to more fully engage in the experience of the participant.

Dimensional analysis was used as a methodological approach to developing this theory. It is described as “an alternate method of generating grounded theory conceived for the purpose of improving the articulation and communication of the discovery process in qualitative research” (Kools, McCarthy, R., & Robrecht, 1996; Robrecht, 1995, p. 314; Schatzman, 1991). Dimensional analysis was developed in response to a belief that the methods available to develop grounded theory were difficult for students to understand and carry out (Kools et al 1996; Robrecht, 1995). As a novice grounded theorist, dimensional analysis provided a structure for my data analysis that had heretofore been elusive. The process of analyzing and describing the data according to their dimensions and properties facilitated the development of the data into a grounded theory through the use of an explanatory matrix. Using the framework provided a method by which the dimensions were organized into various conceptual components. The explanatory matrix tells the story of the work of student nurses. The resulting substantive theory provides an explanation and understanding of how student nurses get through an orthopedic clinical practicum by engaging in work. The relationships between SI, grounded theory, ethnography and Dimensional Analysis and the conduct of this study are further explained in Chapter III.

Summary

This chapter described how the focus of the study changed as data analysis proceeded. It discussed the context of work and identified the gaps in nursing knowledge concerning the work of student nurses. A review of the work literature is included in order to locate the work of student nurses in the body of knowledge concerning work and nursing work.

Chapter II covers the review of the literature of care planning and the nursing process. As the initial intent of this research study was to examine the process of care planning, this review has been maintained as part of the dissertation. A significant part of student work concerns their care plans and as such this information may be useful for some readers.

Chapter III reviews the methods employed to structure the study, the data gathering process, and analytic process used. It includes a description of the process of gaining entrée, a demographic description of the participants, and some of the issues encountered while conducting the ethnographic data collection. Moreover, the process of the data analysis using Dimensional Analysis is discussed.

Chapter IV provides the reader with the context and conditions of the study. This chapter describes the history of nursing education and the current the regulatory guidelines which drive the development of the nursing program curriculum. Also included is a description of the nursing program with which the participants were associated. The clinical experiences describe the environment in which student work took place. The clinical environment includes the physical description of the nursing units, the faculty, and staff with whom the students interacted. Additionally, specific issues that were pertinent to the work of student nurses are discussed here. The most salient of the dimensions, the conditions, of the rules, work, and work expectations are also described.

Chapter V, VI, and VII impart the discoveries made from this research study. These chapters include a description and explanation of the work of student nurses broken down into faculty work, and patient work, and staff work. Student nurses managed the work by navigating the rules of the program, faculty, and nursing staff.

These rules were used to assist the student to get through the work and thus the clinical practicum.

During the clinical experience contingencies arose when the rules did not apply and students would create rules in order to get through. The situations that compelled students to change rules resulted in unanticipated consequences. These consequences are discussed in Chapter VIII.

Chapter IX provides a brief discussion on the conduct of the research. In reflexive discourse I take a deeper look at how I may have influenced the study by my position as a nurse educator. I provide exemplars from my field notes that explain some of my interactions with student and faculty. I discuss some of the strategies I used to increase my awareness of the process and how I used that awareness to create a deeper understanding of the interpretations I made.

Chapter X summarizes the findings from the study, the limitations, and implications for nursing education, administration and research. Nursing education stresses the importance of tailoring teaching strategies for the preparation of nurses. However, developing new ways of teaching can be improved with an understanding and explanation of how students perceive their clinical experiences. Analysis of the work of student nurses adds to the body of knowledge on how students link theoretical methods to actual patient care situations. This study seeks to fill gaps in the literature by producing a substantive grounded theory account of how students get through a clinical practicum. In doing so it follows a once established vital approach to the study of student nurses, that of ethnography. The findings of this study may help to broaden the nursing faculty's understanding of the clinical work and experiences of students as well as assist faculty to

critically examine the clinical expectations they have of students. This study provides a model for future nursing research about the work of student nurses.

CHAPTER II

Review of the Care Planning Literature

Initially this study intended to focus on the process of care planning. The data analysis revealed that care planning was but a small part of a broader phenomenon. Although the preparation of the nursing care plan occupied a significant part of the effort of getting through the clinical practicum, the conceptualization of work as faculty work, patient work, and staff work became the foundation of generating the substantive theory. The ensuing review of literature concerns the care plan and the nursing process. I am leaving this as part of the dissertation since the reader may wish to gain a better understanding of the significance of the care plan as a part of the work of student nurses.

The nursing care plan has a long history of use, both for nursing education and nursing practice. In order to understand the significance of care plan use today, it is helpful to review the history of both the nursing care plan and the nursing process. An in-depth examination shows that the development of the nursing care plan was closely linked to the education and professional development of nursing. Furthermore, regulating agencies adopted the concept of planning care and incorporated the nursing care plan in the laws governing nursing practice. However, in spite of the more than 90 years since inception of the concept, little research has been done that provides an understanding of how students develop a nursing care plan.

This literature review will trace the roots of the nursing care plan and the nursing process, discuss the impact the nursing care plan had on the development of the profession, and examine how students are taught to prepare nursing care plans.

History of the Nursing Care Plan

The nursing care plan and the skills for development have a long history, dating back to the first days of modern nursing. Over the years the purpose of the care plan has changed to meet the current nursing needs. The care plan has been used to provide supplementary educational materials, to illustrate nursing's expertise, to guide patient care, and to teach students the nursing care required by patients. The literature reveals a lively discussion that spans over 100 years.

Late nineteenth and early twentieth century

Nightingale (1859) maintained that nurses needed to be taught reliable methods of patient observation. She believed even though a nurse may be devoted to caring for patients, without solid observational skills the nurse's efforts would be useless. Known as the founder of modern nursing, Nightingale provided the first step of what is now known as the nursing process, observation or assessment. Although Nightingale's description of observation was limited to functional patient behavior, she prepared the foundation for nursing to be a separate and unique profession.

A major drawback for nursing education in the late nineteenth and early twentieth centuries was the lack of textbooks (Kalisch & Kalisch, 1995; Riddle, 1928). Physicians, using their own medical notes, gave most nursing lectures since qualified nursing educators were few. One method of teaching students that resulted from the lack of textbooks and experienced nursing teachers was the case study (Kalisch & Kalisch, 1995;

Stewart, 1943). The case study consisted of a written description of what the student observed about a particular patient, the treatments administered, and a report of the results. The case study method was also used as bedside clinical rounds. Students were asked to answer questions regarding specific patients and to describe the significance of their observations (Parsons, 1911). A review of Mary Adelaide Nutting's case study (as cited in Kalisch and Kalisch, 1995) shows little differentiation between medical and nursing procedures.

Parsons (1911), a nursing educator at Massachusetts General Hospital, describes her use of case studies in an effort to help students manage problems that were specific to nursing. Parsons developed scenarios students might encounter as private duty nurses and helped them find appropriate solutions. She posed questions asking students what they would do in situations where ethical decisions should be made. Parsons believed that while in hospital training, students obediently followed the rules. Yet after graduation these students worked independently in private practice and would benefit from this kind of learning. Parsons' case study method addressed the specific needs of nursing at that time.

Early twentieth century training schools

The social and political arena in the beginning of the twentieth century affected the progress of nursing education. Women did not enjoy many of the same rights as men and thus had limited voice in social and political changes that should occur. Nursing was no different. Hospitals continued to be controlled by male superintendents and physicians and supported the apprenticeship model. Physicians too were against nursing education claiming that soon nurses would know more than doctors. The fear was that as student

nurses became more educated, they would lose interest in performing the menial duties assigned to them (Rafferty, 1995). Up to this time the nursing schools had been successful due in part to emulation of Nightingale's organizational principles and advances in medical science and technology.

The economic climate found more and more hospitals opening their doors to patients resulting in a need for more nursing staff. In order to meet the demand for more nursing labor, hospitals lowered admission standards as a recruitment effort. Additionally, while other professions provided training in collegiate or university settings, nursing education remained in the hospital. Although nursing educators championed for university education, they had to settle for trained nursing instructors. Efforts undertaken to combat these challenges were the introduction of state registration for nurses, the publication of the *American Journal of Nursing*, establishment of the American Nurses Association (ANA) and the National League for Nursing Education (NLNE) (Turkoski, 1995).

The National League for Nursing Education

There was a great deal of disagreement between nursing leaders and physicians about how nurses should be educated. Physicians believed in the apprenticeship method that required nursing students to receive almost all their training in the hospital at the bedside of the patient. Nursing leaders however pushed for reforms that would significantly increase the theory portion of nursing student education (Kalisch & Kalisch, 1995). The National League of Nursing Education (NLNE) proposed standards for hospital training schools. One of these standards maintained "the pupils are doing real live thinking for themselves, and not simply memorizing facts. They are observing,

comparing, judging and learning to seek out reasons and weigh conclusions” (National League of Nursing Education, 1919, p. 28). Furthermore, the NLNE recommended the use of the case study method as a means of teaching students to present reports on their observations and work. In addition to Nightingale’s earlier suggestion that nurses develop skills of observation, nursing instructors were now being asked to teach students to think and solve problems. Seemingly, advocating the use of the case study method was one way the nursing profession could add to the nursing body of knowledge leading to improved or recognized professional status.

The Case and Care Study

Henderson (1973), a long-time nursing educator and historian, reports her personal experience with developing case studies. She was very involved in nursing education development and recounts the national conversation that was occurring in the late 1920’s related to case studies. In 1932, the NLNE published a curriculum guide for schools of nursing (National League of Nursing Education, 1932). In this guide, the League first made mention of a nursing care plan. Their recommendation included the use of the case study method. However, in describing the case method process the NLNE stated “In nursing it means that the individual patient is used as the subject of study, and the student learns to gather together and organize all the relevant material in working out a plan of nursing care for the patient” (National League of Nursing Education, 1932, p. 40). Still used as an educational tool, the case study now included some form of planning for nursing care. Two years later, the Committee on the Grading of Nursing Schools wrote “All professional nurses... should be able to observe and interpret the physical manifestations of the patient’s condition and also the social and environmental factors

which may hasten or delay his recovery” (Committee on the Grading of Nursing Schools, 1934, p. 70). The Committee’s statement contains concepts found in the modern definition of nursing, “Nursing is the diagnosis and treatment of human responses to actual or potential health problems” (American Nurses Association, 1995). The skills needed to fulfill the role of professional nursing were similar to those required for care plan development. The trend in nursing education was moving towards defining nursing roles and responsibility that would be evident in written care plans, a practice that continues in the twenty first century.

Although the concept of case studies and later the care plans were topics of national discussion among nursing educators, the practical reality was that little time was allotted for case study preparation. Since student nurses provided the bulk of the nursing care, hospital administrators were not anxious to reduce bedside time in favor of study time. Furthermore, medicine’s insistence on maintaining a semblance of the apprenticeship model added to the obstacles faced by nursing educators to improve nursing education. Physicians were against nursing education claiming that soon nurses would know more than doctors. The fear was that as student nurses became more educated, they would lose interest in performing the menial duties assigned to them (Kalisch & Kalisch, 1995; Rafferty, 1995; Reverby, 1987).

In a time study conducted at the Bellevue School of Nursing, it was noted that in a 24-hour period, student nurses spent 366 hours in nursing care. Included in the nursing care hours were 64 minutes of study time (Pfefferkorn & Rottman, 1936). The study did not specify how many students were assigned to the unit in during the 24 hours. However, it is important to note that while study time was listed as one of the student

nursing duties, it only represented a miniscule amount of the total time students spent in nursing activity. Clearly the education of students was still heavily focused on bedside care rather than theoretical education.

The First Plan of Care

The NLNE and committed educators continued to publish guidebooks to help schools of nursing improve the curriculum (McManus, 1949; National League of Nursing Education, 1937; National League of Nursing Education, 1942). These guides made recommendations to teach nursing students the skills of collecting patient data through observation and assessment. The students were then to be taught how to analyze the data and determine the patient's problems and solution for the problems by using independent thinking and clinical judgment. Without specifically labeling these skills, the curriculum guides advocated a form of the care planning process.

It was in 1939 that the plan of care was clearly defined (Harmer & Henderson, 1939). In the chapter *The Plan of Care for the Patient*, Harmer and Henderson discuss the need for a plan of care. They specified the patient's involvement is important in order to gain cooperation. Another aspect that was discussed concerned the nursing skills necessary to create an appropriate plan of care. The format for writing up the plan consisted of two columns, one for doctor's orders and a corresponding nursing care emphasis. Although this does not resemble a nursing care plan in the year 2005, the Harmer and Henderson plan noticeably separated medicine and nursing.

Although hospital work was very heavy and time consuming, student nurses did have time to write up nursing care studies. Students were encouraged to submit examples of their work to the *American Journal of Nursing*. The journal devoted a specific section

to students and called it the Student Nurses Page. A random review of the journal during the 40s and 50s shows that students wrote about patients with public health and a variety of medical and surgical problems such as rheumatic fever, peptic ulcers, myocarditis, and mitral stenosis (Boehmer, 1954; Burgess, 1941; Kieliazak, 1946; Stone, 1948; Wells, 1943; Wright, 1940). It is interesting to note that the students used the term “care study” for each of the conditions. Indeed, it seems as if by the 1940s the term care study had replaced the case study.

The Post-war Era

During the 1920s and 1930s there were few nursing positions for graduate nurses in the hospital (Kalisch & Kalisch, 1995). That all changed after WWII. A nursing shortage led to the development of team nursing. Team nursing was defined as “a group of professional and non-professional nursing service personnel working together in planning, giving, and evaluating patient-centered nursing care to a group of patient” (Leino, 1951, p. 665). The main reason for implementing team nursing was that hospitals could employ assistants and technicians to provide basic patient care leaving the professional nurse free to function as a team leader. According to Leino (1951), the major responsibility of the nurse team leader was to plan, provide, and evaluate the nursing care needed by the patients. This change in nursing care delivery consequently required a change in communication. Nurses were no longer the only ones caring for a patient. Fortune (1953) suggested that the nursing care plan could become a communication tool that all members of the team could access.

Although some effort had been made to bring the care study to practicing nurses (Scott & DeCamp, 1942), the evolution of team nursing brought the care plan into the

practicing arena. To meet the challenges inherent in the change, Mauksch and Mauksch (1950) recommended the development of a new role for nursing students, that of a leader. A nurse team leader was described as one who could make observations about patients, decide on the care needed, and be able to delegate that care to team members (Fortune, 1953; Leino, 1952; Mauksch & Mauksch, 1950). Mauksch and Mauksch further went on to say that the nursing care study is the ideal method to help prepare a student for the role of team leader. They also suggested that the care plan should be the major tool used by the professional nurse.

Fortune (1953) noted that since nursing care plans were now used as a method to communicate the status of patients and needs, it would be important to update the plan on a regular basis. However, some changes in format were implemented in order for the communication to be effective. The nursing case studies and subsequently the care studies were long narrative descriptions of the patient. The patient's needs, and nursing care were explained in great detail. This type of care plan was not an efficient way to communicate with all members of the team. As a result, the nursing plan was reformatted using columns to describe the various patient needs and nursing treatments. A caregiver could quickly note the important aspects of patient care. Additionally, the recommendation was made to now make the care plan a permanent part of the patient care record (Mauksch & Mauksch, 1950).

Development of the Nursing Process

During the early 1960's, nursing care plans primarily consisted of three elements, 1) patient data, 2) objectives and nursing activities to meet the objectives, and 3) an evaluation of the plan and the patient's movement towards achievement of the objectives

(Wagner, 1961). However, in 1961 a major change occurred regarding the development of nursing care plans. Orlando (1961) referred to the elements of the care plan as nursing process. This nursing process was based on the interactions of nurses and patients. Essentially, Orlando was identifying the steps for effective communication. However, leaders in academia and nursing practice quickly adopted the notion that nursing was a process rather than a set of separate actions (de la Cuesta, 1983). In 1965 the ANA was instrumental in suggesting that the nursing process should be part of the nursing curriculum (American Nurses' Association, 1965).

Subsequently, the ANA position statement regarding the nursing process defined a trend in nursing that resulted in a major shift in care planning. Now care plans were developed using the nursing process in a deliberate, systematic, and organized manner (Yura & Walsh, 1973). At the same time, the ANA was influential in persuading the Joint Commission on the Accreditation of Hospitals to make nursing care plans a prerequisite for nursing service accreditation (de la Cuesta, 1983). This move had a major impact on the use of care plans in both nursing education and practice. Previously, the care plan had been a teaching and learning tool for students. While some nurses had advocated the use of the care plan in clinical practice, there had been no official mandate. The nursing care plan took on a dual purpose for education, as a method of teaching nursing and as a method to prepare students to be able to develop care plans for actual nursing practice.

At this point the nursing literature includes a dearth of articles regarding the nursing care plan. Instead, the nursing process becomes the focus of the discourse. Since the nursing process had become a mandate for clinical practice, the subsequent nursing

literature will be reviewed from two different perspectives, clinical practice and education.

Nursing Care Plans and Nursing Process in Clinical Practice

McCarthy (1981) states, “in practice, the nursing process is translated into a written nursing care plan” (p. 174). The nursing process and the care plan were closely linked since the second phase of the nursing process was planning. Even though most of the ensuing literature is about the nursing process, the care plan is the result of engaging in the nursing process activity.

As nursing care plans became an accepted part of nursing practice, questions arose regarding the appropriateness of using the nursing process as the primary framework for the organization and delivery of nursing care. Moreover, educators and researcher were exploring the link between the nursing process and clinical problem solving (McCarthy, 1981). Henderson (1982, 1987a, 1987b) questioned the use of the nursing process as a problem-solving method and the trend to identify nursing as solely as a problem-based profession. Henderson maintained that the nursing process was limited in scope and should only be used when the patient exhibited a problem. She also believed the nursing process did not provide for nurses’ subjective or intuitive role as care provider. Donnelly (1987) suggested however, that although the nursing process used a linear and scientific approach to care, it was also a symbol of the dynamic progress nursing as a profession had made. Essentially agreeing with Henderson’s position, Donnelly’s aim was to point out that nursing should be proud of the progress it had made regarding the movement towards professional autonomy.

In the 1980's and 1990's, the discussion continued to focus on the value and appropriateness of using the nursing process to plan patient care. At the same time, the term nursing process became synonymous with clinical reasoning and clinical judgment. Additionally, research was conducted that looked at the abilities of nurses to use the nursing process. One such study revealed that nurses failed to use the planning and evaluation phases of the process (Hurst, Dean, & Trickey, 1991). Fowler (1997) found that community health nurses did not use the nursing process during a problem-solving task. However, Hildman and Ferguson (1991) found that while acute care nurses have a positive attitude towards using the nursing process, these nurses did not have a positive attitude towards the nursing care plan. Indeed, new graduates seemed to have a more positive attitude towards nursing care plans than did experienced nurses.

More recently, the research continues to show that the nursing process limits nursing practice. O'Connell (1998) found that nursing practice is highly complex and that the nursing process impeded care in the fast-paced acute care environment. She recommended a critical analysis of the nursing process be conducted and suggested to limit the use solely to student learning. In a related study, O'Connell, Rapley, and Tibbet (1999) report the results of a chart review related to nursing diagnosis, a phase of the nursing process. The researchers found that the documentation of the nursing diagnosis on the care plan did not coincide with the assessment data collected by the nurse. The reality of this clinical practice is completely contrary to how the nursing process was designed to be implemented, that analysis of the assessment data leads to a nursing diagnosis (Wilkinson, 2000). Tanner (2000) proposes moving beyond the nursing process

in an effort to develop practitioners who think critically, advocate for patients and take action to resolve issues confronting the care of patients.

Nursing Care Plans and the Nursing Process in Academia

According to Yura and Walsh (1973), the faculty at Catholic University of America identified the phases of the nursing process as assessment, planning, implementing, and evaluating. This was later revised and an additional phase added. The extra step, diagnosing, came after the assessment phase (Gordon, 1982). Thus, for the past 25 years the nursing care plan has been formulated using a four or five step process.

Over the years there have been educators who advocate a change in how students are taught care planning. Brown (1989) found that nursing students developed care plans along medical diagnoses and planned interventions along physiological problems. Fonteyn and Cooper (1994) contended that the use of a care plan using the nursing process as the framework was incongruent with health care trends of the 1990's. They based their position on the clinical reasoning research results from the previous 10 years that showed expert nurses do not use the nursing process in a step-wise method (Fonteyn, 1991; Grobe, Drew, & Fonteyn, 1991; Hurst et al., 1991; McHugh, 1986). Fonteyn and Cooper also maintained that teaching the nursing process may be useful for a beginning student but that it should be abandoned as soon as students gained more experience. Lindsey and Hartrick (1996) suggest that since the nursing process is a problem solving process, it severely limits the ability of nurses to manage health promotion practices.

In actual clinical situations, not all students address all parts of the nursing process and care plan (Thorell-Ekstrand & Bjorvell, 1995). In fact, these students commented that they rarely discussed the care plan with the patient. Students were also

not able to identify components of the nursing process when presented with clinical scenarios (Lea et al., 2001). Field (1987) asserted that since the steps of the nursing process are very methodical, sole use of the process may encourage nurses to rely on rules and regulations for decisions. Instead, Field proposed the development of a sound knowledge base to guide nursing expert decision-making. Today, in an effort to make the care plan more useful and meaningful, educators are considering methods to teach care plan development using alternate strategies (Schuster, 2000; Welk, 2001).

The perspectives of nursing students on the care planning process have not been extensively studied. Brennan (1992) studied the lived experience of baccalaureate nursing students during care plan development. Brennan found that while students struggled and encountered frustration during the care planning process, they ultimately experienced accomplishment and satisfaction. A survey of nurse educators showed that the nursing care plan and the nursing process are viewed positively with regard to problem solving and critical thinking (Marshall, 1995). Additionally, both associate degree and baccalaureate degree educators supported the use of other problems solving methods in conjunction with the nursing process. Although this research did not explore what alternate types of problem-solving methods would be supported, educators did indicate that the nursing process would not be beneficial in making ethical decisions.

Linking Care Plans to Credentialing

Regulatory agencies are also involved in determining the requirements of care planning. State boards of nursing provide the rules and regulations detailing how the profession of nursing will be practiced in each state. These rules and regulations are enforceable as law (Boris, 2000). The state boards grant the educational institution the

right to manage and operate a nursing program. State boards of registered nursing have developed criteria and standards that guide nursing practice and education.

Accreditation can also be granted by nursing organization like the NLN and the Commission on Collegiate Nursing Education (CCNE). While this accreditation is voluntary, the main purpose is to ensure that the public need for nursing is met. Additionally, these nursing organizations employ a peer review process using nationally recognized standards for evaluating the integrity of nursing programs (Carpenter, 2000). Community colleges can opt for accreditation by the NLN while baccalaureate nursing programs can opt for accreditation by either the NLN or the CCNE, the accrediting body of the AACN.

The NLN's mission is to "advance quality nursing education that prepares the nursing workforce to meet the needs of diverse populations in an ever-changing healthcare environment" (National League for Nursing, 2002). Within the mission is the goal to set standards for nursing education to guide nursing workforce development. The nursing process is an integral part of the NLN's standards for nursing education. In fact, the NLN closely links the use and understanding of the nursing process to the critical thinking abilities of students (National League for Nursing, 2002).

The AACN (1998) has published standards in order to define the essential elements of baccalaureate nursing education. While the terms nursing care plan and nursing process are not specifically used, there are substantial references to both. The AACN states that one of the core competencies is assessment, and defines this using some of the nursing process terminology. According to the AACN, course work should provide the graduate with knowledge and skill to "use assessment findings to diagnose,

plan, deliver, and evaluate quality care.”(p. 11). Furthermore, the AACN states that the nursing role of provider of care includes the development of a comprehensive plan of care.

The NCSBN works with member state boards of nursing to develop policy and guidelines for the regulation of nursing practice (National Council of State Boards of Nursing). The NCSBN has also developed a model nursing practice act that contains the essential elements of regulations needed for nursing practice. The model does not specifically use the term nursing process, but does clearly describe the phases of the nursing process. Additionally, the NSCBN states that the development of a nursing care plan is part of the scope of registered nurse practice.

The Board of Registered Nursing (BRN) in California states the nursing process, “means the problem solving techniques of assessment, planning, implementing, and evaluating a plan of care, which requires technical and scientific knowledge and judgmental decision-making skills” (Board of Registered Nursing, 2000, p. 54). The BRN of California also requires a nursing educational curriculum, which includes the nursing process. Although the BRN states that the schools’ faculty can define how the nursing process will be taught, the education must result in a nurse who can “formulate a care plan” (p. 58).

Clearly, nursing licensing and accrediting agencies embrace the care plan as one means of developing competent practitioners. Indeed, not only is the care plan required, the nursing process is considered the foundation of the care plan. Even though the care plan may take on different formats in the clinical practice arena, the concepts of care plans and care planning remain an important focus for nursing education today.

How Students are Taught Care Planning

Introducing beginning students to the care planning process can be done in a variety of ways. Although the licensing and accreditation agencies stipulate a requirement for care plans and the nursing process, schools may choose how to present this content. Care planning may be taught in an introductory course like nursing fundamentals, or it may be taught as a separate course (Indiana State University, 2003; Loma Linda University, 2003; Riverside Community College, 2003; University of Illinois, 2003). Regardless of how nursing programs teach this skill, a plethora of resources are available to assist faculty to introduce care planning to new nursing students (Craven & Hirnle, 2000; DeLuane & Ladner, 1998; Harkreader, 2000; Potter & Perry, 2001; Taylor et al., 2001). Additionally, there are many resources for students to help them understand the complex process of care plan development (Doenges, 2000; Wilkinson, 2000). Subsequent to the didactic portion of care planning, the students begin to put these skills into practice with their patients. The care plan becomes the focal point of clinical nursing education.

A review of current nursing fundamental textbooks shows that care planning is approached in a similar manner (Craven & Hirnle, 2000; DeLuane & Ladner, 1998; Harkreader, 2000; Potter & Perry, 2001; Taylor et al., 2001). The units on care planning start with a chapter on critical thinking and clinical judgment. The next chapters are devoted to the phases of the nursing process, one chapter per phase. The nursing process then is explained in great detail with examples to guide the learner.

It is in the planning chapters that a differentiation is made between a clinical practice care plan and a student care plan (Craven & Hirnle, 2000; DeLuane & Ladner,

1998; Potter & Perry, 2001; Taylor et al., 2001). The purpose of a student care plan is to help students learn the skills of clinical problem-solving and decision-making (Craven & Hirnle, 2000). Furthermore, student care plans are designed to assist the student to use the knowledge gained from theoretical courses for actual patient care (Potter & Perry, 2001). The explanations of the different types of care plans suggest that student care plans must be comprehensive in scope.

In addition to the fundamentals of nursing content, the nursing process continues to be referenced in various aspects of nursing education. George (2002) uses the nursing process to explain how nursing theories can be integrated into nursing practice. The nursing process is also used to guide nurses in providing medical-surgical care, nutritional care, medication administration, and patient preparation for laboratory testing (Black, Hawks, & Keene, 2001; Deglin & Vallerand, 2003; Kee, 2001; Peckenpaugh & Poleman, 1999). Undoubtedly, the nursing process and resulting care plans are viewed as an integral part of nursing education. Using these resources students continue to practice the skill of care planning throughout the nursing curriculum.

The Relationship of the Care Plan to the Professional Development of Nursing

As a fledgling profession, nursing needed a way to demonstrate the competence of its practitioners. The nursing case studies and care plans revealed the depth and breadth of knowledge achieved by nurses (Boehmer, 1954; Burgess, 1941; Eady & Jorgensen, 1948; Kieliazak, 1946; Parsons, 1911). But as nursing moved to levels of increasing technology and complexity of care, the care plan in practice was perceived as cumbersome and unrealistic. Nurse educators however continue to use nursing care plans as tools for teaching the practice of nursing. Faculty who primarily use the nursing care

plan as a teaching strategy may not be able to develop the skills newly graduated nurses need to practice in today's health care environment.

The nursing care plan with the nursing process as a foundation is the framework for teaching nursing. Accrediting agencies require care plans and all or part of the nursing process. Considerable disagreement exists within the ranks of nursing as to the value and effectiveness of the nursing process to realistically manage nursing care. There is a little consensus over how students should be taught care planning. Furthermore, there is a little agreement on the role, place, and status of the nursing care plan and the nursing process. The lack of empirical studies on the function and utility of the care plan contributes to the difficulty in facilitating a change in how students are taught to manage patient care.

The nursing process has also been defined as a problem solving process. Researchers have attempted to link problem solving to critical thinking but most of these studies are outcome focused. That is, the purpose is to determine the end result and not the process required to reach the outcome. It is not known if students use the nursing process and how they manage problems as they perform patient care in the clinical areas.

To date there is a dearth of research that attempts to describe how students develop their care plans or how students use the nursing process. There is little understanding of care plan development as it occurs in the clinical arena. It is possible that nurse educators are basing their teaching on the assumption that students are following the progressive phases of the nursing process. Research has shown that experienced practitioners do not base their nursing practice on this step-wise method (Benner, 1984). If nursing graduates are to be flexible in their thinking, have the ability to

creatively solve problems, and advocate for patients, nurse educators may need to move beyond care plan development and use of the nursing process.

Summary

Although the literature review presents a continuous discussion of care planning and the nursing process, limited research has been devoted to the students' experience. Brennan's (1992) research on the lived experience of students in writing care plans included participant observation. However, the observation was conducted as the researcher acted in the role of consultant to the students. There have been no recent studies conducted that utilize observation in the clinical setting. Daily observation of students as they participate in patient care, their interactions with agency staff and instructor, and the specific patient care activities performed, may possibly increase the awareness of how students develop care plans as part of their clinical work. Additionally, a study of students' approach to clinical work may help foster a critical examination of the way nursing is taught.

CHAPTER III

Study Design, Field Site, IRB, Participants, and Research Methods

This chapter presents an overview of this study's design, field sites, and research methods including the process of gaining entrée to the field, the procedure for obtaining consent, a description of the study participants, and the data gathering procedures. Since the ethnographic method of participant observations provided a substantial amount of the data, a discussion of the relationship between grounded theory and ethnography is provided. The process of comparative data analysis and the subsequent change in study focus is described. The data analysis procedures are discussed including the dimensional analysis grounded theory approach and the explanatory matrix that were used to organize the data. A discussion of the explanatory matrix provides an introduction to the narrative story of how students navigate the rules of the clinical practicum work.

Study Design

Observing student nurses during their clinical practicum required permission from a school of nursing and the hospital where the clinical course was conducted. In addition to obtaining permission from the nursing program director and the hospital administrator, individual faculty, students, and staff members also had to agree to participate in the study. Several issues were considered during the planning phase of this study. Since all student nurses engage in clinical work, students in a nursing program in the western part of the United States would be appropriate for study. While there are differences in the baccalaureate and associate degree preparation, the academic level of lower division

clinical work is relatively similar in most degree granting programs. Thus the decision was made to focus the study on students enrolled in the lower division course of the nursing program.

Gaining Entry and Negotiating Access

The first step to gaining entrée involved sending inquiry letters to four local community colleges, the purpose of which were to introduce myself and inquire about participant observation and interest in the project (Appendix A). Although no response was received from two of the colleges, the nursing director of the local community college replied that she would be interested. Over a phone conversation, the details of the proposed research were outlined. Since this community college did not have an Institutional Review Board (IRB) the director indicated she would contact her supervisor for authorization.

One week later the DON made contact and relayed that she had obtained permission to pursue the study from her supervisor. At this time the discussion of the details of the project and how it might be managed both in the classroom and the hospital began. A description of participant observation and how this method of data collection in the clinical setting would occur provided the initial introduction to conduct of the study. The suggestion that the observation would include student interaction with the patients was met with some concern and the director placed some limits on the data collection. She felt it would be uncomfortable for the students to have someone observe them during patient care activities. She then proposed that work with the Assistant Director of Nursing (ADON) commence to fine tune the details of the project.

A phone call to the ADON resulted in a meeting to discuss the research study. The ADON at first insisted that observations were only to be conducted during preclinical and post-conference sessions. A discussion of the conversation with the DON emphasized the agreement that observation was limited with patient contact only. The ADON stated she would verify this point with the DON and agreed to follow-up in a few days. I had a sense that there may have been a change in support for my research project.

At this time a new academic year was starting and it was several weeks before the ADON responded with her support of the project. A subsequent meeting with the DON and ADON proved to be beneficial since all their questions could be answered in person. The DON and the ADON were given an outline of the proposed research study. The major concerns expressed by the ADON were a) what is the risk to the students, b) what can possibly be learned from studying the work of student nurses, c) the faculty may not want to participate, and d) had this type of research with students been done before.

Both the DON and ADON were assured that these were valid concerns and that participation for students would be voluntary; they could drop out at any time. The procedure of informed consent that I had used in a previous study with nursing students was reviewed. That process had consisted of a general information session where an information sheet was distributed along with scheduled times where students could meet with me, the researcher, individually. This gave the students an opportunity to ask any questions related to the research. Student volunteers only signed the consent after all their questions had been answered. The issue of confidentiality was specifically addressed and all students were guaranteed that the information would remain confidential and that all transcripts would be kept in a locked cabinet in a private office.

I explained how participant observation would be conducted in the hospital and the relevance of this type of data collection for an interpretive study seemed to ease the concerns of the DON and the ADON. A clarification of the purpose of the interviews and assurance that these interviews would be conducted at the student's convenience served to help the DON and ADON see the feasibility of the project. I informed them that although limited research had been conducted with nursing students in a clinical setting, Oleson and Whitaker (1968) and Wilson (1995) reported that students were not negatively affected by the presence of researchers. They were also informed that Oleson and Whitaker encountered more resistance from faculty than students. I was very candid about the fact that not many studies of this nature had been done, but that sensitivity to this issue would be a priority.

The final issue to resolve concerned the participation of faculty. The DON and ADON discussed several possible faculty members who might be interested. They decided the DON would contact the faculty and let me know if any would volunteer. I preferred to make my own contact so that the project could be explained from my perspective. However, I speculated that the DON might need to retain a measure of control and so the point was not pressed. If none of the faculty volunteered that issue could be dealt with when it arose.

Later that day the DON approached several faculty members about the study. Two faculty members expressed an interest in participating; one of whom conducted the clinical course at a local community hospital and the other of whom was located at the country hospital. My choice of faculty then depended on which hospital would give permission for the research study.

Field Setting

A letter to the vice president of patient care services at the local community hospital outlined the research project and explained that permission had been secured from the community college (Appendix B). The vice president immediately phoned me and granted permission to go forward with the study. We discussed the nature of the research and how the data collection would be carried out. She offered to take the proposal to the research committee but, state that IRB approval was not necessary since there would be no patient contact. At this time she did not have any concerns about the participation of hospital staff.

The vice president requested that I prepare a formal letter about the dissertation project detailing the nature of the study, the research questions, and the data gathering procedures. This letter was sent two weeks after the approval was obtained (Appendix C). Two weeks later the final approval from the hospital was received (Appendix D). The vice president also gave me the contact information of the name of the orthopedic unit director, so that arrangements about the study could be made.

IRB Approval

I contacted the School of Nursing representative to the IRB at the University of San Diego (USD). I discussed the proposed research study and asked about the need to acquire approval from the hospital Institutional Review Board. The USD nursing IRB representative believed that the letter of approval would be sufficient for the IRB's approval of the research project. The proposal was submitted to the USD IRB and approval for the project was received (Appendix E).

Recruitment of Participants

After obtaining IRB approval, I met with the faculty member, Denise, whose students would be involved in the research study. During this informal interview, I explained the nature of my research study, what it would mean in terms of the students and the faculty, and the initial length of time I would be involved with the students. Denise described how the clinical rotations were organized and how she prepared the students during their orientation session. At this time, I gave Denise the faculty information sheet and a copy of the informed consent document (Appendix F and G). Denise agreed to participate and signed the informed consent document.

The community college utilized a sixteen-week semester. The nursing department director had chosen to divide the second semester of the nursing program into three sections, each lasting five weeks. The clinical faculty then conducted three consecutive clinical rotations on one nursing unit. Thus, each of Denise's groups of students received a five-week orthopedic nursing experience. The clinical experiences were held every Monday from 5:00 PM to 6:00 PM and Tuesday and Wednesday from 7:00 AM to 12:30 PM. During the last rotation of the semester, Denise had an additional student group who were scheduled on the unit from 1:00 PM to 7:00 PM. My plan was to recruit three groups of nursing students for the study.

The hospital staff was also recruited as study participants. The director of the orthopedic nursing units scheduled staff meetings where I was invited to come and talk to the staff about my study. I distributed copies of the information sheet (Appendix H) and informed the staff I would be available to meet with individuals at their request. Although

no one had specific questions at that time, I spoke with several staff members later on in the semester as they were contemplating participation.

I began my data collection with the second group in the semester's clinical rotation. Denise scheduled time during orientation for me to meet with the students and explain the nature of the research project. During that time, students were given the opportunity to ask questions and I handed out the information sheet (Appendix I). The following day at the hospital, I spoke with each student individually, answered more questions, and obtained informed consent (Appendix J). I repeated this procedure with each of the groups of students involved in the study.

I informed the students that at any given time they no longer wanted to be involved in the study, they could choose to discontinue their participation. I pointed out that the consent forms clearly stated that participants could opt out at any time. The consent form also stated that data already collected would not be used if the participant so desired. I also informed the students that during observation times, should they not want to participate, I would not record any of the activities or interactions that were involved with that person.

Obtaining informed consent from the staff was a little less organized. Orthopedic nursing was done on three different units and Denise's students were usually assigned to two of the units. The nursing staff however, floated between all of the units. Frequently, staff would be on different units for the two days the students were in clinical. Additionally, nursing staff from other units would occasionally be assigned to work on the orthopedic units. My strategy then consisted of asking every nursing staff member to participate, even if it was only for one day.

I also recruited staff from the physical therapy department since the students interacted with them on a daily basis. The unit secretaries were recruited since students asked them questions about unit activities. I would introduce myself and give an explanation of my research project. I then asked staff if they would give consent to participate (Appendix K). I emphasized that my focus was student nurses, but that the study looked at interactions the students had while on the unit. I explained that they could at any time decide to terminate participation. This was usually enough information for staff to be able to give consent. In addition to the verbal explanation, I also provided every staff member with a copy of the information sheet.

Data Collection Methods

Most interpretive and ethnographic researchers use some combination of participant observation, interviews, and document review (Janesick, 2000). Keeping in line with these traditions, I employed the three methods of data collection, participant observation, in-depth interviews and written document review. Making use of a variety of data sources are consistently necessary for grounded theory development (Charmaz, 2001).

Participant Observation

As a method of data collection, participant observation started in the fields of sociology and anthropology as part of an ethnographic approach to data collection (Vidich & Lyman, 2000). The first researcher to coin the phrase participant observation was Whyte (1943) who used it to describe his formal research that was part of his life experience (as cited in Vidich & Lyman, 2000). Since then, various types of participant observation have been described and used as data collection methods. According to

Lofland and Lofland (1995) participant observation is a process designed to assist the researcher to understand the ways of life of those in the natural setting. Additionally, participant observation allows the researcher to observe the activities, people, and physical aspects of the situation. The researcher may become partially socialized into the group being studied in order to deepen the understanding of the social interaction that is taking place (Schwandt, 2001; Spradley, 1980).

Different types of participant observation have been identified (Spradley, 1980). Spradley places these along a hierarchical structure ranging from nonparticipation and no involvement to complete participation that entails high involvement. Nonparticipation research requires a setting where there is absolutely no involvement with the people or activities studied. Passive participation allows the researcher to observe in a detached manner, such as in a public place. When assuming the position of moderate participation, the researcher maintains a balance between that of insider and outsider. Active participation requires that the researcher actually do what the people under study are doing. The last level is complete participation that occurs when the researcher is already engaged in the activity or culture to be studied.

For this research study passive and moderate participation were the most appropriate degrees of involvement. I spent 20 weeks in the field for 215 hours of observation. Participant observation was conducted in the classroom during student orientation, post-clinical conferences and on the patient care units. The orientation and post clinical conferences were activities that were part of the clinical experience for the students.

The observations on the nursing units primarily focused on the activities and interactions of student nurses, the faculty member, the unit nursing staff and the physical therapists. Data collection was conducted employing both the passive and moderate approaches. Most of the observation was conducted from the nurses' station and the surrounding areas. Occasionally I would be located in the hallway outside the patient rooms. A detailed description of the setting can be found in Chapter IV.

As I conducted my observations, I would try to be in close proximity to where verbal interaction was taking place. At times when that was not feasible, I would approach the participant afterwards and inquire about the interaction. I held brief and informal interviews throughout the clinical day, with both students and staff. The short interviews helped clarify observations that I made.

To record my observations, I made brief jottings on a small notepad that I carried with me. Then, when the students were in their patient rooms providing care, I would go to an empty room to begin writing up my field notes. I would use a handheld computer with portable keyboard and quickly write down all my observations. Later on at home, I would download that file to my desk computer and fill in the field notes. This system allowed me to capture almost all the actions and interactions soon after they occurred.

In-depth interviewing. Interviewing, used as a data collection method for many years, can be accomplished using a variety of different forms (Fontana & Frey, 2000; Spradley, 1979). The major types of interviews are structured, unstructured, and group. Each is suited to the specific type of data to be collected. While structured interviews yield responses resulting from a specific set of questions, unstructured interviews produce

a greater depth and breadth of data. This makes unstructured interviews compatible with the interpretive methodological tradition used for this research study.

Spradley (1979) maintains that the fundamental nature of unstructured interviewing is the researcher's relationship to the research participant and the researcher's desire to understand rather than to explain. As such, several prerequisites need to be addressed in order to come closer to this understanding. Fontana and Fry (2000) list similar elements that require consideration for effective interviewing. The ones that are pertinent to this research are deciding how to present oneself, gaining trust, and establishing rapport.

Presenting myself, gaining trust, establishing rapport. Deciding on how to present myself prompted some personal contemplation. Because the first impression can be a lasting one, it was important to carefully consider how I wanted to come across to the students, faculty and nursing staff. Presenting myself as a nurse may have provided a connection for students and nursing staff. Coming in as an academic may have been intimidating for students and nurses. I could have also presented myself as a student conducting research but it may have been difficult for the research participants to identify with that role. So I presented myself as a doctoral student in nursing science who was interested in looking at the work of student nurses and who is doing research. I wore street clothes and identified myself with a nametag from the University of San Diego.

Gaining trust was essential to obtaining interviews that would allow me to truly understand what nursing students do as they engage in clinical activities. As an academic, the student may not have wanted to reveal how they went about creating a graded paper. I repeatedly assured them that all information was confidential and would not be revealed

to any faculty member. I also informed the clinical faculty that I would not be able to share any information obtained from the students. This strategy seemed successful as the students and faculty openly shared their ideas and thoughts with me.

In order to reach an understanding of the work of student nurses, establishing rapport with them was also necessary. Fontana and Fry (2000) maintain that although a close rapport can yield more informed research, it can also lead to loss of distance for the researcher. That is to say, by developing close rapport with the students, I could be placed in a position where I could become the spokesperson for them. At no time did this happen. Although I gained valuable insight, there was never an occasion where I was in a position to be a spokesperson for the students. I did experience some overlap in my role as a researcher and my work as nursing faculty. I discuss this in Chapter IX where I present my reflexive comments.

The Interviewing Process

The interviewing process was done using two different approaches. Short informal interviews were conducted during the observation periods on the clinical unit. These interviews were used to clarify immediate questions raised by the observation. Tape recordings were not used for these short interviews and I made notes of these conversations during breaks in the observation.

The second type of interviews was the in-depth semi-structured interview. These interviews were scheduled with the participants and with permission all of them were tape-recorded. A basic set of questions was used to begin the interviews (see Appendix L). The questions were revised as additional data yielded different information. Ideally, I wanted the interviews to be spaced over the five-week clinical period. However, that was

not feasible. With family responsibilities, jobs, and studies, students had limited discretionary time to be available for this project. Thus, most of the interviews were conducted immediately after the post-conference session. On some days, I conducted three interviews in a row. One student requested that I hold the interview in her home. Three other students invited me to a barbeque and swim party to do their interviews at that time. I did go to the barbeque but limited my presence to the front porch where I carried out the interviews.

I conducted many informal interviews with Denise, the faculty member. I also conducted one semi-structured taped interview at the beginning of the research study. This interview helped contextualize the clinical experience and gave me Denise's perspective on how she managed the clinical experience. I also conducted informal interviews with a faculty member who taught in the first semester. This interview helped me to understand the background that students brought to this clinical rotation. A preliminary faculty interview guide can be found in Appendix M.

Document Review

A review of documents related to the work of student nurses was useful to develop the contextual boundaries of student work. Document review usually refers to personal documents that are analyzed in order to add to the research participant's point of view (Emerson, 2001; Hodder, 2000). The documents for this research, however, were used to understand the process students go through to manage their clinical work. The Document Summary form (Appendix N) was used to log the information gained from the review.

The course syllabus and care plan forms were reviewed to provide the foundation on which student learning was developed. The examination of the syllabus also provided me with a perspective of what was required of students to complete the faculty work. Students also gave me copies of their completed care plans after they had removed all identifying information. These care plans provided additional data related to one of the end-products of student work. Program description and information was obtained from the college's WEB site and program handbook.

Participant Sample

The research participants included second semester students enrolled in an Associate Degree Nursing program in a Western State. A total of 36 students, 8 male and 26 female, ranging in age from 25 to 45, agreed to participate in the study (Table 1). Some student participants were single and lived at home while others had families and/or full time jobs. Additional research participants included two faculty members and the staff working on the orthopedic clinical unit. Since the focus of the study was student nurses, detailed demographic data for the faculty and staff were not collected.

The first three groups of students yielded 100% participation for the field work segment of the study, however, for a variety of reasons, several of these students declined to be interviewed. For example, some students voiced discomfort with the interview process, another student stated it would be too stressful, and one student canceled her appointments. From the 30 participants, I conducted 22 interviews. Throughout the discussion presented here, pseudonyms are used to ensure participant confidentiality.

After the semester was completed I spent the summer analyzing the data. The analysis yielded gaps in information that required additional time in the field. And

because theoretical saturation had yet to be achieved, field work continued for an additional five weeks. The fourth group of student nurses had their clinical schedule during the morning hours. I repeated the same introduction to the research study as the previous groups. However, from this group of student nurses, four declined yielding six participants. The students who declined to participate stated they did not want to add any additional stress to their clinical experience. The advantage to having fewer students to observe was that I was able to conduct in-depth informal interviews right on the unit. Even though these interviews were not tape recorded, they yielded significant information.

I identified three subgroups among the student participants, 1) those who had previously failed the course, 2) Licensed Vocational Nurses, and 3) students with health care experience. For the current analysis, possible distinctions between students were not taken into consideration. In the future a secondary analysis comparing these groups may yield additional discoveries of similarities and differences among the groups.

Two faculty members, both clinical instructors, participated in this study. Denise was the primary instructor for all student participants and was the key faculty member in this study. The other faculty member, having students located on the orthopedic clinical units during the research project, had infrequent interactions research participants. This faculty member provided useful information about the nursing program and the care planning process taught to the students.

The staff on the orthopedic clinical unit consisted of registered nurses, licensed vocational nurses, nursing assistants, unit secretaries, and physical therapists. The staff members were recruited on a daily basis as they interacted with student nurses. The data

analysis was based on the observations and informal interviews conducted with the staff. Since the focus of the study was student nurses, no demographic data was sought or obtained. The total number of staff who participated in this study was 28.

Table 1

Demographic Description of Student Nurse Participants

Descriptions	No.	%
Student Nurses	• 36	• 100
Gender		
• Female	• 28	• 71.2
• Male	• 8	• 22.8
Age		
• 20-25	• 12	• 33.3
• 26-30	• 12	• 33.3
• 31-35	• 3	• 8.3
• 36-40	• 5	• 13.8
• 40+	• 4	• 11.1
Marital Status		
• Single/never married	• 13	• 36
• Single/divorced	• 5	• 13.8
• Married	• 15	• 41.6
• Single parent	• 2	• 5.5
Domicile		
• Live alone	• 10	• 27.7
• Live with parents	• 11	• 30.5
• Adult member of family	• 15	• 41.6
Employment		
• none	• 13	• 36.1
• 10-20 hours/week	• 12	• 33.3
• 21-30 hours/week	• 8	• 22.2
• 31-40 hours/week	• 2	• 5.5

Theoretical Sampling

In order to be able to generalize research findings to a larger population, quantitative research methods require sampling that is representative of the population to

be studied (Burns, 2001). Grounded theory methods however require a different form of sampling. In grounded theory development, the sampling progression is driven by the emerging theory, yielding a process that cannot be planned beyond the initial data gathering phase (Schreibner, 2001; Strauss & Corbin, 1998a). Built into the grounded theory approach are data collection and data analysis guidelines for the systematic development of theory (Glaser & Strauss, 1967).

Due to the academic scheduling of the nursing program, data collection needed to be arranged in advance. At first three clinical groups, spread over a period of 12 weeks, were selected for data collection. This length of time in the field was thought to be sufficient to collect enough data for the analysis. However, development of a grounded theory is partially the result of simultaneous data collection and analysis. As observations are made, and interviews are conducted, the data should be immediately analyzed for emerging themes and questions. Subsequent data collection then is driven by the results of the previous analysis. The emerging themes and questions are separated into analytic categories. This process continues until no new categories are revealed (Charmaz, 2001; Strauss & Corbin, 1998b).

Glaser and Strauss (1967) suggest that data collection cease when theoretical saturation has occurred. Strauss and Corbin (1998a) propose that data collection continue “until a) no new relevant data emerges, b) the category is well developed, and c) the relationships among the categories are well established and validated” (p. 212). Additionally, Glaser (1978) suggests that data collection continue until “theoretical completeness”, a point in which all concepts have been explored as thoroughly as possible, occurs. Glaser goes on to say that this happens within the context of the

theorist's available resources since there will always be more data to collect. As long as the theorist has sufficiently explained the concepts that "fit, work, have relevance and are saturated" (p. 125) theoretical completeness can be said to be reached. As theoretical completeness occurs, personal saturation also takes place. At this point the theorist, after countless hours of managing the data, achieves the result of having explained the phenomenon to his or her satisfaction. Although it may seem like Glaser is recommending an early end to data collection, his writings advance the notion of rigorous and deep immersion in to the data. At no time does he suggest a casual limited approach to grounded theory development.

The community college nursing program had divided the second semester students into three different groups. Each group spent five weeks at the hospital on the orthopedic unit. The initial plan for this research study was to conduct participant observation and interviews in the first five weeks of the semester. I spent between six and seven hours every Tuesday and Wednesday with the students. During the second five-week session, based on data analysis and concept development, additional interviews were done and participant observation continued. Analysis conducted during this time informed the data gathering for the last five weeks of the semester. Since clinical time was pre-scheduled, meaning there was no opportunity to draw out observation times, the data gathering occurred continuously without a break. The semester ended upon the completion of the third group of participants.

Over the summer the continuing data analysis, including the observations, the interviews and the documents, revealed additional time in the field was necessary to ensure theoretical completeness. During that time, the phenomenon under investigation

was changing with an increased focus on all the activities students were involved with during their clinical practicum. The last five weeks of field work were conducted during the fall semester. Denise was still the instructor and the same process of data collection continued. The observations and interviews were directed to clarify the concepts that had thus far been generated from the data.

Philosophical Underpinnings of Grounded Theory

Symbolic Interaction (SI) is a theoretical perspective that explains the relationships between individuals and the society they live in and the symbolic communication that occurs to bring this about. SI is based on three premises, a) the meanings that things have for persons will determine the behavior, b) meanings result from the social interaction people have with one another, and c) meanings are managed through an interpretive process (Blumer, 1969). SI's roots stem from an ontological perspective that the form and nature of reality is not objective, that is, reality cannot be known from the observable world. Rather, the symbolic interactionist views reality not as a given, but as socially constructed (Prus, 1996).

Lowenberg (1993) locates grounded theory as “one variant under the sociological tradition with symbolic interaction” (p.60). Grounded theory methodology involves the use of a rigorous set of procedures to develop a substantive theory of social phenomena. These procedures include analyzing the data for properties and dimensions, identifying concepts, developing categories, and selecting a key category that has the power to explain what the study is about. The interpretation of the data results in a story of those who have experienced the phenomenon.

People are active in shaping their own behavior, and interactions with others are carried out through the medium of symbols and their meanings. For the researcher then, it becomes imperative to study and attempt to understand the meaning that motivates or underlies human behavior. The grounded theorist's goal is to "construct a model to explain the action and interaction of a phenomenon of interest." Using data collection methods aimed at hearing the participant's story, grounded theorists attempt to discover the "socially constructed meanings that are the participant's reality and the behaviors that flow from those meanings." (Milliken & Schreiber, 2001 p. 180).

Grounded theory was deemed an appropriate approach for the study of student nurses in the clinical setting. To understand how student get through a clinical practicum, it was vital to hear their voices and discover the behavior and the meanings that motivated that behavior. Extensive field time using participant observation and formal and informal interviews provided rich data for the development of the substantive theory.

Ethnography and Grounded Theory

For this study, ethnographic methods of data collection were used in conjunction with interviews and document review. Charmaz and Mitchell (2001) support the use of ethnographic methods to generate a substantive theory believing that combining grounded theory and ethnographic methods allows the researcher to experience the phenomenon as it is experienced by the participant. Ethnographic methods facilitate the discovery of the phenomenon with a view not always possible with interviews. For this study, the experience of being in the field while students were going through their clinical rotation yielded additional questions that provided depth to the discoveries.

The time spent in the field doing participant observation yielded rich descriptions of the experiences of student nurses. Participant observation provided data to this study that would not have been captured by unstructured interviews alone. For example, observations of students interacting with staff and their peers led to the development of new hypotheses from which to gather additional data. In this study, some of the consequences of implementing the rules and doing the work may not have been discovered without extensive time in the field. Ethnographic methods proved to be a valuable addition to the data obtained through formal interviews.

A tenet of grounded theory method is the simultaneous collection and analysis of data. As data is analyzed, new questions are generated and new levels of theoretical understanding emerge. Through coding, the researcher defines and categorizes the data. Initial or open coding allows for the examination of each line of data and identification of the actions within it. Open coding prevents the researcher from assigning existing theories and thought to the data (Charmaz, 2000; Strauss & Corbin, 1998a). Constant comparative analysis is another major technique of the grounded theory approach. Using this analytic method requires the researcher to compare various elements of data against other elements. Comparing different people's views or experiences, comparing incidents, or comparing data with categories are some ways in which constant comparative analysis is used. This leads to analyses that are more focused and precise (Charmaz, 2000).

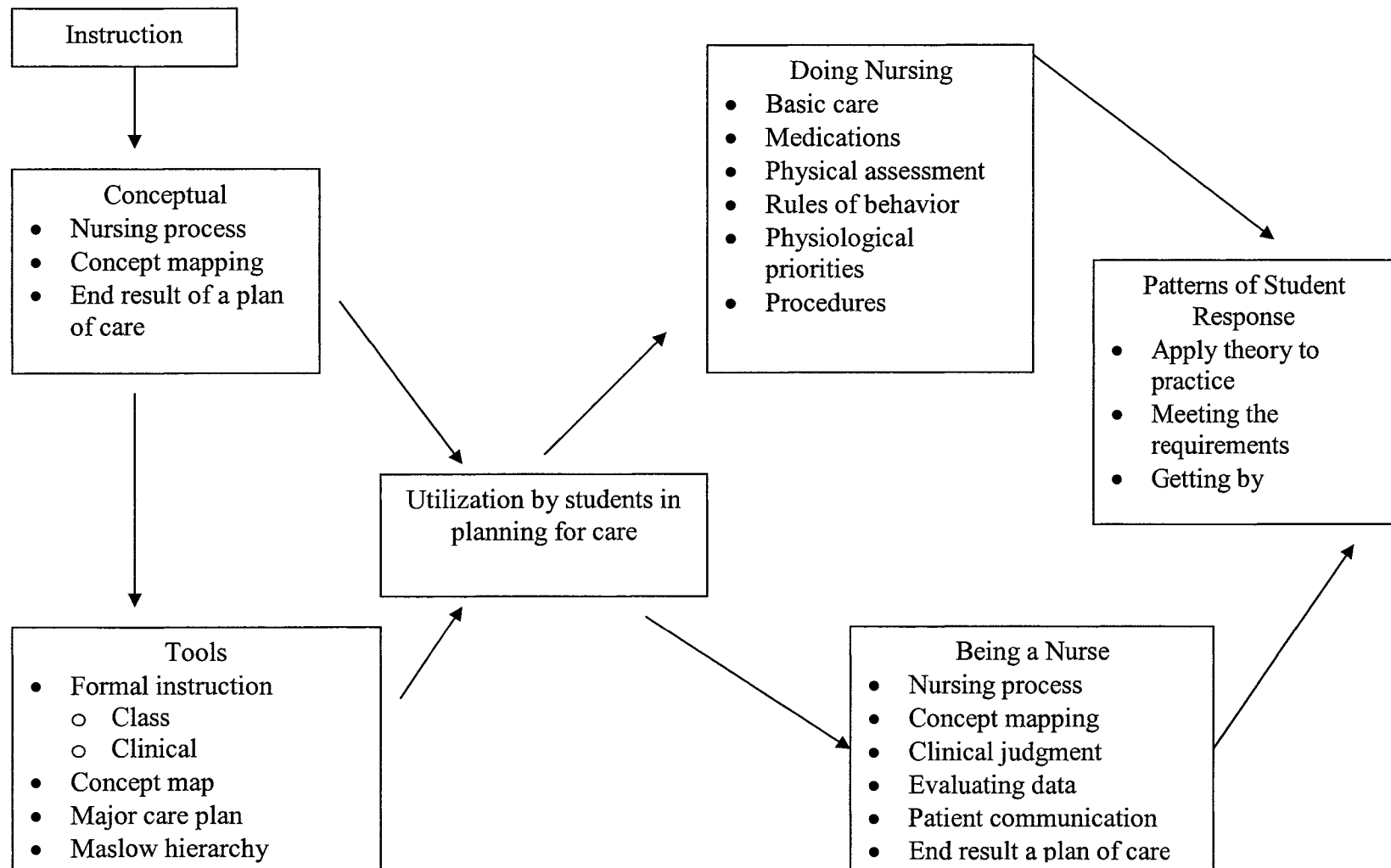
The Analytic Journey of This Study

The initial purpose of this study was to explain how students go about planning for patient care. Data collected with the first three groups of student nurses yielded initial codes that were then developed into categories. Using line by line and open coding key

properties and dimensions were defined. Theoretical memos were written to help inspire thinking and exploration of the codes. Figure 1 is an illustration of an initial organization of the data around the process of planning for care.

Figure 1.

Planning for Care



This first attempt at diagramming the process of planning for care resulted in the identification of key dimensions although these were still very concrete. As Figure 1 shows, the process was very linear and involved specific identifiable tasks. However, at this point the analysis showed a difference between the doing of nursing, which was subsequently labeled direct patient care, and learning to be a nurse. New questions were posed during the interviews and the field work became more focused. Some of the new questions were:

- What is the priority for preparing to care of a patient?
- How do students know what to do for the patient?
- What is the relationship between medication administration and planning for care?
- How are staff involved in helping plan for patient care?

Revisiting the data and posing additional questions yielded the concepts of “nursing work” and “following the rules.” However, at this time, these concepts were added to the growing lists of concepts, not having found a place in the total scheme of the developing theory.

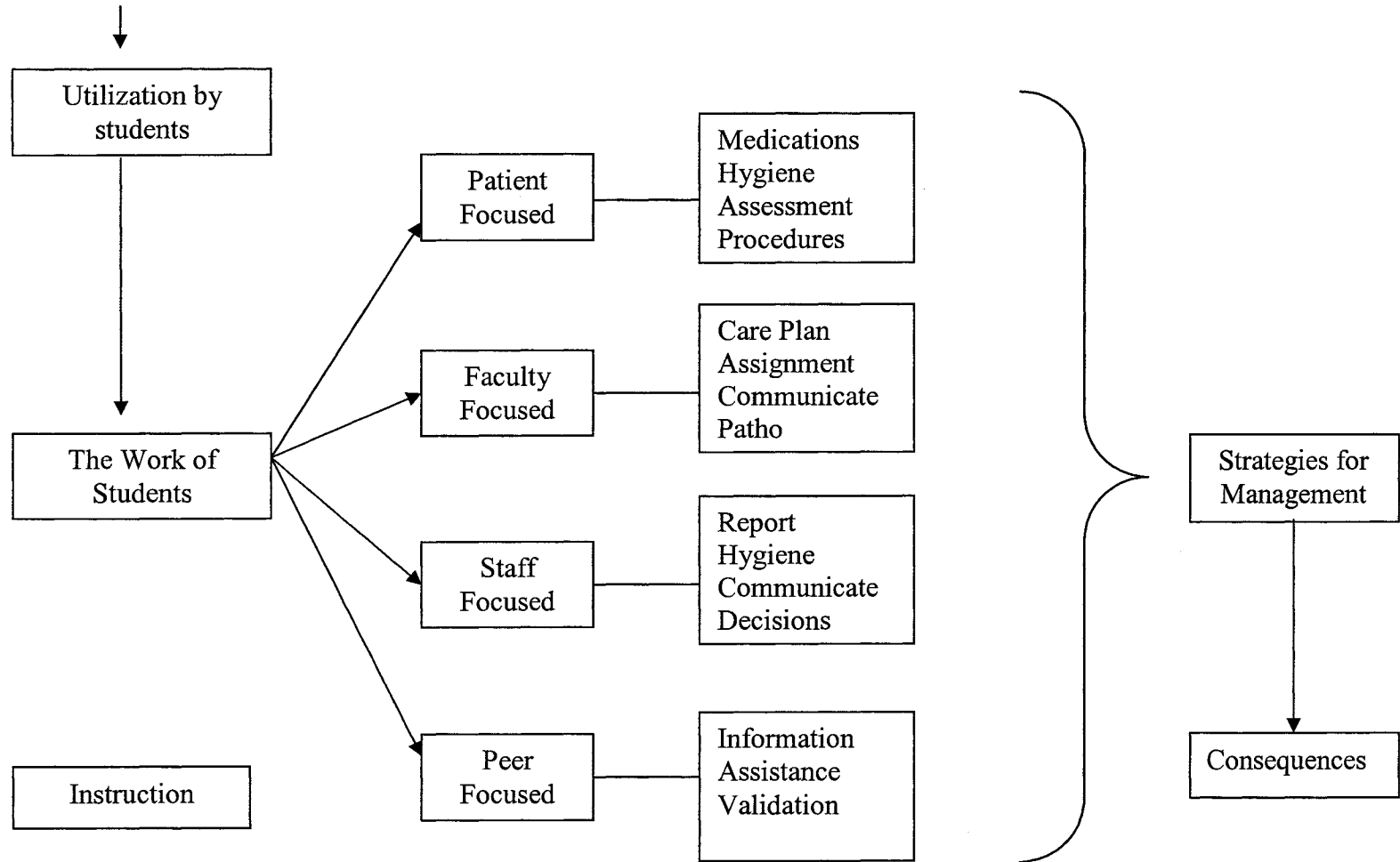
It became clear that additional time in the field was necessary to continue comparative analysis. During the last encounter with the nursing students, new questions were raised and reframed to develop a better understanding.

- What is a typical clinical day like?
- What happens when unexpected contingencies arise?
- How do students manage contingencies?
- What are some of the challenges faced by students in the management of patients?
- What do students hope to accomplish with the patients during a clinical day?

At this time, planning for care continued to be the focus of the study. Figure 2 depicts the second attempt to diagram the process.

Figure 2.

Planning for Care and Work



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Data analysis continued with the goal of raising the theoretical concepts to a higher level of abstraction. One of the pitfalls of the ethnographic approach is the generation of vast amounts of data which are not coded appropriately and promptly. The amount of time in the field and the numerous informal interviews yielded just such large amounts of data. The timing of the academic semester made coding difficult and not as thorough as needed to develop a substantive theory. During discussions with the dissertation committee members they suggested considering work and the work literature to further develop the analysis. Additional retrospective analysis was done and the data was revisited numerous times. It was at this time that the focus of the study changed. It became very clear that planning for care was but a small part of a larger phenomenon, the work of student nurses. New questions were asked of the data which resulted in further refinement of the concepts and categories.

- What do students actually do during the clinical practicum?
- How do students manage their clinical work?
- What are the consequences of doing the work?
- How do students carry out the instructions given them?

The various dimensions of each type of work were labeled and described. Figure 3 illustrates the transition from planning for care to the work of student nurses.

Figure 3. Basic Core Process “The work of student nurses”

What does the work consist of, what does it involve

<i>Patient Work</i>	<i>Faculty Work</i>	<i>Staff Work</i>
<p>Doing - action</p> <ul style="list-style-type: none"> • Background <ul style="list-style-type: none"> ○ Preparing ○ Accessing previous knowledge ○ Following the rules • Foreground <ul style="list-style-type: none"> ○ Providing patient “care” ○ Managing uncertainty 	<p>Figuring it out</p> <ul style="list-style-type: none"> • Faculty specific <p>Anticipating</p> <ul style="list-style-type: none"> • Preparing • Accessing previous knowledge • Following the rules <p>Communicating</p> <ul style="list-style-type: none"> • Validating decisions • Seeking advice <p>Seeking affirmation</p> <ul style="list-style-type: none"> • Verbal • Written <p>Meeting Requirements</p> <ul style="list-style-type: none"> • Assignments • Behavior <p>Doing - thinking</p> <ul style="list-style-type: none"> • Psychosocial assessment • Making judgments • Loss of control 	<p>Negotiating a role</p> <p>Making a connection</p> <p>Surviving contingencies</p>

Patient work
Faculty work
Staff work

} Influenced by peer to peer interaction

Pattern/strategies of student response: a) to manage the work, b) to manage contingencies

1. Following the rules
2. Getting by
3. Challenging the standard

At this point in the analysis, the narrative of the experiences of students was started including the categories of faculty work, patient work and staff work. Yet over the course of developing the narrative, additional questions were raised regarding the developing theory. Listed in Chapter I, these questions included:

- What process occurs when students go about their clinical work?
- How do students use and apply the rules when doing their work activities?
- How do students manage contingencies?
- How do student nurses negotiate their role in the clinical setting?
- What are the consequences of the work of student nurses?

As a novice grounded theorist, the theoretical connections made were still not clear and the analysis lacked the linkages necessary for understanding the work of student nurses. A committee member with expertise in using Dimensional Analysis suggested that this method may be helpful in organizing the data. Approaching the data yet another time using Dimensional Analysis helped focus and organize the analysis.

“Dimensional Analysis” was developed to assist novice researchers in the systematic analysis of data (Schatzman, 1991). While working with doctoral students, Schatzman discovered that the analysis procedures were not always clearly understood. Dimensional Analysis is a variant of the grounded theory approach but has its own epistemology. Natural analysis, one of the key tenets of dimensional analysis, is “conceptualized as a normative cognitive process generally used by people to interpret and understand problematic experiences or phenomena” (Kools et al., 1996 p. 314). Schatzman maintains that these cognitive processes are learned early in life and are used

whenever problems require action. Thus, when the analyst determines to deal with a complex scientific problem, he or she draws on skills learned and used in everyday life.

The second construct of dimensional analysis is “dimensionality”, referring to the “individual’s ability to address the complexity of a phenomenon, noting its attributes, context, processes, and meaning” (Kools et al., 1996 p. 315). These attributes are known as dimensions. According to Schatzman, scientific analysis is an extension of natural analysis and dimensionality is a process of natural analysis that allows the researcher to derive meaning through interpretation of the different attributes of a phenomenon (Kools et al., 1996; Schatzman, 1991).

Natural analysis and dimensionality take into consideration that the person’s past experiences and knowledge are integral to the thought processes. This means that the analysis that may be informed by some previous theoretical thinking. The researcher’s search for meaning includes both the participant and the researcher. Dimensional analysis allows for the possibility that the analyst brings experience and knowledge to the analytic process.

The original aim of this research project was to explore the care plan development process. Shortly after entering the field, it became apparent that care planning was only part of what was actually happening during the clinical practicum. Progressing with the analysis the larger phenomena of rules and work became apparent, of which care planning was but one part. After reviewing large amounts of data, dimensional analysis helped focus and organize the data through the use of labeling the observed dimensions and properties. The process yielded conceptualizations at a more abstract level than the earlier empirical observations.

The second step of differentiation allowed me to determine the salience of the dimensions and organize them logically. The final diagram, labeled the explanatory matrix, is organized around the central perspective and includes the dimensions addressing the context, conditions, actions/process, and consequences (See Figure 4). Kools et al (1996) define context as “the boundaries of the situation or the environment which gives rise to the circumstances” (p. 320). For this research study, the context included the background within which nursing education took place, the organization and characteristics of the particular nursing program, the clinical course in which the students were enrolled, and the clinical environment in which the students practiced. The conditions are the most salient of the dimensions and have an impact on the process, which results in intended or unintended actions and interactions. The most salient dimensions for this research study were the rules and expectations of faculty work, patient work, and staff work. The rules impelled the work activities which were accomplished when students implemented the rules. The consequences or outcomes for student nurses of the specific actions were that students modified the rules. Furthermore, students came to view patients as objects to forward the educational requirements. Lastly, students experienced tension and conflict in transforming classroom learning to the care of patients on an actual clinical unit. The explanatory matrix became the means by which the theory could be transformed into a narrative account of the process by which Associate Degree student nurses get through an orthopedic clinical practicum experience.

Figure 4.

Central Perspective: How student nurses navigate the rules of their work

<u>Context</u>	<u>Conditions</u>	<u>Process</u>	<u>Consequences</u>
<p>Antecedents</p> <ul style="list-style-type: none"> • Educational Leadership • Nursing Program • Course Faculty <p>Clinical environment</p> <ul style="list-style-type: none"> • Nursing units • Staff • Faculty 	<p>Rules</p> <ul style="list-style-type: none"> • of the program • of the faculty • of the hospital/unit • of the staff • of the self <p>Work expectations</p> <ul style="list-style-type: none"> • of the faculty • of the patient • of the staff 	<p>Assigning hierarchical value to the work</p> <p>Implementing the rules and doing the work</p> <ul style="list-style-type: none"> • of the faculty <ul style="list-style-type: none"> • being on stage • performing • validating • of the patient <ul style="list-style-type: none"> • entering into the patient's world • ensuring credibility • of the staff <ul style="list-style-type: none"> • negotiating a role • in-between position 	<p>Modifying the rules</p> <p>Experiencing tension</p> <ul style="list-style-type: none"> • Conflict • Disillusionment <p>Objectifying the patient</p> <ul style="list-style-type: none"> • Good patient • Bad patient

The final phase of dimensional analysis, integration, is the construction of a narrative explanation of the theoretical understanding of the phenomenon. This explanation renders the theory into a “clear narrative version” (Kools et al., 1996, p.319). Chapters IV through VIII discuss this narrative account of how students navigate the rules of their work.

Summary

This chapter has outlined the study design, field site, participants, and research methods. Students were recruited in their clinical groups. The data collection included formal and informal interviews and field observations. Additionally, a review of documents provided some of the background the context within which student work took place. Data analysis was accomplished using constant comparative analysis and dimensional analysis. An explanatory matrix resulted from this analytical process.

CHAPTER IV

The Contextual Boundaries of the Clinical Practicum and the Rules and Work Expectations for Student Nurse Work

In dimensional analysis the explanatory matrix is developed which becomes the cornerstone of the analytic process. The matrix provides the researcher with structure and a context for the explanation of the phenomenon (Kools et al., 1996). As described in Chapter III, dimensionalizing the data for this study resulted in a process whereby all the relevant and salient dimensions were designated as context, conditions, processes or consequences. This chapter describes the context, the boundaries for inquiry and conditions in which student nurses conducted their work. The chapter is divided into two sections, the first of which concerns the historical and larger context in which nursing education exists and the clinical environment where the students in this study conducted a major part of their work. The second section of the chapter is a discussion of the salient dimensions of rules, work, and work expectations.

Nursing Leadership and the Origin of Rules for Student Work

In the late nineteenth and early twentieth centuries, as American nursing struggled to become an occupation, nursing leaders developed standards and guidelines by which nursing should be practiced. The early cooperative efforts of the American Nurses Association and the National League for Nursing Education led to the inclusion and support of training schools where students were taught these standards necessary to care for the sick (Kalisch & Kalisch, 1995). Over the next 100 years, nursing leaders

continued to respond to the changing needs of the nursing profession. New systems, methods, guidelines, and practices were developed in order to facilitate the provision of nursing care that kept pace with the economic and political environment. Schools of nursing and nursing faculty adopted these recommendations and revised curricula to meet the changing needs.

A brief history of the development of the care plan and nursing process is provided to shed light on how nursing education and practice changed. Over the past 75 years the care plan has been an integral part for nursing practice and education. Although informal at first, the care plan became a requirement for nursing practice and education in the 1970's (Yura & Walsh, 1973; American Nurses' Association, 1965).

The nursing care plan, guided by the nursing process, has been institutionalized in nursing education by various accrediting agencies. The National Council of State Boards of Nursing (NCSBN) develops policy and guidelines for the regulation of nursing practice. The NCSBN states that the development of a nursing care plan is part of the scope of registered nursing practice (National Council of State Boards of Nursing, 2002). The California State Board of Registered nursing mandates that nursing education must result in a nurse who can “formulate a plan of care” (Board of Registered Nursing, 2000) p. 58). Nursing education accrediting agencies, like the American Association of Colleges of Nursing (AACN) and the National League of Nursing (NLN), also direct nursing programs to include care planning and the nursing process as a component of the curriculum (American Association of Colleges of Nursing, 1998; National League for Nursing, 2002).

One of the strategies used to provide students with the skills for nursing practice is to teach nursing care plan development. Widely utilized and accepted, teaching care plan development is an integral component of the nursing curriculum (Lea et al., 2001; Schuster, 2000; Welk, 2001). Central to the nursing care plan is the nursing process, the guiding framework for care plan development. Orlando (1961) defined nursing as a process, not as a series of activities. The nursing profession adopted and expanded on the concept of nursing process and used it to identify the steps nurses use to solve problems (Yura & Walsh, 1973). The nursing process is defined as “the problem-solving techniques of assessment, planning, implementing and evaluating a plan of care which requires technical and scientific knowledge and judgmental and decision-making skills” (Board of Registered Nursing, 2000, p. 54). The nursing process then results in a written plan of care (McCarthy, 1981).

Nursing education is guided by the developments occurring in nursing practice. Schools of nursing and nursing faculty create tools and assignments for teaching students how to practice in the various nursing care settings. In the clinical rotation where this study took place, a significant part of the work of student nurses involved the preparation and execution of the nursing care plan. The mandates from licensing and accrediting agencies shape the ways in which nursing faculty conduct their teaching. It is important to maintain an awareness of this perspective when studying the work of student nurses.

The Community College

The following section describes the nursing program and specifically the semester in which the nursing students were enrolled. It also includes a description of the orientation are given in preparation for their clinical rotation. Program rules, regulations,

requirements and practices formed the framework within which students conducted their work. The discussion is an essential component to the context of the study as it explains and defines the boundaries of student work. Additionally, included is a review of the specific course structure and requirements that students were expected to meet and complete. The analysis will show that these structures and requirements were key components in the conduct of student work.

The following description of the community college, the nursing program and the curriculum is derived from a review of college materials, faculty reports, student reports, and the college website. Like all community colleges in the state, the mission for this institution is to make an affordable education available to a diverse student body through the offering of transfer programs that paralleled the first two years of university education. A variety of vocational programs provide opportunities for career preparation; additionally, informational, recreational and skill-building programs are offered throughout the year in response to community needs.

The college is located in the center of the city and provides educational programs including career development and technical programs like cosmetology and culinary training. The professional programs range from administration of justice to art history to nursing.

The Nursing Program

At the time field work was conducted, the college offered one of the only publicly supported registered nursing programs within the western part of the county. The degree, an Associate of Science in Nursing, was awarded after successful completion of four semesters of nursing courses. The nursing program prepared students to function at an

entry-level practitioner in defined community-based settings. The program's goal was to prepare nurses to be critical thinkers and decision maker. Program documents stated that the nursing process was used to achieve this goal.

The nursing department admitted between forty and fifty candidates into the program every semester. Criteria for admission included successful completion of pre-requisite courses, including anatomy and physiology, chemistry, microbiology, and developmental psychology. Students were required to pass these courses with a combined grade point average of 2.65. The nursing program's website stated that due to the rigorous nature of the curriculum, the students should try to complete the majority of the general education courses prior to starting the nursing program. As such it can take three and four years to complete an associate degree.

The selection process, conducted by faculty, was designed to give preference to students meeting district residency requirements and to those who had previously attended the college for their prerequisites courses. Based on these priorities, applicants were stratified into two groups; students who had completed the pre-requisites were admitted first and then those who would be likely to complete the prerequisites prior to the start of the nursing program. Because of the competitive enrollment, applicants applied to more than one program. As one student in this study told me, "I applied to the state university and was accepted there too. But I decided to come here because now I will get done in two years instead of three." After spending one to two years completing prerequisites and required courses, it was possible that that time-to-completion was one factor in selecting a community college program.

The nursing program's curriculum. The curriculum consisted of 37.5 semester units spread out over a total of four semesters. The courses had to be taken in succession, and successful completion of each semester was required to move on to the next semester. That left students relatively few choices as to when and where they could take their courses. Although a few electives were offered, most of these were designed for students who were close to graduation. Once a class of students had been admitted, they progressed in a cohort until graduation.

The first semester students enrolled in "Nursing Module 1", which consisted of an introduction to nursing concepts and nursing practice. Simultaneously, students enrolled in "Nursing Module A", which covered the professional aspects of nursing such as nursing roles and relationships. Nursing Module 1 covered the foundations of nursing practice introducing various topics important to beginning nursing students like the history of nursing, legal and ethical consideration, the nursing process and care planning, cultural diversity, and gerontological nursing. Students were also introduced to the system of preparing clinical assignments. The forms for these assignments and tools for student use were continued throughout the four semesters of the program.

The accompanying clinical laboratory provided the practical experience for learning basic nursing skills such as vital signs, hygiene, mobility, and medication administration. Students spent 216 hours in this laboratory class, half of which was in an actual clinical setting. The experience allowed the students to practice in the hospital the skills they had learned in class.

There was another course students frequently referred to as "block lab" or "Nursing Module B." This class was held every other Friday for a three-hour block. At

first I assumed this was a required course since just about every student mentioned learning nursing procedure skills there. However, upon studying the curriculum, Nursing Module B was an elective offered to every class, every semester. It was a course that allowed students to practice the various procedures they would be responsible for that particular semester. Most of the students took this course and frequently referred to the benefits of doing so.

After successfully completing Nursing Module 1, students progressed to “Nursing Module 2”, which included the beginning concepts of health and illness. This course consisted of 63 lecture hours and 243 laboratory hours and covered three major content areas, a) childbearing families, b) pediatrics, and c) orthopedics. While the laboratory time was divided equally to each content area, the students reported that about 10% of the lecture time was devoted to orthopedic nursing. The Nursing Module 2 lecture was a graded course and students were required to pass with a 72% in order to move on to the third semester. The final grade was derived from the total scores of five examinations.

The laboratory experience for Nursing Module 2 was divided into the three different clinical experiences. Student spent five weeks each in obstetrics, pediatrics, and orthopedics. When they registered for the lab class, the schedule indicated the dates they would be in each section. Since there were five groups of students, they rotated between the clinical sites. The groups involved in this research study were in orthopedics for the second or third rotations.

Additionally, students could opt to enroll in Nursing Module B. This particular semester, Nursing Module B included procedures like management of intravenous solutions, nasogastric tube insertion, urinary catheterization, sterile and non-sterile

dressing changes, and care of the orthopedic patient. Although this was an optional course, all students in the study were enrolled.

The Hospital and Clinical Environment

The next section of this chapter focuses on the clinical environment where much of the actual student work took place. The description serves to inform the reader about the structure, organization, people and practices that made up the work of student nurses. The clinical milieu formed both a spatial and practice boundary in which students were expected to carry out their clinical obligations.

Clinical experiences were gained at a 450-bed acute care community hospital. Located across the street from the community college, the hospital and the college shared a long history of joint cooperation. Many of the hospital's nursing staff were trained at the college and in support, the hospital provided priority placements for the college's clinical site needs. Both the hospital and the college were first built in the early twentieth century.

The hospital offered a range of comprehensive health care services including basic and specialty care and many community outreach programs. Over the course of the nursing program the students had at least four of their clinical experiences there. The nursing educational structure was designed so that students experienced clinical practice in a variety of settings. Students progressed through the program in cohorts of about 50 students. That meant that each lecture class had 50 students who were then divided into clinical groups 10 students each. The program faculty secured locations for students' clinical experiences. In order to provide a variety of these clinical experiences, students rotated through variety of hospitals. Prior to starting the rotation, students were required

to attend a one-day orientation to the clinical facility, which covered two major components, an introduction to the policies, procedures, and physical layout of the hospital and a review of the syllabus and specified requirements for the clinical rotation.

Orientation

Orientation was the time when the rules and work expectations were presented to the student nurses. I first came in contact with student nurses during orientation of the clinical practicum. The following section is drawn from field observations, interviews with both nursing students and faculty, and a review of the documents. The Nursing Module 2 clinical laboratory began with an orientation session on Tuesday. Because of this, the students did not have scheduled lab time on the first Monday of the session. The students usually parked across the street on the college campus and then walked in groups of three or four to the hospital. On any Tuesday and Wednesday at 6:45 AM, groups of students in their white uniforms could be seen crossing the street to the hospital, clipboards and stethoscopes in hand.

For the first day of Nursing 2 laboratory the students were instructed to meet in the hospital lobby at eight in the morning. The hospital had stringent security regulations and no one was allowed access above the first floor without checking in with the security guards first. There was a counter in the middle of the lobby where all those who did not work for the hospital checked in. After stating the reason for the visit, the visitor relinquished his or her driver's license in exchange for a badge. This badge would allow entry to limited areas of the hospital. Nursing students would receive a temporary badge from the hospital's nursing education department, which then would allow them multiple

location access for a limited period of time. Since the students had not received their badges yet, they met their instructor in the lobby.

The instructor, Denise, waited for all the students to arrive and then they moved to the Education Complex where a classroom had been reserved. The Education Complex was located right next to the hospital and was used for meetings and educational sessions by hospital staff, community groups and nursing education programs. Nursing instructors from all schools could request classroom reservations at any time. The complex was designed with flexible walls so that several small rooms could be converted to a large room as the need arose.

Denise led the students to one of the small classrooms. The room had one door and no windows. One side had an accordion type wall that could be moved. The room had about twenty classroom-type seats and each student selected a seat. There was no instructor's desk or table so Denise used the two desks at the front of the room to hold her materials. She welcomed the students and passed out the syllabus. The time allotted for the orientation was six hours and her plan was to review the entire syllabus, go on a hospital tour, and select patients for students to care for the next day.

The syllabus. The syllabus was a 177-page document contained in a yellow three-hole punched binder. The cover page stated that it was the "Clinical Manual for the Hospital and Perioperative and Orthopedic Nursing." Denise had compiled the handbook and included hospital forms, policies and procedures, her own assignments, and the nursing program's care planning forms. The syllabus' table of contents was divided into 57 sections that included such items as student behavior, hospital and unit maps, a multitude of hospital forms, forms to assist students with organization, students

assignments for the operating room, and forms for the various types of care plans students were required to complete. A quick review of the syllabus showed that about 26 of the pages were devoted to hospital forms and information, another 70 to care plan forms, including duplicates for the students to use.

Denise started by giving a general introduction to the routines of the units where the students would be located. She covered the parking rules, how to enter the surgical suites, and provided some general information about the specific units. She read the information from the syllabus and pointed out items that she considered important. I glanced at the students as the syllabus review began. They whispered to each other about the size of the syllabus and seemed overwhelmed at the amount of information it contained. The students read along with Denise from their own syllabi. At certain intervals, Denise would pause and ask if anyone had any questions. Later on many of the students reported to me that they were at this hospital in the first semester for the OB rotation. Subsequently, they did not have any questions and followed along with the reading of the syllabus.

Hospital forms. Denise discussed the next section of the syllabus, which contained specific hospital and unit-based forms the students would be using. These included samples of charting, the medication administration record (MAR), preprinted orthopedic physician orders, and an information sheet titled “Expectations and Guidelines for Nursing Students.” She suggested to the students that they read these on their own time and familiarize themselves with the content.

Denise then directed the students to the pre-printed physician’s orders, called *path orders*. These forms were developed by the orthopedic division of the hospital to

prescribe specific treatments for various orthopedic surgical procedures. The ones included in the syllabus were preoperative and postoperative care for spinal fusions, total knee replacement, and total hip replacement. The path orders listed all the medications, activities, treatments, lab work, IVs, and diet a patient should receive on a day-by-day basis.

Denise then discussed the medications listed on the path orders. As I later discovered, preparation for medication administration was a significant part of the clinical experience. Denise suggested to the students that it might be easier for them to get a head start on the medication review. She explained that each of the order sheets contained common medication orders. Patient undergoing the various surgeries would most likely have some of these medications ordered and the students could prepare the review in advance. The students were required to prepare a comprehensive analysis of all medications ordered by the physician. The students listened attentively and jotted down some notes.

Medication administration rules. The next twenty minutes were spent on medication administration. Denise explained that most medications were given at 9:00 AM. The hospital policy stated that medications could be given a half hour before to half an hour after the ordered time. Denise said she would usually pass medications between 8:30 and 9:30 AM. In order for her to be able to accomplish that with all the students, they must do some advance preparation. She instructed the students to gather all their medications in a little medication cup. Most of the medications were wrapped in individual wrappers and she directed them to leave the medications in the original packaging. The students were not to unwrap the medication until she had checked it with

them. She explained that sometimes patients refused their medications and by leaving the medications in the wrapper they could be returned to the medication cart.

Denise described how medications were delivered to the unit. The pharmacy personnel go from floor to floor with a large cart that holds medication cassettes. Each nursing unit has medication carts and the pharmacy will remove the entire medication section (cassette) and replace it with a new cassette. Each cassette has about twenty individual drawers in it, each labeled with the patient's name and room number. The drawers hold a twenty-four hour supply of medications. The times to exchange the medication cassettes varied from unit to unit.

Medications not supplied in the cassette system, like controlled drugs and bulk medications, were held in a large computerized dispenser. Nursing staff was given a password to access the system. Denise informed the students that if they needed a medication that was in the dispenser, she must get it out for them. On units where she did not have an access number, the staff was to secure the medication.

Denise next informed the students of her pager number they need to use. The number was printed on the second page of the syllabus. She specifically instructed them not to page her for routine medication administration. She explained that she would come to the different units between 8:30 and 9:30 AM. The students should use the pager when they needed her for other things like patient procedures. Denise later explained to me that in order to save time and redundancy, she does not let the students page her for routine medications.

Care planning rules. Denise then moved on to discuss the care planning requirements. The syllabus included "Instructions for Completing Nursing Care Plans."

This guide included a description of how the care planning process had been developed, that curriculum committee of the nursing department, comprised of faculty and students, had devised the care plan format. The guide also contained information stating that the care plan format was an evolving worksheet, to be completed by the student as more and more data became available. According to the instructions, the care planning process started with planning for patient care using chart information and continued through actual patient care activities. The instructions further went on to say that the nursing process was a key component of the conceptual framework of the nursing program. The Nursing Care Plan tool was designed to integrate the all of the nursing process components with a purpose to enable the student to assess, diagnose, plan, implement, and evaluate nursing care.

The students were required to submit three different types of care plans for every clinical section this semester. The first type of care plan was the working care plan. The instructions indicated that a working care plan should be submitted for all patients assigned to the student. The second type of care plan was the complete care plan and the third was the major care plan. All the components of a working care plan were included in the complete and major care plans.

The working care plan. The discussion of the working care plan was lengthy and quite detailed. I refer to it here since the Denise and students used this form in clinical practice on a daily basis. The working care plan included four forms. Denise referred to first form, titled Nursing Care Plan, as the face sheet. At first it was difficult for me to understand the process of the written care plan in its entirety. One of the reasons was that students sometimes use different names for the forms. Whenever they referred to the face

sheet, I could not locate it in my supply of forms. When asked why she called it a face sheet, Elizabeth told me the information came from the “face sheet” on the hospital chart. Yet other students referred to this form as the “demographics” page. This may be due to the fact that the form also contained some demographic information.

Students were instructed to gather the following information from their assigned patient’s medical chart: age, gender, admission date, admitting diagnosis, presenting signs and symptoms, secondary diagnoses, history of present illness, recent surgical procedures, health history, substance use, allergies, religious preference, ethnicity, marital status, and occupation. Denise indicated that this form was to be completed the night before clinical. The demographic section covered half the page.

The other half of the form was designated for pathophysiology, current health problems, and related functional changes. Denise instructed the students that they must complete the pathophysiology section prior to coming to clinical. The information did not need to be typed but had to be legibly written. At this time, Denise gave no further instruction on the care plan requirements.

The reverse side of the form was divided into two sections, labeled the therapeutic multidisciplinary treatment plan and the prescribed treatments. The written instructions on the form for completing the therapeutic/multidisciplinary treatment plan were that this information should come from the textbook. Neither section contained specific instructions although the prescribed treatments included subdivisions like oxygen, diet, respiratory treatment, bowel/bladder, and activity. The form did not specify which disciplines should be included in the plan. One student asked what Denise required on the therapeutic/multidisciplinary treatment plan. Denise responded by saying that her

requirements were that the students indicate the actual ordered treatments and the treatments suggested by the textbook.

The next section of the working care plan was titled, The Adult Laboratory Diagnostic Tool. It listed a multitude of laboratory tests in the first column, normal ranges in the second column, and separate columns for admission and subsequent results. The final column was to be used for students to identify a decrease or elevation of the lab test and the significance of the result. There were no specific instructions on this page and Denise did not review her requirements for managing laboratory tests.

Following the laboratory form was the Prescribed Medications Form. This was commonly referred to as the TACTIS, both by the students and the instructor. TACTIS was an acronym standing for a) therapeutic effect, b) action, c) contraindications, d) toxic effects/side effects, e) interventions, and f) safe dose. These were listed in columns on the form and the student completed the information prior to administering medications. Students were instructed to use their drug information textbook to fill out each section for every medication they were going to give.

The last form for the working care plan was the Concept Map. The students were instructed to start filling this out prior to clinical on Tuesday and then add information after completing clinical care. The center of the form contained a box for writing the medical diagnosis. Just below that was a space for five problems or nursing diagnoses. The instructions on the form stated that the nursing diagnoses were to be prioritized based on Maslow's hierarchy of needs. Surrounding this box in a circular pattern were categories for patient assessment, including oxygenation, circulation, elimination,

nutrition/hydration, safety/skin/sensory, neurological/neurovascular, anxiety/fear/concerns, love and belonging, rest/activity, and comfort/sexuality.

Denise told the students “you should fill out the concept map on Monday night using cues available to you.” One student asked, “What are cues?” Denise responded that cues were assessment information that formed the basis of the nursing diagnoses. She also told them she only wanted abnormal data filled in on the concept map. A student spoke up and said that other instructors wanted all of the data, both normal and abnormal listed on the concept map. Denise thought about this for a couple of seconds and replied that she only required the student to list abnormal data.

The major and complete care plans. Two other care plan requirements were needed to successfully complete Nursing Module 2: the major and the complete care plan. These care plans were identical except that the complete care plan called for three nursing diagnoses and the major care plan called for five. Denise had determined a due date for each student to turn in his or her respective care plans. Denise later on told me that she must stick to a strict care plan due date schedule in order to successfully manage the volume of papers that needed to be graded, as that the completed plan averaged around twenty pages.

Denise did not review the major and complete care plan forms. Instead, she asked the students if they had any specific questions related to the care plans. Of significance to the study was an additional set of forms required for the major and complete care plans. Gathering the information for this form had a major impact on student work. This document consisted of four-page physical assessment form, a two-page psychosocial

assessment form, a nursing care plan form, and a teaching form. All of these forms were to be completed and turned in with the care plans.

The physical assessment form was designed in a check-off format. The first column included a comprehensive physical assessment covering the same categories as the concept map. Under each category, specific parameters for assessment were outlined. For some areas the student could select a result and check the box next to it. Other sections had short blanks that could be filled in with descriptive language. For example, the neurological category contained a subheading of level of consciousness. The check box results offered the student a choice of awake, alert, oriented, restless, drowsy, sedated, or confused. An example of a blank space to be filled in was describing pain.

The second column of the physical assessment form provided space for the students to write in an explanation of abnormal assessment findings. The third column included a list of nursing diagnoses that could be related to the assessment finding in each assessment category. For example, within the category of elimination, the student could choose from several nursing diagnoses, constipation, diarrhea, or incontinence. The physical assessment form did not contain any specific instructions.

The psychosocial assessment form was divided into three main categories, love and belonging, self-esteem, and self-actualization. Under each category were specific questions related to the category. For example, the love and belonging category included questions about health problems and the impact on lifestyle. As with the physical assessment form, the psychosocial form included a column of related nursing diagnoses. There was an instruction at the top of the page that cued students to obtain the information by observing the patient's verbal and nonverbal behaviors. Using that

information, the student was to make inferences and work with the patient toward accomplishing goals and objectives.

The nursing care plan form was designed in columns using the nursing process. It includes the nursing diagnosis with a stated outcome, interventions which must include a rationale with references, and an evaluation. For the major care plan students were to develop five nursing diagnoses and for the complete care plan student were to develop three diagnoses. For each diagnosis there was space on the form for nine different interventions with rationales and evaluation. The form did not include instructions for use and so students needed to figure this out.

In the syllabus both the major and the complete care plan forms included a form called, "M.E.T.H.O.D Daily Teaching Plan and Evaluation." Although this form was not listed on the instruction page, it was mentioned on the care plan evaluation form. The Daily Teaching Plan included a variety of items that patient may need to be taught. Method was an acronym for a) medications, b) environment, c) treatments, d) outpatient referrals, and e) diet. During orientation, Denise did not discuss the teaching plan requirements, however, on the nursing department's WEB site; there was a download for Directions for Using METHOD Daily Teaching Plan. This was a comprehensive guide that explained how to do a teaching assessment and described the kinds of information that should be taught in each category.

End of course evaluations. The last discussion of the morning involved the clinical evaluation tool. It was the last part of the syllabus and contained a comprehensive description of the performance rating. The evaluation was based on a total of possible points of 270 requiring students to earn a minimum of 162 points to progress to the next

quarter. Although the clinical courses were graded as a Pass/Fail, the point system allowed the students to see the consequences of following the rules.

The actual evaluation tool was five pages and covered, in detail, the five areas of the nursing process and the three roles of an Associate Degree Nurse, provider of care, manager of care, and member within the discipline of nursing. The instructions informed students to complete a self-evaluation and bring it to their final clinical conference meeting, to discuss with the clinical instructor the performance over the past five weeks. Denise gave the students the date and times she planned to hold the final evaluation conference. This resulted in an animated discussion as the suggested time conflicted with the student's time to prepare for the final exam. When student study time was affected, it seemed they were ready to defend their position. After a fairly passive orientation session, with the students accepting without comment, the course requirements, and students now spoke up in unison. The times Denise selected to conduct the evaluation conflicted with the time students had set aside to study. One student commented they would be studying and did not want their evaluations then. Denise reconsidered and said she would do them early in the morning on the day of the exam. Another student spoke up and said this still was not acceptable because they would be cramming for the test. Denise finally agreed to conduct the evaluations after the final exam and this seemed agreeable to the students. This ended the classroom session of the orientation and the students packed up their belongings to go on the hospital tour.

The Hospital Tour

The orthopedic clinical rotation was one part of the medical-surgical nursing experience. The students would spend most of their clinical time on one of the three

orthopedic units. The students would also spend some time in the perioperative areas as part of their surgical clinical experience. In order to familiarize them with the hospital, a tour of the facility was part of the orientation. I joined the students on this hospital tour. The following section is drawn from my field notes.

Denise asked the students if they had done any clinical time at the hospital. All of them responded that they had been there before, either during Nursing I or the obstetrics rotation. Denise decided then to limit the tour to the operating room (OR) area and the nursing units. Denise had informed me that usually the OR nurse educator conducted a presentation during orientation but that today, the educator was not available. She also said that if students had not been at the hospital before, she included the cafeteria, gift shop, nursing education, and the admitting department in the tour.

Denise led the group to elevator and ascended to one of the orthopedic nursing units. Here, Denise showed the students where she would post their assignments. She pointed out the medication carts, the various utility and supply rooms, and the location of the charts. Denise also introduced the students to the nursing staff. In the OR area, Denise brought the students to the hallway leading to the OR. She called on the hallway phone and one of the nurse managers came out and addressed the students. This nurse manager explained the rules of the OR and showed the students where they were to go to change their clothes. The manager also provided some instructions about the expected behavior in the OR and whom the students should contact if they had any questions during their assigned time there.

Denise then told the students they could go and have a break while she selected patients for them on the orthopedic units. She instructed them to meet on the unit in front

of the elevator in 30 minutes. Denise told me that usually the students would receive their patient assignments on Mondays, but on orientation Tuesday, patient assignments were given students after orientation so they could care for patients the following day.

The Clinical Units.

The hospital was a 450-bed multi service facility. The focus of this clinical rotation was orthopedic nursing. The orthopedic service covered sections of three floors, the sixth floor housed Unit 1, the second floor housed Unit II and the fifth floor housed Unit III. Denise had decided to place students on the second and sixth floor since another nursing school occupied the fifth floor. Denise explained that it was best not to combine schools on the same unit as it was confusing for the nurses to remember the requirements of different groups. Students were rotated between the two floors and assigned to the operating room for one week.

Orthopedic Unit I physical layout. Orthopedic Unit I was located on the sixth floor. When I got off the elevator I first noticed the white bench, which backed up to a counter of the nursing station. All the units in this wing were similarly laid out. I observed family and visitors sitting on these benches while waiting for the elevator to arrive. This is also where Denise instructed the students to meet her at the beginning of each clinical day.

To the left of the elevator was the visitor's waiting room. In all the time I was on the unit, visitors seldom used the waiting room. This may have been due to the fact that the security staff only released two visitor identification badges per patient room and as such limited the number of visitors on the unit at any given time. Visitors without passes remained in the hospital lobby. At times patients would take walks and sit in the

waiting room to rest. It was large and square with individual chairs placed around the room along the walls and there was a television set in the corner. Three large windows provided a view of the city and the distant mountains.

Adjacent to the waiting room was another room with a closed a locked door. This was the supply room and the only way to enter was to use the numerical keypad on the wall. When students needed to obtain supplies they would get the code from one of the staff nurses. The supply room was large and contained stainless steel shelves around the room along the walls. All manner of patient supplies were contained here, from hygiene items like toothbrushes to pre-packaged treatment trays. Each item had a bar code on it. Whenever a supply was used for a patient, the nurse or student would enter the patient number on a small computer number pad that hung from the wall. After the patient's number was entered, the bar code was scanned and in this way the item was charged to the patient.

The nursing station. The nursing station was a rectangular shape, the boundaries made up of counters. The layout of the station was U-shaped with the back wall providing access to the medicine room and the Director's office. There were two breaks in between the counters that allowed access to inner space of the nursing station. Part of the counter was desk height with round backless stools around it. Here nurses and other staff would sit and chart or use the phone. In addition to the phone, there were two computer terminals. Along the wall were some bookshelves that held a couple of boxes of equipment. On top of the bookshelf was a poster announcing an educational presentation on pressure ulcer care. Next to the poster on the wall was a bulletin board where communications from hospital management and educational department on

charting legalities charting legalities were displayed. There was also a schedule of educational session for the following month. During my weeks on the unit, these notices never changed, nor were new ones added. After a while they became part of the landscape and I did not even notice them.

Underneath the bulletin board was the pneumatic tube station. This system was comprised of air tubes that connected different areas of the hospital. When an item needed to be sent to another station, the nurse would place it in a tube that was about 18 inches long and 6 inches in diameter. The tube was inserted in the send-off section of the system and the nurse would enter a numeric code that corresponded to the receiving station. The tube entered the system and the item would be delivered. This system was mostly used for receiving medication from the pharmacy. The students quickly figured out how to use this system as it provided a way for them to get their patient's medicines.

The middle section of the counter provided a type of boundary so that anyone coming in to the station was clearly visible. Most visitors stayed behind this counter to talk to staff. The hallway side of the counter was raised to about 40 inches while the station side of the counter was at 28 inches, or desk height. Chairs with wheels were placed at various locations and moved as needed. The area provided the space for the unit secretary to work. It was the central information section for the unit. Here the secretary would speak with visitors, communicate with nursing staff, and attend to the business of keeping the work flowing. She answered the phones and was generally the first person visitors would approach with questions. The charge nurse worked here to manage patient care assignments and to be available to visitors and physicians.

One side of the nurses station contained a built-in chart rack with cubbyholes open to both sides of the counter. Most physicians and nurses used this area because of its proximity to the charts. Additionally, the secretary's desk was located close by making the sharing of information convenient. Most of the patient care staff worked in the chart area. Physicians would speak to nurses here and review charts. Other health care staff, like physical therapists, dietary staff, and medical reviewers also used these areas. Each counter section had two computer work stations and several telephones. Since the nurses did all their charting by computer, these work stations were frequently in use. Physicians also used the computers to locate laboratory and diagnostic testing results. Students did not have access to the computers and were required to ask the nurses for any specific information that was not in the paper chart.

Located in the nursing station was a locked door that opened into the medication room, it too had a numeric keypad for entry. I never entered the medication room but since the door had a large window in it, I was able to see the inside. The medication room held all the intravenous supplies, the medication refrigerator, extra boxes of needles and syringes, and the staff mail boxes. The students were given the code number to this room but did not need to use it very often since the medication carts contained almost everything they needed for medication preparation.

Medication carts. An area of continuous activity was at the medication carts or "med carts" as the students referred to them. Nursing Unit I held such carts, parked in the hallway by the nursing station. The med carts were the workplace for medication administration, as such, most of the medication preparation was done while standing near the cart. The top of the cart held the medication administration record (MAR) book,

alcohol wipes, medication cups, and a pill crusher. There was an opening that provided access to a trash receptacle.

The cart locked automatically and in order to gain access the user was required to punch in a code number on a strip located on the top of the cart. If the cart was not used for a pre-set amount of time, usually one minute, then it would lock automatically. This frequently happened to the nursing students during their medication preparation process. Students worked at a slower pace and frequently found themselves with a locked cart that involved re-punching in the code. It was not uncommon for the students to unlock the cart five times during medication preparation.

On the left side of the cart was a container for the disposal of sharp, items like needles; a shelf on the right side held a nursing drug reference guide. The front of the cart was divided into two sections. The upper section was a removable cassette that contained little drawers. Each drawer was labeled with a patient's name and room number. Pharmacy personnel were responsible for stocking patient medications. Once each day, a pharmacist would come up to the unit and exchange the entire cassette for a new one. The lower half of the med cart contained other drawers for supplies like various syringes and needles. The bottom drawer held liquid bottles of medicine that were too large for the individual cassette drawers. When the cart automatically locked, none of the medications or supplies could be removed. This provided for safety and security of the medications.

The controlled substance system. Not all of the drugs were kept on the med carts. Medications deemed "controlled substances" were located in a large computerized machine that stood against the center wall of the nursing station. This machine was about five feet tall and three feet wide and provided for total computerization of these

substances. Whenever nurses needed to obtain a drug from the machine, they would enter their password on the keyboard. After gaining access, they could perform a number of procedures. The nurses could obtain the medications for their patients, access floor stock medications like acetaminophen and aspirin, check on the number of narcotics given per patient, and document when medications or portions of medications were wasted.

The students did not have access to this system. Denise obtained a password but it was only usable on Unit I. On other units students were required to ask the nurse to obtain the medications for them. On Unit I Denise would use her password and then follow the steps to gain access to the medications.

Auxiliary rooms. There were four other rooms used by nurses and students. One was the equipment and storage room. This room housed the wheelchairs used to transport and discharge patients. The second room was the kitchen, which was kept locked with a numeric keypad for entry. The kitchen had an ice machine, a refrigerator and a coffee maker. It was always very hot due to the ice machine that ran almost continuously. The nutritional services department stocked the refrigerator and pantry on a daily basis with containers of milk, juice, flavored gelatin, puddings, ice cream, crackers, and peanut butter packets. These snacks were intended for patient consumption. The staff however was allowed to make and drink coffee.

The utility room, frequently referred to by the staff as the “dirty utility room”, was also locked. Here staff would dispose of patient supplies that were too large for the patient room trash receptacle. It was also used to dispose of contaminated items like blood bags and soiled dressings. There was a large trash bin with a red liner that signified contaminated trash. It also contained the hopper, a drainage system with a flushing

mechanism like a toilet, for the disposal of large amounts of liquid. The utility room was messy, discarded supplies were on the counter, and it always had a peculiar musty odor. As with some of the other doors, this one was locked with a numeric keypad entry system.

The last auxiliary room was outfitted with shelves that held patient linen. In the morning, the laundry personnel would stock the room with a fresh supply of linen. There were neat stacks of pillowcases and sheets, towels and wash cloths, patient gowns and pajamas, and on the bottom shelf bed blankets and bath blankets. However, by noon these neat piles were usually reduced to a chaotic blend of linens as nursing assistants and student nurses had rummaged through the stacks to obtain their needed supplies.

The patient rooms. Unit I had eleven patient rooms with two patients per room. All the rooms had windows with views of the city or mountains. The bed closest to the door was labeled Bed A and the one next to the window was labeled Bed B. A curtain could be drawn around the beds to provide for privacy, creating a small cubicle. The floors were vinyl and the walls were painted a cream color with a blue patterned wallpaper border next to the ceiling. Each room held a bed, chair, visitor chair, nightstand, and bedside table for each patient. Additionally, each bed cubicle had its own television set.

Orthopedic Unit II physical layout. The other unit where the students were assigned was located in an older wing of the hospital. This wing was built around 1940 and had been redecorated many times. This unit also had 11 double occupancy rooms and the census was frequently at capacity. Although the unit contained all of the same auxiliary rooms and nursing station, the space allotted for these was less than half of Unit

I. As a result, the unit always felt crowded and noisy. Between nursing staff, physical therapy, visitors and nursing students, there was little space left to “hang out”

The nursing station was about half the size of the station on Unit I. It was square with a one end divided to create a small charting room and a medication administration area. There was a chest-high counter that separated the station from the hallway. Across the counter was a lower desk where the secretary worked. On the secretary desk was the phone, the call light system, a computer terminal and a large printer. Increased technology meant reduced workspace for the staff on Unit II.

There was a running counter along the two of the walls where the nurse would do their computer work and charting. Along the last wall was a door that led to the medication room. This room was accessible by punching in a numeric code. The supplies in the medication room were similar to Unit I, except that this medication room also served as the supply room. It was very crowded and only two people could stand in there at one time. There was no room for the staff mailboxes, so these were housed in the medication room on Unit II.

The section of the nursing station that was designed for medication preparation was about seven feet by seven feet. The medication cart was along one wall. It was the same type of cart as on Unit I. Along the second wall was the computerized medication machine. It too was the same as on Unit I. The third wall was actually the doorway to the charting/lounge room. The door was usually propped open with a brick covered with a needlepoint wrapper. Squeezed behind the door and next to the computerized medication machine was a dressing cart. Whenever someone needed access to the dressing cart, the brick had to be moved out of the way. The fourth wall in this space was a short wall and

it held the sink and a waste basket. At around 9 AM, this little space would be filled with nurses and students bumping in to each other as they gathered their medication supplies.

Due to the limited space, Unit II had one medication cart instead of two. This meant that some of the patient medications were placed in drawers that were intended for other supplies. Such drawers were not labeled with the patient's name and room number. The medications were in a plastic graduated container in one of the larger bottom drawers that was used for extra syringes and needles. At times this was confusing for students because they could not locate the medications for their patients.

The charting or lounge room was the same size as the medication preparation room. The students spent a great deal of time here, charting and talking to one another. The nurses did most of their charting on the computer and subsequently only used the room for breaks and lunch. The room held a round table and several chairs. There was also a rectangular table along one wall that ended up holding the newspaper, cups of coffee, miscellaneous supplies, and educational material. There was a staff refrigerator that was rarely used. Its main function was to hold notices from various departments, which the nurse managers taped on the door. The room had a window but whereas the windows on Unit I had views of the city and mountains, this view was of the rooftops. Although the workspace on Unit II was small and frequently crowded, it did not seem to affect the nursing staff's behavior or attitudes. Most of the nursing staff worked on both Module I and II and their interactions with the nursing students were fairly consistent.

Composition of Nursing Staff

“Team nursing” was the patient care delivery system used for both orthopedic units. Team nursing meant that a registered nurse and a nursing assistant provided all the

care for a group or team of seven to nine patients. However due to admissions and discharges, a nursing team could care for as many as 14 different patients in one shift. The nursing team met all the patient needs for the shift. Registered nurses administered medications and treatments, conducted patient assessment, communicated with other health care staff, gave patient instructions, and generally coordinated the care of the patients. Nursing assistants provided most of the physical care, like the bathing, toileting, patient ambulation, vital signs and assistance with meals. Nurses and assistants communicated with one another throughout the shift on patient related issues.

A charge nurse was assigned to manage the flow of nursing activities for both units. This nurse did not care for patients but made the assignments and coordinated the flow of patient admission and discharges. A major challenge for the charge nurse was matching the patient needs with the staff allotted for the shift. A central staffing office made the decision about a) the number of nursing staff and b) the skill level of staff they would assign to each unit. This resulted in an inconsistent ratio of licensed to unlicensed personnel that changed from day to day. There could be a varied mix of staff with some registered nurses, licensed vocational nurses, and nursing assistants. The staffing office adjusted the number of allotted staff based on the number of patients on each unit. At times this resulted in a hectic start for the shift as the charge nurse shuffled names and numbers on the assignment board.

Licensed Vocational Nurses (LVN) were sometimes part of the staffing mix. The charge nurse usually assigned these nurses in the same manner as RNs. Registered nurses were also assigned the task of supervising the LVN's work. It made for busy times for the RNs as they juggled their own assignment with the responsibility of overseeing the

LVN's work. Through all of this, the student nurses had to make a place for themselves and their work. As we shall see, developing relationships with staff became an important aspect of student work.

The Conditions and Salient Dimensions

The conditions are the most salient of the dimensions as these have an impact on the actions and interactions on the process of the phenomenon. (Kools et al., 1996). For this study, the rules and work emerged as the most salient dimension due to the effect they had on how students acted in regards to work performance.

The Rules: What They Are and Who Sets Them

For students to engage in faculty work, patient work, and staff work they were required to follow rules. These rules included those set by nursing education leaders and outlined in the Nursing Practice Act, those developed by the nursing program, the rules created and enforced by individual faculty, those set by the hospital, and the rules of each individual nursing student. The rules provided the framework in which students carried out their work activities.

Nursing Program Rules The nursing program had many prescribed school rules. Derived from various regulatory agency requirements, the rules were designed to provide consistency in carrying out the curriculum and provide guidance to the faculty enforcing them. In addition to the State Board of Nursing, the program was required to follow the rules of the National League for Nursing, the academic accreditation organization. The nursing program had little flexibility with some of the rules. For example, the State Board of Nursing clearly defined the number of clinical hours required to sit for the licensing examination. As a result, clinical attendance was a rule faculty and students strictly

followed. Other rules set by the regulatory agencies provided the nursing program some room for interpretation. The requirement for using care planning and the nursing process was clearly defined, yet how those concepts were taught and integrated was up to the nursing program leadership to decide. The rules open to interpretation were frequently the ones faculty followed less consistently.

The rules designed for clinical could be divided into two categories. The first set of rules concerned student behavior and included items such as dress code, attendance, tardiness, and preparedness. These rules were enforced at the discretion of the clinical faculty member. While Denise strictly enforced the attendance rules, she was less rigid about the other rules like the level of preparedness and tardiness. Subsequently, some students figured out the extent of her leniency and stretched their behavior to this limit.

The second category of school rules involved the nursing program's curriculum and practice model. Based on Maslow's hierarchy of needs, the rules prescribed the ways in which students were to conduct assessments leading to the development of nursing care plans and the implementation of patient care. Students and the faculty used their own interpretation of how these rules should be followed and both the faculty and students imposed their own priorities on how the rules were enacted. Students, keeping in mind the specific faculty member's requirements, would follow these rules based on the clinical situation.

Individual Faculty Rules. This statement made by a student, "It's kind of like a treasure hunt trying to figure out what their way of thinking is" describes the student participants' view about individual faculty rules. Students quickly learned that what was taught in the classroom did not necessarily hold true for the clinical setting. The faculty

deviation of rules ranged from minor discrepancies such as when students could take breaks, to a major departure of how to conduct a physical assessment. Students responded to these changes in various ways, some continuing to follow the rules they were taught in class and others experiencing tension over the differences and questioning whether the faculty or nursing program was academically sound. Another group of students spent the time to figure out what each individual faculty wanted and used those methods to get through their clinical practicum. When talking about his pre-clinical prep, John explained to me, “each instructor is different but for Denise, this is exactly what we have to do”.

Denise, the nursing faculty had a specific set of rules governing a) student pre-clinical preparation, b) medication administration, c) documentation of patient care, and d) written assignments. These rules, although explicitly reviewed during the clinical orientation, were not always applied equally in clinical practice. Denise varied enforcement of the rules in response to individual student performance. Based on the clinical dynamics of the day, Denise could and would reduce the level of knowledge required of a student for particular situations. For example, normally, Denise required students to be able to state the action of the drug as well as side effects and nursing implications. However, when Lois was struggling to prepare nine medications for her patient, Denise only asked her about the five rights of medication administration. Lois had to identify the correct medication, dosage, patient, written order, and time. If Lois had been subject to the full medication review, it is doubtful she would have passed that clinical day. These occasions helped some students get through some difficult clinical experiences. Denise also pushed the rules with students she felt were able accomplish more. If students were particularly adept at answering medication questions, Denise

would intensify the questions in order to stimulate their thinking and enhance judgment skills.

Hospital and unit rules. The hospital and unit rules were discussed during the orientation session and outlined in the syllabus. Students mostly adhered to hospital and unit rules and they became part of their everyday practice. The hospital rules included parking policies, locations to take breaks, how to charge a patient for supplies, and rules regarding emergency safety procedures. The unit rules included operational procedures specific to each nursing unit. Occasionally, students would break hospital/unit rules if they believed they would not be caught, though these instances were rare.

Staff rules. Staff rules were set forth by nursing staff members and covered issues like medication administration and patient management. Students needed to be flexible in order to follow staff rules since these rules could be different for every staff member. Staff rules could provide students with practical information on how perform procedures students had only seen in the classroom laboratory. Staff rules could also supplement the instructions given by Denise. When faced with a clinical situation in which students found themselves unsure, staff rules could help to guide them. However, if staff rules were such that the student felt they could not be followed, as in crossing a student practice boundary, students would then need to make a decision about other rules they could enact to manage the problem. At times students would follow the staff rules and at times they would develop alternate strategies to handle the clinical issue.

Self rules. Students brought their own set of rules, self rules, to the clinical practicum and used these when the prescribed rules were not satisfactory to do the work. Self rules were guided by a cost and reward system, the desire to get through the clinical

practicum, and the students' personal values. Students used self rules to make decisions regarding faculty work, patient work and staff work. For example, if the faculty required a certain piece of information on the written care plan that was to be turned in, a student may enact the rule of the *end justifies the means* and opt to fabricate that piece of information. As one student pointed out, "they [the faculty] want to see the blank filled in, so I just fill it in, even if I was not able to get the information". Other students would enact their personal rules in the other direction. If the faculty rule determined that the forms for pre-clinical must be filled out, these students filled out those forms, even if it meant staying up half the night to do so. In spite of the fact that they would see their peers with partially completed forms, these students would not skip any steps.

Students followed the rules based on the perceived consequences of following or not following the rules. When faced with a clinical situation for the first time, student's usually followed a prescribed rule. With additional experience, some students opted to ignore rules or implement only part of the rule. While students would never skimp on their medication preparation, they would cut back on some of the written assignment. Some students completed their concept map for every single patient, regardless of whether that map was going to continue to a major care plan. Other students would report, "I don't have to finish this, my patient isn't a major [care plan assigned]". These students would prepare a cursory concept map with just enough information to pass the morning check-in with Denise.

The Work: Faculty, Patient, and Staff

In this study, student nurses described their work using broad terms related to volume, such as, *it is a lot of work*. When referring to the work, students usually

described either their written assignments or direct patient care activities. The written assignments, completed at home, were time consuming yielding multiple pages of written information. Patient care activities were carried out during the clinical day. However, data analysis revealed that in order to achieve the assignment outcomes, students also engaged in other types of work and work activities. Conceptualizing work as, “a sequence of expected tasks, sometimes routinized but sometimes subject to unexpected contingencies” enabled the study of work as a social process, including the actions, interactions and meanings students made from their experiences (Strauss et al., 1985, p. 9).

The three dimensions of work formed the foundation explaining the ways in which students followed the rules to perform their work. Students, involved in a myriad of activities, performed in response to faculty, patient, or staff requirements. These three types of work explain the activities students carried out to get through their clinical practicum. Sometimes occurring simultaneously and sometimes individually, engaging in faculty, patient and staff work compelled students to manage the expected tasks and unexpected contingencies. Faculty work was the priority focus for students and they addressed most of their efforts to complete this work. Although the clinical was designed to teach students to provide nursing care in the real world, getting through the clinical practicum was of utmost importance. Without success at faculty work students could not become nurses. Student participants expended most of their efforts on completing faculty work, using patient and staff work to support successful achievement of faculty work. Although the students identified patient activities as work, much of the effort expended

with the patient was geared to completion of faculty work. Students engaged in staff work to engender success in both patient and faculty work.

Faculty work. Students defined faculty work as those activities required by the faculty to complete the clinical practicum with a passing grade. The major function of faculty work was to satisfy the clinical requirements, both written and practical, for the successful completion of assignments, the clinical day, and at the end, the clinical practicum. Within the framework of passing the course were numerous activities the student completed in a loosely structured but sequenced order, beginning with pre-clinical preparation and continuing with patient care. Students referred to writing up care plans as a major component of faculty work. However, as the analysis will show, the work was much more comprehensive than simply writing up assignments. A significant part of faculty work involved figuring out how the faculty member interpreted the curriculum and how this interpretation could be reflected in the written and practical assignments.

Patient work. The direct care activities of patient work were clearly described by students in terms of a sequence of tasks they would carry out during their time on the unit. When asked what their plan was for the day students usually spoke about bathing, bed-making, medications, procedures, and charting. The indirect care activities were also an integral part of patient work, yet students spoke of this work in terms of meeting care plan assignments. The feature of patient work that was not so clearly defined, yet what gave the student's great difficulty was entering into the patient's world. Entering into the patient's world meant that students would develop enough of a relationship with the patient would allow the student to acquire information of a personal nature. Entering into

the patient's world enabled students to observe and examine the patient's psychosocial, spiritual, and cultural status. This assessment was part of the care plan requirement yet was problematic for the students to carry out. Whenever patient work consisted of tangible activities, students usually performed those without undue anxiety. Giving a bath and taking vital signs had clearly described steps to follow. However, when the patient work consisted of intangibles such as determining the patient's spirituality, students were more reticent when attempting to acquire that information. The rules were not clearly spelled out how to go about managing this kind of patient work. As a result, students developed their own rules in order to manage this difficult yet necessary task.

Patient work began with the pre-clinical preparation and ended with the post-conference clinical meeting. The pre-clinical preparation served to provide the student with the background of the patient's condition and medication regimen. Thorough preparation helped the students increase their level of comfort when entering into the patient's space. Many students shared a fear that their patients would question their level of knowledge about the patient's condition. The students also feared answering questions for which they may not have an answer. By spending time with pre-clinical preparation, the students felt better equipped to meet the challenges of the day. During the post-conference clinical meeting students would share their experiences with their peers. It was during this time that the students shared some of their anxieties and outcomes of meeting the patient's expectations.

Staff work. Staff work was defined as the expected tasks and behaviors students needed to accomplish in order to establish a working relationship with the nursing staff. The development of the working relationship usually meant students were better

equipped to complete both faculty and patient work. A positive working relationship with the nurses provided the students with access to patient information, advice on how to manage and approach their patients, validation that the student's decisions were correct, and information on confusing orthopedic concepts. I observed a nurse Kelly help a student develop a task list for a dressing change. When they were done, Kelly said, "There, now you will really impress your instructor." Nurses like Kelly contributed to the student's learning and thus developing a working relationship was a worthwhile effort for the students.

Staff work began early in the shift with the change of shift report and continued throughout the clinical day. As the clinical rotation progressed, engaging in staff work did not always become easier. Even though the students quickly familiarized themselves with the routines of the units, variability of the nursing staff required continuous efforts of establishing the student-nurse relationship. The difficulty for students was that they usually had to start staff work from the beginning every time they came to clinical since the nursing staff assigned to their patients could be different week to week or even day to day.

Work Expectations

The three types of work as defined by students consisted of the activities students needed to accomplish to get through the clinical practicum. However, each work entity, faculty, patients, and staff, had work expectations for the students. These expectations were sometimes explicit, such as faculty written assignments, or implicit, such as what the patients required from students. Occasionally, the expectations conflicted with what the students deemed appropriate work.

The faculty expected students to complete the written assignments. These were outlined in the syllabus and made up a significant portion of the final grade. Other expectations were discussed during orientation and students were expected to come to clinical prepared to provide patient care, with a priority placed on medication administration. Most of Denise's expectations were discussed in the orientation session. But during the course of the clinical rotation other expectations surfaced such as the students' role on the clinical unit. Denise expected students to help the nursing staff care for patients other than their own. This meant that if a student had completed the care for the assigned patient, he or she was to help the nursing assistant attend to the patient's requests. Students, however, preferred to use the free time to study for tests. When reminded by Denise of their responsibilities, students would help for a short period of time and as soon as possible would return to studying.

Patient expectations were more subtle. For this study, no patients were interviewed so the following expectations are taken from student accounts. The patients expected students to meet their physical needs related to hygiene, nutrition, comfort and activity. They also expected students to communicate their needs to the nursing staff. The patients may have had other expectations such as keeping personal information confidential; however, these were not verbalized by students.

The staff expected students to complete the tasks that students said they were responsible for. This was especially true for medication administration and bathing the patient. The nurses needed to know whether or not the medications had been administered whereas the nursing assistants needed to know if the bath had been given and the bed had been changed. These two areas of care were of particular importance for

the staff since omission could have detrimental consequences. Even though missing a bath may not result in patient injury, the nursing assistants stated this was their responsibility to ensure the basic care was done. Additionally, the staff expected the students to communicate with them regarding the patient's status.

Summary

This chapter has described the context of the clinical practicum and the rules for student work. The nursing program's structure and requirements provided the foundation for enacting the rules for work. The students were enrolled in the second semester of the nursing program and the curriculum provided the tools and forms for students to use for their clinical experiences. Although some of the students' preparatory work and the formalized care plan work were done at home, the majority of patient, faculty and staff interaction occurred on the two nursing units. While the two units were very different in physical layout, the orthopedic staff nurses had the same nurse managers; they also worked between the two units. Orthopedic Unit 1 and Orthopedic Unit 2 then, became the backdrop of this study in the work of nursing students.

The rules and work emerged as the most salient conditions in this study. The rules consisted of formal rules as defined by the nursing program and hospital, and informal rules that emanated from the faculty, staff, and the student's personal background. The rules were learned through formal instruction and through interaction with the various actors within the clinical setting.

The work, divided into faculty work, patient work, and staff work, emerged as the other dimensions. The work and work expectations consisted of the activities students performed throughout the clinical experience. Work not only consisted of tangible

activities like care plans, medication administration, and physical care but intangible such as negotiating a role with nursing staff and entering into the patient's world. Chapters V, VI, and VII will show the ways in which the students implemented the rules to perform their work.

CHAPTER V

Implementing the Rules of Faculty Work

The central perspective of how students navigate the rules for their work provides an understanding of how students get through a clinical practicum. The particular clinical practicum in orthopedic nursing provided a range of patient care experiences, making it an appropriate venue for this study. The nature of the patients' conditions, including surgeries, medical co-morbidities and chronic pain, provided opportunities for students to make interact and collaborate with nursing staff. Students were also meeting the faculty requirements and these requirements, combined with the activities on the unit, formed the foundation of the work.

Chapter IV described the context and conditions of this study. This chapter begins with a definition of what implementing the rules meant for student clinical practice. A discussion follows of how students developed their priorities for conducting their work by creating a hierarchy of the three types of work, faculty work deemed the most important and other forms subordinate to it. Next, the dimensions and activities of faculty work are defined and an explanation of how student participants experienced and managed this work is provided. A discussion of the division of work into backstage and front stage work elucidates how students sequenced through the tasks of faculty work. Finally, this chapter discusses how students specifically implemented the rules to complete faculty work. The unexpected contingencies and the ensuing outcomes experienced by students will be discussed in Chapter VIII.

Implementing the Rules

The conditions of rules, work, and work expectation compelled the students towards certain actions and interactions designed to help them get through the clinical practicum. The rules guided the work expectations of the faculty, patients, and staff and students employed a process of implementing the rules to meet these expectations. Implementing the rules meant that when students engaged in work activities they used a set of guidelines, some given to them in the nursing program, others learned over time, as a framework to accomplish the work. The rules then guided student behavior and clinical practice. Students learned the rules throughout the nursing program, both from faculty, peers, and other sources. For example, a significant number of rules were presented during Nursing Module I. When faced with a clinical situation requiring action, the students' first response was usually to follow the rules. Rules ranged from a formal set of prescribed rules, as in the procedure for medication administration, to subtle rules that were learned from peers, as in, "keep busy". The rules students enacted provided the framework in which to manage faculty work in the effort to get through the clinical practicum.

Assigning Hierarchical Value to the Work

Although students engaged in three types of work, faculty, patient, and staff, they assigned each type of work a different priority. The primary goal was to successfully complete the clinical practicum and as such, students focused on faculty work. This consigned patient and staff work as subordinate to faculty work. Students spent the most time and effort preparing for clinical situations that involved the faculty and the writing up the care plans. The patient work became a means to do and complete the faculty work.

The focus on staff work was to facilitate both patient and faculty work. Students used various strategies with patients and staff that would enable them to write up their care plans and respond to the questions faculty may ask about their patients. Assigning hierarchical value to the work allowed the students to concentrate on those elements that would make possible successful completion of the clinical practicum.

Being on Stage

For students to successfully engage in faculty work, they undertook two phases of work activities, back-stage and front-stage work. The conceptualization that faculty work consists of backstage and front-stage activities originated with a student's description of how she perceived faculty work. Joan was a student who came to clinical with her daily written assignments completed. These assignments would help her pass the oral medication quiz that Denise gave to every student. The oral medication quiz was a concern for most students as they were required to answer questions about the actions and effects of the various drugs. Joan described the activity of answering these faculty questions as "being on stage", a performance where mistakes were not acceptable. As Joan pointed out, "You have to know everything about these drugs and have them in the right order. And then you have to be able to, on cue, give all the right answers. And everyone is watching you. It's like being on stage."

Observation of other students showed they also came prepared for the clinical day with paperwork completed and ready for answers for Denise. When the medication administration time drew near, students could be seen huddling in groups reviewing their medications with each other. When Denise arrived and began questioning individual students, other students would hover close by and listen to the questions and answers. If

these students felt unsure of their knowledge, they would frantically continue their review. For the student whose turn it was to describe the actions of the medications, it truly seemed as if he or she was on stage, performing for the faculty.

For students, being on stage meant they had to answer faculty questions correctly with no mistakes. They felt as if they were in the spotlight, observed by peers and staff, as they performed the act of responding to whatever Denise may ask. The concept of being on stage conjures up the notion that backstage activities were needed before front stage performance could happen. Backstage work involved figuring out how to prepare for front stage work. It included the preparation of the working care plan and a rehearsal of activities that would occur during the clinical day. Front-stage work consisted of activities where students had to use their backstage preparation and put it into practice. Front-stage work was further complicated by contingencies and the pragmatics of functioning in a dynamic clinical environment.

Backstage Work

Backstage work consisted of those activities that although not clearly defined and delineated by the students occupied a significant part of the student's time, energy, and effort. Backstage work was not quantified and yielded different results for every student yet required judicious thought and planning because without it front-stage work was impossible.

Backstage work was frequently referred to as the "pre-clinical prep". The purpose of the pre-clinical prep was to ready the students to care for the specific patients assigned to them. Students were instructed on how to conduct the pre-clinical preparation during Nursing Module I. Using the patient chart students filled out the paper forms such as the

working care plans, which mainly included the pathophysiology of the disease process, the medication list, patient procedures, and the laboratory tests. Thorough preparation of the working care plan was helpful in doing the front stage faculty work. Results of the field notes and interview analysis revealed that although the orientation and syllabus gave specific guidelines on what was required for the pre-clinical prep, backstage work involved much more than just carrying out the instructions. The pre-clinical prep was a time for students to figure things out. With time at a premium, they had to determine how much effort they would expend on preparation and which sections of the working care plan they would complete. The other pre-clinical focus for student participants concerned procedures where students could be a position to cause harm to the patient. Students had a keen sense of personal responsibility for the work activities that they would carry out that may result in harm to the patient. Thus, figuring it out and preventing harm became the two components of faculty work that impelled the backstage efforts of student nurses.

Figuring It Out

The student participants had experienced some elements of backstage work during Nursing Module I. Thus, many of the students had developed some mechanisms by which they approached the pre-clinical prep. Figuring it out was a major action taken by students to begin back-stage work. Data analysis showed that for student nurses figuring out consisted of identifying specific faculty idiosyncrasies and requirements and determining how much preparation would be required for the subsequent clinical day. Figuring it out commenced with student orientation and continued throughout the clinical practicum, guided by the type of patient and care plan that was required.

Orientation was the time when students first began figuring it out. It was the initial introduction to the faculty, Denise, who discussed general outline and expectations for the course. As discussed in Chapter IV, students asked specific questions regarding the assignments, and more specifically, Denise's requirements during orientation. Students had shared their care plans with me pointing out that the major ones frequently were 20 or more pages. Figuring it out during orientation gave them a clue as to the amount of time and effort a care plan would take.

Students informed me that the consequence of inadequate preparation of the working care plan was that one would be dismissed from clinical that day. Dismissal for the day could have serious consequences for getting through the clinical practicum. The nursing program had strict attendance rules and missing clinical hours could result in not passing the course. So students used the orientation time to figure out specifically what Denise's requirements were to successfully get through the course. The more complicated and intense process of figuring it out happened during the pre-clinical preparation period.

Prior to coming to the hospital to care for their assigned patients, students prepared by creating a working care plan. In review, the working care plan consisted of several documents the students were required to complete before caring for their patients. These documents consisted of a patient demographic page, the Therapeutic Multidisciplinary Treatment Plan, a laboratory form, the medication form, and the Concept Map. Gathering and utilizing the information involved a chart review and filling in portions on the various forms of the care plan. Students then went home and added to the working care plan by researching the medications, the disease pathophysiology and

any treatments that were ordered for the patient. Lastly, the students were required to use the acquired information and make some judgments about the patient's needs.

Every patient cared for by the students required the preparation of a working care plan. For the other care plans, the major and complete, Denise posted a schedule for the students that indicated on which date these care plans were due. On that particular date the student would prepare all the elements of a working care plan which they then expanded on and added the components of the complete or major care plan requirements, mainly nursing diagnoses with multiple planned interventions and evaluations and a teaching plan.

Although the syllabus gave explicit instructions on what to include for each care plan, students set their own priorities as to what part of the working care plan was the most important. Thoroughly completing a working care plan prior to clinical was practically impossible. Students told me sorting through information and researching the medications and medical diagnoses required at least three and sometimes as many as six hours. Lois informed me that on one night, due to the high number of medications, she was only able to get three hours of sleep. Thus, many of the students prioritized the preparation based on the perceived consequences of inadequate preparation. Most students started their preparation work by completing the medication TACTIS form. Students felt responsible for being thoroughly prepared for medication administration. A common statement from students was, "the first thing I do is TACTIS my meds." As John stated,

Actually, I think it ends up being pretty detailed. What I do and I don't know if everyone does it, but I follow this ... like if it says drug classification, so if it says antihypertensive I'll put that, then what's the generic name and what's the brand name. So I write all that down, what the prescribed dose is, whether it's po or IM

or IV or whatever, if it's qid, bid, tid, and the times that the meds are due, and then the actions, contraindications, when you wouldn't use this, you know, different things like that, that you would look for so you know not to give it or bring it up to the physician. Side effects, how it affects each different body system.

The interviews revealed that every student thoroughly completed the TACTIS form for every patient, regardless of whether that patient required a complete, major, or working care plan.

Past experience was a guiding factor in how much additional pre-clinical preparation the student would do. Upon arriving on the clinical unit for the scheduled clinical day, students were required to show their work to Denise who would review the content and decide if the preparation was adequate. The students told me this was a common practice for most faculty. However, the extent to which the faculty reviewed the preparation differed significantly, with some faculty reading every page to others giving the work a cursory glance. Denise's practice was to give the overall work a quick glance, focusing on the pathophysiology section and parts of the concept map. After the first two weeks, most students had figured out the extent of preparation that was necessary to start the clinical day. Additional preparation done by the students was usually done for the purpose of developing a major care plan.

Front-Stage Work

Front-stage work consisted of all the activities occurring during the clinical day and the written care plans students submitted. Students came prepared to use their backstage work to provide direct patient care and meet the requirements of faculty work. Front stage tasks that students performed included passing medications, doing patient procedures, collecting patient data, and completing the various care plans. Additionally,

students followed the rules given them to complete front stage work. For students, completing a front stage activity allowed them to say, “There, I have done that, I have finished”. Front stage work included the direct care activities students were taught during Nursing Module I and the integration of the pre-clinical preparation in that care. The analysis showed that front stage work consisted of performing work where students actually carried out assignments, and validating work where students sought to verify their knowledge.

Performing work. “I don’t know what you [the faculty] want, even though the rules say ‘do this and that’, I don’t know what YOU want.” This statement made by a student, captures many of the student participants’ feelings about faculty work. Although they had learned the rules for clinical performance, they had also learned that every faculty member had his or her own methods of running the clinical course. One segment of the front stage work consisted of putting into practice all the preparations done in pre-clinical. Performing work was defined as all the activities that supported the final clinical grade. Some of these activities were entirely within the control of the student. Rules for behavior, attendance and dress code were things students could take charge of whereas other rules were subject to the dynamics of the nursing unit.

There were many activities that comprised the front stage faculty work. For the students, the two most important aspects of faculty work were the medication administration process and the development of the care plan. Other activities that required Denise’s scrutiny included patient procedures and charting. The direct patient care work like hygiene, nutrition, and mobility management was also performed, however, Denise did not focus on this work. Hence, direct patient care fell under the

purview of patient work. Since medication administration and care planning comprised the bulk of faculty work, the ways in which students managed these activities will be discussed in greater detail.

Managing medication administration. As discussed earlier part of being on stage meant performing the medication routine correctly for the faculty. In spite of the backstage preparatory work, students continued the medication prep work the morning of clinical. The morning of clinical students were involved in a review of the TACTIS form, a search of medication supplies, a review of administration procedures, and a rehearsal of answers to potential questions. A review of formal and informal interviews reveals that students checked physician's orders a number of times. The physician's orders supplied the information for medications and treatments required for patients during the clinical day. Students looked for changes in these orders, and if found, then reorganized their medication administration routine. Making a mistake with medications was a fear expressed by students. They repeatedly told me that they checked and re-checked the medication orders to "make sure" that there were no discrepancies. According to the students, it was important to conduct the check and recheck since the physician orders could greatly change. The students gave me examples that justified this careful scrutiny of physician's orders. As Elizabeth pointed out:

I do personally [check orders] in the morning, to make sure because, my patient today, he had six meds yesterday, today he only had three, and two of them were different ones than he had yesterday. So I always want to make sure that I am giving the correct thing at the correct time. So, and I want to make sure I have everything ready to give my meds at nine o'clock so that's why I check it.

After assuring that all the medications were available and the orders were correct, students prepared for the medication question and answer session each would have with Denise. Students reported that they were required to know the five rights of medication

administration. The five rights included the right drug, the right dose, the right patient, the right time, and the right route. Additionally, Denise asked more difficult questions regarding the drug's action, side effects, nursing responsibility and safe dosing. It was these questions that put students on edge, every single day. In spite of diligent back stage work and attempts to figure out exactly what questions would be asked, the faculty could always come with a point that the student had not prepared for.

For a few students the medication administration procedure seemed to pose little concern and they met this challenge with flair and confidence. These students did not exhibit signs of nervousness and smoothly went through the questioning and medication administration sequence. An informal interview with Jaime illustrates some of the motivation behind successful preparation.

I learned how to do meds in Nursing Module I but not from the Nursing I instructor. The Nursing III instructor was filling in for Dr. C. at the time. And so she took over our rotation and she says, 'oh, you're getting a blood pressure med? What was the blood pressure? Are you giving insulin? What was the blood sugar? You're giving potassium? What was the potassium level?' You know, Digoxin, what is the apical pulse. So when I went to do my TACTIS at night after that time, that one time that I didn't have anything prepared for this one instructor, after that, every time I TACTIS something, um, on the TACTIS it says what you should assess for, I always put that down and make sure I assess it before giving that medication.

Jamie also said during Nursing Module I she did not always know why the patient was getting the medications and this frustrated her. She decided to look all of that up. "I want to know why my patient is getting every single med that he is on." She said this was not really a stated requirement this semester but she felt so much better about her nursing care knowing that information. The intense backstage preparation helped this student get through the medication quiz.

But for most students the medication quiz occupied their thoughts until the test had been passed. Before morning report until Denise arrived on the unit, students could be seen reviewing charts for new orders, asking the nurse about specific medication administration procedures, looking through the medication boxes for the morning's drugs, and looking up medications in their drug books. When Denise did arrive on the unit she would quiz the students one by one. Usually students like Jaime volunteered to go first and the other students would hover close by and watch the proceedings.

When the medication quiz did not go well students experienced frustration and at times humiliation as they suffered through the process. An excerpt from my field notes illustrate the demoralizing experience of one student.

Lois had a patient with many medications, at least 10, and it was her turn to pass medications. She did not have her medications prepared and separated in the little plastic cup. So Lois was starting from the beginning to organize her medications. Lois pulled the entire medication drawer out of the cassette and placed it on top of the medication cart along side the MAR book, which she had open to the MAR for her patient. She first looked at the MAR and selected a medication. Then she looked in the medication drawer for the corresponding unit-dose packet. There were a whole lot of pills in there, all in little individual wrappers. It almost seemed as if the sheer amount of medications were overwhelming for Lois. She pulled out a pill, read the MAR, read the pill package, put it down, picked up another pill and read that pill packet and put it down. She continued to pick up pills and read the packages, set them down, picked up the same ones again a minute later. She was having a very difficult time finding the medications that corresponded to the MAR. The back and forth sequence went on for at least 15 minutes, with Lois making little progress in selecting the appropriate medications. When she finally located the pill, she set it down on the MAR. She then went to the next medication listed on the MAR. However, since she did not put the first pill in the plastic cup, she would pick that one up along with the other medications to see if it corresponded to medication number two; which of course it did not since it was medication number one.

During this time, Denise stood right next to Lois but did not say anything to her. Denise earlier had told me, "I'll let them [the students] set up all the meds, so they're ready to go, and I say, you made a mistake, can you catch it, then they have to start all over again. But I'm not going to correct them, if they make the mistake and they see the mistake, I made mistakes in nursing school and I sure learned from it."

Lois continued to struggle with finding all of her medications. Other students were standing there watching her and occasionally a nurse would ask her to move aside so he/she could get their medications out. It took her 20 minutes to get the medications together. After she had all the medications in the cup, Denise accompanied her to the patient room to give them to the patient. Denise later told me she did not ask any other questions about the medications since she felt that Lois was “wiped out” by the ordeal.

For Lois, this truly was an ordeal and she was not required to answer any questions except the one related to the five rights. Other students fell somewhere between the experiences of Jaime and Lois. But for all students, medication administration represented the essence of being on stage.

Managing the care plans. The work of creating the care plan was the second activity that occupied the student’s time. The two care plans included all the information obtained during the back stage work plus the development of nursing diagnoses with nursing interventions and an evaluation of the interventions. Students developed a love-hate relationship with the care plans. On one hand they complained about the immense amount of time and work that was involved yet they expressed that they learned so much from doing the assignment. As Matt stated,

Like I said a lot of us complain about this...doing this care plan but I myself also complain, it takes so much time, but then understanding the purpose of it and the implications related to it, I guess you know, it’s just...it’s cumbersome because we don’t get graded for it, but in the long run it helps in patient care and patient management. So I guess we should just stop our complaining about this care plan.

Only one student informed me that she expended minimum effort on the care plans. She maintained that since the clinical was graded as a pass or fail, she only needed to score 70 points on the care plan to pass. She rationalized that she would rather spend the time studying for the lecture class since that is where she was more likely to fail. The other students informed me they spent between fifteen and twenty hours for each care

plan. As with medication administration, the ways in which students managed care plan development varied from student to student but the overall outcome was similar.

When a patient was assigned as a care plan patient, the students spent the majority of their time collecting information from the chart. At times, direct patient care was not completed in an effort to glean as much information as possible from the chart. When I asked June what her plan for the patient was that day, she informed me that the patient was a major care plan patient and that she was going to spend the time looking at the chart. She had asked the nursing assistant to bathe the patient for her. Since Denise focused more time on medications rather than direct care, students were able to spend significant amounts of time reviewing the chart. Spending time gathering data in the chart became a priority for the care plan patient.

The written care plan totaled about twenty pages, including the pathophysiology discussion and the laboratory reports. The area of the care plan that gave the students the most difficulty was the nursing intervention section. Each nursing diagnosis was to include seven nursing interventions and each of these interventions was to be evaluated. That meant that the student had to actually perform the intervention with the patient and evaluate the results. I asked the students how they managed to cover five problems with seven interventions each. Matt responded,

Well they require us to get 7 interventions down so we put 7 interventions down even if we have to “divvy” up the major, the big thing you know. So I have to do 35 interventions. Like if I say, assess for physiological function like respiration, vital signs, they want 7 to itemize it. So assess for physiological function can be one intervention, but if I break it up into cardiac, respiratory, etc, then I get more. Otherwise I couldn’t do it.

Since the care plans were written after the students actually cared for the patient, they used creative ways to write up their nursing care interventions. An example from a

care plan shows that a student selected the nursing diagnosis of “powerlessness” with an intervention to provide an environment conducive for patient control. The student’s evaluation statement read, “I allowed the patient to choose the time she wanted a bath”. The intervention of patient choice regarding the bath was one most students used on a daily basis. However, using choice as part of the care plan enabled this student to meet the requirement of implementing and evaluating seven interventions. Students creatively developed the care plans to match the care they had provided.

Validating Work

Throughout the clinical rotation students were in a position whereby faculty and staff made inquiries about their knowledge about the patient and the patient care required. The inquiries could be planned, such as those occurring with medication administration, or they could occur impromptu, requiring the student to have the answer readily available. Students would attempt to anticipate what some of the spontaneous questions might be. In this process, student work consisted of validating their knowledge and information.

Validating work occurred when students encountered situations where they believed they should know the answer including all the areas covered by the pre-clinical preparation. Thus, students felt they needed to be able to answer questions related to the patient’s pathophysiology, medications, treatment regimen and nursing care interventions. The students knew that any of that information was “fair play” for the faculty and the nurses. The second condition under which validation work took place concerned areas of knowledge the students did not believe they were required to know. These could include new laboratory tests, the results of the physician’s visit, a

problematic nursing intervention, and new medications. The ways in which students went about the validating work differed based on the clinical situation involved.

When students encountered a situation where they believed they should know the information, they would seek validation from the players in the clinical arena. In spite of the pre-clinical preparation, circumstances would arise where the students were not fully prepared. For example, while conducting early morning rounds Denise could bring up issues about the patient's condition that would require an answer later on. Regardless of the circumstance surrounding the information gap, students anxiously strived to get the answer to the question. Student nurses had an intuitive hierarchy of participants who they would access for validating their knowledge. In selecting those who would validate their knowledge, students first chose the players who had the least amount of authority over them. Thus, students first used one another as primary resources for validation. Throughout the clinical rotation, students could be seen questioning one another about various clinical situations. The next level of participant students accessed was the nursing assistants. With this group, students would usually try to validate some basic patient care procedures that the assistants were qualified to do. Next, students would access the nurses assigned to care for their patients. The last person students accessed for this type of information was the instructor. An excerpt from the field notes illustrates how this hierarchical selection took place.

Kerry rushes in to the staff lounge where several students are charting. She is breathless and says, "You guys, I have to give a fentanyl patch, I don't know how to do that. What is it? My patient did not have it ordered yesterday because he gets it every three days. I just forgot about it. Dave, do you know what to do with it?" Dave responds in the negative, as do the other students. Kerry says, "What am I going to do? I know, I'll ask the nurse because I don't want Denise to know that I don't know." With this Kerry rushes out of the room.

When I asked other students about how they validated their knowledge they informed me that they were supposed to know these things by looking them up in the book. They also believed that if they came up short without the answer, that this might affect their clinical grade and ability to pass the course. During my field observations, when students came up with the correct answers, the looks on their faces showed relief and excitement at scoring a clinical point.

If the students encountered a situation where they believed they had no responsibility of needing to know, they would usually access the instructor first. Sue, who displayed great anxiety every time she prepared for medication administration, had no difficulty asking about a rare disease that ran in her patient's family. New laboratory tests and new physician's orders were also deemed appropriate for seeking the instructor's help. But usually these conversations were held at the end of the morning, after the difficult question and answer periods were over.

Implementing the Rules for Faculty Work

In order to be successful in accomplishing faculty work, student participants implemented the rules. A combination of nursing program rules, hospital rules, and faculty rules were implemented to complete the faculty work. When none of these rules were appropriate to manage specific clinical situations, students would use self rules. The program rules and hospital rules were learned during the first semester and students could depend on these to remain constant. They were a credible foundation from which to work and if a student was questioned about a decision, he or she could fall back on these rules. Some faculty rules were learned during orientation but as students soon discovered, additional rules were presented to them in the clinical arena as conditions warranted. The

new faculty rules were a source of frustration since students could not anticipate when a new rule would be forthcoming.

The first day of clinical most students had a thoroughly prepared working care plan. As the five weeks progressed however, the levels of preparation began to vary from student to student. Past experience provided the best way to figure out what the minimum clinical preparation requirements really were. Although the syllabus and forms were quite prescriptive regarding the assignments, the reality of the bench check proved to be more helpful for students in making their clinical preparation decisions. Although students did not come right out and admit that they cut corners, they had ready explanations for Denise about why various sections of the care plan were not completed. Students had figured out that the faculty rules regarding the working care plans were not strictly enforced throughout the clinical rotation.

Students also quickly learned that the rules for behavior, such as attendance and dress code were a priority for Denise. There was no second chance here; an infraction of these rules warranted immediate intervention. Thus forgetting to bring a watch or chewing gum elicited a quick response from Denise and the errant behavior was recorded for the final evaluation resulting in an immediate change of behavior. The clinical rotation was graded as a pass or fail and the students did not know the weight and effect these rules may have had on their final score. Thus, in order to get through, the behavior rules were the rules that students followed exactly as written.

The rules for performing work were a combination of program rules and faculty rules. Students used the program rules to develop their initial plan for carrying out faculty work but over the course of the clinical rotation, added the faculty rules. Once students

figured out the ways Denise enforced the rules, they combined their own judgment on which rules to follow.

Summary

The students in this study assigned a hierarchical value to their work, resulting in the subordination of patient and staff work to faculty work. Success at faculty work was seen as crucial to getting through the clinical practicum. Students implemented a variety of rules to do their faculty work and used the processes of being on stage, figuring it out, performing and validating to actually do the work. As we shall see, there were consequences that resulted from implementing the rules and these are discussed in Chapter VIII.

CHAPTER VI

Implementing the Rules for Patient Work

The patient is at the center of nursing practice and student nurses are taught early on the various skills needed to perform patient care activities, referred to here as patient work. The student's focus for the clinical practicum was to get through and pass the course. The analysis of the data showed that patient work became subordinate to faculty work. Even though the intent of the clinical course was to prepare students to become nurses, the faculty requirements were a priority for the students. According to the students, being successful at patient work meant that a portion of faculty work had been completed.

This chapter will discuss patient work in terms of what it involved and how students implemented rules. Patient work required students to give direct care to the patients assigned to them. This direct care included providing assistance with hygiene, helping with nutrition, administering medications, teaching patients, and assisting the patient with mobility. The second aspect of patient work included indirect care, which necessitated the patient's involvement to meet the requirements of faculty work. The indirect activities were performed mostly for the benefit of the student, rather than the patient, and provided key pieces for the nursing care plan. These activities included the patient interview, the psychosocial assessment, and the implementation and evaluation of care plan interventions.

Both direct and indirect patient care activities mandated that the students enter into the patient's personal domain. Successfully entering into the patient's world not only would enable students to provide the direct care and but it would give the students access to the personal information they needed to complete the care plan. For many students, the process of entering into the patient's domain elicited fear and uncertainty about acceptance from the patient. They needed the patient's trust and cooperation in order to provide direct and indirect care. Students felt that in order to enter into the patient's world they needed to establish their credibility. They believed that direct care activities were an obvious part of their role on the nursing team. The indirect care activities were more difficult for students to justify as these required them to obtain personal information from the patient. Most students were uncomfortable asking for personal information and feared that patients may question their motives.

In order to engage in patient work, the students implemented the rules set by faculty, the nursing program, and the nursing staff. The rules were designed to help the students be successful at not only completing the faculty assignments but to effectively work with their patients. Many rules were useful and resulted in adequate provision of patient care. Other rules were vague and open to interpretation leading students to modify the rules. At times situations arose where the rules were not adequate resulting in tension and disillusionment and the objectification of the patient in order to meet the requirements of faculty work and these consequences of patient work are discussed in Chapter VIII.

Work of Meeting Patient Expectations

Regardless of the depth and breadth of pre-clinical preparation, the dynamic face to face patient interactions were unpredictable. Even though students were taught how to manage physical care activities using a step-by-step approach, the patient's expectations could influence the ability for students' to complete their direct care work. Even though students were given a time schedule of when to accomplish specific activities, the patient's expectations could put that schedule on hold. Combined with the nursing unit's needs, the students' capability to complete their work was not guaranteed. However, the one task that had to be completed, regardless of the patient's wishes or nursing unit milieu, was entry into the patients' world. Successful entry meant that students could probably accomplish direct care activities and faculty assignments as well.

Entering Into the Patient's World

Entering into the patient's world is a requirement for nursing care to occur. For students, this experience could be fraught with pre-conceived ideas of the patient's response to their well-intentioned plans. Physical signs such as closed doors or sleeping patients made it difficult for students to initiate the first step of making contact with the patient. Some of the notions regarding possible rejection of the students were self-imposed. Nervousness and not knowing what to expect drove some of the anxiety that students felt when first meeting a patient. Tami explained, "It's like the anticipation of the nervousness of interacting you know, with the patient, not knowing how they are going to react to you."

Other beliefs came from nursing staff reports regarding a particular patient's previous behavior. As Jennifer revealed,

There was a patient, that on report I got...I actually went in with a bad feeling because the way report was given. They [the nursing staff] said that the patient was really rude and was cussing out the CNA, and I'm thinking, 'Oh great!' I went in there cause I got a bad, I got a bad report you know. I got to thinking this patient is going to be mean, she's going to be rude.

Yet in spite of the nervousness and dire forewarnings, students forged ahead even though they had misgivings about how they would be received. During my observation times in the clinical setting, it was not uncommon for students to comment on their patient's response to them. It was as if a great burden was lifted when students were successfully accepted into their patients' world. A comment from Amy illustrates this point, "My patient talks a lot and I like that; she likes me and tells me all kinds of things about herself."

Entering into the patient's world for the purpose of providing direct care was deemed easier than gaining entry for indirect care. Even though patient could refuse any or all direct care students believed this would not lead to censure by the faculty. Students were taught and believed in the patient's right to have an active voice their care. Additionally, physical care included some authoritarian foundations. If a patient refused to have their vital signs taken, the student could respond that the physician requested the information. Being able to say that the doctor had ordered a medication or treatment, gave the students the courage to talk to the patient about why they, the student, had to provide that care. Providing the physical comfort care of bathing, nutrition, and personal hygiene was an easy method to get into the patient's world. It was a purposeful endeavor that was easily explained. Furthermore, when providing physical care students believed they were doing something positive to benefit the patient. As pointed out by Sue, "After I

finished giving my bath I knew that my patient felt so much better. She is now able to sleep.”

Conversely, entering into the patient’s world for the purpose of performing indirect care, a faculty and care plan requirement, was much more difficult. A major piece of the indirect care consisted of completing a psychosocial assessment. For this assessment students had to obtain information regarding the patient’s emotional state, family relationships, developmental level, self esteem, body image, culture, and spirituality. Students were at a loss for how to approach the patients and the care plan instructions or rules for doing so did not help to pave the way for them. In fact, the assessment form contained the following instructions, “It is not appropriate to ask the patient direct questions as you would during a history. Information is obtained by observing verbal and non-verbal behaviors and making inferences as you and the patient work toward accomplishing goals and objectives.” The specific sections then contained questions the student needed to answer. According to the students, these questions were not worded in such a way that made it easy to obtain the information from the patient. The following are samples of the types of information students needed to acquire:

- How have previous life experiences affected the patient’s perception of the health problem?
- What evidence indicates that family life has changed?
- What is the patient’s perception of body image and how has it changed?
- What spiritual/religious belief does the patient express?

Students over and over shared their difficulties of performing this aspect of patient work. Stacy was a student who admitted she struggled with collecting

psychosocial information. She felt she would be intruding on the patient and was also unsure of how to acquire the needed information. As she said,

I tell them, I hate to bother you but I need you to do this for me and you know, you feel like you are pestering them. You can't directly ask questions like, how do you feel about your illness ... but you kind of just talk to them as you are assessing them.

Students also spoke about how they believed patients would respond to them and subsequently developed justifications for their own behavior. One student said, "Because I was kind of hesitant, you know, I felt like I was invading their privacy. I didn't want them [the patients] to be upset at what I was doing."

The concern of invading the patient's privacy stemmed in part from the value students placed on psychosocial information. The nursing program had adopted the *Maslow's Hierarchy of Needs* model which required students to address physiological needs first. As a result the psychosocial assessment was not valued as much as the physical assessment. In various ways, students informed me that conducting psychosocial assessment, in addition to being difficult to accomplish yielded limited useful results. John reported that, "In Nursing Module I they told us to ask the patient 'Who gave you those pretty flowers?' That's dumb, who cares anyway?"

Additionally, some students had a clear sense of which pieces of the rules on psychosocial information, and where the emphasis was placed, were relevant and which were not. Their issue was about having to ask the questions, regardless of the patient situation. Paula explains,

When I first started in Nursing I, I use to sit down and try and ask them but it just puts people on the spot, but it's kind of hard you know it says, how is their self-esteem threatened by their illness...well I can gather from talking to my 19-year-

old that breaks her back you know that she's going to have problems and it's going to be a long haul. She's uncertain, she's worried about the future, is back surgery going to cause her problems you know without saying how's your self-esteem affected. You know that sort of thing. And I've had geriatric patients that are like you know I've lived my whole life, who cares if I had a hysterectomy I had my 7 kids, you know, that kind of thing.

At this point in their educational trajectory, student could easily identify and manage physiological needs but the psychosocial needs proved to be problematic.

It Makes Me Look Stupid

A recurring theme surrounding patient work was the student's desire and need to appear credible in front of the patient. A rule of clinical practice was that the students had to have contact with their patients. These contacts occurred during patient care activities such as bathing, feeding, and medication administration. The times of patient contact placed the students' ability to respond to patients in jeopardy. Patients could ask students questions about their qualifications to provide care or plans regarding their own hospitalization. Patients could also question students about why they needed to gather all the personal information and what the students planned to do with it. Closely tied to the work of entering into the patient's world was the notion that the patient would judge the student.

Knowing full well that they did not have the skills of a practicing nurse, the students expressed concern about how they might be perceived by the patients. Just as pre-clinical preparation helped them prevent errors, the preparation also helped the students to perceive themselves as possessing a measure of credibility for the patients. As Tami shared with me,

I learned, look at the chart before you walk in because I don't want to walk in and not know what's going on because it makes me look stupid, the patient lacks trust in you if you don't know what's going on.

Students would provide a rationale for their behavior in a patient's room. Barb explained how she wrote down her assessment data in the patient's presence.

I don't like to write in front of them [the patients] unless I am looking at their medications, then it makes them feel secure like you know what you're doing. I'll be writing down what they're saying and pretending like I'm doing something else just to make them more comfortable.

In this passage, Barb explains that writing in front of the patient makes the patient uncomfortable. She believed that the patient might question the extent of her nursing knowledge so devised a way whereby her actions would not lead to any additional inquiry.

Carrying Out the Rules for Patient Work

In order to engage in and complete patient work, students were required to follow certain sets of rules. As described in Chapter IV, rules consisted of faculty rules, self rules, staff, rules, program rules and hospital rules. Students followed many of those rules to carry out patient work. When situations arose for which a rule did not exist or apply, students would use self rules or create new rules.

The nursing program had developed a curriculum outlining rules for student behavior and the care they were to provide to patients. These rules for patient work were taught in Nursing Module I and students practiced them during that first semester. During nursing Module II these rules were carried over, however, they could be modified by individual faculty members. The patient work rules were divided into two categories, rules regarding direct patient care and rules regarding the indirect care. The nursing program also had developed rules related to clinical specialties. These rules usually were

listed in the form of practice competencies. For the orthopedic competencies the rules explicated how to a) care for patients in traction, b) manage the care of casts, c) manage patients in pain, d) mobilize patients, and e) care for patients experiencing various orthopedic surgical interventions. To accomplish patient work there were very few staff rules to follow. Aside from following unit routines, students mostly interacted with staff regarding physical patient care rules. Procedures like pain management, dressing changes, and patient activity required that students follow staff rules. For the indirect care activities, students relied on the program and faculty rules to guide them

Implementing the Faculty Rules for Patient Work

Faculty did not interpret the rules the same way as written in the curriculum so students had to continuously learn new ways of implementing or dropping the rules. Some of the initial rules taught to students in Nursing Module I were totally eliminated in Nursing Module II. Students reported that at first they were perplexed about this. For some, the confusion then led to anger and resentment as they believed their time was wasted in learning rules that would only be used for one semester.

Carmen explained,

Nursing Module I is totally detached from Nursing Module II. So first we're told we can't use clipboards, we can't put anything on the patient's bed or table, fomites and germs and all that stuff. So you had this big wad of paper in and out of your pocket. Then this semester we can use clipboards and bring them into the patient's room. What happened to the fomites and germs? Go figure.

Not all students abandoned the rules learned in Nursing Module I. Elizabeth methodically followed the rules and carried them over to Nursing Module II. She did not experience any tension and provided her patient care as she was taught. As Stacy pointed out, "those rules are drummed into our heads and we don't easily forget them". The

students had some leeway in deciding whether or not to follow these types of rules since these rules did not violate hospital policy and Denise rarely questioned them.

On occasion students would learn about new faculty rules in the middle of caring for a patient. The student would begin to implement a procedure the way they were taught in Nursing Module I only to have Denise correct them midway. A clash between faculty of Nursing Module I and Denise illustrates how a student learned new faculty rules. For part of the semester Nursing Module I students were placed on the orthopedic units along side Denise's students. An incident with a student passing medications highlights the conflict between the two semesters as the student tries to follow the rules. The rule from Nursing Module I was that students must use a medication tray to carry their medicines into the patient room. This excerpt from my field notes illustrates this conflict:

All the meds are ready to go in the room. Paula [the student] looks around and says, "I need a little tray to put these on, in first semester we had little trays to carry our meds on. She asks [Denise], "Should I go and get a little tray? I can borrow one from the first semester instructor". The first semester instructor hears that and comes in and says, "Here is a tray, you can use this one". Denise says no, she does not need a tray. The first semester instructor tries to give the tray to the student while ignoring Denise. Denise again says no, they'll be OK. The first semester instructor continues to press the tray on the student while Denise continues to refuse. The student is standing there and looks unsure of what to do. Finally the first semester instructor leaves. Denise tells the student she needs to figure out how she is going to get the meds to the room. She decides to use her clipboard as a tray. Denise says 'that is good, you have done a good job'.

This demonstrates the quandary for students as they have to make decisions about which rules to follow. At first Paula had decided the rule of using a medicine tray was needed. But when the two faculty continued to disagree, she backed off and followed Denise's rule. When I later asked her how she came to the decision, she informed me that Denise was her current instructor and she would just do what Denise required. She

wondered why Denise did not want her to use the medicine tray but felt she was better off just doing it Denise's way. Thus, students had to learn how each faculty interpreted the rules and adjust their way of carrying out their patient work.

Direct care rules. The rules for providing direct patient care were a blending of faculty rules, program rules, and hospital rules. Students had learned all the essential steps for providing direct care and only had to adjust these rules to the schedule, equipment, and nuances of the particular hospital where the clinical was located. Denise had few specific requirements for the basic care students provided. She did not get involved in bathing, bedmaking, ambulation of patients, and mealtime. This gave the students some leeway in deciding on when to provide the care and which rules they would carry over from Nursing Module I.

On days where the assigned patient required a care plan, students would spend less time with the patient on direct care and focus on gathering the information they needed to develop the care plan. At times students had very little time to collect this information because circumstances could change whereby the patient would not be on the unit the following day. This left the student scrambling for data. One rule learned in Nursing Module I was that of teamwork; students should help one another. In cases like these, students would ask their peers to make their beds or answer the call lights so they could finish copying the chart. This rule of helping was used and respected by all students.

Indirect care rules. Indirect care rules were few. Students were given the forms and told to turn them in by a certain deadline. The instructions mainly consisted of an explanation of the nursing process. First assess your patient, look at the data and

determine if a problem exists. Next, develop a nursing diagnosis with at least seven interventions for each. Finally, evaluate the results. Students could recite this process without looking at their notes. But these instructions were a far cry from what students believed they needed to actually implement the nursing process. Indeed, comments from students indicated there a great deal of confusion regarding the development of a concept map and the care plan. As Jaime succinctly stated, “Honestly, this is the part I hate the most [speaking about the working care plan]. I don’t know if I just don’t understand it? If I’m lazy? If I haven’t been taught properly or what.”

As previously discussed, students were hesitant to ask patients questions about what they perceived as personal information. In Nursing Module I the students were taught how to conduct a both a physical and psychosocial assessment. Students preferred the step-by-step approach of the physical assessment whereby they could systematically go through and collect the data. However, the psychosocial assessment had few hard and fast rules. From the lectures, the students interpreted the course content to mean that there was a list of do’s and don’ts regarding psychosocial assessment. As a result, students approached the psychosocial assessment with a loosely structured set of rules. Based on the assessment form, students explained his interpretation of the rules:

- I was like, how do I ask the patient these questions? They [the faculty] said, you just observe, you try to basically, almost like you see what they are doing, how they are doing and then you say it in your own words. You don’t actually go out there and say ‘okay how are you feeling?’”
- “So I’ll just ask in general conversation, I’ll ask little bits and pieces of questions and stuff and I’ll piece together what I need.”
- “I go in there and make small talk, so I find out a lot about their psychosocial stuff”
- “It’s not like I’m going to come out and ask my patient how they feel about these things because it’s kind of awkward.”

All the students shared the difficulties described. In this case, they wanted additional rules to help them obtain the information but these rules were not forthcoming from the faculty.

The rules about obtaining a specific amount of psychosocial information were also unclear. Some students said they were to have at minimum one psychosocial patient problem while others said the minimum was two. Another group of students said they only used psychosocial problems when there weren't enough physiological problems. I asked Denise what her expectations were regarding the psychosocial assessment. She informed me that she focused more on the physical assessment and the organizational skills of the students. She required the assessment form to be completed but did not place a heavy emphasis on the specific results that the students obtained. Even when students asked Denise if they needed a psychosocial nursing diagnosis, she would respond no, however they were required to conduct the psychosocial assessment.

Summary

In this chapter I have examined how students define and carry out patient work. Subordinate to faculty work, patient work was the key element to be successful at faculty work. Patient work consisted of direct care and indirect care activities and students followed prescribed rules to carry out the work. Entering into the patient's world became a key issue for completing both direct and indirect care. Students expressed their fears and concerns regarding the solicitation of personal information needed to complete part of the faculty work. Implementing the rules for direct care activities included blending program, faculty and hospital rules. The rules for gathering assessment data, specifically psychosocial data, were not clearly delineated and students experienced difficulty while

engaging in indirect patient care. As we shall see in Chapter VIII, students created their own rules in order to manage several aspects of patient work.

CHAPTER VII

Implementing the Rules for Staff Work

Students relied on the nursing staff to help facilitate the completion of some of their patient and faculty work. The staff included Registered nurses, Licensed Vocational nurses, and nursing assistants. Registered nurses and Licensed Vocational nurses were assigned the responsibility for all patient care and students needed the knowledge and expertise of these staff members to successfully carry out their patient care assignments. Nursing assistants too were valuable in providing information about how to locate items and how to manage patient issues such as the best way to mobilize a patient. Although the total daily amount of time spent with the nursing staff was at times limited, working with the nursing staff was essential to accomplish both faculty and patient work.

This chapter will discuss staff work in terms of what it involved and how students implemented the rules for staff work. First, students needed to negotiate their own role in the context of the day's workload. Successful role negotiation could mean a productive day, that is, facilitating completion of faculty and patient work. It was crucial that the student and the nurse worked in harmony since duplication of or omission of nursing care activities could result in significant negative consequences for the patient. Second, students needed to manage their in-between position. In caring for patients students found themselves in situations where their role was somewhere between a nurse and a student. Additionally, as with faculty work, staff work required implementing the rules regarding patient care and student conduct. These rules were sometimes part of the nursing unit

rules but could also include the individual staff nurse's rules. Negotiating a role, managing the in-between positions, and implementing the rules could also result in tension between what students were taught and believed what they should do and the reality of working with nurses who had their own ways of managing patient care. As with faculty work and patient work, these consequences are discussed in Chapter VIII.

Negotiating Their Role

For students, negotiating a role meant that they needed to establish their responsibilities for that day and become an integral part of the patient care team. In order to meet the faculty requirements, students had to secure the cooperation from the staff since without this cooperation staff might complete clinical procedures, vital signs, and the medications before the students had a chance to do so. Patient safety was a key issue for students and effectively negotiating their role meant that the line of communication between the nurse and the students would remain open. Students were fearful of making a mistake and a productive working relationship with the staff could decrease the chance of making mistakes. As Cindy pointed out,

It works so much better for me if the nurse is around and takes an interest in what I am doing. Otherwise, I might do something she doesn't think is right and I could make a mistake. The teacher isn't always around.

The students also had to work with the licensed nurses and the nursing assistants to meet the requirements for the day and to maximize their clinical experience, a key component for completing faculty work.

In order to negotiate their role, students had to make a connection with the nursing staff. Students relied on the staff to complete some of their clinical activities and connecting with the staff facilitated completion of the other aspects of student work.

When students were successful in connecting, the relationship with the nurse and the

nursing assistant could result in the student having access to information, receiving advice, and having their decisions validated.

Ideally the process of negotiating the role and connecting was done in cooperation with the nursing staff. However, due to the dynamic nature of the functioning of a nursing unit, not all staff cooperated in this effort. For many students this meant they had to employ strategies that made them agreeable and helpful. In order to be successful, students were required to be self-motivated and assertive in order to establish an effective working relationship for the day. Two examples of negotiating their role demonstrate how students managed this part of staff work.

Negotiating Their Role With Staff Cooperation

Negotiating a role started early in the morning with the change of shift report. For students, the change of shift report served two purposes; the place to obtain patient information and the place to establish the relationship with the day nurse. Before the students went to their patient rooms, they would wait and get report from the nurse. Change of shift report was a time when the off-going nurse would update the on-coming nurse on the patients' status. The actual practice of this system though was very hectic. Before the students could listen to report, they had to find out which nurses were assigned to their patients and this could be a difficult and confusing task.

The ideal way for students to negotiate their role was when the nurse was proactive in engaging the students in morning report and subsequently patient care. Denise and the students described one nurse, Diana, as the "best nurse for students". According to Denise, Diana was a nurse she could trust to teach the students correctly, to help the student resolve problems, and who provided excellent patient care. From the

student perspective, Diana was approachable and volunteered information freely. Students felt they could ask her questions and be guaranteed a sincere response. Nurses like Diana made the process of negotiating a role and connecting flow smoothly and stress-free for the students.

I frequently observed Diana starting her morning. She would first ask if any of the nursing students had her patients. She then would look on the assignment sheet and individually approach the students to ask them if they were assigned to her patients. Diana would locate the night nurse who gave a verbal report on the patients' status. After report, Diana filled in any missing information for the students and asked the students what their specific duties were for the day and if they needed any more information. Diana created an environment whereby students felt free to communicate their needs for information, advice, and validation of their decisions. She initiated the process of negotiating the student's role for the day. The students who worked with Diane responded favorably to her approach. As Cindy commented, "She is great to work with; she really takes an interest in what we do." Maria echoed this belief and said, "It is easy to approach her because she makes time for me. I don't feel like my questions are bothering her".

Some other nurses demonstrated similar characteristics when interacting with students. Although their actions were not as focused as Diane's, they did facilitate the processes of negotiating a role and connecting. This was demonstrated by several of the night nurses. During report they would ask if they had given the students enough information. At times the night nurses might comment that they had saved a procedure for the students to do. By including the students in report, the night nurses set up a

situation whereby the students could easily negotiate their role with the day nurse. I observed James and the day nurse, Tracy, receiving report from the night nurse. After the night nurse had asked James if she had given him enough information, Tracy said, “What will you be doing for patient care today”? James replied that he would be doing all of the patient care, including medications. By including the James in report, the night nurse had initiated the process of negotiating James’ role, which then led on to making a connection between student and nurse.

Negotiating Their Role Without Staff Cooperation

The processes of negotiating a role did not always go smoothly and students struggled to connect with their assigned nurses. The students informed me that in Nursing Module I they had been instructed to first listen to report and then inform the nurse what they would do during their time on the unit. The student was responsible for discussing with the nurse what types of patient care activities they would be responsible for. They would also clarify any specific medication needs they had identified. The students were very clear on these expected tasks and most were eager to develop a working relationship for the day.

During a hectic time of the day, students had to approach several staff to find out who the nurse assigned to their patient was. Although each staff member wore a name badge, these were not always clearly visible since sometimes the badge would be flipped over making it not readable. So students might approach a nursing assistant who did not know anything about the assignment. Students could also approach a night nurse but these people were busy completing their charting. In response to the question of who the day nurse that was assigned to their patient, students were frequently told, “go look on

the assignment sheet”. However, between 7:00 AM and 7:30 AM the assignment sheet was in the hands of the charge nurse, and thus not available to the students. Students told me they were reluctant to interfere with the nurses as they were getting ready to start the day or leave to go home. The nurses were busily engaged in talking to one another and the students were not always invited to join the conversation. However, it was important to get report because if they missed the report it was unlikely that the night nurse, who wanted to go home, would repeat it just for them. As John reported,

What we are supposed to do is get report first, but sometimes it takes forever...they all go off to their little corners and cubbyholes and you've got to find them. Okay and they don't put on the board who the new nurse is. Okay, and so you have to find out who the old nurse was and kind of follow her around

During the first part of the semester the students would stand in little groups by the wall, observing what was going on. The students told me they were just going to wait and when nurses started talking together they would see who had their patient. Frequently I noticed students subtly moving towards the groups of nurses in an attempt to find out which day nurse was assigned to their patients. One student, Elizabeth used a different strategy to get report. She remembered that the nurses were to do walking rounds. Walking rounds meant that the night nurse and the day nurse would walk from room to room and give a brief report on each patient. Elizabeth said, “if I stand by my patient's room, sooner or later they will come up for walking rounds and I can then hear report.” This method worked as long as the night and day nurse actually did the walking rounds.

Other students relied on the assertiveness of their peers to locate their nurse. Joan determined that the assignment had been made. She observed several nurse getting together in groups of two and talking. She approached one twosome and asked if they had her patient. The day nurse responded in the affirmative, and explained to Joan where she

was in the report process. She invited Joan to stand close by so she could hear report. Subsequently, several other students who noticed this interaction moved closer and started listening to report. During a break in the report one student, Paula, spoke up and asked if they would be reporting on her patient. The nurse responded no and pointed to the nurse who was assigned to Paula's patient. Paula had used the friendliness of the Joan's nurse to find out who her nurse was. Although the students rarely commented on the extent of helpfulness of the nursing staff, it seemed that when nurses took time to talk to students it made it easier for the students to approach them.

Nursing Staff Response to Negotiating the Student's Role

Negotiating their role seemed more important to the students than the nurses. Students had more at stake in the negotiation because if they were unsuccessful, they might not accomplish their requirements for the day. Students wanted the nurses to include them in the discussion about their patients. When nurses did not respond with a positive comment or attitude, some students felt disappointed or let down. As Stacy reported, "It makes it so much easier if they act like we are a help for them. If my nurse is rude or acts like she just doesn't care, it makes it harder for me to go to her if I need help".

Once students had heard report for their patients, they would inform the day nurse what they would be doing for the day. The students would specify that they would be doing all the patient care and the passing the medications. The students would then add that they were not able to give intravenous medications. The nurses would usually respond by asking how long the students would be on the unit and if they were administering medications. The nurses would jot this down on their report forms. Only a

few nurses like Diana would ask additional questions regarding the student's clinical focus for the day. Most of the other staff, while friendly and helpful when approached, did not actively participate in student learning. The only exception to this was with patient procedures. The nurses would seek out students when procedures like dressing changes were to be done. This was in part due to the fact that Denise approached the staff on a daily basis and asked them to notify her that if any procedures came up, she would like to do them with the students. Procedures were time consuming and having students perform them could reduce the nurses' workload.

Nurses, however, dealt with students on a continual basis. According to the BRN, nurses retain responsibility for the patient, even if student nurses are providing care (Board of Registered Nursing, 2000). In her research on nursing roles and the division of labor, Allen (2001) maintains that in an organization where there are many routines, negotiation processes are minimized. So although the students viewed their role as crucial in the context of patient care, nurses were more likely to consider students as part of an everyday routine. One of the charge nurses let me know that students were not a consideration in how the unit work was divided. In fact, she said, "Students all do the same thing. I know they do all the basic care, and then depending on the semester they pass meds. That's all I need to know, do you pass meds". So for the nursing staff, the students' role was to communicate how long they would be on the unit and which medications they would administer.

Negotiating Their Role With the Nursing Assistants.

Nursing assistants were important members of the nursing team. They were the ones who engaged in direct patient care by taking vital signs, taking care of nutritional

needs, managing the patient's hygiene, and reporting their observations to the nurse. The nursing assistants took great pride in their work and felt responsibility for making sure the work was done correctly. As one assistant pointed out to me, "I am the one who is responsible for the patients and I have to make sure the work is done". The patient work of students and nursing assistants overlapped since both were responsible for vital signs, meals, hygiene, and mobility.

Just as Diana was a nurse who was helpful and supportive to students, Darlene was a nursing assistant who made it easier for students to negotiate their role. Before starting her patient care, Darlene would look on the student assignment sheet to see who was assigned to her patients. Darlene would then approach those students and ask them what they would be doing for the patients that day. This set the stage for students to inform Darlene of their planned activities. I heard Darlene tell the students, "I love when you are here; you make my job so much nicer". Students reported they liked working with Darlene because she was helpful and created an environment where they could carry out their work.

At times, some of the nursing assistants saw the students as infringing on their work. While Darlene perceived the students as helpful, some of the nursing assistants were worried about the quality of work the students performed. During a casual conversation Helen, a nursing assistant, told me:

You have to be really careful with the students. Some of them don't want to do any work. They leave the beds and baths and don't even tell us they're not done. Then I have to follow behind and do all the work, and then I get behind in my own work. It's like all they [the students] want to do is medicines and sit around and talk.

However, Helen's perception of student nurses was generally not shared by most of the nursing assistants. Students developed working relationships with the nursing assistants and saw them as valuable assets to accomplish faculty work. An excerpt from my field notes illustrates how a student accessed information from a nursing assistant resulting in successful completion of a part of faculty work.

Then Denise arrives on the unit and Kathy says she can do a dressing change today and can she [Denise] help her. Denise responds in the affirmative and asks where her supplies are. Kathy looks crestfallen and says she doesn't have them yet. Denise tells her to get her supplies and that she [Denise] will be back when Kathy is ready. Denise leaves the unit. Kathy starts looking for her supplies. She goes to the supply cart, looks around, goes to the supply room and in a few minutes comes back to the nursing station and starts to ask Aaron, another student, where to find her particular supplies but he is busy with his nurse and doesn't respond. Kathy goes back to the cart and starts rummaging around. Her actions are quick and frantic and she is making no progress. She looks around to see if there is anyone to help her. Two nurses are sitting at the computer terminals talking and entering data. But Kathy does not go up to them to ask them where the supplies may be. A CNA passes by and Kathy rushes over to her and asks her where the sterile gloves are. The CNA goes to the cart and gets a couple of pair. Kathy then asks her about other supplies and the CNA locates all of them for her. When Denise returns to the unit Kathy is waiting and ready with her supplies.

Although Kathy could probably have asked one of the nurses to assist her, she selected the nursing assistant because she had successfully negotiated a role with her. Perceiving students as a helpful part of the patient care team, the CNA in turn provided the assistance Kathy needed. This reciprocal relationship did not always exist with the licensed staff and students were quick to use the positive association of the CNA to their advantage.

Caught in the Middle: Managing the In-between Position

Managing the in-between position was the second activity of staff work. The in-between position meant that students faced situations where they were not in control. Their status as students required them to follow the faculty and nursing program's rules

and guidelines, yet they performed their patient care in an environment run by nursing staff. Using the tools and instructions given them in earlier nursing courses, students were prepared to provide patient care in specific and prescribed ways. But nursing staff retained the responsibility for patient care and they could intervene with a student's plan. Staff could require that the student perform patient care in the manner designated by the nurse. At times, the nurse's ways were in direct conflict with what students had been taught. Joan described the in-between position this way:

I want to give my patient her pain pill. Bev, the nurse says I can't because the patient has chronic pain. I said to her Bev I know that but he [the patient] is still in pain. So the nurse says, 'What else can you do besides giving a pain med?' I am responsible for my patient and his comfort. I know that he has chronic back pain and that it's difficult to treat. I know that we are supposed to do all those other non-pharmacological things like back rubs and guided imagery. But they didn't work. She [Bev] acted like I didn't do my job but I did. I did all those things for him and he still was in pain. If I could, I would have called the doctor and asked for more medication, but she [Bev] just wasn't buying it. It makes it hard when I'm caught in the middle, I want to give my patient the best care but I can't.

Students needed to figure out how to manage these situations from their student status, which required them to provide the type of patient care they were taught but limited their authority to carry it out. Although some students could be nonchalant about this, other students ended up experiencing frustration.

Noah, a student who was very engaged with his patients, usually spent a great deal of time in his rooms and went out of his way to provide compassionate care. Noah reported to me that one afternoon he was assigned to a male patient with a diagnosis of chronic back pain resulting in a spinal fusion. The patient also had a history of schizophrenia. According to Noah, the patient had experienced a difficult day with frequent complaints of pain. The nurse had called the physician on several occasions to try and get the level of pain medication increased. When I saw Noah early in the shift he

was at the desk looking through his chart. I asked him what his plan for his patient was for the day. He reported that his patient had had a difficult day and that the nurse told him [Noah] that he could not go in the patient's room. Noah also said he felt really badly because as he walked down the hall, the patient called out to him, "nurse, nurse." Noah said he wanted to go in the room and talk to his patient but was afraid the nurse would get angry. Noah's other concern was that when he finally was allowed to go in his patient might be upset because Noah had ignored him. Noah said he could not understand why a nurse would purposely ignore a patient. Noah found himself in an in-between position resulting in a dilemma that forced him to choose between following the nurse's instructions and providing patient care. Noah decided to do what the nurse had requested and he did not go into the patient's room until the pain medication issue had been resolved. And although he felt uncomfortable ignoring his patient, he said the nurse was the one with the final responsibility and that he needed to follow her orders. He said he was disappointed with the nurse's method of managing his patient.

John experienced a similar situation during the morning hours. During report, he was told that he was not to go in his patient's room and wake the patient up. John said, "It took an hour to get report and then they tell me I can't wake up my patient because he is cranky." Denise had told me in her interview that the faculty expected students to get the vital signs right after report. So now John had to deal with meeting the instructor's expectations and following the nurse's orders. John's solution to this problem was to have an explanation ready for Denise. When Denise made patient rounds, he told her he was not allowed to wake the patient and that he was spending his time helping the other students with their patients. Denise was satisfied with this explanation and complimented

John on his decision to help his peers. John told me that as a student, he felt he had to do what the nurse said. “When I get my RN [license], then I can make my own decisions about my patients. But for now, I just go along.”

In the previous illustrations, the students abided by the nurses’ instructions. These instructions were to omit doing some aspect of nursing care. However, at times students were told to do things they felt were not appropriate. Instead of leaving out an aspect of care, the students were told to do something to the patient. There seemed to be a difference between omitting care and proactively doing something to the patient. When the situation involved “doing something to the patient”, that the students had not been taught, the students were more likely to involve Denise in their dilemma.

Mary Ann described a situation where the nurse asked her to give a medication that was not ordered for the patient. Mary Ann’s patient had a fever of 100.1 Fahrenheit. Mary Ann looked on the MAR and did not see an order for anything to reduce the fever. She then went to the chart, looked through that and did not find an order for any medication. She reported this to her nurse who instructed her to give the patient two Tylenol tablets. Mary Ann told the nurse that the patient did not have Tylenol or anything else ordered. The nurse told her to give it anyway. Mary Ann knew she could not give a medication without an order and decided to talk to Denise about it. When Denise came to the unit, Mary Ann explained what the nurse had asked her to do and why she, Mary Ann, did not feel this was right. Denise agreed with Mary Ann’s explanation and told the nurse they could not give a medication that was not ordered. Mary Ann later told me she realized the nurses were busy but she did not understand how a nurse could take it upon herself to order medications. Mary Ann seemed disappointed with this nurse’s decision

and said, “You know, I know they are busy and everything but I don’t think it’s just OK to go ahead and do what you want, I mean, instead of calling the doctor. It made me really uncomfortable that she asked me to give a medicine without an order”.

The students experienced the in-between many times and struggled to make a connection between classroom learning and the reality of the clinical unit. At times they would ridicule the things they learned in the nursing program as when John and Carmen made fun of how they were taught to bathe a patient. “We spent so much time learning how to give a bath, folding the wash cloth a specific way. Then we come here and it’s like the patient just goes through a car wash, they slather the water and soap all over. What a waste of time [the classroom teaching].” Other times students expressed grave concerns about the way nursing was practiced. The student response to the reality of nursing is discussed in Chapter VIII.

Implementing the Rules

As with faculty and patient work, staff work involved implementing the rules. These rules included those set forth by Denise the faculty, and the rules set forth by the nursing staff. Some of the staff rules were nursing unit policies and some were specific to each individual nurse. Students brought rules from the previous semester and learned new faculty rules during orientation to Nursing Module II. Staff rules were also discussed in orientation and students learned new rules from individual staff nurses. The intent of the faculty rules was to give the students the tools to manage specific clinical situations. At times circumstances arose where a rule did not exist or was impossible to apply. Students then created their own rules and this is discussed in Chapter VIII as part of the consequences of staff work.

Faculty Rules for Staff Work

Denise's rules for staff work dealt mostly with student behavior when working with the staff. The faculty designated rules were designed to help students negotiate their role. As discussed earlier in this chapter, students had specific instructions on how to enter into the nurses' work world for the day. Students diligently followed the rules for negotiating their role and setting up their clinical experiences for the day. Unfortunately, following Denise's rules did not necessarily guarantee a successful role negotiation. The dynamics of the unit and the specific staff issues could impact the outcome, even if the student followed the rules.

The other dimension of following rules was based on communication. Denise wanted to the students to communicate with the staff throughout the morning regarding their patient care. Students were very conscientious about doing so yet at times were put off by the negative reception from the staff. Some staff nurses welcomed updates on their patients and involved the students in their discussions. Other nurses were busy and gave the appearance of being pre-occupied. As Jessica pointed out, "I tried to tell my nurse about my patient education plan but she just wasn't interested. In fact, she hasn't even gone in to see the patient." When students did not receive the response from the communication that they thought was warranted, they frequently made the assumption that the nurse did not care.

Staff Rules for Staff Work

Staff rules were the guidelines set forth by either the nursing unit or the individual nurse. The students were informed of these rules, most of them unwritten, during the orientation and when these rules were broken. The unit rules were straightforward

covering things like schedules for vital signs, where to place personal book bags, and how to document on the chart. The rules set forth by the individual staff however were not as straightforward. Students would follow a specific nurse's rule one week only to find out it did not apply the next week. For example, some nurses would allow students to call the pharmacy to request missing medications while other nurses preferred to do the calling themselves.

Students were very flexible though and admirably managed the day by day changes in staff rules. They commented that they learned new and more efficient techniques from individual nurses. Subsequently, if the role negotiating yielded positive results then the students would readily follow the staff rules. If a limited role was negotiated, there was less interaction between the nurse and the student which resulted in fewer individual staff rules to follow.

Summary

In this chapter I have examined the ways in which students engaged in staff work. Subordinate to faculty and patient work, being successful at staff work could make a difference for students and potentiate the completion of care plans and written assignments. To the extent possible, students followed the faculty prescribed rules to negotiate their role as part of the patient care team. Students experienced the in-between position when performing patient care and part of the staff work was balancing their role as student and nurse. As we shall see in Chapter VIII, the consequences of engaging in staff work led students to create new rules and deal with the tensions that resulted from ineffective negotiation.

CHAPTER VIII

Consequences of the Work

As one step in the trajectory of nursing education, the orthopedic clinical practicum provided opportunities for students to experience nursing in the real world. Armed with the knowledge gleaned from the classroom and the previous nursing semester, student nurses approached the orthopedic practicum prepared to perform their clinical work. Successfully engaging in faculty, patient, and staff work would enable the student to get through this portion of the nursing program. However, the dynamic nature of patients and nursing, individualism of faculty, and practice patterns of nursing staff members, combined with regulations of accrediting organizations, created a challenge for getting through the clinical course.

Implementing the rules was one process enabling students to manage their clinical work. Throughout the clinical practicum students were guided by various types of rules but since work is a sequence of expected tasks, sometimes routine but sometimes subject to unexpected contingencies, students discovered that following and implementing the rules were not always feasible. Student nurses experienced contingencies and uncertain situations for which the prescribed rules were not adequate or non-existent. The students attempted to do what was right, but were also conflicted by the goal of getting through the practicum. The efforts to manage the unexpected contingencies required innovation, perseverance, and flexibility. This chapter discusses the consequences of implementing the rules when engaged in faculty work, patient work, and staff work.

Three major outcomes resulted from doing the work. The first was that students modified the rules to manage unforeseen contingencies. If rules did not exist or if the rules were deemed inappropriate for the situation, students modified the rules or created their own rules. Guided by the rules of the self, students implemented these strategies in order to get through the orthopedic clinical practicum.

The second outcome concerned the role of the patient for students in the realm of orthopedic nursing. Since faculty work was the major focus for students, the patient took on a secondary role. Students established the patient as an object of care, rather than a subject of care. As an object, the patient became a means to an end, a way to accomplish faculty work in order for the students to get through. Accomplished with respect and compassion, the patient as an object was used to advance the student through the clinical practicum.

The final outcome for students was that they experienced tension and conflict over implementing the rules. They experienced the real world perspective and this left them at times disillusioned with nursing education and nursing practice. Their socialization into the nursing profession demonstrated to them that what was taught was not always practiced. They questioned the motives of practicing nurses and wondered if their own personal motivation to become nurses, compelled by a desire to serve with compassion, would erode over time. Student nurses managed to strike a balance between their need to get through and functioning as part member of a nursing team.

Modifying the Rules

In the previous chapters I have examined how students defined the different types of work. The work of student nurses included tangible activities such as the provision of

patient care and completing written assignments required by the faculty. In order to be successful at this work students engaged in supporting activities like the pre-clinical preparation. However, to accomplish the more tangible aspects of work, students were required to engage in activities that would support completion of direct care and the written assignments. These less tangible activities included work such as figuring it out, entering into the patient's domain, and negotiating a role with the nursing staff. I have described how students defined and managed this work by following the rules and have illustrated the student's perspective with excerpts from my field notes and interviews.

In spite of the fact that students were provided with rules to manage their clinical experiences, caring for patients could result in unpredictable situations. Unexpected contingencies led the students to question the rules that existed, search for rules that did not exist, and expand on the rules that were vague and ambiguous. All of these circumstances resulted in students creating new rules to facilitate their faculty, patient, and staff work. This section will use some of the situations described in the previous chapters to illustrate how and why students created new rules.

Questioning the existing rules

The nursing program had developed rules concerning curriculum and student behavior. The hospital and nursing unit also had a set of rules governing nursing practice. Both sets of rules were subject to interpretation by individual faculty and students figured out early in the practicum which rules were required of them. That did not mean that students would follow the rules exactly as the faculty stated. The faculty rules were further subject to interpretation by the students. Students questioned the pertinence and

appropriateness of some rules to specific clinical situations. When students questioned existing rules they then had to make a decision on whether or not to implement the rule.

Students used one another as sounding boards when they were making clinical judgments. At times, general consensus meant that the student would follow the group norm whereas at other times, the student's personal conviction was stronger than that of the group. A conversation between several students about the correct timing of taking vital signs demonstrates how students questioned the existing rule and came to a conclusion of how to follow it and adapt it to their individual clinical situation.

3 students are sitting together in the conference room, Noah, Raymond, and Kathy. They are talking about when to take vital signs because they would like to go on break and take their vital signs when they return. It is 3:50 PM and vital signs are due at 4:00 PM. Noah says you can take them before 4 PM, like 3:30 or so. The Kathy says no they should be taken at 4 PM because that's the rule. Raymond thinks for a minute and says they can take them before 4. He says he thinks there is leeway before and after, about 15 minutes. Noah says that like medications there is an overlapping time frame, you should be able to have some time before and after since a person cannot possibly pass all the meds at the same time. He tells Kathy that if a CNA has 8 patients and it takes 2 minutes per patient that proves that it is not possible to take all vitals at 4 PM. Kathy says that may be ok for the CNA but she only has one patient so she is going to take them exactly at 4 PM.

Kathy made her decision to honor the existing rule since she was in a position to implement it correctly believing that patient care should not be compromised.

Similarly, students questioned the rules about pre-clinical preparation. They figured out what the faculty rules were and proceeded accordingly. However, students questioned some of the rules and opted to revise them to meet their personal goals for providing patient care. When students changed these rules it was to improve their ability to safely care for patients. The pre-clinical preparation could be extensive and students prioritized the rules to meet their personal objectives. As discussed in Chapter IV, the

forms used for pre-clinical preparation were very comprehensive. Students, almost without fail, placed these rules in the order that would ensure patient safety. The patient safety rule superceded all the other pre-clinical preparation rules. The focus on patient safety originated during Nursing Module I. As Jamie stated,

In first semester, when I was passing meds, the instructors would make me really nervous, they would act all anxious about the various drugs and that would make me anxious. They would say things like, 'Oh, did you know this drug could do this and that to a patient?' And lots of I time I wouldn't know. So now I prepare my meds very thoroughly so that I know as much as possible about what they [the medications] do in the body.

The experiences of the first semester weighed heavily on the decision to prioritize the patient safety rule. Most students referred to their personal responsibility for patient safety. When describing his approach to medication preparation, Noah stated,

The priorities for me when I'm doing this [pre-clinical preparation] are the meds cause that's probably the biggest area where I can make a mistake and I don't want to make a mistake on the meds.

Questioning the existing rules led students to develop their own methods of managing the pre-clinical preparation rules. Kathy described how she set her priorities:

Okay well with preclinical well like our teacher... teacher-wise we're suppose to have like the face sheet prepared and the treatment, the meds, and the concept map, basically everything done except the nursing diagnoses. But me, my priorities are the meds. So I usually don't finish everything. I make sure I have my meds, my TACTIS done so that I know what I'm giving, why I'm giving it, you know so that I'm aware of what to look for in my patient if they are having side effects. And I'll write a little bit on the concept map but I don't want to pay attention to it just my meds and my patho.

Questioning existing rules enable the students to manage the complexity of providing nursing care. At the same time, students were able to maintain control over the areas where they believed the patient would receive the best care.

When a rule does not exist

The physical patient care activities were guided by explicit rules. Students could research in their textbooks how to give a bath, care for a patient with a cast, prepare medications, or document care. Each one of these activities included step-by-step instructions or rules. But work was subject to unexpected contingencies and for these situations rules did not exist. As discussed before, the physical and psychosocial assessments were difficult for the students to complete. Students expressed concern over writing in front of the patient not wanting the patient to see them with a six-page assessment tool diligently taking down notes. There was no rule to guide students on how to document their assessment findings so students created their own rules. One of the ways in which students minimized their discomfort was to limit their writing activities while in the patient's room. The students rationalized that in this way the patient would not realize that such a thorough assessment was being done. Moreover, this method gave the opportunity for the student to review the assessment tool outside of the patient's presence enabling them to enter the patient's room, complete a small part of the assessment and write it down after leaving the room. The students, not wanting to unduly disturb the patient or intrude on his/her time, would perform the assessment in little bits and pieces throughout the clinical day. Excerpts from both the interviews and field notes illustrate how students created new rules to guide them in collecting assessment data.

- When I go in there and I do like the head-to-toe assessment, I just try in my head to remember everything and then I'll go back to this [the assessment tool] and I'll fill everything out as to what I just did. And if I forgot anything then I can go back. But I mean I don't bring this in here and do each thing [the assessment categories and subcategories] as this says...it's just easier for me cause I feel like I'll get flustered you know, trying to say 'Okay, I've got to do this, let me do that, okay, I've got to do this, let me do that.

- Well basically I have a cheat sheet, it's just so I don't forget anything, IV lines, all those things, identifications, symptoms, all those things. I put them together, that way I'm sure I don't get to miss anything and this is how I do my charting...This one [the assessment tool] is a bit awkward to be lugging around. This patient does not really want to be asked and then write, and asked, the write. It is too cumbersome to take in.
- I hate writing in front of the patient because then they're looking at you like, 'what are you writing?'
- I don't necessarily check it [the assessment form] off. I have a little notepad that I just like write stuff on.
- I don't fill it out in the room. I like, write everything down on a little piece of paper but then I'll go and sit down and I'll transfer what was on the little piece of paper onto this form right here.

These new rules served a two-fold purpose. First of all, students believed they were conducting the assessment in a somewhat covert manner. They were gathering the information yet not bombarding the patient with questions; a practice they felt was invasive. The second objective achieved by this piece-meal method is that it gave the students a reason to continue to go into the patient's room throughout the morning. For patients who required little in the way of physical care, this process would spread the work out over time, allowing the students to be continuously occupied.

Engaging in staff work also engendered the creation of new rules. For students, one aspect of staff work was the negotiation of their role. Chapter VII describes some of the ways in which students managed the work of negotiating their role. Individual students devised creative strategies to connect with the nurse. Students who were successful at this reported satisfactory clinical experiences for the day. The new rules created by students involved public relations skills that facilitated their achievement of staff work. The students complimented staff on their nursing abilities, made themselves available to help, thanked staff for taking on students, and generally acted agreeable and

flexible. Students who were not proficient at public relations were slower to develop working relationships with the staff and experienced some tension in trying to accomplish their goals.

Managing the Vague Rule

Sometimes students encountered rules that were vague or ambiguous. Wide-open to interpretation these rules covered general concepts but left the details up to the student to figure out. Hence, students used creative strategies to make these rules work for them. The vague and ambiguous rules usually applied to indirect care activities and it may be one of the reasons students struggled more when trying to operationalize these concepts.

Students were taught the essentials of physical assessment during Nursing Module I. The students literally interpreted the course content to mean that there was a list of do's and don'ts regarding the gathering of assessment data. Many students believed it was not acceptable to ask patients direct questions. The rule indicated they were to observe the patient and infer from the behavior what the problem was. As Raymond pointed out,

I was like, how do I ask the patient these questions? They [the faculty] said, you just observe, you try to basically, almost like you see what they are doing, how they are doing and then you say it in your own words. You don't actually go out there and say 'okay how are you feeling'? It's not like I'm going to come out and ask my patient how they feel about these things because it's kind of awkward.

This rule did not work for the students. It was vague and ambiguous and did not yield the results students were looking for. Consequently, students developed new rules while achieving the desired result.

- So I would bring it up in a round-about way and if they seem hesitant or if they seem embarrassed about it I'll say, oh yeah, I quit smoking like 4 years ago. You know, I'll just throw it out there and then it makes them realize oh, I [the student] was a smoker

- So I'll just ask in general conversation, I'll ask little bits and pieces of questions and stuff and I'll piece together what I need.
- I go in there and make small talk, so I find out a lot about their psychosocial stuff
- When the social worker is in the room, you know, instead of me asking the questions I can hear the social worker ask it and hear the patient response.

The students started with the vague rule and expanded on it by developing creative methods to obtain the desired information. There were other ways in which students creatively interpreted vague and ambiguous rules. Some were discussed with peers and others were developed and implemented on the spur of the moment. Students demonstrated flexibility and ingenuity managing situations for which the rules were lacking.

Objectification of the Patient

A breakthrough in the analysis occurred with a change in the line of questioning regarding planning for care. Previous to this time, questions concerned what the student's plan was for the day. Usually students gave responses that rarely varied from giving a bath, making the bed, to giving medications. A change in the phrasing of the question focused on the outcome rather than the plan. Subsequently the question to the student became, "What do you hope to accomplish with your patient today?" On this day, the student responded with, "I have a really good patient today. I am going to watch and see how the speech therapist does the swallowing assessment because I haven't learned that yet." The conclusion that this student was not planning for her patient, she was planning for herself led to a re-examination of earlier data regarding the activity of planning for patient care. The results showed that students focus on faculty work and use the patient as a means to get the faculty work accomplished. In essence, the patient became an object of

care rather than the subject of care, resulting in the conceptualization of the good patient and the bad patient.

The Good Patient

Limited research has shown that student nurses use the good and bad labels to characterize nursing preceptors and clinical units. Good nurses were the staff who allowed students to perform many procedures and good units were those where the patients required many procedures (Greenwood, 1993). Students were concerned about real world nursing and actively participating in patient care procedures made them feel like nurses.

In the present study, students classified patients as good patients if they possessed certain qualities or characteristics that would support faculty work. The strong focus on faculty work placed the patient in a position whereby he or she would be judged based on what the student could glean from the experience. In describing her patient assignment for the day, Jennifer said,

I have a good patient today. I got to insert and NG (nasogastric) tube and DC (discontinue) a foley (urinary catheter). Then she couldn't bathe herself so I had to do all of that for her too. Since she got the NG, she needs to stay in bed.

The characteristics that qualified Jennifer's patient as a good patient were mainly physiological although not all the characteristics of good patients related to their physical state. Good patients afforded students the opportunity to complete or support their faculty work. Thus a good patient could keep the student busy, support the care plan process, and reduce clinical stress. Table 2 lists the characteristics of a good patient. In order to give the reader better understanding of the good patient, a description of some of the characteristics follows.

Table 2

The Good Patient

- Has acute pain
- Is constipated or has diarrhea
- Had surgery
- Can't bathe self
- Has an indwelling catheter
- Has prn meds
- Is non-white
- Has overt religious items visible in the room
- Has surgical drains
- Has a LOS of 3 or more days

The busy patient. As previously discussed, one of the rules students had learned from one another was to keep busy and good patients kept the students busy. By virtue of the complexity of the physical care, most of the clinical time could be spent with the patient performing nursing care activities. The busy activities included feeding the patient, providing a total bed bath, behavior monitoring, managing incontinence, carrying on detailed conversations, and performing procedures like dressing changes. When a student was assigned a good patient, they would report during post-conference that they had such a busy but good day.

The care plan patient. Good patients also made the process of care planning easier for the students. As described earlier, students experienced difficulty conducting a psychosocial assessment and deriving a nursing diagnosis from the assessment. A patient who required a great deal of physical care usually qualified for multiple physiological nursing diagnoses. Thus, patients with pain, self-care deficits, nutritional deficiencies, toileting impairments, activity limits, a potential for infection, impaired skin integrity, and constipation provided concrete data from which to derive a nursing diagnosis. Since

the major care plan required the student to work up five nursing diagnoses, the patient with physiological problems provided the students with problems they felt they were equipped to manage.

Another way in which the good patient helped students with care planning concerned the interventions and evaluation for the selected nursing diagnosis. Students were required to list between seven and nine nursing interventions and to implement those interventions with the patient. After they had implemented the interventions students were to evaluate the results. Interventions for physiological nursing diagnoses were tangible activities performed for the patient. So if a patient was at risk for developing skin breakdown, the student could massage the skin, rotate the patient's position, and increase nutritional intake. These interventions could then easily be evaluated in the care plan with statements like:

- The skin was massaged and no breakdown was apparent
- The patient was rotated from the left to the right side every 2 hours, no breakdown noted
- The patient ate 100% of his meal.

Thus the good patient made the entire care planning process flow smoothly due to the tangible physiological needs that the patient presented.

The psychosocial patient. Even though students preferred patients with multiple physiological needs, there were patients who exhibited certain psychosocial characteristics and thus were considered good patients. These characteristics concerned the categories on the psychosocial assessment form. Thus, if a patient displayed overt religious items in the room, such as a rosary, a bible, or a religious picture, the students

could answer the spirituality question on the form. If a patient talked about a higher being, then students could also complete the spirituality section. If the patient was non-white, they could usually answer the cultural questions. As Becky a Vietnamese student pointed out,

It is hard with a Caucasian patient, there is nothing in the book [nursing text] about white culture, just others like Hispanic, Asian and Black. So I don't know what to write, they [Caucasians] don't have, you know, a culture.

Patients who had family members visit them in the hospital too were a help in completing the psychosocial assessment. The students' previously expressed concerns about not wanting to invade the patient's privacy were lessened when these traits were present.

The patient with simple medications. The medication review was usually a dreaded part of faculty work. Although students did not share this sentiment equally, most would agree that once the medication question session was successfully completed, they were able to relax. Good patients then were also those who had few if any medications. The younger patients usually had fewer medications ordered. If a patient had undergone orthopedic surgery, he or she would probably have an intravenous antibiotic and a stool softener given by mouth. Since the students did not administer intravenous medications, this left them with one medication to pass. A lighter mood was present when the students did not have many medications to pass. As Elizabeth commented, "It is easy today for all of us, our patients don't have any medications and once in a while that is a good thing."

The Bad Patient

Conversely, bad patients made faculty work more difficult. Unlike practicing nurses who define a difficult patient as one who possesses objectionable behavioral

characteristics (MacDonald, 2003), student nurses labeled a bad patient as one who impeded the student's progress with faculty work. Bad patients, a) performed self-care, b) had complex psychosocial problems, c) required complex medication regimes, and d) were sustained by complicated equipment. Bad patients were not exactly the opposite of good patients. Rather, they were considered bad patients by virtue of the influence their care had on the successful completion of faculty work. Table 3 lists the characteristics of a bad patient. In order to give the reader better understanding of the bad patient, a description of some of the characteristics follows.

Table 3

The Bad Patient

- Is an atheist
- Has heart failure
- Is young
- Has psychosocial problems
- Has no family
- Is confused
- Has a chest tube
- Is Caucasian
- Has co-morbidities
- Has 7 medications or more
- Has chronic pain
- Is being discharged

The atheist. The student nurses tended to equate spirituality with religiosity and a common strategy was to take the preferred religion from the chart's demographic information page and use that to answer the spirituality questions. Usually students believed this was sufficient to pass the spirituality section of the care plan. Although a review of their completed care plans showed that the faculty did not place a lot of emphasis on spirituality, students still felt the need to fill in the blanks. Consequently the bad patient was one who had no preferred religion or was an atheist.

The cardiac patient. Closely related to the good patient who required no medications, the cardiac patient embodied all the difficult aspects of medication administration. In addition to managing the patient's orthopedic needs, the students had to be knowledgeable and aware of the pathophysiology of cardiac disease and the medications used to treat it. Furthermore, cardiac patients frequently had co-morbidities such as hypertension and diabetes and it was not uncommon for these patients to require six to ten medications. Each one of these medications involved a review with Denise. The complexity of the medication regime also meant that laboratory values and patient assessment parameters were involved in the discussion. An excerpt from my field notes illustrates how Jessica managed this difficult task:

Jessica does the med review with Denise who asks her what the patient's blood pressure is and she says 116/80. Denise then asks her how does this medication work? Jessica says, without looking at her notes, that it prevents the conversion of angiotensin 1 to angiotensin 2 and angiotensin2 is a potent vasoconstrictor so it reduces BP. Denise says very good, in a tone of voice that sounds like she is impressed. She then asks Jessica what the drug classification is and she says antihypertensive. Denise says yes but what is the subcategory and Jessica says it is an angiotensin converting enzyme. Denise says yes, it is an ace inhibitor. Another student who is watching the whole interaction looks at me and rolls her eyes in fear as if to say, wow, this is hard.

The young patient. Young patients usually did not have co-morbidities and complicated medication regimens. They were able to care for themselves except for the orthopedic issue that brought them to the unit. For example, Elizabeth was assigned a young man who had undergone surgery for a compound fracture of the thumb. The patient required some additional antibiotic therapy and monitoring and was expected to be discharged the following day. The nursing care consisted of tying the patient's gown for him. For Elizabeth, he was a bad patient. She could not keep busy and the patient denied having any problems. Elizabeth summed it up when she said,

Younger patients make you think more. Last semester we had mostly older patients and they have lots of problems. You know, we had to feed them and bathe them. But with younger people you have to do more psychosocial problems and that's hard.

The chronic pain patient. Managing pain was a skill students were able to discuss at length. They knew how to assess for pain, how to monitor the medications, and to provide non-pharmacological pain measures. The orthopedic unit admitted patients who experienced chronic pain, mostly back pain. The medical and nursing professions have not been able to successfully manage chronic pain on a consistent basis yet student nurses were assigned these patients and expected to manage their pain. When students were not able to provide satisfactory pain relief for their patients, the students became frustrated. Moreover, the only problem the patient would talk about was pain. This situation was difficult for students in that they could not provide the care they believed was necessary and the patients frequently withdrew not giving students entry into their world. All of this combined to make the chronic pain patient a bad patient.

Tension, Conflict and Disillusionment

When students prepared to care for patients, they generally had a mentally prepared plan of what they would do with the patient for the day. In addition to the routine of direct physical care, students had an idea of how they would spend the remaining clinical hours. If the patient had been assigned as a care plan patient, the student nurse would be focused on gathering data for the care plan. At other time students would volunteer to do procedures for the nurses. However, contingencies arose that prevented students from carrying out their plans. Students experienced tension and conflict and sometimes disillusionment as they struggled to manage the unexpected changes. Additionally, behavior demonstrated by nursing staff that conflicted with what

students idealized as acceptable nursing behavior also contributed to the feelings of disillusionment. The analysis showed, however, that the type of contingency influenced the nature of the student's response.

Faculty Contingencies

The faculty possessed the greatest amount of control over the student nurse's work. The students focused their primary goal on getting through the practicum and this involved engaging in faculty work. Usually students directed their efforts at pleasing Denise and tried follow the rules exactly as instructed. But students brought previous nursing experiences to the clinical situation that at times were in conflict with what Denise required. When these conflicts arose, students experienced disillusionment since what had been taught was not carried out in the orthopedic clinical practicum. However, since Denise was the one in control of the grades, students would only pose a limited challenge. As Mike, a student who was repeating this semester pointed out,

Last semester I failed this clinical. I think it was because I challenged what Denise said. I notice this semester she is really giving me a hard time with my medication review. I'm just going to do whatever she says, it's only two more weeks and then I'll be through.

Students learned early on in the nursing program how to assess and manage a patient experiencing acute pain. A review of their care plans showed that students were well versed in the various aspects of pain management. Thus, when they were assigned a patient with acute pain, they were ready to implement nursing interventions that could result in an uncomplicated evaluation for the care plan. Pain management for students was the ideal nursing diagnosis to use for their care plans.

Jaime tells me that her patient with a fracture is going to be ambulated by a physical therapist. She says one of the rules of pain management is to pre-

medicate a patient before activity so that the pain will not be so severe. This is Jaime's plan. She checked the medications and found out that the patient could receive pain medication. She checked and found out that the physical therapist would come at 9:00 AM. She is going to give the pain pill at 8:30 AM so that it will have time to be absorbed. At 8:00 AM she informed Denise of her plan and Denise agreed to be on the unit at 8:30. It is now 8:40 Denise had not arrived. Jaime pages her and asks if she can give the medicine with the nurse. Denise says no and that Jaime will have to wait until Denise gets there. When Denise arrives at 9:10, Jaime's patient is up and walking with the therapist. Jaime gives the patient the medication in the hall and Denise leaves. Jaime is so upset. She says, "You know, I was doing it right, just the way we were taught. I know Denise gets busy with other students but she should have let me give the pill with the nurse. Now it's my patient who suffers."

Jaime told me she never discussed this with Denise. Her reasoning was that nothing would come of it and that she didn't want her grade to suffer. She was convinced that she knew what the right thing to do was and that was enough for her. Yet she was disillusioned by what the nursing program said they valued and what she experienced with her clinical faculty.

Following the rules could also result in disillusionment when students were forced into rigid interpretations of the rules. While for some students the straight and narrow path was reassuring, knowing exactly what to do all the time, for others it became a source of conflict. For these students patients did not fit into a neat category from the nursing textbook. They wanted to individualize care based on what they discovered during the patient assessment. But the rules at this time in the program did not allow for any deviation. So students acquiesced on paper but disagreed with the faculty's judgment. Carmen explained this to me illustrating with an event that happened with her.

Interviewer: Does your nursing diagnosis ever change? You have used this one [infection] several times.

Carmen: You probably could. You probably could except we have to play according to their rules. In fact I challenged one teacher because the priorities were not according to Maslow. This patient, he had tissue perfusion problems, he was in end-stage renal failure, he had this and that. But his big issue was,...what's

the one where they, ...Oh yeah, ineffective therapeutic management type thing. That was really the biggie. That was the reason all the other ones [problems] were happening. So I said, that's not it for him. Tissue perfusion is not an issue for him. His issue is... So it's like that too. You know just because it's not according to Maslow for that patient but we have to put that Maslow thing.

This illustrates the conflicts students experience when they try to use their clinical judgment without support from the faculty. But as Carmen stated in the first part of this discussion, students believed they had to play by the faculty's rules. Getting through the clinical practicum was first priority for the student nurses.

Nursing Driven Contingencies

Since nurses retained the ultimate responsibility for patient care the students and Denise usually followed their instructions and decisions. On occasion if the nursing being practiced was in direct conflict of what was taught in the nursing program, Denise would explain to the nurse why the students would not be able to participate. These situations were rare but other nurse driven contingencies made it difficult for students to do their work.

Students experienced disillusionment when they perceived the nurse to be uncaring or lacking in compassion. This excerpt from the field notes illustrates a situation where the student was unable to provide her patient with appropriate care due to the nurse's lack of assistance.

Paula's patient had a pressure ulcer dressing that became soiled during morning care. Paula needed to change the dressing but did not know exactly how to proceed because the type of dressing used was different from what she had used before. Paula notified the nurse who told her to remove the soiled dressing and that she, the nurse, would come in and replace it with a new one. At 0930 Paula was standing in the hall next to the nursing station. She was discussing this with Jaime. Paula said, "It's already 9:30 and she [the nurse] still has not gone in to do the dressing change. My patient is lying there all exposed. I waited in the room for a while but I think it's better if I wait out here, that way she'll see me." Jamie responded, "Why don't you ask her again?" to which Paula replied, "I have

already asked her twice. She just kind of ignores me. Look at her, she's just sitting at the computer doing her charting. She has not really gone into any patient rooms."

The nurse indeed was sitting at the computer terminal entering data. Paula continued to stand in full view of the nurse waiting. After about ten minutes, the nurse got up and walked down the hall, towards Paula's room. Paula eyes lit up and she started to follow the nurse, only to stop when the nurse walked past the room, opened the door to the stairwell and disappeared from view. Paula angrily said, "I know where she's going, she gone to smoke, she's already done that once before. It's been an hour now and my patient is still exposed."

After about five minutes the nurse returned. Paula approached her and said, "Can we do the dressing on my patient now?" The nurse mumbled something and went back to the computer and left Paula with tears of frustration in her eyes. Soon after Denise came to the unit and Paula explained the entire situation to her. Denise went to the nurse and said she would be happy to do the dressing if the nurse would tell her what to do. The nurse pointed to the dressing cart and named the type of dressing they should use. Denise then called Paula over and they gathered their supplies and went to the patient room. Jaime stayed behind and told me how frustrating it was when the nurses act like students are a bother. Jaime said, "We are here for the patients and if we could do it by ourselves we would, you know, it's not like we bug them on purpose."

While this is an extreme example of an unforeseen contingency, students commented on similar behaviors they observed with their nurses.

In negotiating their role, students were required to communicate with the staff nurse. One of the ways to accomplish this was for the student to develop a short written report of what had occurred during the morning, which was presented to the staff nurse upon leaving the unit. This practice gave the student the experience of communicating the patient's status while at the same time providing updated information to the nurse. For some students this was a difficult task and they painstakingly prepared the report and presented it to the nurse. The field notes illustrate the shock students felt as one of the nurses responded to the report.

As one student approached her nurse with the report, Sue and Jamie, two other students, were standing on the side watching. The first student reports off to the nurse and hands her the written report. The nurse responds by saying thanks. As soon as the student turns her back, the nurse, without looking at the paper, throws

the report in the trash. Sue and Jaime observe this and raise their eyes and look at each other. As soon as the nurse moves away, they comment on how rude that is. Jamie says, "I can't believe she did that. Isn't what we give them important at all? At least she could have read it!"

The ways nurses treated patients and students were key reasons student experienced disillusionment. Lack of demonstrated caring affected students and they wondered why that person had chosen nursing as a career. Professional socialization occurs when the student has a sense of occupational identity characteristic of a member of that profession. These incidents showed students that some characteristics were not worthy of membership in the nursing profession. Students expected the nurses to behave in the manner they were taught during Nursing Module I and that meant the patients come first, communication is open with a focus on team work, and students, although burdensome at times, are part of the future of nursing and should be treated with respect. When these behaviors were lacking, students determined that when they became practicing nurses, they would remember their experiences as student nurses.

Patient Contingencies

Unexpected contingencies concerning patients were accepted by the students as non-preventable events. Unlike nurse and faculty driven contingencies, patient contingencies were something students absorbed and dealt with. Students did not express concern or anger with patients if the day's events did not go as smoothly as planned. If anything, students were grateful to patients when they were able to accomplish faculty work. When students developed a working relationship with patients they would share this with other students. When patients preferred to hold back and possibly make it more difficult for students to accomplish their clinical work, students accepted that as the

patient's right. Since students believed it was a privilege to enter into the patient's world, being denied that entry was not deemed as negative.

Summary

Engaging in work and implementing the rules resulted in several consequences. When rule were inadequate for students to carry out their work, they created new rules or added to the existing rules. Focusing on getting through the clinical practicum, students used their own clinical judgment and experience to craft methods of accomplishing their work. Another consequence resulted in designating the patient an object of care rather than a subject of care. The intense focus on faculty work impelled students to view their patients in terms of how the patient could help facilitate faculty work. Labeled the good patient, students developed a classification of patients based on desirable characteristics. Conversely, the bad patient possessed traits that made faculty work more difficult to accomplish. Finally, some faculty and nurse driven contingencies resulted in experiences of tension, conflict and disillusionment for students. Students gained a new perspective on nursing education and practice as they progressed along their educational trajectory.

CHAPTER IX

Reflexivity

In conducting ethnographic research, scientists have engaged in a dialogue debating the role of the researcher. Writing about the history of reflexivity, Finlay (2002) comments that today reflexivity has a “firm place within the qualitative research agenda” (p. 212). Qualitative research findings are constructions of the researcher’s interpretations of the data and are a joint effort between researcher and participants. Recognizing that remaining purely objective and keeping a distance is not possible, or even probable, it behooves me to write about the influence I may have had on the activity in the field. Moreover, my close professional ties to the area I chose to study and the community in which the research took place, resulted at times in the blending of my role as a researcher and that of nursing instructor and community member.

In this chapter I discuss some of the difficulties I had separating research from clinical evaluation, the exchanges I had with my participants, and what I learned about teaching nursing. I discuss some of the strategies I used to increase my awareness of the process and to use that awareness for a deeper understanding of the interpretations I made.

Evaluating Nursing Program

As my data collection progressed, I experienced occasions where I found myself thinking in the role of a nurse educator. As a novice ethnographer, I made jottings and transcribed those into field notes. As I reviewed the field notes in the evening I did not

notice anything unusual about what I had written. But then, as I reviewed my line-by-line coding, I realized that I was evaluating how the faculty member conducted the clinical experience. An excerpt from my notes on the first day in the field and my follow-up memo illustrates this.

Field note: Denise goes to breakfast during report because she says there is nothing to do until after the students have heard report. She asks me to join her but I feel the need to hang around the unit and see what is going on. The students are standing at the medications carts doing some kind of work with the paperwork and medicines.

Memo: Why does Denise go to breakfast, instead of being with the students as they do their morning work? Are there no teachable moments? The breakfast break lasted 30-45 minutes. During that time students were hearing report and getting their medications ready. This may be the first opportunity they have to hear from nursing staff about the patient. Medication preparation can be difficult for students and this task is started right after report. I think what is going on here is that the instructor is missing teachable moments.

It is interesting to note that I was writing field notes and memos like this for several weeks. My moment of recognition came during spring break. Since school was not in session for one week I did not go to the research site. Instead, I reviewed what I had accomplished so far. Instead of uncovering what was going on in the field, I found myself with a long list of suggestions of how a clinical section should be managed. I was actually embarrassed that I had engaged in such blatant evaluation rather than research.

Taking time to step away from the field was valuable for me. I recognized that my passion for teaching clinical nursing could interfere with focusing my observations on the action in the field. I developed a strategy that although new to me, was a crucial part of writing up ethnographic field notes. I began to write my field notes with much more description than I had done before. I took my field notes to a level that included the thick rich descriptions suggested by Geertz (1973). As a result, I found myself focusing on the

actions and behaviors of the players, rather than taking small data bits and turning them into evaluative situations.

Writing rich descriptions definitely helped in moving my analysis away from evaluation. But from time to time I still found myself observing in the clinical instructor role. I managed this by writing up the incident in a separate section of memos that I titled with my name. So when I encountered situations where I felt compelled to “evaluate” I was able to separate that out from my field notes. I was able to dialogue with myself and then put that issue aside.

Relationship with Student Nurses

Lofland and Lofland (1995) suggest that relationships with participants in the field can lead to potential barriers to data. Issue like trust and attitude can hamper the researcher’s ability to maximize the information. Developing trust with the students seemed to be an obvious task for me. After I had explained my research project, I made myself available for individual students to ask me questions. Most students readily signed the consents. I explained how I would keep all observations and conversations confidential. In my explanation I specifically said I would not reveal information to the students about their peers, to the faculty about the students, and to any community members who may inquire about the progress of my research.

Most students seemed to believe that the data I collected would remain confidential. They were open and honest with me about their experiences and feelings. I cannot recall any student asking me about what other students revealed. Indeed, it seemed as if students expressed their own opinions freely, at times even commenting that the faculty would not be pleased if they were aware of the stated opinions.

During my last session of observations, four out of ten students opted not to participate in the study. I did not ask what their reasons were since I did not want to appear coercive. However, several of these students commented that it was too stressful to be observed. My success at recruiting 100% of each of the previous groups made me feel as if I were rejected by the last group of students. Subsequently, as a researcher I felt uncomfortable whenever I was around those students. How I managed this was to leave the area when any of the non-participants were engaged in clinical activities. Even though they were friendly and would greet me, I did not want to prolong contact for fear they may think I was recording their behavior. Later on a student who did participate informed me that at first she was nervous thinking about someone watching her. But she decided to participate anyway because her friend said it would be fun to be part of a research study.

The relationship I developed with the students became one of trust and mutual sharing. I told them about my clinical teaching and experience. They in turn would ask me clinical questions. They seemed to consider me as a safe instructor, one who could answer questions but not judge them. I had rehearsed the line that I was there doing research and not clinical teaching, but a few times I communicated with them as I would with my own clinical students. An excerpt from my field notes shows how this came about.

Raymond wants to know if 'ineffective airway clearance' is a good nursing diagnosis for COPD. Barb says she doesn't know. They look at me and I say I don't know. They argue back and forth about what the appropriate nursing diagnosis would be. They look at me again and ask if they are on the right track. I tell them that the nursing diagnosis comes from the patient's response to illness, not the medical diagnosis. If the patient has stuff in the airways and cannot get it out, then the DX is appropriate. I tell Raymond he could use it for a stroke patient who cannot cough, a fatigued patient, an asthma patient, and a pneumonia patient. Darla almost shouts and says "So that's how it works, I get it now."

I have to admit I obtained the satisfaction of seeing students grasp a difficult concept. However, I wrote up these incidents in my memos and it helped to increase my level of awareness. After a while, students did not ask me clinical questions and seemed to be content to let me listen to their conversations with one another. For the purpose of research, it was much better to observe students trying to figure something out, seeing who and what they would access. I believe writing it all down helped improve my research methods.

Loneliness as a Researcher

I wanted to share my findings with colleagues but due to confidentiality this was impossible. One of my faculty peers had recently been employed as a nursing instructor at the community where my research was being conducted. Although she never asked me where I was doing my data collection, I could not be sure that the information had not gone beyond the college. So I found myself contemplating with myself and only sharing my ideas with my school colleagues, many who at the time were not engaged in academia. I have since moved out of the state and have been able to share my findings with my current colleagues. It was good to be able to openly talk about my work with faculty who were interested in using the findings with their own clinical situations.

What I Learned About Teaching

I ended up spending quite a few hours with the instructor. When students were in their rooms, Denise and I would have time to talk about various issues. At first we just shared our beliefs about teaching but as I collected and analyzed more data I changed my focus. I was now listening to Denise from the perspective of the students. I had heard their voices and knew what their perceptions of nursing school were. It changed the way I

approached teaching clinical rotations. The first clinical I taught post data collection and analysis revealed some of the same student behaviors. My students were focused on faculty work, not the patient. It was a powerful realization for me that my findings may not be limited to the small groups of students in the study. It was exciting to think that the research could be a springboard for additional studies.

Summary

Engaging in reflexivity has helped me become a better researcher. By deliberately focusing on some of the troublesome aspects of the research process, I was able to fine tune my data collection and analysis which I believe yielded a stronger outcome. Reflexivity also increased my awareness of my role as a field researcher. When I compare my first field notes with subsequent ones, I can see the growth and improvement in my data collection methods. I plan to continue to refine these skills with future research endeavors.

CHAPTER X

Discussion and Implications

The findings of this research study led to the development of a substantive theory of how student nurses get through an orthopedic clinical practicum. Developed from the perspective of how students navigate the rules of their work, the theory outlines the context, conditions, processes, and consequences that occur as students engage in three types of work, faculty work, patient work, and staff work. Using ethnography and grounded theory research approaches, this study fills in a gap in nursing knowledge since limited studies have been conducted examining what student nurses actually do in the clinical setting and thus giving voice to the student participants' experiences.

The students in this study assigned a hierarchical value to their work, which placed greater emphasis on faculty work. They focused on this work more than patient and staff work, leading to the conceptualization that patient and staff work were subordinate to faculty work. Faculty work was the force driving the efforts and performance during the clinical practicum. The goal of getting through the clinical practicum superceded the motivation to engage in patient and staff work. Students managed the three categories of work by implementing rules derived from the nursing program, individual faculty, the hospital and staff, and self. Rules guided student practice for completing the work. When the rules did not meet students' needs rules were modified or new rules were created. Engaging in work and implementing the rules

resulted in the consequences of creating new rules, objectifying the patient, and experiences of tension and conflict.

The use of ethnographic methods allowed for the study of work as it was occurring, providing a deeper understanding of the students' experiences. Ethnography yielded a full description of the clinical practicum rather than just one segment. Immersion in the field added to the context of student work, filling in gaps left by interviews. Being present while students actually engaged in work may have enhanced the analysis and may have resulted in obtaining a more meaningful story (Charmaz & Mitchell, 2001). Interviews alone would not have provided the richness of the account or an understanding of how students construct meanings from their clinical world.

This chapter will discuss the findings of this study in the context of previous research concerning rules and work in nursing. The discussion will show where this study fits in with contemporary nursing education and clinical practice. Additionally, the implications for nursing education, practice, administration and future research will be discussed.

Navigating the Rules

The findings of this study show that rules were an important part of the organization and operation of the clinical practicum. Students were taught the rules upon entering the nursing program and continued to receive additional rules as they progressed from the first to the second semester. The nursing program incorporated the requirements set by licensing and accrediting agencies into the curricular rules. Students learned that each faculty member also had a set of rules and these varied among different instructors. From the student's perspective, the clinical practicum was a rule-bound experience and

these rules needed to be implemented to accomplish clinical work. Navigating the rules was the perspective taken by students to make sense of their clinical experience.

For student nurses, rules are an important part of learning. Novice nurses do not have the background of experience to guide their work. Context-free rules, those developed to provide the framework in which to practice, are usually written to manage objective tasks like vital signs and direct patient care activities. Novices can implement these rules but experience difficulty when the situation does not fit all the elements of the rule (Benner, 1984). Students are guided by professional rules and norms; adherence to the rules is a common practice for students in the clinical setting (de Casterle, Grypdoneck, Wauters, & Janssen, 1997; Dyches, 1998).

The concept of responsible subversion was identified as situations whereby practicing nurses bend the rules for the benefit of the patient (Hutchinson, 1990). Hutchinson suggests that administrators create rules and these rules may be in conflict with nurses' personal beliefs. Nurses engaged in rule-bending when a conflict of personal values arose and the rule prevented them from doing what they thought was in the best interest for the patient. The findings from this study show that student nurses did experience conflict over some of the existing rules and rule bending did occur. However, unlike the nurses in Hutchinson's study, students usually modified the rules for personal benefit, to get through the clinical practicum. For example, when a student decided use an open washcloth for bathing the patient rather than folding it into a bath mitt, this was done for the convenience of the student, not the patient. Unlike the nurses in Hutchinson's study, student nurses did not bend rules regarding things like medication administration. As de Casterle, Grypdonck, Wauters, and Janssen (1997) suggest, student

nurses are guided by professional rules and norms of duty and do not make ethical decisions based on their own principles and values.

The student participants in this study, novices to nursing, came to the clinical area armed with a set of prescribed rules but they soon discovered that not all the rules fit all the clinical situations. Contingencies arose making some of the rule impossible to implement. So although they possessed the rules to carry out their clinical work, these rules were not adequate to cover all the circumstances encountered. The student nurses in this study, like those student nurses in earlier studies Benner (1984), deCasterle et al (1997), and Dyches, (1998), followed the rules given them; some students followed the rules exactly as they were given to them while others took a more flexible approach. However, the findings from this research also suggest that students defined rules in a broader context. In addition to step-by-step procedural rules developed for carrying out tasks, these students identified issues such as expected behavior, ways to establish staff relationships, and individual faculty requirements as rules. The ways in which students implemented these rules did not always mimic the behavior of novices described earlier. This study has touched on implementing the rules in the context of doing various types of work, however, more research is needed on what constitutes a rule for student nurses and how students decide when to follow, break or modify these rules.

Student Work and Education

To date, few research studies have been conducted aiming to uncover student nurse experiences during clinical courses. Previously, the focus has been on the phenomenon of professional socialization, how students adopt the behaviors, values, and characteristics of the profession (Bradby, 1990; Melia, 1989; Oleson & Whittaker, 1968;

Simpson, 1979). These studies present an in-depth view of students' experiences during a nursing program and how these students entered into the nursing profession. Current research concerning student clinical practice focuses on components of clinical practice such as communication and critical thinking, problem solving and role development (Clifford, 1996; Cook, Gilmer, & Bess, 2003; Kotecki, 2002; Myrick, 2002; Secret, Norwood, & Keatley, 2003). Although the conceptualization of student clinical practice as work has not been researched, some aspects of student work have been studied. These components of student work share some commonalities with the findings from this study.

Nurse-patient relationships

Some of the findings of this study are similar to findings in the professional socialization literature. Although not conceptualized as work, studies of student nurses in clinical practice point to student concerns about entering into the patient's world. Simpson (1979) found that students perceived, early in the nursing program, that faculty were concerned about clinical procedures rather than psychosocial issues. Interviews with students revealed a desire to develop nurse-patient relationships yet they lacked the skills to initiate this relationship. These students believed they would better serve the patient if they had some methods to connect with the patients. Similarly, Melia (1987) discovered that students wanted more classroom time to learn about developing a professional relationship with their patients. Although these students recognized the value of experience in clinical practice, they believed more attention should be given to the development of a nurse-patient relationship. The students in the present study described similar sentiments. Entering into the patient's world was the main thrust of patient work, generating anxiety and uncertainty. The study participants developed elaborate strategies

to accomplish the task of developing the nurse-patient relationship. The work of developing a therapeutic relationship continues to be a challenge faced by beginning nursing students.

Melia (1989) refers to the term “face-saving” when students were confronted with awkward situations. For these students an awkward situation was present when the student lacked information or did not know the answers to patients’ questions. In response, students developed strategies to manage the uncomfortable event such as being evasive, changing the subject, and deferring the question to a staff nurse. Moreover, the students reported that restrictions were placed on what they were allowed to say to their patients. The students in the present study encountered similar experiences. In addition to the concern of looking stupid, students believed they could not ask patients straightforward questions. Requiring students to conduct themselves as nurses, while not providing them with useful tools, creates a barrier for students as they enter into the patient’s world.

The Good Patient, the Bad Patient

The conceptualization of good patients and bad patients has not found its way into the nursing education literature. Although Greenwood (1993) describes how students labeled good and bad nursing units and staff, the reference concerned the level of activity encountered on the unit. These activities however consisted of patient procedures and as such, good units may have included a number of good patients. In this study good patients and bad patients were labeled according to the impact they had on the accomplishment of faculty work. As a result, the patient became an object of care.

Identification of the patient as an object of care rather than a subject of care has received limited attention in the nursing literature. In the context of work, May (1992) describes two ways in which nurses come to know the patient. The first he describes as foreground work which entails the physical aspect of the patient, the medical diagnosis, physical limitations, and physiological care required. A focus on the physical characteristics designates the patient as an object of care. Background work consists of nurses knowing the patient, the personal part that makes the patient a unique individual. Labeled as the “the patient as subject”, May contends that nurses focus on this type of work beyond the accumulation of bio-medical symptoms. The differentiation between the patient as an object of care versus a subject of care forms the basis of May’s conclusion that nurses’ work is complex and requires a blending of the two types of work.

In two unrelated studies, researchers concluded that nurses focus their care on the objective aspect of the patient. Hardey, Payne, and Coleman (2000) explored what was reported and recorded at the change of shift. These researchers found that nurse adopted a “body-centered” approach when exchanging information about their patients. The body-centered approach included the medical diagnosis, treatments, diet, code status, and equipment. Using May’s (1990) conceptualization that a focus on physical characteristics deems the patient as an object of care, this study supports the differentiation between the patient as an object and subject. Although the researchers focused on the content taken away from report, the definition of the patient as an object of care is applicable. Similarly, an examination of the content of nursing documentation found a focus on “body-work” (Heartfield, 1996). The researcher suggested that nursing as constructed in documentation portrays the patient as an object of care. Heartfield maintained the

individualism of the patient is lost the moment of entry into the hospital and that the patient as a subject is not presented in the documentation.

The subjectification and objectification of patients in nursing needs further exploration. The results from this study provide one step towards understanding the role patients play in the education of student nurses. Additional research is warranted in order to make any connection between nursing practice and the perspectives of student nurse.

Student Work and Staff Nurse Relationships

In this study staff work emerged as one of the salient dimensions of student work and as such required significant efforts to accomplish this. While staff work as a concept has not been studied, the relationships with students and the roles of staff nurses in clinical education have found its way into the nursing education literature. Jackson and Mannix (2001) identified helpful and non-helpful staff nurse behaviors when the staff interacted with student nurses. The study sought to describe student nurses' perspectives on the role of clinical teachers. Helpful staff nurse behaviors included friendliness, showing interest, and explaining. Students found unhelpful behaviors, such as passivity, made them feel unwelcome in the clinical area (Jackson & Mannix, 2001).

Student beliefs about what constitutes effective mentorship are similar to their beliefs about staff nurse behaviors. Even though mentors are selected to support student nurses, students have similar expectations. Gray and Smith (2000) found that student nurses desired mentors who would be supportive and guide them in their learning. The behaviors included active tasks like giving feedback and assisting with problem solving. Although the beliefs of effective mentorship changed over the course of the nursing

program, beginning nursing students desire a supportive relationship with the nurses they are assigned to work with.

Student nurses in Great Britain also expressed a desire for improved working relationships with staff nurses. At the time Melia's (1989) study was conducted, the students were enrolled in a diploma program where they performed many hours of clinical duty. Described as "nursing in the dark", Melia recounts the conversations with student nurses who complained they were left short of information necessary to provide therapeutic nursing care. These students expressed frustration with the staff and a system that relegated them to provide direct care yet kept them ignorant of essential knowledge of the patient.

The above mentioned studies describe student nurses' perceptions of helpful staff nurse behaviors. The student participants in this study, in addition to identifying helpful behaviors, describe how they worked within the clinical environment to develop working relationships with staff. Furthermore, this study examined the ways in which students conducted the staff work of negotiating a role and managing the in-between position. The conceptualization of staff work as a key activity for student nurses provides an understanding of how they go about doing the work and complete work expectations. Thus, in addition to a description of what was desirable behavior of a staff nurse, this study of student work adds additional depth and breadth of insight of the impact of clinical staff on student nurse education.

Nursing Work and the Work of Student Nurses

One of the compelling reasons to study nursing work has been the drive to demonstrate its value. In a society where output and production are measured and

quantified, many dimensions of nursing work are not captured. Yet the elements of intangible work are key components to the management of the patient and success of the organization (Liaschenko & Fisher, 1999). The impetus to study the work of student nurses came from a desire to understand what students do to get through a clinical practicum. The exploration led to the discovery that students engage in different types of work. Conceptualizing work as “a sequence of expected tasks, sometimes routinized but sometimes subject to unexpected contingencies” formed the foundation from which to analyze field data on student work (Strauss et al., 1985, p. 9). The work of student, although somewhat different than nursing work, shares some common ground with the ways in which nursing work has been described.

Invisible and Visible Work

Research and commentary on the invisible work of nursing has probably received the most attentions in the literature. Described as necessary yet non-quantifiable activities, invisible work is like the mortar that holds bricks together. Invisible work connects all aspects of patient care into a whole. Comprised of emotional labor, relationship work, and in-between work, invisible work is an essential aspect of nursing (Aldridge, 1994; Liaschenko, 2002; May, 1992; May & Purkis, 1995; Williams, 1998).

For student nurses, engaging in faculty work involved some elements similar to invisible work. The actual backstage work of pre-clinical preparation was not visible to the faculty member, yet without it, the clinical work could not take place. The efforts students expended in doing backstage work were not quantifiable. Depending in the complexity of the patient, students could spend a great deal of time on the preparation yet the results may not be evident during the clinical day. Although students and faculty felt

that backstage work was necessary and inevitable, the students did not believe their work always received the recognition they felt it deserved.

Staff work could also be described as invisible work. Important to the success of patient and faculty work, staff work yielded no credit. If a student was successful in staff work, they did not receive compliments or positive feedback on their efforts. Staff work was deemed necessary but certainly was devalued. When staff work went well students could accomplish the other aspects of work but when staff work did not produce the desired results, students struggled. In either case, students were not rewarded for their attempts to accomplish staff work.

Body Work

Lawler (1993) maintains that body work is central to nursing work. She conceptualizes the body as a private space entered into by nurses. Although Lawler argues for theoretical development about the human experience of the body, the students in this study did experience the difficulty and discomfort of entering into that space. Thus the student participants in this study engaged in body work when they entered into the patient's world. Students repeatedly spoke of invading the patient's privacy and questioned the need to do so. As novices in the nursing profession, the students had not made the connection between the physical ability to get well and the emotional or psychological desire to get well. As such, engaging in body work constituted a dilemma of meeting course requirements and invading someone's personal space.

Dirty work

In nursing, dirty work has been described as those tasks associated with bodily processes like bathing, toileting, and dealing with bodily fluids (Wolf, 1988). Hughes

(1994) maintains that dirty work is acceptable if the result is gratification from the patient or family. The students in this study welcomed dirty work as this gave them purpose of action. A review of the good patient-bad patient outcome shows that good patients are those who need assistance with physical needs. Students appreciated these types of assignments since these patients provided substance for the care plan. Moreover, patients who required physical care, usually in terms of dirty work, also kept the student engaged during the clinical hours. Dirty work meant a busy patient. In this study, students were not overheard to make disparaging comments about the physical needs of their patients.

Implications and Recommendations

This study was conducted with students enrolled in an associate degree nursing program during the orthopedic clinical practicum. This set of experiences was selected because they are common to most nursing education programs. The findings of this study cannot be generalized to wider populations of student nurses at this stage because they are limited by the methodology used and the context in which the data were collected. The convenience sample consisted of four groups of nursing students from the same associate degree nursing program, who shared the same faculty member, and practices on the same nursing units. However, apart from providing insight and understanding into the phenomenon of how students navigate the rules for their clinical practicum work, a number of recommendations concerning nursing education, administration and practice can be made.

Strengths and Limitations

One of the major strengths of this study involves the extensive data collection methods. More than 200 hours in the field facilitated the opportunity to experience work

as students experienced it. If the data collection had been limited to interviews, it is doubtful that the same discoveries would have been made. The sustained involvement with the student nurses allowed for observations of their work which then yielded additional questions. The results yielded a substantive theory, truly grounded in the data.

One of the limitations was that my experience as a clinical instructor prevented me from going into the field without pre-conceived notions. As described in Chapter IX, I compensated for this by focusing my field recordings and creating separate field memos. I am convinced however, that someone without a different background may have come away with a different interpretation of the data. Studying student nurses in an area other than medical surgical nursing will be beneficial in expanding the scope of this investigation.

Nursing Education

A goal of nursing education is to prepare students for practice in a variety of health care settings. The complexity of health care including expanding technology, a diverse population, increases in aging, and advancements in chronic illness management, requires that the student nurse enter the workforce with the skills necessary to function effectively in the health care environment (National League of Nursing, 2005; Tanner, 2000). Nurse educators are challenged to find ways to teach students while working within the constraints of legislative and accreditation requirements.

Leaders in nursing education have advocated for changes in how nursing is taught, both in the classroom and in the clinical settings (American Association of Colleges of Nursing, 1998; McCannon & O'Neal, 2003). A commitment from faculty leaders within each individual nursing program is essential for initiating these changes.

The traditional ways in which students are taught may not be adequate to prepare a skilled clinician. An examination of a traditional clinical rotation revealed that students spend 75 percent of their clinical hours unsupervised by either the faculty or staff (Polifroni, Packard, Shah, & MacAvoy, 1995). The goal of bringing classroom learning to the clinical setting is frequently not actualized as the clinical environment does not mirror what is taught in the classroom (Benner et al., 1996; Landers, 2000). Furthermore, the practice of preparing a care plan in advance of caring for the patient implies that the most important knowledge to be learned comes from textbooks, leaving out the context within which the patient resides. The ready availability of care plan books provides students with standardized plans that do not necessarily require the student to use clinical judgment (Benner et al., 1996). The combination of these issues suggests that in order to prepare skilled nurses, the educational strategies and focus may need to be changed.

The student participants in this study prioritized their work along faculty requirements. They completed their care plan as part of the requirements to pass the course. Students commented that what they learned in the classroom frequently did not connect to clinical practice. Although the participants were in the beginning of the nursing program, the clinical practicum was organized along traditional curricular systems. The findings in this study support the suggestions to critically examine and change the way nursing is taught.

Individual clinical faculty are constricted in how they design and conduct the clinical experience. Regulations from the Boards of Nursing and nursing education accrediting agencies require the implementation and adherence to prescribed standards. These standards include use of the nursing process and nursing care plans and are

embedded in the nursing curriculum. Subsequently, clinical faculty adopt the curriculum and implement it with their students in the various clinical settings. Teaching strategies such as Problem Based Learning provide faculty with the tools to prepare students to be effective at problem solving (Alexander, McDaniel, Baldwin, & Money, 2002). Research has shown that faculty feel compelled to cover content resulting in lectures where there is virtually little active participation by students. (McKeachie, 1999). This adherence to the traditional methods of teaching may not provide the students with the problem solving skills needed for practice.

The findings from this study suggest that individual faculty members may not be in a position to effect change to the total curriculum. The shortage of nursing faculty makes it difficult to find enough qualified nurses to teach. Subsequently, practicing nurses are recruited to fill part time clinical instructor positions. Adjunct faculty are usually not involved in designing the curriculum. Moreover, faculty who solely teach clinical courses may not have a grasp on what students are learning in the classroom. However, the discoveries made in this study have some implications for individual nursing faculty in the conduct of their clinical courses.

When designing clinical experiences, faculty may want to take into consideration that from the student's perspective, patient and staff work are at times a means to accomplish faculty work. In this study, assigning a patient for a care plan directed the students' focus towards collecting data. As such, students spent more time reviewing the chart than providing actual patient care. In order to maximize student learning, it may be helpful for faculty to understand the students' perspective and create an experience whereby the student can incorporate both classroom and clinical learning. Helping

students to explore the context within which the patient enters the healthcare system may lead to a better comprehension of the patient's goals and expectations. Nursing care plans are designed to individualize care yet care plan books provide standardized care. Active faculty involvement in the actual student-patient interactions can be beneficial for identifying student nurses' problem solving abilities.

In this study, a significant part of the faculty member's time was spent supervising the administration of medications. While this activity is vital for patient safety, other skills needed by students may be shortchanged. A critical examination of what is required of clinical faculty may assist in identifying opportunities for change in practice. Concentrated efforts to connect classroom learning with clinical experiences may help maximize the hours students spend in the practicum. Thus, instead of requiring faculty to observe physical demonstrations of the ability to pass medications, increased emphasis could be placed on significance of the medications to the patient's illness or recovery.

A significant amount of the data points to the fact that students experience discomfort entering into the patient's world. Supported by previous studies, student nurses desire focused instruction on how to develop a nurse-patient relationship. Faculty may want to incorporate more of this content in their classes. Role modeling by faculty may also be beneficial as students have pointed out that observation of experienced nurses is one way they learn this difficult skill (Melia, 1989). Designing patient scenarios for student role plays may be another strategy for easing student fears. Faculty understanding of the ways in which student nurses create their own rules may be instrumental in guiding the students to developing the nurse-patient relationship.

As students engage in staff work, it may be helpful for faculty to bridge the gap between student and nurse. This study demonstrated the importance staff work in relation to patient and faculty work. Faculty may be able to foster strategies that facilitate working relationships between students and nursing staff. Furthermore, faculty could conduct routine assessments of the individual nursing units to which students are assigned and continuously monitor the student-staff interactions. This would provide an immediate assessment of how students manage staff work. In this study, students notified faculty of problems encountered with staff nurses. A proactive approach may offer insight into the problems and successes of staff work.

Students in this study suggested that the first and second semester of nursing were disconnected. Concepts taught in the first semester were not carried through to the second semester. Program directors and faculty may want to periodically examine course content for consistency and relevance to current nursing practice. Involving practicing nurses in course content development may help bridge the gap between theory and practice. Providing course content that includes a balance of theoretical concepts and clinical practice could serve to benefit students and ease their transition to the clinical arena.

Nursing Administration and Practice

The nursing shortage is predicted to last for many more years. It is not uncommon for hospitals to offer hiring bonuses in order to attract nurses. Student nurses' first clinical encounter may be the acute care hospital and as such, form opinions about potential places of employment. In this study, students commented on clinical experiences at other hospitals. In order to recruit newly graduated nurses, nurse administrators may want to explore how students have perceived the clinical experiences.

Developing strategies in cooperation with schools of nursing to enhance the student clinical experience may have an impact on the recruitment of new staff.

Staff nurses are in key positions of influence on student nurses. Student nurses look to the staff for guidance and feedback and desire to work with staff nurses who are helpful and receptive to student clinical practice. This study provides a unique view of how students perceive not only the patient and the clinical experience but also their own relationships to the staff nurse. An understanding of the ways in which students approach staff work and the strategies they use to negotiate their role, may help staff to support students in this effort. A system whereby staff nurses openly communicate with student nurses may result in an environment where students can learn, question, and explore their clinical skills and findings.

The student nurses in this study prioritized faculty work and patient work and staff work. At times they faced uncertainty when staff rules conflicted with faculty rules. In their efforts to complete both faculty and patient work, students experienced tension when the rules were not adequate to manage the clinical situation. It is not clear if the staff nurses in this study were aware of the tension and conflicts. An understanding of how students go about following the rules might help nursing staff provide the guidance students need to function in the particular clinical unit. Staff nurses who are attuned to the special circumstances faced by students may possibly be of assistance in helping students manage the realities of nursing. Awareness of the students' views and experiences of the clinical practicum could perhaps bridge the gap between classroom learning and clinical experience.

Future Research

There are extensive possibilities of further research that stem from the findings of this study. Additional research concerning the work of student nurses may generate data sufficient to move the substantive theory towards more formal theory. Replication of this study in other schools of nursing and other clinical areas may serve to strengthen the analytical findings. For example, conducting a study of this type in one of the early semesters of a baccalaureate program may reveal some variation of how students prioritize their work. Similarly, research on a different clinical unit such as an obstetric unit could possibly provide a comparison of the findings in this study.

Of interest is the students' concern of entering into the patient's world. The professional socialization research points to the discomfort students experience in developing a nurse-patient relationship. Additional research could possibly explore how faculty perceives the student's ability to engage in this relationship. Focused research aimed at examining how students are taught and subsequently initiate psychosocial assessments can be helpful to develop a better understanding of the process of entering into the patient's world. This study was limited in that patient contact was excluded. Thus research including actual observations of student-patient interactions may yield significant insight into this phenomenon.

This study gave voice to student nurses accompanied by a limited faculty perspective. Gaining the faculty views of what they think student nurses do in clinical is another area of related research that might help further explain the phenomenon of student work. Nursing clinical faculty are driven by the need to ensure patient safety and may prioritize their own work accordingly. Recognizing that faculty play a key role in

orchestrating the student's clinical experiences, research of this nature may fill in a gap about what is known about how students get through a clinical practicum.

Another question generated from this study concerns staff nurses and how they define the work of student nurses. Clinical sites are used extensively by schools of nursing and health care programs and staff nurses spend significant time with various groups of student nurses. In light of the recommendations that staff support student nurses, it would be helpful to examine the staff nurse perspective of the impact of student nurses on their work. An understanding of how staff nurses cope with student nurses may help nursing faculty implement strategies to facilitate staff work.

The student participants in this study voiced a concern about the in-between position, simultaneously being a student and a nurse. Further exploration of this concept may perhaps identify the depth and breadth of this phenomenon. Additional research might possibly uncover the methods students use to manage the in-between position. Results of such research could inform faculty of the tension students experience leading to teaching strategies to help students successfully manage this position.

Summary

The findings of this study led to the development of a substantive theory of the work of student nurses. The study describes the ways in which students get through a clinical practicum. Student nurses engaged in three types of work, faculty, patient and staff, in order to be successful at passing the course. While engaging in work, students followed a variety of rules including program rules, faculty rules, staff rules, and self rules. At times rules were not sufficient to manage contingencies that arose and subsequently created new rules. Students prioritized faculty work over other types of

work resulting in a view of the patient as an object of care. During the orthopedic clinical practicum students experienced tension and conflict as they implemented skills learned in the classroom on an actual nursing unit. The clinical experience allowed students to gain new perspectives on nursing education and practice.

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Appendix A

Letter of Inquiry – Community College

Dear _____,

I am a nursing doctoral student at the University of San Diego and am currently in the dissertation phase of my program. I have a research idea that I would like to propose to you. My research interest concerns nursing students and the social processes related to their clinical experiences. I would like to explore the possibility of conducting my research at _____. The nature of the research project requires some time commitment from the students. It involves participant observation as the students go through their clinical experiences. Additionally I would like to hold interviews with selected students regarding their perceptions of the hospital environment.

I am a graduate of _____ and would appreciate the opportunity to cap off my education there. If this seems like something you would want to participate in, I would like to set up a meeting with you to discuss my ideas. I can be reached at (909) 780-6532 or email at pwslls@earthlink.net.

Thank you for your consideration.

Sincerely,
Leonie L. Sutherland PhD(c), RN
Doctoral Candidate
University of San Diego

Appendix B

Letter of Inquiry – Hospital

October 10, 2002

Vice President Patient Care Services
Local Hospital

Dear _____,

I am currently a nursing doctoral student at the University of San Diego and am in the dissertation phase of my program. My research interest concerns nursing students and the social processes related to their clinical experiences. I have received permission from _____ to conduct this research with their nursing students. The nature of the research project involves participant observation as the students go through their clinical experiences. I would like to conduct the clinical observation at the Local Hospital.

While conducting the research I would be present at the hospital while students are engaged in their clinical rotation. My main focus is to understand how students approach and manage the process of patient care. I have agreed not to observe students in the patient's room, as this could be intimidating. I would however be present on the clinical unit observing their interactions with the instructor, staff members, physicians and their peers. Additionally, I may in the course of the research want to interview some staff nurses regarding their interactions with students. The unit suggested by the college is the orthopedic unit. I hope to be able to start data collection around March of 2003.

I would like to talk to you regarding the possibility of conducting this research at your hospital. I can be reached at (909) 780-6532 or email at pwslls@earthlink.net.

Thank you for your consideration.

Sincerely,

Leonie L. Sutherland PhD(c), RN
Doctoral Candidate
University of San Diego

Appendix C
Follow-up Research Description – Hospital

Vice President Patient Care Services
Local Hospital

Dear _____,

I would like to follow up on our conversation regarding the research project I proposed with the College students and the Local Hospital. The purpose of the research study is to gain an understanding of the processes nursing students go through to develop a nursing care plan. I plan to use an interpretive methodology, specifically a grounded theory approach. This will require me to observe nursing students as they interact with staff, their instructor and peers during their clinical time. The nursing students will be in their second semester of nursing and will be doing their clinical work on the orthopedic unit. My goal is to begin data collection some time in February 2003. At no time during the data gathering will I be involved with patients.

The specific research questions are as follows:

- How are nursing care plans developed?
- What process occurs when students go about the task of writing a care plan?
- How do nursing students select, assemble, and use information in developing a care plan?

The significance of the study relates decision-making. Understanding the process of how students develop the final care plan may help educators in creating teaching strategies that incorporate both didactic and experiential content. Additionally, an analysis of student care planning and clinical reasoning processes may provide information on how students link theoretical methods to actual patient care situations.

Should you need any additional information please call me at (909) 780-6532, or email at pwslls@earthlink.net. My faculty advisor, Dr. Mary Rose Mueller, is also available and can be reached at (619) 260-4562, or email at mmueller@sandiego.edu.

Sincerely,
Leonie L. Sutherland
Doctoral Candidate
University of San Diego

Appendix D
Hospital Approval Letter

November 18, 2002

Leonie L. Sutherland
6772 Blackwood Street
Riverside, CA 92506

Dear Leonie,

In response to your letter and our recent conversation, it is with pleasure that I accept your proposal to conduct your research study project here next February as part of your Doctoral Degree requirements.

I have forwarded your letter to Pat Bridenstine and will look forward to seeing you again at

Please feel free to call me if there is anything else I can help you with.

Sincerely,

Vice President, Patient Care Services

Appendix F
Information Sheet for Faculty

The Care Plan Development Process of Nursing Students

Principal Investigator

Leonie L. Sutherland, Ph.D. candidate, R.N.
Doctoral Student
Hahn School of Nursing and Health Science
University of San Diego
(909) 780-6532
pwslls@earthlink.net

Faculty Advisor

Mary-Rose Mueller, Ph.D., R.N.
Hahn School of Nursing and Health Science
University of San Diego
5998 Alcala Park
San Diego, CA 92110
(619) 260-4562
mmueller@sandiego.edu

Purpose and Explanation

Leonie L. Sutherland, a doctoral candidate at the University of San Diego, is doing a research study on nursing student care plan development. I am being asked to participate in this research study because I am involved in teaching the development of nursing care plans. Ms. Sutherland hopes to learn more about the care plan process. Ms. Sutherland will be responsible for collecting and analyzing the data in this study. Dr. Mueller serves as the faculty advisor. Ms. Sutherland may consult with Dr. Mueller regarding data analysis.

Procedures

If I agree to participate in the study, the following will occur

1. I will be given a chance to ask questions about this research study before I am asked to sign the consent form.
2. Ms. Sutherland will observe my interactions and activities during my clinical hours with my students, nurses, physicians, and ancillary health care personnel at XXX Hospital.
3. Ms. Sutherland will not observe me while I am engaged in patient care with the students.

4. Ms. Sutherland will observe my interactions and activities with my students during the pre and post conference sessions.
5. Ms. Sutherland will make hand-written notes of my interactions and activities during my clinical hours at XXX Hospital.
6. I will be interviewed at either XXX Hospital, XXX College, Ms. Sutherland's office or at some other location at a time convenient to me. The interview will take between 30 and 90 minutes. If I get tired, bored, uncomfortable, or for any other reason, I can ask that the interview be terminated or completed on a different occasion. It may be necessary to conduct the interview on more than one occasion. If so, subsequent interviews will be arranged for my convenience.
7. An audiotape will be made of the interview conversation.
8. In the interview I will be asked about my experience with teaching care plans.
9. My participation is voluntary and may be terminated at any time for any reason. If I wish to withdraw from the study, Ms. Sutherland will destroy the interview tape and any transcription of it will not be included in the data analysis.

Risks/Discomforts

I have been informed that participation in this study may involve some risks or discomforts. These include:

1. I may experience discomfort while being observed. I can ask that observations be discontinued at any time.
2. Some of the interview questions might make me feel uncomfortable, but I am free to stop the interview any time I feel uncomfortable. Also, I can decline to answer any particular question.
3. I may be uncomfortable with having the interview audiotaped. I may request that the interview not be audiotaped, but instead that Ms. Sutherland take hand-written notes.
4. Participation in research could result in some loss of my privacy. Ms. Sutherland, however, has taken steps to protect my identity. I have been informed that my name and the name of my school, XXX College, will be identified in the study by a code. My name and the name of XXX College will not be identified in any published report.

Benefits

There will be no direct benefit to me from participating in this research project. Ms. Sutherland, however, may gain a better understanding of the care plan process and development.

Confidentiality

I have been informed that research records will be kept confidential. Study information will be coded and kept in locked files in Ms. Sutherland's office. Only Dr. Mueller, as the faculty advisor, will have access to the files. Ms. Sutherland has informed me that the Committee for the Protection of Human Subjects of the University of San Diego has approved this research project.

Authorization

I have read the explanation above and understand it. Ms. Sutherland has explained the study to me. I have had a chance to ask questions and have them answered to my satisfaction. I voluntarily agree to take part in this study. I have not been forced or made to feel obligated to take part. If I have further questions I can call Ms. Sutherland at (909) 780-6532. I must sign the consent form and I will be given a copy to keep.

Appendix G
Consent Form for Faculty

The Care Plan Development Process of Nursing Students

Principal Investigator

Leonie L. Sutherland, Ph.D. candidate, R.N.
Doctoral Student
Hahn School of Nursing and Health Science
University of San Diego
(909) 780-6532
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Faculty Advisor

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Hahn School of Nursing and Health Science
University of San Diego
5998 Alcala Park
San Diego, CA 92110
(619) 260-4562
mmueller@sandiego.edu

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If I agree to participate in the study, the following will occur

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3. Ms. Sutherland will not observe me while I am engaged in patient care with the students.

4. Ms. Sutherland will observe my interactions and activities with my students during the pre and post conference sessions.
5. Ms. Sutherland will make hand-written notes of my interactions and activities during my clinical hours at XXX Hospital.
6. I will be interviewed at either XXX Hospital, XXX College, Ms. Sutherland's office or at some other location at a time convenient to me. The interview will take between 30 and 90 minutes. If I get tired, bored, uncomfortable, or for any other reason, I can ask that the interview be terminated or completed on a different occasion. It may be necessary to conduct the interview on more than one occasion. If so, subsequent interviews will be arranged for my convenience.
7. An audiotape will be made of the interview conversation.
8. In the interview I will be asked about my experience with teaching care plans.
9. My participation is voluntary and may be terminated at any time for any reason. If I wish to withdraw from the study, Ms. Sutherland will destroy the interview tape and any transcription of it will not be included in the data analysis.

Risks/Discomforts

I have been informed that participation in this study may involve some risks or discomforts. These include:

1. I may experience discomfort while being observed. I can ask that observations be discontinued at any time.
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3. I may be uncomfortable with having the interview audiotaped. I may request that the interview not be audiotaped, but instead that Ms. Sutherland take hand-written notes.
4. Participation in research could result in some loss of my privacy. Ms. Sutherland, however, has taken steps to protect my identity. I have been informed that my name and the name of my school, XXX College, will be identified in the study by a code. My name and the name of XXX College will not be identified in any published report.

Benefits

There will be no direct benefit to me from participating in this research project. Ms. Sutherland, however, may gain a better understanding of the care plan process and development.

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Authorization

I have read the explanation above and understand it. Ms. Sutherland has explained the study to me. I have had a chance to ask questions and have them answered to my satisfaction. I voluntarily agree to take part in this study. I have not been forced or made to feel obligated to take part. If I have further questions I can call Ms. Sutherland at (909) 780-6532. I must sign the consent form and I will be given a copy to keep.

 Printed Name of Subject

 Signature of Subject

 Date

 Location (e.g. Riverside, CA)

 Signature of Person Obtaining Consent

 Date

Appendix H
Information Sheet for Hospital Personnel

The Care Plan Development Process of Nursing Students

Principal Investigator

Leonie L. Sutherland, Ph.D. candidate, R.N.
Doctoral Student
Hahn School of Nursing and Health Science
University of San Diego
(909) 780-6532
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Faculty Advisor

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5998 Alcala Park
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mmueller@sandiego.edu

Purpose and Explanation

Leonie L. Sutherland, a doctoral candidate at the University of San Diego, is doing a research study on nursing student care plan development. I am being asked to participate in this research study because I am involved with nursing students. Ms. Sutherland hopes to learn more about the care plan process that students engage in. Ms. Sutherland will be responsible for collecting and analyzing the data in this study. Dr. Mueller serves as the faculty advisor. Ms. Sutherland may consult with Dr. Mueller regarding data analysis.

Procedures

If I agree to participate in the study, the following will occur

1. I will be given a chance to ask questions about this research study before I am asked to sign the consent form.
2. I will have informal interactions with Ms. Sutherland about my work and contacts with nursing students and faculty from XXX College.
3. Ms. Sutherland will not observe me while I am engaged in patient care.
4. Ms. Sutherland will make hand-written notes of my interactions with XXX College nursing students during my work hours at XXX Hospital.
5. I may be informally interviewed about my interactions with nursing students and their care plan development.
6. Ms. Sutherland will make hand-written notes of the informal interview.
7. My participation is voluntary and may be terminated at any time for any reason. If I wish to withdraw from the study, Ms. Sutherland will destroy the

interview notes and any transcription of it will not be included in the data analysis..

Risks/Discomforts

I have been informed that participation in this study may involve some risks or discomforts. These include:

1. I may experience discomfort while being observed. I can ask that observations be discontinued at any time.
2. Some of the interview questions might make me feel uncomfortable, but I am free to stop the interview any time I feel uncomfortable. Also, I can decline to answer any particular question.
3. I may be uncomfortable with having the interview audiotaped. I may request that the interview not be audiotaped, but instead that Ms. Sutherland take hand-written notes.
4. Participation in research could result in some loss of my privacy. Ms. Sutherland, however, has taken steps to protect my identity. I have been informed that my name and the name of my organization, XXX Hospital, will be identified in the study by a code. My name and the name of XXX Hospital will not be identified in any published report.

Benefits

There will be no direct benefit to me from participating in this research project. Ms. Sutherland, however, may gain a better understanding of the care plan process and development.

Authorization

I have read the explanation above and understand it. Ms. Sutherland has explained the study to me. I have had a chance to ask questions and have them answered to my satisfaction. I voluntarily agree to take part in this study. I have not been forced or made to feel obligated to take part. If I have further questions I can call Ms. Sutherland at (909) 780-6532. I must sign the consent form and I will be given a copy to keep.

Appendix I
Information Sheet for Students

The Care Plan Development Process of Nursing Students

Principal Investigator

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Faculty Advisor

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Purpose and Explanation

Leonie L. Sutherland, a doctoral candidate at the University of San Diego, is doing a research study on nursing student care plan development. I am being asked to participate in this research study because I am involved in teaching the development of nursing care plans. Ms. Sutherland hopes to learn more about the care plan process. Ms. Sutherland will be responsible for collecting and analyzing the data in this study. Dr. Mueller serves as the faculty advisor. Ms. Sutherland may consult with Dr. Mueller regarding data analysis.

Procedures

If I agree to participate in the study, the following will occur

1. I will be given a chance to ask questions about this research study before I am asked to sign the consent form.
2. Ms. Sutherland will observe my interactions and activities during my clinical hours with my students, nurses, physicians, and ancillary health care personnel at XXX Hospital.
3. Ms. Sutherland will not observe me while I am engaged in patient care with the students.

4. Ms. Sutherland will observe my interactions and activities with my students during the pre and post conference sessions.
5. Ms. Sutherland will make hand-written notes of my interactions and activities during my clinical hours at XXX Hospital.
6. I will be interviewed at either XXX Hospital, XXX College, Ms. Sutherland's office or at some other location at a time convenient to me. The interview will take between 30 and 90 minutes. If I get tired, bored, uncomfortable, or for any other reason, I can ask that the interview be terminated or completed on a different occasion. It may be necessary to conduct the interview on more than one occasion. If so, subsequent interviews will be arranged for my convenience.
7. An audiotape will be made of the interview conversation.
8. In the interview I will be asked about my experience with teaching care plans.
9. My participation is voluntary and may be terminated at any time for any reason. If I wish to withdraw from the study, Ms. Sutherland will destroy the interview tape and any transcription of it will not be included in the data analysis.

Risks/Discomforts

I have been informed that participation in this study may involve some risks or discomforts. These include:

1. I may experience discomfort while being observed. I can ask that observations be discontinued at any time.
2. Some of the interview questions might make me feel uncomfortable, but I am free to stop the interview any time I feel uncomfortable. Also, I can decline to answer any particular question.
3. I may be uncomfortable with having the interview audiotaped. I may request that the interview not be audiotaped, but instead that Ms. Sutherland take hand-written notes.
4. Participation in research could result in some loss of my privacy. Ms. Sutherland, however, has taken steps to protect my identity. I have been informed that my name and the name of my school, XXX College, will be identified in the study by a code. My name and the name of XXX College will not be identified in any published report.

Benefits

There will be no direct benefit to me from participating in this research project. Ms. Sutherland, however, may gain a better understanding of the care plan process and development.

Confidentiality

I have been informed that research records will be kept confidential. Study information will be coded and kept in locked files in Ms. Sutherland's office. Only Dr. Mueller, as the faculty advisor, will have access to the files. Ms. Sutherland has informed me that the Committee for the Protection of Human Subjects of the University of San Diego has approved this research project.

Authorization

I have read the explanation above and understand it. Ms. Sutherland has explained the study to me. I have had a chance to ask questions and have them answered to my satisfaction. I voluntarily agree to take part in this study. I have not been forced or made to feel obligated to take part. If I have further questions I can call Ms. Sutherland at (909) 780-6532. I must sign the consent form and I will be given a copy to keep.

Appendix J
Consent Form for Students

The Care Plan Development Process of Nursing Students

Principal Investigator

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mmueller@sandiego.edu

Purpose and Explanation

Leonie L. Sutherland, a doctoral candidate at the University of San Diego, is doing a research study on nursing student care plan development. I am being asked to participate in this research study because I am involved in developing nursing care plans. Ms. Sutherland hopes to learn more about the care plan process. Ms. Sutherland will be responsible for collecting and analyzing the data in this study. Dr. Mueller serves as the faculty advisor. Ms. Sutherland may consult with Dr. Mueller regarding data analysis.

Procedures

If I agree to participate in the study, the following will occur

1. I will be given a chance to ask questions about this research study before I am asked to sign the consent form.
2. Ms. Sutherland will observe my interactions and activities during my clinical hours with nurses, physicians, ancillary health care personnel, my instructor and classmates at XXX Hospital.
3. Ms. Sutherland will not observe me while I am engaged in patient care.
4. Ms. Sutherland will observe my interactions and activities with my instructor and classmates during the pre and post conference sessions.

5. Ms. Sutherland will make hand-written notes of my interactions and activities during my clinical hours at XXX Hospital.
6. I will be interviewed at either XXX Hospital, XXX College, Ms. Sutherland's office or at some other location at a time convenient to me. The interview will take between 30 and 90 minutes. If I get tired, bored, uncomfortable, or for any other reason, I can ask that the interview be terminated or completed on a different occasion. It may be necessary to conduct the interview on more than one occasion. If so, subsequent interviews will be arranged for my convenience.
7. An audiotape will be made of the interview conversation.
8. In the interview I will be asked about my experience with developing care plans.
9. My participation is voluntary and may be terminated at any time for any reason. If I wish to withdraw from the study, Ms. Sutherland will destroy the interview tape and any transcription of it will not be included in the data analysis.

Risks/Discomforts

I have been informed that participation in this study may involve some risks or discomforts. These include:

1. I may experience discomfort while being observed. I can ask that observations be discontinued at any time.
2. Some of the interview questions might make me feel uncomfortable, but I am free to stop the interview any time I feel uncomfortable. Also, I can decline to answer any particular question.
3. I may be uncomfortable with having the interview audiotaped. I may request that the interview not be audiotaped, but instead that Ms. Sutherland take hand-written notes.
4. Participation in research could result in some loss of my privacy. Ms. Sutherland, however, has taken steps to protect my identity. I have been informed that my name and the name of my school, XXX College, will be identified in the study by a code. My name and the name of XXX College will not be identified in any published report.

Benefits

There will be no direct benefit to me from participating in this research project. Ms. Sutherland, however, may gain a better understanding of the care plan process and development.

Confidentiality

I have been informed that research records will be kept confidential. Study information will be coded and kept in locked files in Ms. Sutherland's office. Only Dr. Mueller, as

the faculty advisor, will have access to the files. Ms. Sutherland has informed me that the Committee for the Protection of Human Subjects of the University of San Diego has approved this research project.

Authorization

I have read the explanation above and understand it. Ms. Sutherland has explained the study to me. I have had a chance to ask questions and have them answered to my satisfaction. I voluntarily agree to take part in this study. I have not been forced or made to feel obligated to take part. If I have further questions I can call Ms. Sutherland at (909) 780-6532. I must sign the consent form and I will be given a copy to keep.

Printed Name of Subject

Signature of Subject

Date

Location (e.g. Riverside, CA)

Signature of Person Obtaining Consent

Date

Appendix K
Consent Form for Hospital Personnel

The Care Plan Development Process of Nursing Students

Principal Investigator

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5998 Alcala Park
San Diego, CA 92110
(619) 260-4562
mmueller@sandiego.edu

Purpose and Explanation

Leonie L. Sutherland, a doctoral candidate at the University of San Diego, is doing a research study on nursing student care plan development. I am being asked to participate in this research study because I am involved with nursing students. Ms. Sutherland hopes to learn more about the care plan process that students engage in. Ms. Sutherland will be responsible for collecting and analyzing the data in this study. Dr. Mueller serves as the faculty advisor. Ms. Sutherland may consult with Dr. Mueller regarding data analysis.

Procedures

If I agree to participate in the study, the following will occur

1. I will be given a chance to ask questions about this research study before I am asked to sign the consent form.
2. I will have informal interactions with Ms. Sutherland about my work and contacts with nursing students and faculty from XXX College.
3. Ms. Sutherland will not observe me while I am engaged in patient care.
4. Ms. Sutherland will make hand-written notes of my interactions with XXX College nursing students during my work hours at XXX Hospital.
5. I may be informally interviewed about my interactions with nursing students and their care plan development.

6. Ms. Sutherland will make hand-written notes of the informal interview.
7. My participation is voluntary and may be terminated at any time for any reason. If I wish to withdraw from the study, Ms. Sutherland will destroy the interview notes and any transcription of it will not be included in the data analysis.

Risks/Discomforts

I have been informed that participation in this study may involve some risks or discomforts. These include:

1. I may experience discomfort while being observed. I can ask that observations be discontinued at any time.
2. Some of the informal interview questions might make me feel uncomfortable, but I am free to stop the interview any time I feel uncomfortable. Also, I can decline to answer any particular question.
3. Participation in research could result in some loss of my privacy. Ms. Sutherland, however, has taken steps to protect my identity. I have been informed that my name and the name of my organization, XXX Hospital, will be identified in the study by a code. My name and the name of XXX Hospital will not be identified in any published report.

Benefits

There will be no direct benefit to me from participating in this research project. Ms. Sutherland, however, may gain a better understanding of the care plan process and development.

Confidentiality

I have been informed that research records will be kept confidential. Study information will be coded and kept in locked files in Ms. Sutherland's office. Only Dr. Mueller, as the faculty advisor, will have access to the files. Ms. Sutherland has informed me that the Committee for the Protection of Human Subjects of the University of San Diego has approved this research project.

Authorization

I have read the explanation above and understand it. Ms. Sutherland has explained the study to me. I have had a chance to ask questions and have them answered to my satisfaction. I voluntarily agree to take part in this study. I have not been forced or made to feel obligated to take part. If I have further questions I can call Ms. Sutherland at (909) 780-6532. I must sign the consent form and I will be given a copy to keep.

Printed Name of Subject

Signature of Subject

Date

Location (e.g. Riverside, CA)

Signature of Person Obtaining Consent

Date

Appendix L

Topical Guide for First Student Interview

- Most students have some experience learning the process of writing nursing care plans. What kind of learning experiences have you had?
- What was it like when you had to write your first care plan?
- Describe how you go about writing a care plan.
 - What do you do first?
 - What happens after that?
 - What resources do you use?
- Do you discuss your care plan with others? What is the discussion like?
- What is it like writing a care plan?
- What do you experience during the process of writing a care plan? Are these experiences good or difficult?
- What benefits are there in writing a care plan?
- How does your care plan affect your patient care?
- Is there anything you wish to add?

Appendix M

Topical Guide for Faculty Interview

- Most nursing faculty have some experience teaching the process of writing nursing care plans. What kind of teaching experiences have you had?
- What was it like when you teach care plan development?
- Describe how you go about teaching the process of developing a care plan to nursing students.
 - What do you do first?
 - What happens after that?
 - What resources do you use?
- Do you discuss the student care plans with others? What is the discussion like?
- What do you experience during the process of teaching care plan development? Are these experiences good or difficult?
- What benefits are there for students in writing a care plan?
- How does the student care plan affect patient care?
- Is there anything you wish to add?

Appendix N
Document Summary Form

Name of document:

Description of Document:

Activity or course with which document is associated:

Significance of Document:

Summary of content: