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CLEW'd In: Exploring The Lived Experiences Of Leaders Performing Clinical Learning Environment Walks (CLEWs)

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CLEW'D IN: EXPLORING THE LIVED EXPERIENCES OF LEADERS PERFORMING CLINICAL LEARNING ENVIRONMENT WALKS (CLEWs)

by

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ABSTRACT

The purpose of this phenomenological study was to explore the lived experience of leadership using Clinical Learning Environment Walks (CLEWs) to ascertain the current culture of the clinical learning environment. Physician trainees deserve the opportunity to train in an environment where staff are high performing and continually work to improve the quality of care provided to patients. The capacity to assess the clinical learning environment in its entirety is a novel concept brought to the forefront recently by the Accreditation Council for Graduate Medical Education (ACGME) due to the need for critical communication that is inherent in creating an optimal learning environment. Survey tools exist to ascertain the perception of residents regarding the clinical learning environment. There is little knowledge of tools using the framework of walking rounds in which leaders can ascertain the qualities of the clinical learning environment in their entirety.

Participants of the study included eight leaders who are physicians, nurses, and management within the university and healthcare system. The purposeful sample was identified using participants currently participating in the Clinical Learning Environment Walks (CLEWs) process. The study applied Giorgi's phenomenological methods to analyze leaders' conscious descriptions of their lived experience conducting CLEWs.

The findings provide a greater understanding of the lived experiences of leadership using CLEWs to ascertain the current state of the clinical learning environment in its entirety. Six themes emerged from the analysis: *Us vs Them; Open and Honest Communications; Improved Communications; Enhanced Focus; Opportunities for Improvement, and Culture Change*. The

findings also include a diagram representing the connections between these themes. Researchers must continue to explore the efficacy of the CLEWs process in determining the current state of the clinical learning environment, which during the COVID-19 pandemic, is now more important than ever.

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CHAPTER 1: INTRODUCTION

Improving the quality of physician trainee education and practice takes strong, engaged leadership with the ability to assess the current clinical learning environment, particularly when the sponsoring institution and participating sites are separate entities with no lines of authority between them. This study sought to ascertain the perceptions of leaders lived experiences using Clinical Learning Environment Walks (CLEWs) to gain the current state of the clinical learning environment. Residents and fellows deserve the opportunity to train in an environment that is high performing and that continually works to improve the quality of care provided. The ability to assess the clinical learning environment in its entirety is an idea that has come to the forefront of training due to the need for critical communication inherent in creating an optimal learning environment.

A clinical learning environment is an environment in which residents and fellow physicians train. This clinical learning environment can be made up of hospitals, clinics, nursing homes, ambulatory surgery centers, and others. In some cases, the clinical learning environment is owned by the university or, as in the case of this study, owned by the healthcare system. The university and clinical learning environment partner together to provide the necessary training. Residents and fellows learn to diagnose and treat patients who have entered their doors for care not necessarily considering the clinical learning environment in which they train.

Research conducted by the American Council of Graduate Medical Education (ACGME) has shown that it is of utmost importance for an institution to assess the clinical learning environment, especially when no lines of authority exist between Graduate Medical Education (GME) and the healthcare system. An article published by Colbert-Gertz, Kim, Goode, Shochet,

and Wright (2014) stated, “Without knowing how students and residents perceive the learning environment, institutions are limited in their means to effectively improve it” (p. 1687).

Weiss, Bagian, & Nasca (2013) wrote that the ACGME, in an effort to help GME offices and participating sites improve their clinical learning environments and as a part of the Next Accreditation System (NAS), the Clinical Learning Environment Review (CLER) was established to assess the learning environment of the sponsoring institution and its participating sites. A key dimension of the ACGME common program requirements, CLER emphasizes the importance of a learning environment that engages residents and fellows in patient and healthcare quality (ACGME, n.d.).

Patients want and need physicians trained in high performing learning environments that prepare them to meet the challenges of an ever-changing healthcare system (Weiss, Bagian, & Nasca, 2013). A March 2015 article published in the *Journal of Graduate Medical Education* stated, “Training in a hospital with better outcomes is associated with significantly better outcomes observed in practice 20 years later” (Bump et al., 2015, p. 109). An important aspect of improving the clinical learning environment is ensuring that patients are receiving the safest care possible by providing physician trainees tools and resources in the areas of quality improvement and patient safety. According to Dr. Tom Nasca, Executive Director and Chief Executive Officer of the ACGME (2014):

> In the past decade there has been only modest progress in improving patient safety. Physicians need to be encouraged to interact more with hospitals, medical centers, and ambulatory sites to effect lasting improvement in patient care. It is critical to engage residents and fellows early in their careers as studies show there is a direct link between a

physician's performance in initial training and their clinical performance throughout their lifetime of practice. (p. 608)

In 2009, the ACGME Task Force on Quality of Care and Professionalism concluded it is necessary to evaluate the clinical learning environment to ensure compliance with the ACGME mission of improving healthcare and population health while advancing the quality of the residents' education through accreditation (Nasca, 2016). In an effort to encourage residency and fellowship programs to examine their Clinical Learning Environment (CLE), the ACGME developed and implemented the Clinical Learning Environment Review (CLER) program (Weiss, Bagian & Wagner, 2014). CLER visits include the site visitors performing walking rounds within the clinical learning environment asking questions of residents, fellows, faculty, and employees of the hospitals or clinics (Nasca, 2016). CLER site visits have demonstrated that there is a need to focus on the clinical learning environment (Nasca, 2016). A national survey conducted by the American Hospital Association found that "residents and fellows who were starting their careers as independent physicians varied as to their training around system-based practice issues such as coordinating care with other providers, working effectively with healthcare teams, and skills in effective communication and information exchange" (Nasca, 2016, p. 7). These same findings were found in the National Report of Findings from the first round of CLER site visits.

According to Nasca, "CLER was created to directly explore the clinical learning environment by establishing a periodic site visit for those US hospitals, medical centers, and clinics that serve as the clinical learning environments for ACGME Sponsoring Institutions" (Nasca, 2016, p. 7). The ACGME published the first CLER National Report of Findings (2012–2105) after piloting the CLER program and a first round of initial visits to sponsoring institutions

and participating sites. The report provided a baseline of information including challenges and opportunities for improvement.

The CLER National Report of Findings identified four overarching themes regarding clinical learning environments:

a) Clinical learning environments vary in their approach to and capacity for addressing patient safety and healthcare quality, and the degree to which they engage residents and fellows in these areas.
b) Clinical learning environments vary in their approach to implementing Graduate Medical Education (GME). In many clinical learning environments, GME is largely developed and implemented independently of the organization's other areas of strategic planning and focus.
c) Clinical learning environments vary in the extent to which they invest in continually educating, training, and integrating faculty members and program directors in the areas of healthcare quality, patient safety, and other systems-based initiatives, and
d) Clinical learning environments vary in the degree to which they coordinate and implement educational resources across the healthcare professions (Bagian & Weiss, 2016).

The focus of assessing the clinical learning environment has moved from service line or department specific to the clinical learning environment in its entirety. CLER site visits provide a glimpse into the clinical learning environment; moreover, it is important for leaders to know the true pulse of the clinical learning environment. CLER has shown a great deal of variability among clinical learning environments spending only a short amount of time in each environment.

The need for a face-to-face process with those on the frontlines of caring for patients is necessary to help leadership determine the current state of the clinical learning environment.

Problem Statement

Topical research in the area of clinical learning environments has primarily been done within a single service line or nursing unit. The interest of the state of the clinical learning environment in its entirety is a novel process brought to the forefront by the ACGME. For many years, graduating from a residency or fellowship program was based on one's ability to diagnose and treat patients' diseases and disorders. Now, the ACGME is stepping outside the box and looking at residents and fellows becoming engaged within the clinical learning environment and with leaders to improve patient care as a part of strategic planning for the facility.

It is important to note that when CLER was first introduced, the university and the healthcare system created a CLER team, focusing on the six focus areas and discussed issues and opportunities for improvement. These meetings proved challenging from the onset as a divide was created between the university leaders and the leaders of the healthcare system with both teams defending their work instead of working together. Due to the non-productive nature of the meetings, the CLER team was disbanded and it became necessary to seek other avenues of assessing the clinical learning environment. The leaders within the university and clinical learning environment created and implemented Clinical Learning Environment Walks (CLEWs) as a tool to remove the alleged finger pointing and defensiveness between the two entities.

A review of the literature has shown that studies have used survey instruments to seek the perceptions of residents, fellows, and nurses but has not sought the perceptions of positional leaders regarding the clinical learning environment as a whole. Due to this fact, leaders within the university and clinical learning environment created and implemented Clinical Learning

Environment Walks (CLEWs). This study sought to ascertain the perceptions of educational and healthcare leaders' lived experiences using a process to assess the current state of the clinical learning environment in which resident and fellow physicians train.

Purpose of the Study

The purpose of the study was to ascertain the perceptions and lived experiences of leadership regarding the use of Clinical Learning Environment Walks (CLEWs). In an effort to determine the current culture of the clinical learning environment, leadership members from the sponsoring institution and the largest participating site developed a novel process that may provide leadership an answer to this question. Clinical Learning Environment Walks (CLEWs), using a templated questionnaire, allow leadership to engage with and obtain a first-hand perception of the health of the clinical learning environment. Other instruments such as Veterans Administration (VAs) Learner Perception Survey, Postgraduate Hospital Education Environment Measure (PHEEM), and Hospital Survey on Patient Safety Culture have been used with the same purpose but do not include face-to-face conversations between leaders and those working or training in the clinical learning environment. Once leadership has determined the health of the clinical learning environment using Clinical Learning Environment Walks (CLEWs), a follow-on study will look at opportunities for improvement and whether implementing action items improves the learning environment.

Research Questions

Implementing the CLEWs process and templated questionnaire, leadership has developed a process of teaming to determine the current state of the clinical learning environment in which a sponsoring institution has no lines of authority in the participating site. The primary research questions for this study crafted to determine the efficacy of the CLEWs process are:

1. What are the lived experiences of leadership participating in CLEWs?
2. Can CLEWs assist leadership to gain a better grasp of the pulse of the clinical learning environment?

Conceptual Framework

The conceptual framework for this study is based on the concept of leadership walking rounds. Walking rounds, whether performed by leadership or others, places a person in situ, hearing and seeing what is occurring in the moment. Walking rounds also provide an opportunity to talk with those performing tasks, or patient care, providing an ear for them to discuss their opportunities or barriers to providing safe, quality patient care. Using the concept of leadership walking rounds, Clinical Learning Environment Walks (CLEWs) were created based on accreditation standards to understand the current state of the environment based on common program requirements, clinical learning environment review properties and goals, and information from incident reporting databases and other opportunities.

Assumptions

This study assumes that determining the perceptions of leadership regarding the use of the CLEWs will lead to changes within the clinical learning environment leading to a high performing environment for physician trainees as well as an increasingly safe environment for patients. This study also assumes that, if the participants of the study have a positive view of CLEWs, the program will be expanded and will have the opportunity to determine and track opportunities for improvement.

Limitations

Due to scheduling difficulties, CLEWs are limited to one walk a month per team. On many occasions rescheduling was necessary, leading to a reduced number of walks per month.

Another limitation in the study is that CLEWs are routinely completed from 8:00 am to 5:00 pm, leaving remaining shifts out of the process. Due to the COVID19 pandemic, CLEWs were discontinued for the safety of leaders and those that would be interviewed as per implemented protocols in the clinical learning environment.

Significance

Designated Institutional Officials (DIOs), hospital/clinic leadership, and others in GME have an investment in the "health of the actual culture in which residents and fellow physician trainees learn" (Jones, Maturo, & Hutcherson, 2016, p. 459). CLEWs allow senior leaders to identify opportunities for and challenges of improving the CLE leading to enhanced patient care.

> As stated in the CLER Pathways to Excellence,
>
> Since the CLER assessments are based not only on what is taught, but what is actually practiced at the bedside, progress within any of the pathways can only be achieved through the joint efforts of the GME leadership and executive and clinical leaders at the clinical site. (Weiss, Bagian & Wagner, 2014, p. 7)

Understanding the lived experiences of leadership participating in the CLEWs process and sharing this information can gain buy-in for the process, leading to growth in participation and identified opportunities for improvement.

Definitions

ACGME—Accreditation Council for Graduate Medical Education. Accrediting body for Graduate Medical Education (acgme, n.d).

CLER—Clinical Learning Environment Reviews. Site visits that occur every 18 to 24 months. Designed to provide U.S. teaching hospitals, medical centers, health systems, and other clinical settings affiliated with ACGME-accredited institutions with periodic feedback that

addresses the following six areas: patient safety, healthcare quality, care transitions, supervision, well-being, and professionalism (Nasca, 2016).

CLE—clinical learning environment (hospital, clinic, or other healthcare facility) in which resident/fellow physicians train.

Clinical Learning Environment Walks (CLEWs)—process adopted from the San Antonio Uniformed Services Health Education Consortium and expanded to fit the needs of UT Health San Antonio. CLEWs are walking rounds in which leadership can assess the health of the clinical learning environment (Jones, Mature, & Hutcherson, 2016).

Graduate Medical Education—any type of formal medical education pursued after receipt of the M.D. or D.O. degree. Education includes internship, residency, subspecialty and fellowship programs, and leads to state licensure and board certification (acgme, n.d).

Participating Site—an organization providing educational experiences or educational assignments/rotations for residents/fellows (acgme, n.d).

GEMBA—translation from Japanese language is “the real place” or “the place where value is created”. From the practice of Lean and Six Sigma, GEMBA walks are taking the time to watch how a process is done and talking with those that are directly involved in the process or job (sixsigmadaily, n.d.).

Sponsoring Institution (SI)—Organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements (acgme, n.d.).

Conclusion

Knowing the current state of the clinical learning environment is a first step in giving leadership the ability to employ best practices and to improve where necessary. A 15-year cohort study design of obstetrical care demonstrated that

> The clinical site of training is an important predictor of the quality of care provided long after completion of training. Nearly one-third of the differences in patient outcomes in this study could be associated with the site of training, and these differences persisted up to 15 years after graduation from residency. (Nasca, 2016, p. 7)

A study published in *Medical Teacher* regarding the clinical learning environment found that assessing the clinical learning environment is essential, but assessing alone is not sufficient (Nordquist, et al., 2019, p. 372). Nordquist et al. (2019) state that the understanding of the clinical learning environment is fragmented and that additional studies are needed to better understand the clinical learning environment.

CLEWs and its associated questionnaire are a process that can be utilized by leadership to ascertain the current state of the clinical learning environment in its entirety and fill a gap in the current literature. The aim of this study is to gain knowledge of the lived experiences of leaders participating in CLEWs. Obtaining the lived experiences of leadership may inform opportunities for improving the educational experiences provided to residents and fellow trainees while employing best practices. Patients and the communities served by healthcare providers are the priority and they deserve better prepared physicians for themselves and their families.

CHAPTER 2: LITERATURE REVIEW

The literature review was conducted with the purpose of exploring the breadth of knowledge regarding assessing clinical learning environments and instruments used to study the perceptions of those working, educating, and training within these clinical learning environments. Based on the scope of the study, Flexner (1910) argued that educational institutions were more concerned with the livelihood of the teachers than training physicians how to provide effective medical care for patients (as cited in Miller, Moore, Stead, & Balser, 2010). Healthcare is a complex, fast-changing system and it was determined that current approaches did not prepare physicians for these complexities. Centered on the scope of this study, this review concentrates chiefly on the literature addressing resident and fellow physician training and assessing the environment in which they train. Topical research in the area of clinical learning environments has primarily been done within a single service line or nursing unit. The interest of the clinical learning environment as a whole is a novel process brought to the forefront by the Accreditation Council for Graduate Medical Education (ACGME). This focus is a departure from previous program evaluation practices, which were directed at the ability of graduates from a residency or fellowship program to diagnose and treat patients.

Assessing the clinical learning environment is also important in assessing the hidden curriculum that may exist with a residency or fellowship program. The hidden curriculum is not a part of competencies set forth by the ACGME. An example of a hidden curriculum may be a faculty member teaching a short cut to a process or dismissing a process such as quality improvement or mistreatment of trainees as a process of learning. Uncovering inconsistencies in behavior that are being taught and behaviors that are being espoused by faculty is a step in optimizing the clinical learning environment (Lehman, Sulmasy, and Desai, 2018).

Lehman, Sulmasy, and Desai (2018) discuss the hidden curriculum and the potential of disconnects between what residents and fellows are being taught and what they are seeing from their faculty.

Using MedPro, a search for the terminology “clinical learning environment” yielded 7,247 results. Adding “resident clinical learning environment” yielded 260 results between 1981 and 2019. These results yielded little information on what a clinical learning environment is, but looked at perceptions, quality improvement, wellness, and other topics.

Keywords used to perform additional searches were “resident perceptions,” “ACGME,” “Clinical Learning Environment Review (CLER),” and “instruments to assess the clinical learning environment.” Whereas there is a gap in the literature regarding assessing clinical learning environments in their entirety, the search yielded results on topics such as assessing the clinical learning environment within specialty departments or hospital units. Some searches generated scholarly documents regarding the clinical learning environment and its effect on wellness and physician burnout. It is noted that more research has been conducted in the area of nursing assessments but continue to look at a specific service line and not the clinical learning environment in its entirety. The clinical learning environment has been and will continue to be an important part of training residents and fellows in an ever-changing, fast-paced, healthcare environment. During this literature search, three prominent authors emerged.

Prominent Authors

As the importance of resident and fellow training in a high-performing clinical learning environment builds, there are three important authors that have emerged: Dr. Thomas Nasca, Dr. Kevin Weiss, and Dr. James Bagian. Dr. Thomas Nasca is the Chief Executive Officer for the ACGME and has been involved in medical education since 1981. He has authored more than

100 peer reviewed articles, chapters, and other publications (National Health Policy Forum, n.d.). This researcher has heard him speak passionately several times during the ACGME Spring Conferences about medical education and his commitment to working to improve not only the clinical learning environment but resident and fellow wellness as well.

Dr. Kevin Weiss is the Senior Vice President–Institutional Accreditation and the Co-Chair for the CLER evaluation committee. Dr. Weiss is considered to be an expert in the field of quality improvement and patient safety.

Dr. James Bagian, a former astronaut, is the Co-Chair for the CLER evaluation committee. Dr. Bagian is also a leader in quality improvement and patient safety in the GME arena as well as in the clinical environment. The remaining prominent authors include many ACGME team members participating in the CLER evaluation committee and those performing the CLER site visits.

Tools for Assessing the Clinical Learning Environment

Assessing a clinical learning environment is more than just walking around and looking. An instrument such as the Postgraduate Hospital Educational Environment Measure (PHEEM) or Clinical Learning Environment Questionnaire (CLEQ) can be and is an important part of the process of assessing the clinical learning environment. Whereas instruments may assist in the assessment, many studies find that more research is necessary in accessing the clinical learning environment (Alqaidi, 2010). These survey instruments have been used in nursing as well as residency programs but have assessed certain services lines or units and have not assessed the clinical learning environment as a whole.

Hooven (2104) found that the clinical learning environment is essential to student learning and supported many other studies in this area. Hooven's study is a literature review on

instruments used to assess the clinical learning environment aiming to explore the current quantitative instruments available to measure the clinical learning environment in nursing education to gain a better understating of the nature of the environment. He found the wording of the instrument was different, often due to language, as many were created in different countries and teaching styles may differ from country to country. The Clinical Learning Environment Inventory (CLEI) and CLEQ are the most widely used instruments. Hooven's (2014) conclusion to this study was that future development and testing of instruments to evaluate the clinical learning environment are necessary to evaluate from a staff nurse and nurse faculty perspective.

Additionally, Alhaqwi, Kuntze, and Mohen (2011) conducted research on the factor structure, validity, and reliability of the Clinical Learning Evaluation Questionnaire (CLEQ). The CLEQ was developed to solicit the perceptions of undergraduate medical students. The CLEQ was structured to explore the five main areas of clinical learning, using a Likert Scale to answer 40 questions. The CLEQ was based on a previous study of students and teachers concerning the clinical learning environment and a literature review. This research concluded that the CLEQ can be used as an evaluation tool and stated that further research is needed into other dimensions of the validity of the tool. With that said, the study demonstrated the CLEQ is multidimensional and a reliable instrument; however, there is little evidence that the tool is currently being used.

Pursuing this topic further, Colbert-Getz et al. (2014) conducted a study to explore the validity of existing instruments used to determine perceptions of the learning environment (LE). This study was a literature search of other studies that provided quantitative data published through 2012. Colbert-Getz et al.'s (2014) study focused on two questions:

1. What instruments have been developed to measure the LE in medical education?

2. What is the strength of the validity evidence associated with the interpretation of the scores from the instruments?

Twenty-eight instruments were found in 102 studies. Only four of these instruments were used in both medical school and residency settings. Limited validity evidence was found in existing instruments.

Furthermore, Newton, Jolly, Ockerby, and Cross (2015) conducted a factor analysis and prepared a report of psychometric testing of the Clinical Learning Environment Inventory (CLEI) tool. BSN students (n=659) from two campuses of a university in Australia completed the CLEI from 2006 to 2008 and 77% of the BSN students were eligible for the study (Newton, Jolly, Ockerby, & Cross, 2015). The CLEI was modified to include student-centeredness. Scales added took into account the nuances of the learning environment such as the affordability and engagement required to enable the development of a learning practice. The authors found through replication of the factor analysis that use of the CLEI tool requires further research.

Many instruments for assessing the clinical learning environment have been created, tested, and require further research to ensure reliability and validity of the instrument. The point in fact is that the instruments used were built as surveys and face to face interviews were not used. Just as instruments are important in the assessment of the clinical learning environment, knowing how the learner perceives the clinical learning environment is just as important. This point has become a topic of interest proving the point of creation and implement of the Clinical Learning Environment Review (CLER).

The ACGME requires GME programs to provide residents a clinical learning environment using competencies to prepare for independent practice; patient care is supervised, safe, and high-quality. Torralba et al. (2016) conducted a study on the residents' perceptions of

whether their clinical learning environment was psychologically safe. Few studies have been done measuring resident perception of patient safety in the teaching hospitals while making correlations with the clinical learning environment. The Veterans Administration used the Learners' Perception Survey for this study. The study had only a 30% completion rate. Other limitations of the study were:

(a) The study was based on self-reports;

(b) Patient safety was measured based on a single question that was available across all 4 study years;

(c) Surveys may not be the best vehicle to assess patient safety.

Even with the limitations, the study showed strong evidence that patient safety is important to residents' perceptions of their clinical learning experience. Studies have also been conducted to look at wellness and job satisfaction of residents within the clinical learning environment.

Lee, Appelbaum, Amendola, Dodson, and Kaplan (2017) found that job satisfaction, burnout, work-life balance, and residents' perceived support have been studied little in the context of the clinical learning environment. Lee et al. (2017) evaluated the relationship between available academic resources and well-being, the clinical learning environment, and in-service exam performance for surgical residents. The programs studied were surgery and surgical specialties. The clinical learning environment was measured for perceived workplace climate and organizational support. Results were consistent with organizational psychology researcher suggestions that providing academic resources may relate to better resident wellness and more positive perceptions of the clinical learning environment (Lee, 2017). As the ACGME CLER program becomes a more prominent factor in surgical residencies, program directors and

department administrators must take a more active role supporting residents using both conventional and innovative means.

As GME and participating site leaders' perceptions of the clinical learning can vary, issues may be overlooked based on costs and other factors. Perceptions may also differ based on the faculty approach to teaching in the clinical learning environment. It appears there is a gap in the literature regarding the perceptions of leaders and the clinical learning in its entirety.

Gap in the Analysis

Collecting and reviewing the literature was a rigorous process looking to address assessments in the clinical learning environment. Several studies have been completed either using or evaluating assessment instruments. Studies, such as the PHEEM, CLEQ, and Learners Perception, show that additional research is necessary but follow-on studies could not be found. The same can be said for studies looking at the learners' perceptions of the clinical learning environment.

A part of this study is intended to address a gap in the current knowledge by looking at the clinical learning environment in its entirety. Research has shown assessment in specialty departments such as surgery and/or wellness; however, there is little to no research on the leadership skills necessary to ensure information gained is based on open and honest conversations with the learners, as most CLE assessment instruments are survey based. The creation and implementation of Clinical Learning Environment Walks (CLEWs) is a novel process providing leaders the ability to leave their offices and talk with frontline caregivers and potentially assess the clinical learning environment in its entirety.

While studies are being conducted at this time by the ACGME regarding the clinical learning environment, another gap in the literature is whether the existing instruments and

surveys can produce data that will lead to improving the learning environment. Many of the studies have identified perceptions of the learning environment and stop there. Through a rigorous literature search there appears to be no research showing findings have been used to turn identified opportunities for improvement into action for improving the clinical learning environment.

Building on the framework of walking rounds, CLEWs is not just an opportunity to shake hands and have a quick conversation with the staff. The conceptual framework of this study builds upon the premise of walking rounds elevating it a level of asking questions and soliciting perceptions of the those learning and practicing within the clinical learning environment.

Beginning in 1999, walking rounds were used by healthcare leadership to maintain relationships with bedside providers and heighten the collection of information necessary for patient safety (Frankel et al., 2008). Typical clinical learning environment leadership walking rounds do not include leadership from the medical school or residency programs as in this study. The Long School of Medicine and University Health System where this study was conducted are separate entities having no lines of authority, which can lead to limited conversations and assessments of the clinical learning environment; thus it was necessary to build a program in which all leaders had access to the clinical learning environment and the ability to speak with all providers. Performing leadership walks collaboratively is supported in the literature as a backbone for rounding methodologies (Reiner & Herbener, 2014).

Based on the conceptual framework of leadership walking rounds and the fact that there are no lines of authority between the two facilities, Clinical Learning Environment Walks (CLEWs) were created and implemented. A leader from each institution makes unscheduled or scheduled walks to an area of the clinical learning environment. In this protocol, leaders speak

with residents, fellows, faculty, nurses, allied health professionals, or any member of the care team that is available. A specific set of open-ended questions are prepared to help begin and keep conversations moving. If it is determined that an identified issue is serious, it will be dealt with immediately. Just-in-time training can also be accomplished. Other issues are brought back to a CLEWs debrief and issues or opportunities for improvement will be discussed and next steps determined. Information from the debrief meeting is tracked using an Excel spreadsheet.

Colbert-Gertz et al. (2014) stated, "Without knowing how students and residents perceive the learning environment, institutions are limited in their means to effectively improve it" (p. 1687). Further, Nasca et al. (2014) suggested that training appears to happen in silos limiting exposure to other residents and members of the care team. This study asks the questions: What are the lived experiences of leadership participating in CLEWs? Can CLEWs assist leadership to gain a better grasp of the pulse of the clinical learning environment? Research has shown that instruments have been used to assess the learning environment but used in specialty departments and service lines. Within the current literature, instruments have proved useful in gaining the perceptions of learners concerning their clinical learning environment. Some research is emerging on assessing the clinical learning environment in its entirety, but none currently provides results on improvement of patient care or communication. As such, Clinical Learning Environment Walks were implemented.

Clinical Learning Environment Walks (CLEWs)

As reported by Jones, Maturo, and Hutcherson (2016) CLEWs walks, based on GEMBA walks, are focused on assessment of the learning environment using the CLER Pathways to Excellence six focus areas: patient safety, healthcare quality, care transitions, supervision, duty hours/fatigue management, and professionalism. Using a templated questionnaire, visits are

made to any area of the healthcare facility or clinic with the goal of obtaining the interviewee's perception of the clinical learning environment. In an environment where the sponsoring institution does not own the participating site, GME and hospital leaders' partner on CLEWs to provide a level of teamwork between the two institutions to promote communication and transparency. CLEWs were established to provide leaders with a better understanding of the clinical learning environment and insight to opportunities for improvement and optimization of the clinical learning environment.

Summary

This chapter provided a detailed review of the existing research related to tools used for the assessment of clinical learning environments. These tools, made up of surveys, study a moment in time regarding a particular service line or department. The review of literature has shown that a gap exists in tools and strategies that can assess the clinical learning environment in its entirety. An association between findings presented in this chapter and the findings obtained from this study is discussed in Chapter Five. The following chapter covers a discussion of the phenomenological method in psychology and methodology applied for data collection and analysis.

CHAPTER 3: METHODOLOGY

The present study is an exploration of the lived experiences of educational and healthcare leaders using a process to assess the current state of the clinical learning environment in which resident and fellow physicians train. To answer the research questions and obtain a better understanding of the lived experiences of leaders participating in Clinical Learning Environment Walks (CLEWs) the researcher has designed a descriptive phenomenological research study focused on exploring the lived experiences of leaders participating in CLEWs.

Descriptive Phenomenology

Among the studies of clinical learning environment assessment tools, none were found that address the assessment of the clinical learning environment in its entirety. With limited information available, phenomenological research seeks to discover constructed meaning and draw conclusions from the data making this an appropriate method for this study (Creswell, 2013; Dyurich, 2017; Hill et al., 1997). Phenomenology seeks to discover a common understanding of a lived experience as expressed by several people. "It assumes that we make sense of lived experience according to its personal significance for us, and implies that experiential, practical, and instinctive understanding is more meaningful than abstract, theoretical knowledge" (Standing, 2009, p. 20).

Proposed by Amadeo Giorgi using Husserlian phenomenology as its philosophical foundation, this is a four-step approach to the descriptive phenomenological psychological method. Descriptive phenomenological methodology is positioned towards discovery rather than verification (Broome, 2001; Dyurich, 2017). The role of the researcher is to act as the principal instrument in the collection and analysis of data (Dyurich, 2017; Merrian & Tisdell, 2015;

Patton, 2014; Robson, 2002) offering analysis and interpretation of the lived experiences of participants as it appears in the participants' consciousness (Dyurich, 2107).

This descriptive phenomenological analysis process required this researcher to adopt the scientific phenomenological reduction attitude that includes two epochēs (or bracketing attitudes), allowing them to perceive implications the data produced to the phenomenon researched without the influence of preconceived ideas or knowledge (Dyurich, 2017; Giorgi, 2009). This researcher was able to bracket any preconceived bias that may have been based on this researcher's experiences with CLEWs. This researcher was also able to bracket their own attitudes providing the ability to identify the meanings articulated by the participants lived experiences using CLEWs as a tool to assess the clinical learning environment as a whole. Through this analysis of lived experiences, this researcher sought to arrive at conscious experiences of the participants and not be the architect of the meaning (Dyurich, 2017).

Setting

The clinical learning environment is any location in which residents and fellows train. These locations can include hospitals, clinics, and large healthcare systems. More specifically the clinical learning environment may include, but is not limited to, operating rooms, medical intensive care units, and rehabilitation units. The setting for this study is a large healthcare system located in San Antonio, Texas, that is the teaching hospital for a large medical school. The university and the healthcare system were built on the premise of partnership and working to better the health of the residents of San Antonio and surrounding communities.

Built on the site of two grain silos and on one hundred acres of a dairy farm, the South Texas Medical School, as it was first named, was created by House Bill 9, passed by the 56th legislature. Land for the project was donated by the South Texas Medical Foundation. The

school was built in 1968 with students attending in Dallas and Galveston. The first students attended classes in San Antonio in 1969 (uthscsa.edu, 2018).

A catalyst for the building of the medical school was the need to provide healthcare for the indigent and needy sick of Bexar County. The city fathers, wanting to address a physician shortage, lobbied the University of Texas Medical Branch for a medical school. As a condition to building the medical school, the Texas legislature added that the medical school and the county hospital be built within a mile of each other (Elkind, 1989). Today the school is connected to the hospital through breezeways and corridors.

In 1972 the sponsoring institution's name was changed to The University of Texas Health Science Center San Antonio. In 2017, through a large endowment, the medical school was renamed the Joe R and Teresa Lozano Long School of Medicine. That same year a rebranding of the institution and the entire campus has come to be known as UT Health (uthscsa.edu, 2018).

UT Health is dependent upon the state legislature, endowments, and grant funding to continue its mission of educating and training healthcare professionals. The institution has seen some lean times, especially when the price of oil drops. UT Health San Antonio supports 1.25 million patient visits a year through 700 providers. These providers practice in 140 medical specialties and subspecialties (uthscsa.edu, 2018). The 2017 fiscal year revenue operating budget for the university was $806.6 million. Currently the university is funded in several ways. Twenty-seven percent of the budget comes from state appropriations. As of August 2016, endowments totaled $487 million and annual research awards totaled $172 million (uthscsa.edu, 2018).

The hospital is the primary teaching facility for the medical school. In 1994 the hospital district became University Health System, promoting a greater association with the academic

mission. The healthcare system began to expand its outpatient services and is currently serving twenty-four locations. The health system is a Level 1 trauma center and the area's only Level 1 pediatric trauma center. The health system has recently undergone a $778M expansion increasing the number of beds from 498 to more than 700 (https://www.universityhealthsystem.com/about-us/history).

Institutional Review Board

The Institutional Review Board (IRB) review of this study was completed at UT Health San Antonio and determined to not need full review. The healthcare system completed a review and determined to stand with the University's decision. An IRB application was completed at University of New England and received approval for the researcher to move forward.

Informed Consent

As the principal investigator, the researcher obtained informed consent from each participant who volunteered to be interviewed (sample informed consent in Appendix D). Prior to beginning interviews, participants were given an opportunity to read through the consent and sign. Forms are maintained in a locked file.

Study Participants and Their Rights

Participants were leaders within the hospital clinical learning environment as well as the Office for Graduate Medical Education (GME). GME provides oversight to the programs teaching residents and fellows. These leaders have the authority to enact change within the clinical learning environment itself or within the teaching institution. Eight of the participants hold the distinction of medical doctor, one a Master of Nursing. Each participant had the right to not be a part of this study. The researcher met with each of the participants and obtained informed consent for their participation prior to the start of the interview. The researcher

scheduled meetings with each participant to discuss the study topic for the dissertation. A letter of consent was prepared by this researcher and emailed to the participants for their review. Prior to the interview beginning, each participate was asked to review the consent and sign if they agreed to participate in the study.

Most participants had been using the CLEWs process for at least two years prior to this study, with one participant for only six months. Participants were paired in teams of two, one from the university and one from the health system. This pairing is due in part to the fact that the institution does not own the hospital and vice versa. For institution leaders to gain access into the clinical learning environment the pairing was necessary.

Data

This study sought to document the lived experiences from the participants who have conducted CLEWs, using semi-structured, face-to-face interviews to ascertain their perceptions of the CLEWs process. Interviews were constructed using a set of guided questions as an interview protocol (Appendix A). The protocol was constructed using the researcher's past experiences with the CLEWs process and the need for face-to-face interviews. This protocol was used consistently across all interviews. Interviews were audiotaped, transcribed verbatim by a professional transcriptionist, and participants were de-identified. Post transcription, the principal investigator analyzed the review responses manually using different colored highlighters for each participant, identifying pertinent comments regarding their lived experiences while conducting CLEWs. The qualitative method of coding to detect themes and patterns based on statements and quotes was used.

Analysis

The role of the researcher is by nature connected to the methodological procedures of the study. The researcher is the principal mechanism for the collection of qualitative data and analysis (Dyurich, 2017; Merriam & Tisdall, 2015; Patton, 2014; Robson; 2002). To perform the analysis, lending rigor and trustworthiness, the researcher must accept the phenomenological reduction attitude (Giorgi, 2009).

Face-to-face interviews were conducted with participants that volunteered for the study. Completed interviews were transcribed and individuals de-identified to ensure confidentiality of the participants and data were stored on a secure server.

Interviews were read thoroughly multiple times by the researcher to gain a better understanding of the answers provided to the questions. After a thorough review, specific highlighter colors were used for each interview to mark important or impactful statements. These highlighted statements were cut out and placed on foam boards to identify themes. A photo of the finished coding process can be found in Appendix C.

CHAPTER 4: RESULTS

The process of data analysis required an immersion of the researcher in the data to understand the lived experiences of leadership using Clinical Learning Environment Walks (CLEWs) seeking to gain a better understanding of the clinical learning environment in its entirety. This chapter will reveal the findings to the research questions presented in Chapter 1 and will summarize the responses from leaders participating in CLEWs. The purpose of this study was to analyze the lived perceptions of leadership using Clinical Learning Environment Walks (CLEWs) to gain an understanding of the pulse of the clinical learning environment in its entirety. The data being analyzed refers to leaders' responses obtained through face-to-face interviews and will be presented in a thematic approach. The following themes and subthemes were developed from analyzing the transcriptions of interviews.

Themes

The following themes and subthemes were developed from the interviews with leadership conducting CLEWs and described in Table 1.

Table 1 – Emerging Themes

Theme	Example
Us vs Them	Green – "…why aren't we doing this together" Orange – "…there was a blame culture" Purple – "…had not been an inviting culture"
Communication Open and Honest Improved Communications	Blue – "…it allows us to partner with each other and understand our relationship" Orange – "I feel like the communication continues to grow in the right direction" Lavender – "…leadership from the university and health system are in the same space" Purple – "there is a fostering of communication among the nursing staff, residents, and faculty"

	Pink – "I thought the interns we were speaking with were being very open" Yellow – "…they were very open, I was amazed" Green – "…they talked about what was and was not happening"
Enhanced Focus	Citrus – "…the impression I had was not entirely accurate" Yellow – "Most of the time things are just perceptions and opinions and feelings and as we did the CLEW walks, we did some deep dives …and found a number of deficiencies" Blue – "…one positive is that for me it's been mostly knowledge gaining and understanding"
Opportunities for Improvement	Mauve – "…tremendous opportunities for improvement through observations and learning together" Green – "It really showed where the holes were and also where people are doing great stuff" Citrus – "…an example is the resident lounge – it was a need and it was implemented"
Culture Change	Green – "It gets out the idea you know that we're in our trenches in the battlefield – we're on the same side here" Mauve – "It was a paradigm shift" Purple – "I see the CLEW program as building that bridge, the gateway, that walking together and looking at the hospital together" Pink – "…some may come with their own perspective, but you are hearing the same things"

Following is the researcher's interpretation of the findings to include how the data were organized and analyzed. A diagram is presented to represent the context and connection among the themes.

Interpretation of Findings

Interviews were conducted with each of the nine voluntary participants. Simultaneously, the completed interviews were transcribed and participants de-identified. After all interviews were transcribed each interview was read through several times for clarity and interpretation. The interviews were then color-coded to further de-identify the participants. Statements and comments of importance or impact were then highlighted.

After an additional review each highlighted statement was cut out and put in envelopes of like connections. These statements where then reviewed and pinned to foam boards and reviewed, with themes emerging. An overall pattern referring to the need for improvement emerged from these themes. This cycle of continuous improvement connects all the themes and provides a general sense of direction, as depicted in Figure 4.1

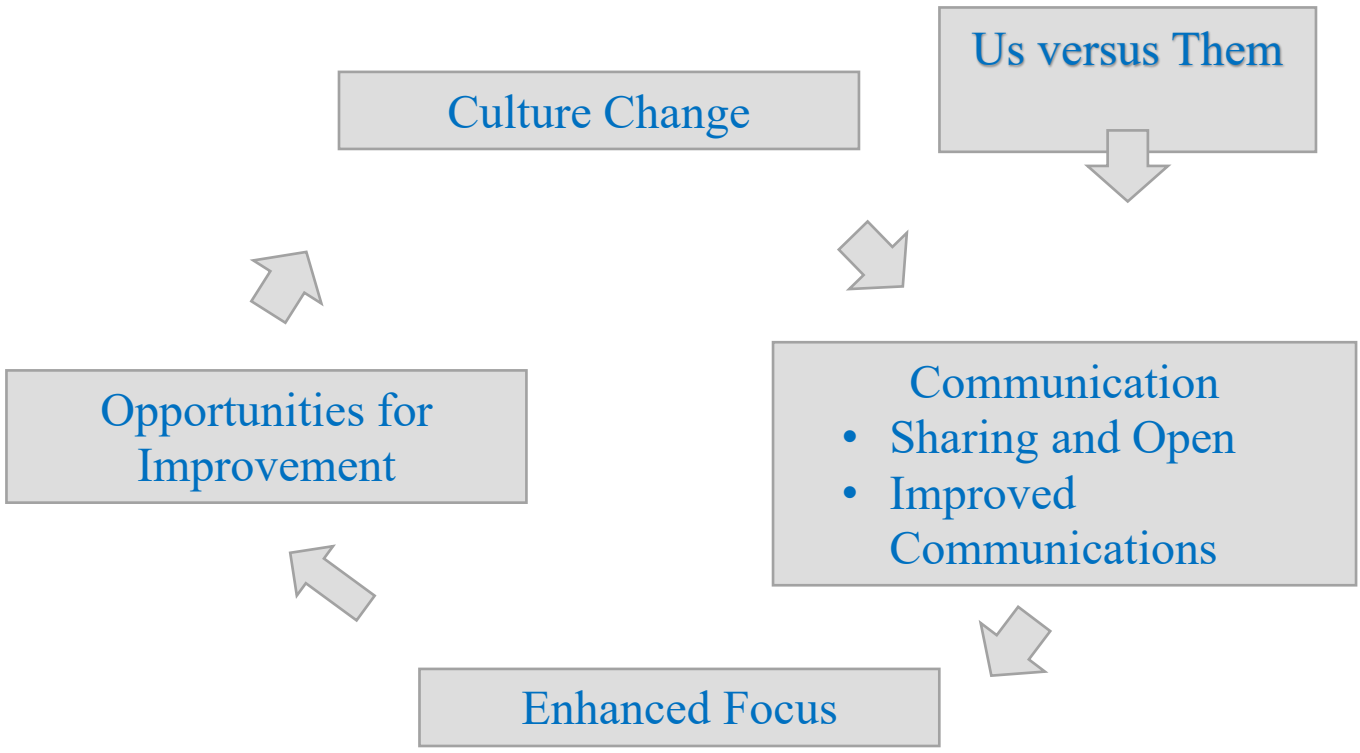


Figure 1 – Cycle of Continuous Improvement

The following themes will be explored in the upcoming sections based on the lived experiences of leaders participating in the CLEWs. Key quotes from leaders are included to support the researcher's findings and interpretation of the data.

Us versus Them

The perceived lived experiences of leadership prior to beginning CLEWs was that of an Us versus Them mentality, creating a clear differentiation between the team from the university and the health care system. This separation was perceived as a barrier to teamwork and especially to ownership of the improvement process, when each individual team could recognize the advantages of working together and the positive steps the other team has taken. As stated by Green, "There was a little bit of us versus them in not taking ownership that we're all in this together—the university, the medical school, and University Hospital." Green also stated, "There was a lack of ownership. Why aren't we doing this together?" Mauve found that prior to the CLEWs program, "there was a perception that the individuals responsible were responsible for knowing what was actually happening in these key domains in the clinical learning environment."

Orange, one of the newest leaders to perform CLEWs, described a similar lived experience, "Some of our walks have validated there is a little bit of blame culture. Before I got here, I understand there was a greater manifestation of problems with communication between the two organizations." Purple felt that in some areas, "There was no integration at all." These findings confirmed the issue of lack of integration and responsibility as mentioned earlier, when explaining that a CLE Council had been created to discuss issues including all responsible players within the clinical learning environment and was disbanded due to the inability to communicate.

Communication

With an already established difficulty for effective communication, as explained above, and the preconceived idea that the university and health care system were working separately from each other, a theme related to communication was likely to arise. Once CLEWs were implemented, the lived experiences of leadership regarding communication began to change. The positive impact of CLEWs in the communication style and effectiveness between the university and health care system leaders became apparent and two clear subthemes emerged from the data: Improved communication and Open and honest.

Improved Communications.

The first subtheme that emerged from the data indicated that after the implementation of CLEWs, and actually because of this implementation, has improved communications. There has been an improvement in communications between the two institutions. It is important to note that CLEWs have been in process for some time and this is the first opportunity for leadership to discuss their lived experiences regarding the process. As with any improvement process, changing a culture takes time.

This improvement in communication became apparent in most of the participant comments. For example, Blue found that CLEWs "allows us to have a forum to partner with each other and to understand our relationship. Further, for me as a new employee has helped to facilitate communication." Citrus echoed the improvement in communications, "I feel the communication continues to grow in the right direction. I think CLEWs are a part of that improvement. We have an opportunity to be more human to each other and therefore communicate better." For Citrus the improvement in communication was due in part to the practice of pairing leaders from each institution to perform the CLEWs together, which may take

away blaming accusations, or at least the perception of such. Citrus explained, “I don’t have somebody from the UT leadership structure coming to me with what sometimes could potentially feel like an accusation. But if we discover the information together, then there’s no accusation. It’s just a discussion.” Furthermore, Citrus credited this improvement in communication as the reason for improving agreement among the leaders by stating,

> I don’t think that we’ve ever had a finding where one leader has said, ‘that’s not a problem,’ and the other individual said ‘that’s a significant problem.’ So, you immediately get this shared pool of understanding by bearing witness to the current state of affairs together.

In Orange’s opinion, the physical practice of CLEWs, walking together, is in itself a way to promote better communication among leaders while at the same timely showings to residents, fellows, and healthcare staff that the two institutions are working together. “It’s just another mechanism for them to have to communicate. From a visibility standpoint they know that the institutions are at least working together to look at this stuff. I like the fact that we do this together.”

Lavender agreed that the CLEWs “have improved communications because our leadership here at UT Health SA needs to be more physically present in the clinical learning environment at University Hospital.” He also underscored the advantage of being present and witnessing the responses from residents, fellows, and staff firsthand by citing the Heisenberg uncertainty principle in which any observed phenomenon changes merely by the fact that it is being observed. Lavender perceives this physical presence in the CLEWs as a positive and describes its impact.

> We are beginning to get out of the CLEWs walks, people's eyes are pointing to the front of the room and paying attention. Fostering of communication among the nursing staff, the residents, and the faculty . . . the greatest effect has been on transitions of care for patients and secondarily discharge planning in terms of a collaborative effort between each.

But while the overwhelming majority of leadership agreed that communications have improved using CLEWs, Yellow thought that communications had not improved, or at least not at the bedside levels. This comment may present opportunities for improvement and it still reflects the benefits of CLEWs. Noticing a lack of effective communication in a specific area or program,5 Yellow can also help determine the interventions needed to improve the dissemination of information.

Open and Honest Improved Communication.

It is crucial for the assessment of the clinical learning environment and the identification of opportunities for improvement that those being interviewed are comfortable with their leaders in discussing issues, opportunities, and best practices. The data showed CLEWs could serve as a vehicle for improved communication not only among leaders of the different institutions but between leaders and the residents, nurses, and staff members that compose the CLE. This was an important reflection for Purple, who commented that he was "tremendously pleased because we had an opportunity to communicate." Purple calculated that half of the persons interviewed by his team were nurse leaders and the other half were either a resident or faculty member intimately involved in that clinical learning environment. Purple expressed, "and uniformly I found that the individuals were open and appeared to be honest and really were attempting to describe to the best of their ability how that unit functioned in response to the standardized

questions we asked them." Yellow, probably the most skeptical of the process, found "they were very open and honest. I was amazed." Pink was also reserved in his expectation for the CLEWs and still found open communication to be the most common experience with the interviewees:

> The interns that we spoke with at that time were being honest. There was possibly one out of the five or six that seemed a little bit hesitant; other than that I thought they were fairly transparent. Most of the nurses that I spoke with were very open and welcoming.

Orange found herself reassured by the openness and honesty of those she spoke with. Orange was

> . . . actually really pleasantly reassured that folks, I thought, were pretty eager to talk to us and that they were excited to share their stories, both positive and negative and neutral, and my feeling was we were getting honest answers. I didn't observe body language that was protective or language that was coached. I thought they were pretty amazingly open and honest.

Moreover, Mauve found that especially when talking with nurses, other members of the nursing team would join in the conversations, explaining that once his team started talking to one nurse and overcame the initial reticence others started listening, then they drifted over and started sharing. Mauve stated, "Moreover, these conversations were also significantly open when the leadership created the right environment and invited honesty. I found that nursing had a great openness to want to share when you create the right environment."

Enhanced Focus.

Putting yourself in the environment can change the way you see and think about what is going on around you. Leadership shared many thoughts and lived experiences as they immersed themselves in the clinical learning environment. Many leaders shared that they perceived the

environment to be one way based on their specific department but began to change as they ventured out into the clinical learning environment in its entirety.

Mauve began by sharing,

> So I think as long as you have your eyes open, your ears open to go where the conversation goes you might discover something else and that's okay. You combine the GME office in CLEW walks with an executive leader you kind of actually . . . or the way UT has done it is actually kind of melded the two together with a focus on recognizing--I think perhaps better than traditional executive walks that residents are such a critical aspect of any teaching hospital. And because they are so busy and you don't see them all the time and they are not going to be out in the nursing station, the traditional places that executive walks kind of go through. And engaging residents that are pretty shy and kind of staying away from executive leaders when they come in, you're going to miss an absolutely critical component of what's happening in your organization. I think when you bring executive leadership and GME leadership together it actually pulls that team together that can really have a more holistic view of what is happening.

Citrus found that CLEWs provided a more disciplined look at the clinical learning environment.

> I think the gestalt impression that I had was not entirely accurate. It wasn't a particularly disciplined impression and I think that the CLEWs provided an opportunity to have a more disciplined and thoughtful look at the clinical learning environment and give us a little bit more solid direction about where we needed to put our efforts. I think really it was the CLEWs walk that had the most influence. I don't think we would have understood the issue unless we had done the CLEWs walk. It came through a survey that there was a flag from the survey, but had we not done the CLEWs walk and then

> followed it with subsequent CLEW walks I don't think we would have gotten the satisfactory understanding or resolution of the issue. . . . I mean the CLEWs walks offer insights into the reality those trainees face each day and the reality the nurses face each day working with the trainees and other ancillary staff. So, without those insights it's very difficult to be proactive in making the environment safer and safer.

Pink's lived experience also shows that an enhanced focus of variability was brought about by CLEWs.

> What I recognized was it's a lot more varied almost by location even more so than service because even some services overlap in similar locations and can have different approaches. Services are in different locations and can vary in how they work with the staff in the learning environment so it's not I think as easy to understand how things work without almost going to each and every location both on the inpatient side and the outpatient side to understand well what are the workflows and how are the learners interacting with the faculty, how are the learners interacting with the support staff, and then what are their opportunities if they have questions or comments or concerns to share information. I think awareness is a big one because that helps to either validate or invalidate your assumptions about what you think is going on between interactions with staff and residents or residents and residents or residents and faculty. So, understanding what's happening on the ground and getting immediate feedback from folks who are in the learning environment is very, very helpful. It's often an opportunity to dig a little more deeper into information we might have collected through a survey or if we've had an eRAF (electronic risk assessment form) or some sort of an event report on a particular service, in a particular area, and you're doing a CLEW in that location you could dig

> deeper into what that concern might be to try to find more information outside of the scope of the more formal investigation, RCA (root cause analysis) or something like that.

Yellow found that in some cases, thinking that things were being done were not actually happening.

> Most of the time things are just perceptions and opinions and feelings, and as we did the CLEW walks, we did some deep dives into the areas and issues and found a number of deficiencies. Things we thought were done but weren't being done.

Blue stated, "I think the one positive is that for me it's been mostly knowledge, gaining and understanding the organization."

> Orange had a lived experience of not necessarily knowing what the residents did:
>
> I'll tell you that I think it changed because I don't think I understood. I'll just use the residents for example, I don't think I understood how valuable the residents were to the actual care of the patients within the facility. I learned, I have a higher appreciation for being here now and being out, from the CLEWs walks and just seeing it and it's another mechanism for our nurses if needed. They have another provider that they can talk to. Now again, we have to make sure that faculty is aware of things and that's to me is how we can ensure communication is good so that's always going to be the opportunity with another level. But I think the benefit outweighs that opportunity because it's another person that's informed of what's going on with that patient, they can escalate or take care of things as needed. I think it allows folks like myself who do round a lot but I think the pairing process is good and I think it's from a visibility factor for the residents and our staff to see multiple types of people rounding on them and asking specifically about the education. Because usually, when we round we talk about patient experience, we're

> talking about quality, we're talking about those types of things but CLEWs specifically asks we're focused on the learner so I think that's a huge positive in a different approach than probably what they are used to.

Lavender's lived experience provided insight into variability:

> I think as a leader it really gave me some insight into the tremendous variability of processes from unit to unit. I really wasn't expecting that level of variability and the two areas of variability that give me the greatest concern are transitions of care and again discharge planning. My perception was largely limited to my actual direct patient care which was on pediatrics and so the pediatric clinical learning environment is highly controlled because we work with children and the children under our care given to us by their parents and so it is a generally highly structured environment and I was hoping to some degree that similar structure would be in place on other services.

Through the lens of lived experience, Purple went to areas where they normally would not go.

> I just went to areas that I wouldn't normally interact with very much you know, you know if you go to an outpatient skin clinic or something like that, that's just people I'm going to interact with day to day so I do think it helped me understand kind of what the residents are doing, what their rotations are like, what their supervision is like, what some challenges are that they have maybe in inpatient to outpatient handoffs, things like that.

Opportunities for Improvement

Lived experiences of leadership conducting CLEWs has been an opportunity to identify areas of improvement. Not all stated improvements will be documented in this section. Specific patient care areas and opportunities are sent to a root cause analysis.

Green stated, “It really showed where the holes were and also where people are doing great stuff.” Mauve expressed,

> My impression was yes, there are tremendous opportunities for improvement through observation in learning together with the hospital. You need to have periodic observation and so it’s really taking the same principles and education and taking them into the clinical learning environment because indeed that’s the classroom. We identify those deficits that we will engage in that learning environment with the hospital to bring about corrective changes and follow-up on those. CLEW walks feed our CLEW process, the CLEW i.e., the information then better feeds our CLEWs. CLEWs really become a part of the PDSA (plan, do, study, act) cycle. CLEWs are an observant way of feeding more information into the cycle.

Orange stated,

> A good example is the resident lounge that we’re putting that into place. That came up, that was one of the important things when you’re at burnout and those types of things that we as a hospital needed to put in so that was recommended.

Pink spoke of providing information to the residents.

> I think sometimes we had an opportunity to inform residents and others about the taxi program, you know, when they are too tired or to make sure they knew about some of the efforts that are going on with wellness that they may not have known about.

Lavender stated,

> It impressed upon me the need to look at each unit individually and tailor as I said previously the quality improvement prescription for that unit and I think through the interviews that we had we were able to come up with quality improvement points for

each and every unit that we visited and we shared those with them at the end of each walk.

As the identified cycle of CLEWs continues it is apparent that through improved communications, identifying opportunities for improvement, that the participants of this study began to see a culture change.

Culture Change.

Culture change can be described as the changes that occur in policy and processes in response to various circumstances (medical-dictionary, The free dictionary, n.d.). CLEWs provided an avenue for leaders to see first-hand the culture of the learning environment in its entirety, providing an opportunity to begin discussions of change. Green was encouraged by the team building that has grown from performing the CLEWs. Green stated,

> You know in a given month you generally have five teams where it's a leader from each institution doing this together and then the less frequent meetings of all the teams getting together, I mean it really was a way of making everybody realize we really have to be team, really cementing the relationship as a team. Just the fact that a leader from UHS and from GME, and of course that we do this together so it's a real statement . . . but it was a wow, we're learning so much about how our residents and fellows fit into this hospital—this clinical system from the get-go and then you add on to it what is it like when you have a hospital leader and GME leader doing it together, it's very powerful. It gets out the idea, you know, that we're in the trenches together in this battlefield, we're all on the same side here.

Leadership found that the shared experience has a purpose. Pink explained,

> I think it's also a shared experience because you've been purposeful about it as you pair the leaders one from each organization so everybody comes with their own perspective but you also hear the same things at the same time. Changing a culture in an environment with no reporting lines can be difficult. Ensuring representation from both sides. You may hear them differently or you may interpret them differently, but everyone's hearing the same voice so I think that was smart thing on your part to say well alright let's make sure there is representation from both sides provides an environment of teamwork from both entities.

Pink was encouraged by the opportunity for those doing the work who wanted to share what they are doing, but also that leadership had the opportunity to provide feedback, celebrate victories, and offer to help when they can in ways to make their work easier to accomplish those goals.

It was apparent that there is now an investment in the process. Lavender stated,

> Indeed we're invested in what's happening in their hospital and obviously that shows synergy of purpose and mission that they care deeply about, and then it also has allowed us to better communicate the importance of them being transparent in sharing their quality data with us and they have. I see the CLEWs program as building that bridge, that gateway, that walking together, and look at the hospital together.

Mauve found the CLEWs process to be a paradigm shift. Mauve stated,

> So then we began to look and so it really moved us from being a secondhand person looking at what was happening to being a firsthand viewer of the clinical learning environment. We were able to communicate the benefit to both the participating site and the sponsoring institution, we got investment. I think because we're able to now follow

> up better with the CLEW walks, we get just a better general sense of the areas in which we think we're making implemented changes through policy and/or other action plans really leading to the desired effect. You can't beat the value of observation.

Leadership had an excitement that there was a culture of really getting things done. There was an overwhelming sense that there was no longer the idea that it's not a he-said or she-said environment but one of hearing the same thing simultaneously—the bringing of a shared perspective, the hospital perspective, a GME perspective hearing the same thing at the same time that provides clarity of the findings.

Lavender shared a perception of investment, stating:

> You cannot beat the importance of bringing in hospital leadership and GME leadership to seeing the same things at the same time getting an investment on both sides because you know it is their hospital. I think it helps understanding of the stresses and challenges the residents face at times as well. I think it was a very important step forward in building bridges with the participating site, the sponsoring institution so I think that was a vast improvement. It's a way of walking in each other's shoes. They're walking with their perspective, I'm walking with my perspective, but we walk together, we're actually walking in each other's shoes. You can't help but listen and hear and pay attention to the way they are seeing the situation and it takes me out of the scope of my perhaps more limited way of seeing the situation. CLEWs becomes an ongoing and continuous process because if you don't have the ongoing walking together in each other's shoes, it humbles you to realize how little change you actually can effect and it also helps you think about your process for effecting change in ways that you better enlist and bring in others in your effective change, i.e., talking to the people in the trenches.

Research has shown an overwhelming sense of the removal of the Us vs Them mentality and moving to an era of improved communications, enhanced focus, open and honest communication, ability to identify opportunities for improvement, and the beginning of culture change within the two entities. Leaderships perception of CLEWs is positive in gaining the pulse of the clinical learning environment and providing opportunities to move the clinical learning environment to a high performing environment as imagined by the accrediting body and expected by the patients and communities served by physician trainees.

Summary

The researcher presented in this chapter the themes and subthemes that emerged from the illuminating descriptions of the participants' own experience participating in CLEWs. The findings are concerned with the psychological dimension of the experience (Dyurich, 2017) using the CLEWs process to ascertain the pulse of the clinical learning environment in its entirety. The six themes include: *Us vs Them, Communications - Open and Honest Improved Communications, Enhanced Focus, and Culture Change.* This researcher also presented a diagram that represents a continuous cycle of improvement with the Us vs Them being removed. The next chapter will offer a discussion of the findings and how they will help to fill a gap in the literature regarding tools available to assess the clinical learning environment in its entirety, implications for practice, and recommendations for future research.

CHAPTER 5: CONCLUSION

The motivation of this study was due in part to the researcher's individual enthusiasm for quality improvement and patient safety. This study took on the challenges of ascertaining the lived experiences of leadership conducting Clinical Learning Environment Walks (CLEWs) and determining if CLEWs can provide leaders the ability to assess the pulse of the clinical learning environment. This study is also an opportunity to fill a gap in existing research by providing a tool to assess the clinical learning environment in its entirety. Leaders completing CLEWs were more than willing to share their lived experiences of the process and their appreciation of healthcare providers and other employees within the clinical learning environment being so open and honest with their perceptions.

This chapter presents conclusions of the study questions based on the data gathered as well as the implications of results that may be of use to other individuals, communities, and institutions with the potential of transforming other clinical environments. It also presents recommendations for action and further studies.

Interpretation of Findings

The first question of this study asked, what are the lived experiences of leadership participating in CLEWs? The leaders participating in CLEWs were willing to share their lived experiences of being involved with the CLEWs process. These lived experiences show that at the beginning of the CLEWs process, communications between the two institutions was an Us versus Them environment, which made improvements in the environment very difficult. Several leaders found that thoughtful consideration of team building has improved the communication issues, especially the ability to hear things at the same time, removing the finger pointing that had been occurring. The lived experiences also showed the building of bridges, further

improving communications between the two institutions. One participant felt they have been provided a forum to begin to understand the relationship through partnering.

Another lived experience of leadership was the open and honest conversations being held with those on the front line. Even the one leader that was the most skeptical of communications being improved was amazed at the open and honest conversations with staff. Some leaders felt some reticence in the beginning but as conversations continued this disappeared and others close to the conversations occurring would walk over and join in. It is through these open and honest conversations that opportunities for improvement were identified and created an enhanced focus for those completing CLEWs.

Prior to leadership becoming involved in the CLEWs process felt they knew what the clinical learning environment looked like. These perceptions began to change as they left the comfort of their service line and entered the clinical learning in its entirety. One participant felt that CLEWs provided a more disciplined look at the environment while another felt that the enhanced focus showed the variability within the clinical learning environment. One participant felt that they did not know what the residents really did in the clinical environment until performing CLEWs. Leaders began to look at the variability between the units and service lines placing them in situ and offering an enhance focus. CLEWs provided an opportunity to see if changes that had been implemented were still in place, sometimes finding them not in place. Leaders were able to see the clinical learning environment in its entirety and not just through the lens of their specialty.

The second study question asked, Can CLEWs allow leadership to gain a better grasp of the pulse of the clinical learning environment? Leaders from the university felt they were no longer standing outside the door looking in but were able to interact with the health system and

become a part of the process working towards providing a high performing learning environment for the physician trainees, staff, and patients. Through the lived experiences of leadership, CLEWs had allowed them to step out of their comfort zone, listening and hearing from front line providers best practices and opportunities for improvement. While there are no lines of authority between the university or health system, leaders feel they can work together to provide a learning and working environment beneficial to all, providing the safest and most optimal care environment for the patients.

It is time to implement a tool that considers the perceptions of the residents, fellows, faculty, nursing staff, and others that have the responsibility of caring for patients. Residents and fellows do not work alone in the clinical learning environment and any process created should be inter-professional. Clinical Learning Environment Walks (CLEWs) takes each of these pieces into consideration.

Clinical Learning Environment Walks provide leadership an opportunity to step out from their desks and their closed doors to interact with their followers directing, supporting, participating, and helping them to achieve not only the goals of the institution but their own goals of building a better environment. The path-goal theory fits the CLEWs process as it allows leaders to gain the followers' perspective, which allows them to be supportive, directive as necessary, and participate in their planning for improvements. Building on the principles of the path-goal theory, CLEWs can help to build better leaders while motivating residents, fellows, faculty, and staff to recognize where improvements need to be made and know that they will have the support of top leadership to put these improvements into place and build a high performing and sustainable clinical learning environment.

As noted in the literature review, previous studies have documented tools that have been used to determine the health and wellness of a specific department or service line. There is a gap in the literature in that assessing the clinical learning environment in its entirety has not been a focus of researchers. Further study is necessary to ascertain if the CLEWs process will be beneficial to other Graduate Medical Education and health care systems.

CLEWs are a process that can be modified for other healthcare endeavors or businesses. CLEWs can be modified to ensure the Centers for Medicaid/Medicare and Joint Commission standards are not only met but exceeded. CLEWs could provide an avenue to gain the perceptions of morale within healthcare and other industries. While CLEWs, in its current form, has been suspended due to COVID-19, a modified form has been created to do personal protective equipment (PPE) rounds ensuring PPE is worn correctly and that all healthcare providers have the PPE necessary to keep patients and staff safe.

Further, CLEWs will be restarted when it is safe and protocols, in place due to COVID-19, are changed. This researcher will suggest to UT Health San Antonio and University Health System to grow the number of teams completing CLEWs and the ability to schedule night and weekend shifts. A goal will be to explore the lived experiences of the new leaders added to the CLEWs teams and continue to improve the CLEWs process.

This study, along with future studies can bring about a broader understanding of the clinical learning environment and promote a sense of teamwork between leaders leading to better communication between leaders and followers. Leadership having a better understanding of the learning environment can lead to better communication, improvement opportunities, enhancing the focus, while removing finger pointing leading understanding and improving the clinical learning environment.

References

ACGME home (n.d). Retrieved from https://acgme.org

Alhaqwi, A. I., Kuntze, J., & Molen, H. T. (2014). Development of the clinical learning evaluation: Factor structure, validity, and reliability study. *BMC Medical Education, 14*(1). doi: 10.1186/1472-6920-14-44

Alqaidi, S.A. (2010). https://doi.org/10/1016/51658-3612(10)70118-9

Association of American Medical Colleges. (n.d.). www.aamc.org/learningenviornment

Bagian, J. P. & Weiss, K. B. (2016, May). The overarching themes from the CLER report of findings 2016 [supplemental material]. *Journal of Graduate Medical Education Supplement*, 21–23.

Broome, R. E. (2011). Descriptive phenomenological psychological method: An example of a methodology section from doctoral dissertation. San Francisco, CA. Saybrook University.

Bump, G. M., Calabria, J., Gosman, B., Eckart, C., Melvo, D. G., Jasti, H., & Buchert, A. (2015). Evaluating the clinical learning environment: Resident and fellow perceptions of patient safety. *Journal of Graduate Medical Education, 7*(1), 109–112. http://dx.doi.org/10.433

Colbert-Getz, J. M., Kim, S., Goode, V. H., Shochet, R. B., & Wright, S. M. (2014). Assessing medical students and residents' perceptions of the learning environment: Exploring validity evidence for the interpretation of scores from existing tools. *Academic Medicine, 89*(12), 1687-1693. http://dx.doi.org/10.1097/ACM.0000000000000433

Common Program Requirements—ACGME Home. (n.d.). Retrieved from https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements.CPRResidency2019.pdf

Creswell, J.W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA. Sage

Dyurich, Adrianna E. (2017). *Experiences of pregnant women using a mobile application as treatment companion*. Texas A&M University – Corpus Christi

Frankel, A., Grillo, S. P., Pittman, M., Thomas, E. J., Horowitz, L., Page, M., & Sexton, B. (2008). Revealing and resolving patient safety defects: The impact of leadership walking rounds on frontline caregiver assessments of patient safety. *Health Services Research, 43*(6), 2050–2066. doi:10.1111/j.1475-6773.2008.00878.x

Gillespie, C., Paik, S., Ark, T., Zabar, S., & Kalet, A. (2009). Residents' perceptions of their own professionalism and the professionalism of their learning environment. *Journal of Graduate Medical Education, 1*(2), 208–215. doi:10.4300/jgme-d-09-00018.1

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach.* Pittsburgh, PA: Duquesne University Press

Gustafsson, M., Blomberg, K., & Holmefur, M. (2015). Test-retest reliability of the clinical learning environment, supervision and nurse teacher (CLES+T) scale. *Nurse Education in Practice, 15*(4), 253–257. doi:10.1016/j.nepr.2015.02.003

Hill, C., Thompson, B. & Williams, E. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist. 25*, 517-572

Hooven, K. (2014). Evaluation of Instruments developed to measure the clinical learning environment. *Nurse Educator, 39*(6), 316–320. doi:10.1097/nne.0000000000000076

Jones, W. S., Maturo, S. C., & Hutcherson, L. R. (2016). Get a "CLEW": Using clinical learning environment walks (CLEWs) to optimize clinical learning environments. *Journal of*

Graduate Medical Education, *8*(3), 458–459. http://dx.doi.org/10.4300/JGME-D-15-00620.1

Keitz, S. A., Holland, G. J., Melander, E. H., Bosworth, H. B., & Pincus, S. H. (2003). The veteran's affairs learners' perception survey. *Academic Medicine, 78*(9), 910–917. doi:10.1097/00001888-200309000-00016

Lee, N., Appelbaum, N., Amendola, M., Dodson, K., & Kaplan, B. (2017). Improving resident well-being and clinical learning environment through academic initiatives. *Journal of Surgical Research, 215,* 6–11. doi:10.1016/j.jss.2017.02.054

Lehmann, L. S., Sulmasy, L. S., & Desai, S. (2018). Hidden curricula, ethics, and professionalism: Optimizing clinical learning environments in becoming and being a physician: A position paper of the American college of physicians. *Annals of Internal Medicine, 168*(7), 506. doi:10.7326/m17-2058

Lewis, M. & Staehler, T. (2010). *Phenomenology: An introduction*. London: Continuum International Publishing Group.

Merriam, S. & Tisdalle, E. (2015). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Wiley

Miller, B. M., Moore, D. E., Stead, W. W., & Balser, J. R. (2010). Beyond Flexner: A new model for continuous learning in the health proessions. *Academic Medicine, 85*(2), 266–272. doi:10.1097/acm.0b13e3181c859fb

Nasca, T. J. (2016). Introduction to the CLER national report of findings 2016. *Journal of Graduate Medical Education* 8(2s1), 7–9. doi: 10:4300/1949-8349-8.2s1.7

Nasca, T. J., Wiess, K. B., & Bagian, J. P. (2014). Improving clinical learning environments for tomorrow's physicians. *New England Journal of Medicine, 370*(11), 991–993. doi:10.1-56/nejmp1314628

National Health Policy Forum. (n.d.). www.nhpf.org.speakerbio.thomasnasca

Newton, J. M., Jolly, B. C., Ockerby, C. M., & Cross, W. M. (2015). Clinical learning environment inventory: Factor analysis. *Journal of Advanced Nursing, 66*(6), 1371–1381. doi:10.111/j.1365-2648.2010.05303.x

Nordquist, J., Hall, J., Caverzagie, K., Snell, L., Chan, M., Thomas, B., Razack, S., & Philibert, I., (2019). The clinical learning environment. *Medical Teacher, 41*(4m), 336–372. doi:10.1080/0142159x.2019.1566601

Northouse, P. G. (2016). *Leadership: Theory and practice* (7th Ed). Sage Publications.

Reimer, N., & Herbener, L. (2014). Round and round we go: Rounding strategies to impact exemplary professional practice. *Clinical Journal of Oncology Nursing, 18*(6) 654–660. doi:10.1188/14.CJON.18-06AP

Robson, C. (2002). *Real world research. A resource for social scientist and practitioner researchers* (2nd ed.). Malden, MA: Wiley

Saarikoski, M. H., & Warner, T. (2002). Clinical learning environment and supervision: Testing a research instrument in an international comparative study. *Nurse Education Today, 22*(4), 340–349. doi:10.1054/nedt.2001.0715

Six Sigma Daily (n.d). www.sixsigmadaily.com

Standing, M. (2009). A new framework for applying hermeneutic phenomenology. *Nurse Researcher*. 16.20.30. 10.7748/NR2009.07.16.4.20.c7158

Torralba, K. D., Loo, L. K., Byrne, J. M., Baz, S., Cannon, G. W., Kertz, S. N., . . . Kashee, T. M. (2016). Does psychological safety impact the clinical learning environment for resident physicians? Results from the VAs learners' perception survey. *Journal of Graduate Medical Education, 8*(5), 699–707. doi:10.4300/jgme-d-15-007191

Wagner, R., Weiss, K. B., Passiment, M. L., & Jasca, T. J. (2016). Pursuing excellence in clinical learning environments. *Journal of Graduate Medical Education, 8*(1), 124–127. doi:10.4300/jgme-D-15-00737.1

Weiss, K. B., Bagian, J. P., & Nasca, T. J. (2013). The clinical learning environment. *JAMA, 309*(16), 1687–1688. doi: 10.1001/*jama*.2013.1931

Weiss, K. B., Wagner, R., & Nasca, T. J. (2012). Development testing and implementation of the ACGME clinical learning environment review (CLER) program. *Journal of Graduate Medical Education, 4*(3), 396–398. doi:10.433/jgme-04-03-31

Weiss, K. B., Wagner, R., Bagian, J. P., Newton, R. C., Patow, C. A., & Nasca, T. S. (2013). Advances in the ACGME clinical learning environment review (CLER) program. *Journal of Graduate Medical Education, 5*(4), 718–721. doi:10.4300/jgme-05-04-44

Weiss, K. B., Bagian, J. P., & Wagner, R. (2014). CLER Pathways to excellence: Expectations for an optimal clinical learning environment (Executive Summary). *Journal of Graduate Medical Education*, *6*(3), 610–611. http://dx.doi.org/10.4300/JGME-D-14-00348.1

Appendix A

Interview Guide

Interview Guide

1. What is your role in the clinical learning environment?

    a. Are you responsible for ensuring residents and fellows are engaged in the Clinical Learning Environment (CLE)?

2. Prior to your first CLEWs, what was your perception of the CLE in which residents and fellows train?

    a. Is the CLE conducive to learning?
    b. Are residents and fellows provided the necessary tools to ensure patient safety and quality care to the patients?

3. After instruction on the CLEWs process and completing your first walk did your perception of the CLE change?

    a. What was your perception of the CLE?
    b. What are some areas of improvement that you were able to identify?
    c. What was your perception of those being interviewed as to their being open and honest?

4. Do you feel that CLEWs have provided you a better insight into the CLE?

5. What positives and/or negatives have you seen from participating in CLEWs?

6. How would you improve the CLEWs process?

**Additional questions were asked as needed to clarify the participant's response

Appendix B

CLEWs Questionnaire

Clinical Learning Environment Walks

Interviewer:_____ Team _____
Unit:_____Date/Time:_____

Interviewees: Resident (R)Fellow (F)Faculty (Fa)NurseOther

1. Supervision -
    a. Are there concerns about R/F supervision? Yes No NA/DK
    b. Are there concerns about reaching a supervising attending? Yes No NA/DK

2. Communication/Transitions –
    a. Are there concerns with R/F/Fa transitions of care on unit? Yes No NA/DK
    b. Are there concerns with communication between teams? Yes No NA/DK
    c. Are there concerns with Patients/families having adequate contact with providers (can patient identify primary provider) Yes No NA/DK

3. Duty Hours/Fatigue Mitigation
    a. Are there concerns regarding R/F duty hours? Yes No NA/DK
    b. Are you aware at any time of any R/F/Fa impairment due to fatigue? Yes No NA/DK

4. Professionalism –
    a. Are there concerns regarding R/F/Fa and professionalism? Yes No NA/DK
    b. Are there concerns about resident abuse/mistreatment? Yes No NA/DK
    c. Are there concerns about documentation in med records? (cut and paste?) Yes No NA/DK
    d. Are you aware of any R/F that has been pressured to compromise their integrity to satisfy an authority figure? Yes No NA/DK

5. Patient Safety –
    a. R/F/F know hospital's patient safety priorities? Yes No NA/DK
    b. R/F file occurrence (eraf) reports? Yes No NA/DK
    c. R/F receive feedback on occurrence reports (eraf)?YesNoNA/DK
    d. Patient Safety concerns are openly discussed on unit (Safety Huddles)? Yes No NA/DK
    e. R/F conduct timeouts when performing bedside procedures? Yes No NA/DK

6. Quality Improvement –
    a. Are R/F involved with QI on this unit? Yes No NA/DK
    b. Are there QI projects that would benefit from R/F involvement? Yes No NA/DK
    c. R/F know the core measures relevant to their unit/program? Yes No NA/DK

7. Do Physician rounds involve nursing and others? Yes NoNA/DK

8. Are you aware of the process to call for a taxi voucher used by R/F when fatigued? Yes No NA/DK

9. Is a standardized process and/or template used for hand-offs? Yes No NA/DK

10. Are you able to verify R/F procedural competencies (NI)? Yes No NA/DK

11. Is there a culture of respect between teams on units? Yes No NA/DK

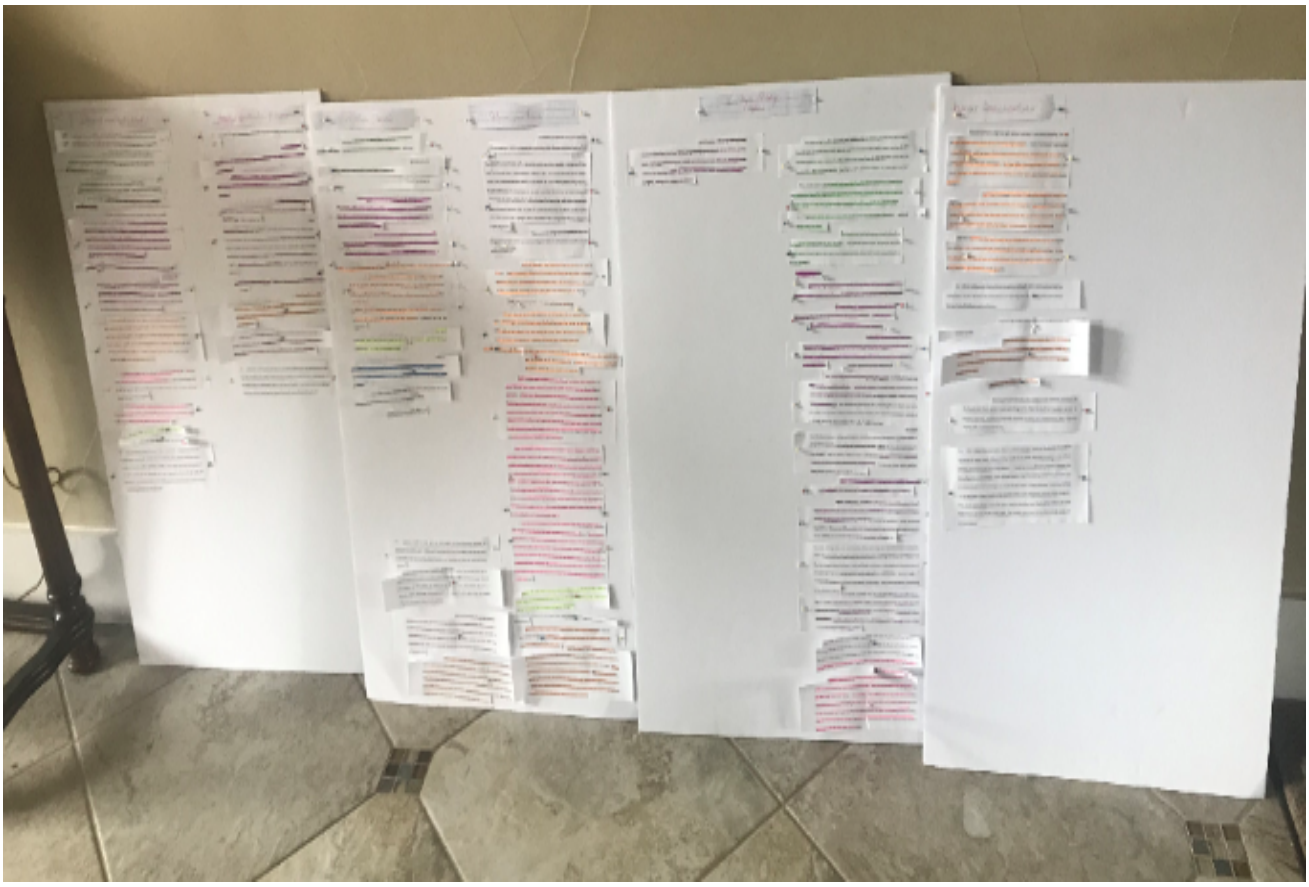
12. How would you improve patient safety on your unit?

13. What is your greatest concern regarding residents?

NOTES:

Appendix C

Coding of Themes



Appendix D

Participant Consent Form

Version 8.22.18

UNIVERSITY OF NEW ENGLAND

CONSENT FOR PARTICIPATION IN RESEARCH

Project Title: CLEW'd In: Exploring the lived experiences of leaders performing Clinical Learning Environment Walks (CLEWs)

Principal Investigator(s): Lisa Hutcherson

Introduction:

- Please read this form. You may also request that the form is read to you. The purpose of this form is to give you information about this research study, and if you choose to participate, document that choice.

- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. You can take as much time as you need to decide whether or not you want to participate. Your participation is voluntary.

Why is this research study being done?

This study is being conducted to determine the efficacy of the Clinical Learning Environment Walks (CLEWs) process.

Who will be in this study?

Leaders from UT Health San Antonio and University Health System.

What will I be asked to do?

You will only be asked to answer questions regarding your perceptions of the CLEWs process.

What are the possible risks of taking part in this study?

None

What are the possible benefits of taking part in this study?

Benefits of taking part in this study will help to improve the CLEWs process in turn leading to identification of opportunities for improvement for the learners leading to better patient care.

What will it cost me?

There will be no cost to the participants

How will my privacy be protected?

Interviews will be de-identified and transcripts will be maintained on the UT Health server accessible only by the principal investigator.

How will my data be kept confidential?

Information will be held on the UT Health Server accessible only by the principal investigator.

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University.
- Your decision to participate will not affect your relationship with the principal investigator, UT Health San Antonio, or University Health System.
- You may skip or refuse to answer any question for any reason.
- If you choose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You are free to withdraw from this research study at any time, for any reason.
    - If you choose to withdraw from the research there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You will be informed of any significant findings developed during the course of the research that may affect your willingness to participate in the research.

What other options do I have?

- You may choose not to participate.

Whom may I contact with questions?

- The researchers conducting this study are Lisa Hutcherson, MS. MEd.L
    - For more information regarding this study, please contact Lisa Hutcherson, 210-567-2268 or 254-715-5951 or hutchersonl@uthscsa.edu

- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact Lisa Hutcherson.

- If you have any questions or concerns about your rights as a research subject, you may call Mary Bachman DeSilva, Sc.D., Chair of the UNE Institutional Review Board at (207) 221-4567 or irb@une.edu.

Will I receive a copy of this consent form?

- You will be given a copy of this consent form.

_____

Participant's Statement

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

_____ _____

Participant's signature or Date

Legally authorized representative

_____

Printed name

Researcher's Statement

The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

_____ _____

Researcher's signature Date

_____

Printed name