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Running Head: Learning Formative Skills of Nursing

Learning Formative Skills of Nursing Practice in an Accelerated Program

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Abstract

The purpose of this qualitative research study was to describe how students in an accelerated master's entry program experientially learned the practice of nursing. One research question examined in this study was: What formative experiences did students identify as helping them develop and differentiate their clinical practice? Data from clinical observations and a combination of small group and individual interviews were collected and analyzed using interpretive phenomenological methods. Students identified formative skills learned through the independent care of a patient as pivotal in their identity and agency development. By experiencing the responsibility and action from within the body and from within concrete situations, students developed a new understanding that changed their embodied ways of perceiving and orienting to the situation, as well as their skills and sense of agency.

Keywords

education, professional; embodiment/bodily experiences; existential approaches; hermeneutic phenomenology; lived experience; narrative methods; nursing, education

How student nurses develop their sense of responsibility in practice and experientially learn to exercise their agency as professional nurses is a relatively unexamined aspect of professional nursing education. In this study we examined the development of agency in a reflective and articulate group of students learning to be nurses after earning a baccalaureate degree in another field. We observed existential skills developed through the responsibility and action of independently caring for patients. In this article, existential is used as a descriptive term to emphasize action prompted by the particular context of the situation of which the individual was an integral part.

Students who already hold baccalaureate or higher degrees in a field other than nursing are one of the most active groups of recruits to nursing schools in the United States (American Association of Colleges of Nursing, 2005). Despite this recruiting emphasis, few programs have developed specially designed courses for second degree students. Because of stringent educational budgets, most schools of nursing have tried to use preexisting courses to fit the second degree students and have blended their undergraduate and second degree students.

The education of professionals requires attention to intellectual, practical, and ethical aspects of the role. The social contract between the public and the professions inscribes a duty to serve the interests of both the individual and the society. According to Gardner and Shulman (2005), the six “commonplaces” of the professions include:

a commitment to serve in the interests of clients in particular and the welfare of society in general; a body of theory or specialized knowledge with its own principles of growth and reorganization; a specialized set of professional skills, practices, and performances unique to the profession; the developed capacity to render judgments with integrity under conditions of both technical and ethical uncertainty; an organized approach to learning from experience both individually and collectively and, thus, of growing new knowledge from the contexts of practice; and the development of a professional community responsible for the oversight and monitoring of quality in both practice and professional education. (p. 16)

Judgments under uncertainty are the heart of any professional practice. A gap exists in our informed understanding of the second degree nursing student’s experiential journey to learn the knowledge, skills, and attitudes that form clinical competency and how these cohere to serve the best interests of patients. Agency, the ability to take a stance and influence the situation, forms and develops because situations are often ambiguous and the practitioner must choose from a number of options and actions. Although the literature captures survey data

about second degree students, there has been little research on how these students experientially learn the practice of nursing, and there is no published research on the lived experience of students beginning their study of nursing within a master's program.

Literature Review

Second degree students who participated in accelerated programs experienced their entry into nursing practice differently than traditional baccalaureate entry students. Accelerated students were typically self-motivated (Meyer, Hoover, & Maposa, 2005; Miklancie & Davis, 2005; Vinal & Whitman, 1994), had a variety of life experiences (American Association of Colleges of Nursing, 2005; Shiber, 2003; Vinal & Whitman, 1994; Wu & Connelly, 1992), and fit the profile of adult learners (Cangelosi, 2007; Miklancie & Davis, 2005; Seldomridge & DiBartolo, 2005; Vinal & Whitman, 1994). These students held higher expectations of the academic experience, were intolerant of busy work, challenged faculty, and expected contemporary teaching practices (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Miklancie & Davis, 2005; Vinal & Whitman, 1994). These students acknowledged the limits of their experience and therefore felt a strong need for more clinical hours as well as more meaningful clinical experiences during their education (American Association of Colleges of Nursing, 2005; Cangelosi, 2007; Shiber, 2003).

Because of the limited studies of the clinical experiences of students in accelerated programs, we reviewed qualitative studies of generic undergraduate nursing students within the clinical environment. Three significant themes were evident across the studies. One was the relationship between confidence and increasing competence as one developed skills (Garrett, 2005; Haffer & Raingruber, 1998; Kosowski & Roberts, 2003; Stockhausen, 2005; White, 2003). A lack of confidence in skills tended to cause preoccupation with performance and the possibility of making an error whereas proficiency and competence in performing skills freed the student to focus on the patient.

Another theme was the unanticipated emotional impact of caring for the sick (Beck, 1997; Cooper, Taft, & Thelan, 2005; Neill et al., 1998; Sedlak, 1997). Students often felt overwhelmed by their exposure to human suffering (Eifried, 2003). A related theme was an enormous sense of what was at stake in caring for the sick and vulnerable (Baxter & Rideout, 2006; Beck, 1993; Cooper, Taft, & Thelan, 2005; Haffer & Raingruber, 1998; Neill et al., 1998; Sedlak, 1997). Confronted with their own lack of knowledge and skill and related lack of clinical agency (i.e., the ability to affect or change clinical situations), students felt anxious and fearful of making errors and

harming patients. They frequently found themselves in situations of uncertainty with little if any background skills and knowledge to guide their action.

A third theme included the relational aspects of nursing. Nursing practice occurred within relationships formed between caregiver, patients, and families. Connecting with the patient meant being open to understand what mattered to the patient (Cooper, Taft, & Thelan, 2005; Ironside, Diekelmann, & Hirschmann, 2005b; Kosowski, 1995; Sedlak, 1997; Stockhausen, 2005; White, 2003). Ways of connecting with the patient included envisioning possibilities for the patient (Eifried, 2003; Ironside, Diekelmann, & Hirschmann, 2005a; Kosowski, 1995), seeing the patient's and family's perspective (Cooper, Taft, & Thelan, 2005), learning the humility of caring and being with the patient (Stockhausen, 2005), and connecting the patient's past, present, and future (White, 2003).

Study Design

Phenomenologists strive to uncover the taken-for-granted and tacit meanings behind skills and practices, and their interconnectedness, in this case, within the practice of nursing and the taking up of that practice. In this study, we investigated the lived experience of second degree students, intending to build on the reviewed studies of undergraduate students. In doing so, we sought to examine the background understandings that ground the taking up of the practice of nursing, as well as explore the possible differences that might exist between students with different educational and experience levels.

Using interpretive phenomenology, we described how master's entry into the practice of nursing (MEPN) students experientially learned the practice of nursing in the clinical setting. A specific aim of the study was to describe the pivotal formative experiences that students identified as helping them develop and differentiate their clinical practice towards the formation of their identity as nurses. Following institutional human subjects research approval, MEPN students from a program located in the western region of the United States were recruited for this study. In this program, students with non-nursing baccalaureate degrees took foundational nursing courses and clinical practica over the course of their first year of study, and were then eligible to sit for their nursing boards. After obtaining their licenses as registered nurses, many students opted to "step out" and practice nursing for a year before re-entering the program. Subsequently students began two years of advanced practice study to become midwives, clinical nurse specialists, or nurse practitioners.

Data Collection

Four semi-structured interviews were scheduled with each participant (n=19) throughout the first year of study so that we could capture transitions in the students' understanding over the course of time. Fifteen students participated in alternating small group and individual semi-structured interviews (two small group interviews and two individual interviews); four students participated in four individual interviews. During interviews students were asked to retell a story about their involvement in actual situations of care. Narratives gave us, as researchers, access to particulars of how the individual students understood their world, and directed our attention to what mattered to the informants (Benner, Tanner, & Chesla, 1996). By thematic interpretation of the narratives (Tetley, Grant, & Davies, 2009) we aimed to understand the lived experiential learning of the students within the clinical environment.

This research report is based on three interviews that took place during the first seven months of the students' experience in the MEPN program. During the first interviews we noted that when asked to recount pivotal clinical experiences, students often related a story of being responsible for the independent care of a patient. In subsequent interviews students were asked to describe more about these specific experiences and why the students considered these as pivotal events. This strategy for interpretation was deemed effective based on time considerations balanced with the fact that this particular line of inquiry surfaced in early interviews, and became a focal point of the second and third sets of interviews.

Data Analysis

We interpreted the students' narratives describing their independent care of patients, specifically to articulate the concerns of the students within their involvements with patients. Documentary sources such as clinical observations, field notes, and notes on the MEPN curriculum were considered integral in interpretation of the data (Hunt, 2009). Our analysis began by reading through the entire interview, field notes, and other background information to get a sense of the whole. Our interpretation proceeded by moving back and forth between parts and whole; the whole examined in light of what was understood from the part and vice versa. Interpretive notes were written during and after each reading of the narrative text.

Our subsequent thematic analysis interpreted the common threads of meaning, comparing the literal meanings of the participant's words to developing themes, as influenced by our changing understandings. In the same manner that shared social meanings allow us to understand the flow of a conversation, in interpreting narrative texts "we recognize the kind of situation people are acting in and the concerns and involvements their activities

embody” (Packer, 1989, p. 111). We used exemplars to illustrate qualitative distinctions both within and between themes. As noted by Benner (1994), this strategy is useful for articulating shared meanings within the culture.

Findings

The particular clinical learning afforded by practicing on their own was pivotal for these second degree MEPN learners. Themes apparent in their narratives signaled a shift from observing a more experienced nurse or working in a paired fashion with a nurse to a more independent stance that challenged them in qualitatively different ways. Evident themes included: developing personal authority for care; heightened vigilance in developing clinical responsibility; developing agency by performing physical skills; developing agency through the experience of providing care; developing habits and styles of practice; learning to communicate with a team while enacting care; navigating with a need in mind; gaining familiarity, autonomy, and confidence; and gaining trust from the staff.

Developing Personal Authority for Care

At first, novice students felt like guests wearing costumes. Their dress designated them as nurses, but they did not yet have the confidence to give directions to patients or to expect that patients would believe in them sufficiently to follow those directions. In the following account Nancy (pseudonyms are used throughout this account) described how she perceived a change in her relationship to the patient when she cared for the patient on her own; the student had gained legitimacy through her experience and her increasing knowledge and capacities. She now had reason to be with the patient other than idle chatter. She no longer felt like a guest who was intruding on the patient, or making illegitimate claims or requests from another person:

I’m not intruding . . . maybe they didn’t want to talk to me, maybe I shouldn’t bother them. But you know, they’re my patient[s], I have to take care of them; I’ve got to go in and ask this and I don’t care if they’re ready to do this or not. . . . I learned how to be a little more confident and . . . not like I’m bothering them but I’m doing this for them.

Often students felt insecure in their new found skills and hesitant to approach the patient in an authoritative manner. They gradually had to feel both the entitlement and responsibility to coach and instruct patients, or especially, to perform uncomfortable procedures. Sometimes these responsibilities for care, such as turning the patient, dressing wounds, or getting the patient out of bed were unwanted by the patient in discomfort. Students had to learn their legitimate responsibilities and roles as nurses. When “charged” with the care of patients, students were gently pushed towards a more authoritative stance by the need towards action, aided by their clinical instructors, their

theoretical knowledge, and the patients' needs. For example, they now had a better grasp of the hazards of immobility and felt more entitled to assertively prevent the hazards of bedrest, such as deep venous thrombosis or stasis pneumonia. Initially, students did not have first hand evidence of the dangers of immobility nor did they sufficiently sense the efficacy of turning and changing the patient's position in bed. Once they were clear about the dangers of immobility and the health benefits of mobilization, students felt entitled and empowered in the role of nurse to prompt the patient to turn, move, and ambulate for the patient's own well-being, even when contrary to the patient's desire. Nancy demonstrated this initiative to enact a patient need:

Let's say I'm afraid to walk into the room- I don't want to go in right now because I'm kind of scared. I'll just tell my nurse, right? . . . Is it okay if you come in with me, he really needs this right now, can we check on it together? And then there's always a reason for me to not have to take the initiative and do it. [But] when I am on my own, I don't have a nurse I can follow so I have to go in, suck it up and just go in.

If the student had entered the room with the nurse the authority for care would have shifted from the student to the nurse. While managing care on her own the student did not "have a nurse to follow." In addition there was a shift motivated by the direct connection with the patient without the middle person of the staff nurse to interpret what was needed to care for the patient. Feeling the weight was formative for the student, moving her from acting like a nurse to being the responsible nurse in the situation. Another student, Diane, received direction for action from the patient in the following situation and bypassed the filter of the nurse's judgment:

I feel more confident and independent. I can do more stuff and I'm making decisions more now, coming to conclusions about patient care, taking information that I'm receiving from the patient as to what they need or how they're doing and turning that into action. Whereas before I think I'd take information and then run to my nurse or my instructor and then have them turn that into action.

Sometimes there were aspects of care that students felt less confident about, and therefore sought out a nurse to obtain more background information before they felt comfortable performing the skill. In this way students built a repertoire of situations in which they could reason independently:

Sometimes it's a situation where something happens and I think okay, in this situation, this is what needs to be done. But I don't necessarily act on it because I'm not totally confident. It's what I

think is right. And then if I go and have it affirmed, then I think to myself okay, so that's right. And then next time it happens I won't need that affirmation, so it's like building a repertoire of pre-affirmed things that I can do on my own afterwards.

In this situation Diane was fairly certain what needed to be done, yet felt enough uncertainty that she wanted to have her judgment affirmed by a nurse. In this situation, Diane understood her role as agent yet knew she did not yet have sufficient knowledge about the range of possibilities to act without first checking out the appropriateness and correctness of her chosen approach with an experienced nurse.

Heightened Vigilance in Developing Clinical Responsibility

For each of the student participants independently caring for patients meant taking on ownership and responsibility for someone's well-being. This sense of being in charge of the patient's safety heightened students' vigilance. The students' perceptions were altered as they focused on aspects of the situation. In the following exemplar, being in charge of the patient's care solicited the student, Anna, to pay attention to equipment and to the particular details of care:

I think naturally there's something when you're responsible for that patient; I think you just act completely differently. You ask more questions, you have to think through what's wrong with them and what could go wrong with them. You just even walk into the room and see things completely differently. I know I do. If I'm just observing I may not pay attention to how many lines they have or what's running or how many liters of oxygen they're hooked up to. But if I'm actually trying to take that patient on, I'd better stop and look at every single detail, because I actually have to be responsible. I know observation is beneficial. I really prefer to see someone do something first before I do it. But as a learning experience, it's much better to be the person who has to do it. Now the corollary of that I guess is that . . . it's riskier for patients. When we're actually the ones responsible, it means we can miss things.

A feeling of accountability motivated Anna to view the situation differently, although she understood there was an element of risk to the patient's safety within her experiential learning. She expressly acknowledged that the nurse she was working with was ultimately responsible for the patient's well-being:

I'm responsible for catching something. And I'm responsible for making sure things are going well . . . I mean of course there are nurses that are observing and really the buck kind of stops with them. But I do try to take it on as my personal responsibility. . . . I take it very seriously and without that seriousness I don't think I learn as well. . . . Without the gravity for me- without feeling like the patient's health is a little dependent on me, I just don't learn as much. I think I need to feel that what I'm doing is making a difference, and I just take it more seriously. It's also why I wake up in the middle of the night concerned about something that I forgot. You know, I find it to be very anxiety provoking, but I don't think I could learn to be a nurse if I just observed patients.

When students took on the responsibility for caring for patients, they experienced emotions of concern and vigilance. Their involvement, sense of agency, and responsibility allowed them to feel the pull of different risks and possibilities within the situation. Students experienced in a new way the concern for what ultimately happened to the patient, sometimes awakening in the middle of the night anxious about what they might have forgotten. The sense of responsibility and commitment became a motivating force.

Developing Agency by Performing Physical Skills

Care and concern for the patient are often demonstrated in nursing by physical acts or skills. These are physical acts done by a sentient skillful physical body for a similar, but now compromised physical body. These skills are necessary for the well being of the patient. Successfully learning such embodied actions was achieved from within the enactment of the physical action as described by Helen:

Much of nursing is physical, like physically re-positioning somebody in bed. Or physically doing a wound care, or even giving a bed bath, that is about how you physically do something. Or putting in an I.V., how you physically do it. Yeah you can watch somebody put in IVs all day, but—not just putting in the I.V., but what's your relationship with the patient when they're nervous and you've got the light on, and you're trying to make it as anxiety-free an experience as possible. But you also are kind of shaking, your hands. It's totally different than observing it. Because you're doing it. I mean your whole body is doing it and it gives you confidence. I mean, we gave each other high fives when we got in an IV. It feels good to do that.

Successfully learning a skill was an exhilarating experience for students and was often an experience that was shared with fellow students. In this exemplar Helen was aware of the particular aspects of the situation. She sensed the patient's fear was heightened by the fact that her hands were shaking and she had turned on an additional light to focus on the task at hand. This exemplar also revealed the experience as shared with the patient, as the student's shaking exposed her fear, and her shared humanity, to the patient and family in attendance, in a similar manner to what Hawley and Jensen (2007) referred to as "humanizing differences" in their study of intensive care nurses. Though it remained unsaid, if the student had hung the wrong intravenous solution, or thought she had successfully punctured the vein but was actually outside the vein, she would have felt regret.

The student's account also highlighted the embodied aspect of her developing skill ("I mean your whole body is doing it"). Learning embodied skills happened from the inside out; the dexterity to perform the skill well happened from within the body as in Diane's embodied act of removing a Foley catheter:

For example, with an act like taking out a Foley. If you're just watching someone do it, it seems easy and seamless, and only once you actually do it yourself do you realize this or that can go wrong and you have to remember things, and as a result you have the drive to perfect it. Whereas if you're watching, there's nothing for you personally to perfect or do.

When observing the experienced nurse enact a skill such as removing a Foley catheter the student observed it done with an effortless flow. It was only from doing the act on her own that the student gained the experience of what could go wrong and what one could do to perfect the skill.

Developing Agency Through the Experience of Providing Care

In a comparable way students learned to enact care from within the experience of providing care. Physically performing the work of caring for patients required students to respond to situational demands. Situated cognition and skillful responses became more integrated for students. Planning arose organically from being within the situation and needing to find their way; this is what is meant by agency as an existential skill. For example, in the following exemplar Lina's way of being in the situation, her efficacy and agency, were transformed in ways that she felt and experienced as a newly gained capacity:

So with the hands-on, with the med surg [medical-surgical rotation], the reason why I like it is because that's how I learn. I do the work, right? So anything that I find I have to follow up with . . . for instance last week I had a patient who had an order for Metoprolol at eight o'clock at night. It

was a one-time thing. And [I] took her blood pressure throughout the day and it just kept slowly rising. So I had to follow up with a physician and go, “Look, her blood pressure is 165 over 70. Should I, I think I’m going to give the Metoprolol now. This is high, you know.” So I don’t know if that makes sense but I was the one who found it. I was the one who addressed it and followed through and I ended up giving her medication early.

In this exemplar the student transitioned to a more authoritative stance mid-sentence, in making her case to the doctor that a patient needed to have a medication given earlier than the scheduled time. She began the sentence with “should I” and then transitioned to “I think I’m going to” to further clarify her stance. She strongly felt her agency in the situation. Her identity shifted from being a student who observed and learned to one who took action and followed through. She was able to contrast her newly won “insider” stance to an earlier clinical situation where she was only an onlooker:

[Whereas], in labor and delivery the nurses’ll let you do things and they’ll show you how to read the fetal heart strip and you can do that and you can make your observations. But you don’t, you’re not touching the pit[ocin], you’re not touching any of that. . . . I wasn’t communicating with the physicians. I wasn’t “Oh, I’m noticing something and I have to call a physician.” I didn’t take a part. I remember . . . one of the women who I watched give birth. When she started going into active labor, my preceptor was the one who called the team to get everyone in there so that everyone was prepared to have the baby. And I didn’t really understand. All of a sudden, why now? You know it didn’t make sense for me. . . . I didn’t feel like I was as integral. I felt like I was an assistant and helping out. Whereas in med surg, you’re actually doing the work. You’re charting everything you find. And you have someone supervising you, but you’re doing it, and anytime you need—I mean they’re depending on you to reach out when you need help. And to ask questions if something doesn’t seem right. I guess it makes a really big difference when you’re in charge . . . for me I just feel much more forced to think critically.

Lina’s comparison of labor and delivery and medical-surgical nursing experiences demonstrated the requirements for experiential learning where one’s identity and a sense of agency were formed and remembered through being responsible for actual interventions, and for being depended upon as integral to

the team and to the care of the patient. That Lina remembered her recognition of the patient's high blood pressure, and called the doctor in order to give the medication early, showed that it held significance for her. It was a benchmark event where she began to feel like a nurse.

Developing Habits and Styles of Practice

Becoming at home in the social and physical environment of the hospital entailed using equipment flexibly, navigating the physical environment, dealing with social expectations smoothly and skillfully, and, in addition, developing one's own care routines. Students acknowledged that managing care on their own allowed them to develop their own style of care. Nancy stated: "I control what I do for people, and [I'm] not shadowing the nurse anymore, and not doing it her way anymore. I can do it my way." In a similar vein Mary described the motivating force of independence: "being able to take my own initiative and have my own way of doing things." Having a sense of control allowed students to take initiative and develop personal strategies for handling the care of patients. In addition, from within the provision of care, students were able to improvise towards better organization, as Freda noted:

I think it's extremely important because everyone has their own flow. I think the only reason for me that it's important to shadow a nurse is to see how people do things and to draw on their ideas and what works for you and draw on their knowledge. But I think managing your own patient aids you in developing. Because you're eventually going to develop your own way of doing things, and being able to do it in practice and kind of refining it as you go before you're actually thrown into the wolves and actually managing four or five patients on your own.

Freda emphasized the importance of developing one's style in managing care skillfully, while drawing on the skills and knowledge of experienced nurses that she observed. Freda's description pointed to the embodied development of the individual nurse's clinical imagination, and ongoing organization of a complex yet open-ended practice, that was existentially refined as the situation unfolded. Her statement demonstrated a movement from imagining and performing skills as singular tasks or elements of care into a sequenced whole that works and makes sense to the nurse. Developing a beginning capacity for "flow" was an essential step in clinical learning of a complex practice such as nursing.

Learning to Communicate With the Team While Enacting Care

Students' appreciation of the communication skills needed to effectively provide care for patients was enhanced by the charge to provide independent care. Inez stated:

One of the biggest things I've learned is: how do you communicate with the rest of the team? When you're doing care on your own, rather than listen to your nurse talk to the doctor you actually have to talk to the doctor, call respiratory therapy, or just kind of figure out, "how do I work with dietary if I need to change something?" And being in charge of those things, or having to discharge someone and actually do[ing] that. . . . And at first it's a little intimidating to reach out to these different parties. But then you do it a few times and . . . it's a lot easier than you think it is. I see the network of the hospital much clearer now than I did before. Whereas [before] I felt like I was kind of floating and not really interacting with these different parties.

Inez's sense of responsibility to provide effective care propelled her to communicate with other members of the health care team. In this case her sense of her own agency overcame her prior feeling of intimidation. By practicing direct communication, Inez enlarged her understanding of the network of people involved in care and the ways to communicate with affiliated caregivers that enabled her to give more effective care. Learning how to talk to doctors, learning why and how to call a respiratory therapist, and learning how to work effectively with dietary when a change in diet was ordered were all existential skills the student took up to navigate the clinical environment for the sake of the patient. The student's care of the patient was also more efficient, as it took less time when treatment decisions were not filtered through the nurse as conduit. The student felt more anchored to the network of care providers through the concrete experiences of managing the care of patients. She was no longer "floating" but felt like an insider, a participant member in the health care team.

Navigating With a Need in Mind

As part of learning to navigate in the clinical environment, students also learned the skills of where to go and who to get for expert help with particular aspects of care. When asked about what he had learned from caring for patients independently, Ed described these aspects of his own resourcefulness for managing equipment and the particulars of a patient's diagnosis:

As a result of having to be responsible on your own . . . you learn who and where your resources are. Like this great nurse on our unit. He's an L.V.N., actually, but the guy is a wound stud. He knows everything there is to know about wounds. Don't ask any nurse before you ask him.

Ed's need to cope with the intricacies of intravenous equipment as well as wound care led him to seek out the specialists within the unit culture of care. The "wound stud" had gained a reputation based not on the title of his role, but rather on his ability to describe and treat the qualitative distinctions in types of wounds. The student began to gain an insider's sense of the local and specialized knowledge between team members on the unit.

Gaining Familiarity, Autonomy, and Confidence

When providing care to the same patient for consecutive days, the students gained familiarity from one day to the next and learned the particular needs of a patient. On the second day the student incorporated her learning into a care routine that was smoother than the day before. In the following exemplar, Carol had gained familiarity with the patient situation and this familiarity added to her sense of comfort and confidence:

I've worked with him and I spent the morning getting used to crushing all of his medications and calling the pharmacy to see which ones could be crushed and changing the forms for the ones that weren't crushable--just spending my time learning how to care for this patient. . . . By Friday I felt a lot more confident about taking care of him and having an idea of how I should manage my time . . . because I was familiar with his medications, familiar with what was required for his care, like checking his wrist restraints for circulation . . . so I felt more comfortable.

Working with the same patient for two consecutive days allowed Carol to become familiar with physical aspects of her patient's care, extending her knowledge of medication administration and gaining a better understanding of the hospital culture through her discussions with the pharmacist. Consecutive care also allowed the student to improve her practice the second day, which gave her a sense of efficacy as a nurse.

Many students felt a sense of empowerment through their ability to care for patients on their own. This autonomy encouraged the students' confidence. In this exemplar, Ed's independence made him feel more confident as he recognized that he could navigate the practice environment on his own:

Totally on your own? Yeah, being completely independent, flying solo, as I call it, builds your confidence. I can handle this, is what you get from it. Particularly if you pick a patient who needs a

whole lot of different stuff. You know, they've got the rebreather mask on, they're getting a tube feeding, IV meds that you have to hang. We have to stick I.V.s on them, or do blood draws, q4 hours or whatever, just being responsible for all that stuff, and actually having to do it. Doing it and accomplishing it builds your confidence so much, and I think it's important for everybody to at some point in time fly solo, preferably on a high acuity patient.

Flying solo within the care of a high acuity patient was a high stakes situation and handling this responsibility effectively built confidence in the student. However, clinical faculty needed to remain vigilant and remind students that the goal of independent care should never take precedence over patient safety. For beginners, caring for a high acuity patient required dialogue with a clinical instructor and the staff nurse ultimately responsible for the patient. Ideally a staff nurse and the student should perform as a team, with the student planning and enacting care, but in close collaboration with the staff nurse as safety consultant. In Ed's account it was unclear how "solo" he really was and whether a staff nurse, as safety consultant was close by, unbeknownst to Ed.

Gaining Trust from Staff

The ability to care for patients independently was noticed within the unit culture of the floor, provided the student was assigned to the same unit over time. This reputation led to an unanticipated reward:

The resourcefulness, the confidence, and I think you kind of build a reputation off of being able to fly solo. Oh he can handle really acute patients. He worked last week with Mrs. Nine Bed One. He can handle it. He could probably also then handle Three Bed Two, you know? —and these nurses talk amongst each other, so you build yourself a reputation, and you know, you'll work with another nurse and you automatically have trust. . . . I got a good reputation on the unit, and a nurse manager talked to me about a potential job opportunity this summer. Because you know, they trusted me, and I gained that trust by flying solo, by being solely responsible.

Social recognition of being a responsible member-participant of the team was essential for smooth and effective functioning and for forming the social identity of a nurse. Over time the nurses on the clinical unit had an opportunity to observe students enacting care. In this way the nurses developed trust in the student's abilities even before the nurse and student shared a patient assignment. However, in this account Ed's criteria for flying solo successfully seemed based on managing many complex tasks with the patient represented as an object ("Mrs. Nine

Bed One”) to be “handled”. In the prior exemplar as well, Ed’s focus was on “stuff” and tasks: rebreather masks, I.V.s, and blood draws. Confidence during experiential learning is fragile. Situated coaching would have been useful to Ed at this juncture to pull his focus from the tasks and “stuff” to a more coherent account of the patient’s clinical condition, the goals and risks of the patient’s current clinical condition, and the patient’s responses to the therapies being administered.

Discussion

The students’ accounts of learning the practice of nursing included many taken for granted aspects of their every day coping in the clinical world. They gave insights into the process of moving from lay person, to becoming a nurse, to the sense of being a nurse. This progression illustrated the role of practical reasoning in forming the nurse’s identity, character, and agency (Benner, Sutphen, Leonard, & Day, 2009). Students in this study often used the term “navigating” to describe existential skills in particular clinical situations; these were skills enacted in response to situational demands and a desire to provide good care for the patient. According to Hubert Dreyfus (1999), the three interrelated and foundational aspects of human intelligent behavior are: “the role of the body in organizing and unifying our experience of objects, the role of the situation in providing a background against which human behavior can be orderly without being rule-like, and finally the role of human purposes and needs in organizing the situation so that objects are recognized as relevant and accessible” (p. 234). In this description of human behavior, it is apparent that actions and emotions cannot be separated from the context in which they occur.

As well as articulating MEPN students’ developing practical reasoning, our research described the students’ developing clinical agency gained through concrete experiences in relationship with patients and families, other students and clinical faculty, and health care professionals. Developing moral agency, the ability to impact a situation for the good, was central to forming the capacities required for being an effective nurse. Being responsible for patient outcomes led the students to pay attention to situational nuances and equipment that were not obvious before. The ability to pay attention to the appropriate aspects of situations was enlarged as students developed new perceptual abilities to notice salient aspects of ambiguous situations and the skilled know-how to act in the situation. The students gained a sense of initiative to ask more questions in order to deepen their understanding of the clinical picture. The additional guidance of meaningful emotions as the students took up “the gravity” of their responsibility increased their vigilance, attentiveness and initiative to learn. Being responsible for the care of a patient allowed the student to develop a personal style of care. Forming one’s own clinical agency was not achieved in the abstract but

through direct responsibility, by navigating concrete clinical situations with real risks and developing the appropriate knowledge and skill to act in and influence clinical outcomes. In this way, taking up the unfamiliar of experiences created new embodied understandings (Gadamer, 1975/2004; Todres, 2008) for the students.

Implications

Developing Agency and Responsibility through Independent Care

Our research uncovered a rich description of students' formation while developing a sense of agency and responsibility through caring for patients as the primary provider of care. However, as noted by one student, when students enact care relatively independently rather than alongside a nurse "it's riskier for patients." Patients in most medical surgical units are sicker than in the past, have more co-morbidities, and shorter stays. In addition, clinical faculty often depend on staff nurses to provide direct oversight of students and these staff are seldom provided with pedagogical training. One student in this study voiced a tacit and taken for granted aspect of clinical practice, "what is meant by managing two patients?" Without clear definition of the expectations for providing independent care, students might focus more on the outward manifestations of efficiency rather than focusing on the efficacy inherent in taking up the multiple responsibilities associated with care for the particular patient.

Many of the students in this study took a position of hyper-responsibility that implied a program expectation of high independence. In fact, the interviewer frequently asked if the clinical instructor was available for advice, and the answer was most typically "yes." It is possible this high level of independence was in some way attributable to second degree students' former lives of responsibility and success in academia as well as careers. However, clear program guidelines about the level of independence anticipated could reduce students' performance anxiety and increase patient safety. The existential skill of knowing the limits as well as the possibilities in one's level of knowledge, skill and practical grasp of situations is central to forming an ethos of safe and self-improving practice.

Students, especially in accelerated programs, could benefit from providing more independent care in subacute settings earlier in their program of clinical practice. Post partum units with healthy mothers and babies, or skilled nursing facilities with relatively healthy older adults can serve as venues for students to develop their agency and responsibility in a less acute setting. Each clinical setting would require the clinical instructor or charge nurse to prescreen patients to select those that are subacute and should include frequent reports from the student to a buddy nurse with findings and an updated plan of care. Understandably, staff nurses are often reluctant to give up control

of patient care decisions to nursing students; therefore it is important to introduce the expectation of frequent student check-ins as protocol guided by patient safety concerns. In addition, preclinical dialog and post clinical debriefing with students about their experiential learning for the day would help students reflect on and identify areas of knowledge skill and cognitive knowledge gaps.

The Significant Role of Clinical Faculty

Clinical faculty need to establish a presence and expectation that the faculty role does not focus primarily on evaluating students' capacities to practice tasks such as medication administration, intravenous starts, dressing changes, and Foley catheter insertions. The primary role of clinical faculty is to guide and coach students towards a greater understanding of and sense of professional responsibility for the underdetermined practice of nursing. Each time clinical faculty reappears on the unit, he or she can encourage the students' understanding of the practice by questioning students about their patients in such a way that significance is brought up from the background. Although these questions can have meaning for the student working alongside a nurse and performing tasks, their significance is greatly increased while the student is responsible for more independent care of the patient.

Such focusing questions within specific clinical situations have been called situated coaching by the Carnegie National Study of Nursing Education (Benner, Sutphen, Leonard, & Day, 2009). Lisa Day, described as one of the paradigm cases of excellent teaching within the Carnegie study, structures both her classroom case studies and clinical teaching around these questions: (a) What are your concerns for this patient? (b) What are you planning to do to cope with these concerns (What will you watch for? What nursing actions will you perform? What lab work will you look for? What tests do you anticipate will be done? What else are you concerned might happen?) (c) What are the patient's concerns? and (d) Who/where are your resources? Coaching focuses on what is necessary for the student to notice and attend to in learning a complex practice such as nursing. In addition, a faculty focus on coaching develops a routine and expectation from the student that this is a primary role of clinical faculty, rather than the observation of new task performance.

Although often taken for granted, faculty's intention to "shine a light" on the ultimate good of the healing arts in concrete cases can provide guidance to students learning the practice of nursing. Through the direct care of patients, students develop a sense of agency while learning to individualize care and maintain patient safety. The challenge for clinical faculty is to structure clinical practica so that students can develop their own ability to act and be responsible for patient care within a safe environment.

Implications for Other Health Care Practitioners

Existential skills of other clinical practices could be articulated in studies of practitioners or students within other practice disciplines. In her book, *How Doctors Think*, Kathryn Montgomery (2006) describes medicine as an interpretive practice that relies on scientific information, clinical skill, and the practitioner's former experiences to practically reason within situations of uncertainty. Knowledge gained through experience broadens, extends, and refines existing knowledge and allows the fledgling practitioner to begin to recognize what is important in situations and compare situational similarities with prior experiences. Other practice professions could benefit from studies describing the development and enactment of practical reasoning skills particular to that discipline.

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