AN INTERPRETIVE STUDY OF NURSES' TEACHING-CARING PRACTICE

by

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ABSTRACT

This qualitative nursing study used interpretive or hermeneutical phenomenology, and ethnography to explore and describe how nurses, practicing in an acute care setting, perceive their patient teaching function. The teaching-coaching domain of nursing described by Benner provided the sensitizing framework for the study.

Data were collected over a ten week period in a twenty-six bed medical nursing ward located in an 800 bed, tertiary care Canadian hospital. Participant-observation and informal interviews were conducted with fifteen nurses as they interacted with ten patients. One formal interview was conducted with each nurse following observation of their patient teaching activities. Nurse participants included the Head Nurse, Assistant Head Nurse, and 13 bedside nurses. Patient participants included two admitted with the medical diagnosis of Chronic Obstructive Lung Disease and eight admitted with Myocardial Infarction.

Data analysis utilized an interpretive approach based on Heideggerian phenomenology. Verbatim transcriptions of fieldnotes and audio-taped interviews constituted the text for analysis. Consensual validation was sought from the nurse participants, the study's thesis sponsor, and from readers of the thesis report.

Three major themes emerged from the data. These include: (a) contextual factors influencing nurses' teaching function, (b) how nurses' described their teaching function, and (c) how nurses were observed practicing their teaching function. Two key findings were identified. They include: (a) the centrality of caring to teaching and nursing; and, (b)

the identification of the purpose of nurses' teaching as the enablement of patients and families to restore, maintain, and promote their health; to cope with illness; and to die in peace.

The major significance of this study is its contribution to the clarification of nurses' teaching function as it is understood and conducted by nurses practicing in the acute-care setting. Recommendations for future research include the exploration of patients and families' experience of illness as well as issues of nursing practice, administration, and education referable to nurses' teaching function.

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CHAPTER 1: INTRODUCTION

During a pilot project involving observation of nurses' work in an acute care setting, the investigator noted that teaching activity was a fundamental part of nurses' practice (Young, 1989). Much of what nurses did involved teaching, coaching, and supporting patients through their hospitalization and illness experience. However, while nurses commonly engaged in various dimensions of patient teaching and frequently discussed their teaching function, little teaching as described by proponents of the dominant patient education model for nursing (Coutts & Hardy, 1985; Narrow, 1979; Pohl, 1978; Rankin & Duffy, 1983; Redman, 1988; Wilson-Barnett, 1985) was observed.

Furthermore, teaching by nurses was an aspect of nurses' work that was minimally documented in patients' records. Administrative audits of documented nursing care held the assumption that unless a nursing activity such as patient teaching was recorded, it was not done. This assumption was incongruent with observations of nurses' teaching activities.

Statement of the Problem

Practicing Nurses' Understanding of Their Teaching Function

Within the profession of nursing, there is an expectation that nurses should teach (American Nurses Association [ANA], 1979; Canadian Nurses Association [CNA], 1987; General Nursing Council for Scotland, 1980 cited in Coutts & Hardy, 1985; National League for Nursing [NLN], 1981). The central question generated from the pilot project concerns how, in actual practice, clinical nurses understand and carry out their patient teaching function within the context of the acute care clinical setting. Several more specific questions arise from this central question.

In the process of patient teaching, do nurses view the patient as someone to be instructed, or as an active partner in a care relationship? Does the nurse's view of the individual affect the content of, and approach to, patient teaching? Do nurses value the patient's own interpretation of their illness? If so, how is this interpretation elicited and understood?

How are time and caring related to teaching in nursing? Teaching that is more than telling requires time. Time is necessary for repeated interchanges wherein coaching and clarification can occur, as well as for the building of a caring relationship (Benner, 1984a).

Nurses attend patients on a twenty-four hour basis. How, in the reality of practice, do nurses use this time for patient teaching? How do the conditions of acute care nursing work life--workload, patient assignment methods, and administrative and professional expectations--impact on how nurses carry out their patient teaching function? What is, in fact, realistic to expect of clinical nurses regarding their patient teaching function?

Since nursing is part of a health care team in the acute care setting, how do nurses co-ordinate and communicate their teaching with that of other team members? Since the need for teaching may extend beyond hospitalization, what is the role of nurses in assisting patients to obtain necessary teaching on discharge?

Purpose of Patient Teaching for the Hospitalized Adult

Individuals hospitalized in an acute care setting face learning about significant changes in role, environment, and routine life events. This learning occurs while the individual is in a state of decreased energy and

frequently, increased physical and emotional stress.

The complexity of learning by the patient and family pose many questions for practicing nurses. How do nurses assist patients to learn about their patient role? How do nurses aid patients' learning about the nature of their disease? How do nurses foster patient learning related to a much more subtle and complex aspect--the meaning of the illness to the patient (Benner & Wrubel, 1989)?

Nurses' goal of health facilitation (CNA, 1987) is clearly articulated. Within the acute care setting, however, how do practicing nurses define teaching to attain that goal? Is learning about one's disease, treatment and coping with an illness different from or part of learning to accept and attain a new definition of health necessitated by the presence of disease and the experience of illness? Further, is health "defined" by the patient, by health-care professionals, or through patient-professional collaborative effort?

Context of Patient Learning and Nurses' Teaching

The context within which the patient experiences disease, illness, and care influences patient and families' learning. That context also influences the clinical practice of nursing, including nurses' teaching function. Therefore, that context must be considered if patient learning and nurses' teaching function are to be understood.

Three significant and interrelated trends impact on the context of acute health care within which patient learning and teaching occurs. Currently, increasingly complex care is being carried out during shortened hospital stays. This trend represents an attempt to make the best use of available health care facilities, and to reduce costs of these

expensive facilities. Shortened hospital stays result in less time available for patients to learn and for health care staff to teach. Many acutely ill patients are hospitalized for short periods with recovery continuing at home. Earlier discharge of patients also results in staff with an increased workload of more acutely ill patients (Rankin & Duffy, 1983; Ruzicki, 1989; Stanton, 1983).

Also, the advent of high technology health care is accompanied by the potential for information overload of the patient. Teaching becomes crucial to enable patients to understand their own care and treatment, to participate in decision-making for that care and treatment, and for the giving of informed consent. Increasingly, patients are being discharged from hospital requiring "high tech" care at home. To enable management of this care at home, complex teaching of the patient and their family is required (Drew, 1986; Folta, 1979; Rankin & Duffy, 1983). Patient advocacy, teaching, and coaching throughout the health care experience are becoming increasingly important to counter experiences of dehumanization, alienation, and loss of control that can be associated with "high tech" health care.

Increasingly complex, "high tech" care is associated with increasingly complex hospital organization (Strauss et al., 1984). For example, the health care team has expanded from the traditional nurse-doctor dyad to a multi-disciplinary team of increasingly specialized categories of health care providers. This development is associated with the requirement that individual health care workers and categories of workers function within the framework of a complex patient-care team. It is also associated with the need for coordination of the care provided to individual patients by

members of this complex team. Consequently, if nurses' teaching function is to be understood, it must be studied within the context in which it occurs (Benner, 1984a; Brykczynski, 1985; Field, 1983; Luker & Box, 1986).

Purpose of the Study

This study explored and described the lived experience of nurses' teaching function from the perspective of nurse participants. The question addressed was, how do nurses, practicing in an acute care setting, define and practice their teaching function with adults hospitalized with the medical diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or Myocardial Infarction (MI)?

To understand the practice of nursing, it must be studied within the context in which it occurs (Benner, 1984a; Brykczynski, 1985; Field, 1983; Luker & Box, 1986). This study took into account the context within which patient teaching, a specific aspect of nurses' practice, occurred.

CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Literature Review

Given that the purpose of this study was to explore and describe how nurses, practicing in an acute care setting, define and practice their teaching function with hospitalized adults, a review of nursing practice and research-based literature was conducted to determine how nurses' teaching function has been defined, described, and studied in the literature. Key references from the literature of sociology and medicine were also reviewed.

Content areas comprising the literature review include: historical and current justification for and conceptualization of the teaching function within nursing, the purpose of the teaching function in nursing, perspectives of and influences on patient teaching in nursing, patient teaching within the acute-care setting (review of research literature), and nurses' teaching specific to individuals hospitalized with chronic obstructive pulmonary disease (COPD) or myocardial infarction (MI).

The Teaching Function Within Nursing

Traditionally, teaching has been seen as an important component of nursing practice. Florence Nightingale, the originator of modern nursing, outlined the beginnings of a nursing paradigm based on concepts of health: hygiene, environment, and care; and advocated that nurses become health educators (Coutts & Hardy, 1985; Meleis, 1985; Nightingale, 1859).

More recently, nursing theorists (Hall, 1964; Henderson, 1964; Orem, 1980; Peplau, 1952) have identified nursing's teaching function as a key aspect of nursing. They emphasized the similarity of teaching and nursing; each involving a helping relationship with the objective of developing

independence in the subject (Redman, 1988).

Currently, professional nursing bodies identify nursing's teaching role as an independent function of every nurse (ANA, 1979; CNA, 1987; General Nursing Council for Scotland, 1980 cited in Coutts & Hardy, 1985; NLN, 1981). Reviews of nursing research in the area of nursing's teaching function, support the benefit to patients of that function (Lindeman, 1988, 1989; McCain & Lynn, 1990; Wilson-Barnett & Osborne, 1983).

Purpose of Teaching in Nursing

As nursing's purpose is focused on assisting the patient/client to promote, maintain, and restore health, or to assist the patient to a peaceful death (CNA, 1987; Henderson, 1960; Meleis, 1985), the purpose of nursing's teaching function is seen as supporting that aim (Narrow, 1979; Pohl, 1978; Rankin & Duffy, 1983; Rovers, 1987). This implies an understanding of what constitutes health as well as disease and illness.

Health. Recognizing that health can be viewed as a value statement, Coutts and Hardy (1985) caution that professional statements about health are also value judgments, based on the profession's goals and beliefs. It behooves health care professionals to be aware of the origins and limitations of their concept of health (Keeler, 1981), and to appreciate that individuals may want to decide for themselves about their life and health.

Until approximately two hundred years ago, health was viewed as soundness of body, mind, and spirit (Seedhouse, 1986). As the biomedical model began to evolve and prevail, disease was seen as the failure of body parts that must be treated to achieve health, and health as the absence of (or control over) disease. Teaching from the biomedical model involves

explanation of anatomy, pathology, disease process and therapy. The emphasis is on outlining therapy and aiming for compliance with that therapy to achieve disease eradication or control, that is, health (Benner & Wrubel, 1989; Coutts & Hardy, 1985; Kleinman, Eisenberg, & Good, 1978; Norris, 1982; Pender, 1987; Vorni, 1980).

More recently, a multifactoral concept of health with both individual and societal influences, has evolved. This concept of health has implications for goals, content, and methods of teaching in nursing (Chalmers & Farrell, 1990; Dunn, 1959; Epp, 1986, 1987, 1988; Hancock, 1986, 1987; Hancock & Duhl, 1986; Hancock & Perkins, 1985; Labonte & Penfold, 1981; Lalonde, 1974; U.S. Surgeon-General, 1979; Vuori, 1980; World Health Organization [WHO], 1978, 1984a, 1984b, 1986). Within the Canadian context, A New Perspective on the Health of Canadians (Lalonde, 1974), published by the Canadian government, identified the contribution of lifestyle and environment to morbidity and mortality outcomes. Even though the report has been criticized for its emphasis on the individual's role in reduction of disease through life-style modification, that is, "blaming the victim" (Lalonde & Penfold, 1981), the report is recognized as a milestone because of its identification of the multiple factors influencing health (Chalmers & Farrell, 1990; Hancock, 1986). Findings of the Canada Health Promotion Survey (Epp, 1987) also emphasized that health is affected by social and environmental factors as well as lifestyle and medical factors.

Internationally, recognition of the multiple factors affecting health is evident in the WHO Ottawa Charter for Health Promotion (1986). In this document, health promotion is defined as:

> the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs and to change and cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion goes beyond life-style to well-being (p. 1).

Benner and Wrubel (1989) use the term "well-being" to reflect the lived experience of health. From their phenomenological perspective, defining health must incorporate being as well as becoming, and must be based on an integrated view of mind, body, and spirit as well as on what is possible given the situation rather than on the view that radical freedom is possible. "Well-being is defined as the congruence between one's possibilities and one's actual practices and lived meanings and is based on caring and feeling cared for" (Benner & Wrubel, 1989, p. 160).

Reynolds (1988) found in her review of quantitative nursing research literature that nurse researchers most often operationalize the concept of health as the absence of illness, disability, or symptoms. They frequently ignore multiple dimensions, such as physical, mental, or sociological aspects, as well as reliability and validity measures when assessing subjects' health. However, documentation in the nursing practice and theory-based literature indicates that nursing, as well as society as a whole, is beginning to appreciate that health is more than absence of illness, and that it is more than just the individual's responsibility. "Healthful" societal values and environment are also required (Chalmers & Farrell, 1990; Kefler, 1981; Meleis, 1985; Milio, 1986; Murphy, 1982; Pender, 1987; Rovers, 1987; Tripp-Reimer, 1984).

Disease. Major disease causation during this century has shifted from

infectious disease processes to diseases of lifestyle. This trend, along with that of increased longevity, is associated with an increased prevalence of chronic illness. There is a need for teaching to promote healthy lifestyles among the population generally, and to assist those with established chronic illness and their families to adapt and cope, and attain and maintain their optimal level of health (Gull, 1987; Innes & Ciliska, 1985; Johnson, 1983; Pender, 1987; Redman, 1978, 1981; Searl, Hughes, & Majumdar, 1985; Strauss et al., 1984; Wilson-Barnett, 1985).

The trend of a general increase in the age of the Canadian population (Epp, 1986) is associated with the potential for increased numbers of adult and elderly-adult citizens to seek acute care. Learning through the life cycle necessitates an understanding of learning needs related to life stages as well as approaches to teaching and learning appropriate for each state (Pender, 1987). Adult learning theory (Knowles, 1978; Long, 1983) has received emphasis in nursing literature (Gessner, 1989; Narrow, 1979; Pender, 1987; Shaw, 1981; Pohl, 1978; Redman, 1988; Walsh, 1982). Testing of the appropriateness of the use of adult learning theory in the setting of the acutely ill adult and in particular, the acutely ill elderly-adult is required (Kick, 1989; Luker & Caress, 1989).

Disease differentiated from illness. Illness can be seen as the human experience of loss or dysfunction, whereas disease is a physiologic manifestation (Benner & Wrubel, 1989; Cassel, 1976; Cousins, 1983; Kleinman et al., 1978; Zaner, 1985). Illness can affect disease through a "meaningful climate" of emotional responses (e.g., hopefulness, fear, despair, and denial) just as disease can influence the illness experience through direct impact of physiologic changes (e.g., hunger, fatigue,

paralysis) (Benner & Wrubel, 1989). Essential to the provision of adequate nursing and medical care is an understanding of how the individual interprets their symptoms, how symptoms are noticed, and what they interrupt (Benner & Wrubel, 1989).

Eliciting the patient's "explanatory model of illness" and awareness of the "explanatory model of disease" are identified as important for to the teaching function of nurses and other health-care personnel (Anderson, Nowacek, & Richards, 1988; Bartlett, 1987; Benner & Wrubel, 1989; Holland, 1986; Jenny, 1979; Kleinman et al., 1978; Murphy, 1982; Strauss et al., 1984). The patient's illness model identifies beliefs they hold about their illness, the personal and social meaning attached to their condition, expectations about what will happen to them and what the physician will do, as well as their own therapeutic goals (Kleinman et al., 1978). Kleinman et al. (1978) contend that negotiation between the patient's illness "explanatory model" and the disease "explanatory model" is part of the clinical process. Through comparison of the illness and disease models, major conflicts that may impede clinical management, areas of the disease model requiring clearer exposition to the patient/client and family, and appropriate patient education based on clarification of conflicts related to values and interests rather than educational needs may be identified.

Squires (1980) recommends that data-gathering sessions such as patient interviews and participant observation, be conducted as the first stage of patient education program planning. These sessions would result in a more naturalistic view of the patient, that is, an in-depth understanding of the patient's experience with coping with the disease.

These data would also enrich program planning as well as bring into focus the complexity of patients' specific situations.

Perspectives of and Influences on Teaching in Nursing

Various perspectives of teaching and of health care delivery as well as societal trends have influenced patient and client teaching within nursing.

Educational perspective. The nursing literature, particularly that from the United States during the past three decades, documents that the educational perspective has dominated nursing's understanding of and approach to its teaching function (Benbow Plewes, 1984; Close, 1988; Cohen, 1981; Coutts & Hardy, 1985; Narrow, 1979; Rankin & Duffy, 1983; Pohl, 1965, 1978; Redman, 1971, 1978, 1988; Stanton, 1985; Wilson-Barnett, 1985). This perspective views teaching as structured, and to a lesser extent informal activities, based on educational principles such as setting of learning objectives, choice of teaching method, and evaluation of change in learner behaviour and teacher effectiveness. From this perspective, teaching is generally seen as being conducted according to the steps of the nursing process: assessment, planning, implementation, and evaluation.

Some authors and proponents of the educational model for patient teaching write that nurses do not fully utilize this model due to lack of knowledge of and/or comfort with its use (Benbow Plewis, 1984; Doak, Doak, & Root, 1985; Redman, 1975); others contend that it may not be an adequate or appropriate model given nurses' teaching function relative to the hospitalized patient and the realities of clinical practice in the acute care setting (Benner, 1982, 1984a; Johnson, 1984; Palm, 1971; Ruzicki,

1989; J.P. Smith, 1979; Strauss et al., 1984).

While the linear nursing process model may be useful for describing how nursing should be performed, it has been criticized as deficient in accurately describing how nursing is actually performed (Benner, 1984a; Benner & Wrubel, 1982; Lundh, Soder, & Waerness, 1988). Given the context within which acute care nurses work, Luker and Caress (1989) question how, in actual clinical practice, the nursing process is related to patient teaching. In a study of patient teaching in two Canadian hospitals, unexpected discharge and lack of control over when discharge would occur were identified by nurses as two major factors influencing their patient teaching efforts (Tilley, 1985). Even the best assessment, planning, and intervention for patient teaching by nurses can be thwarted by the patient discharge that is unexpected, or early in terms of patient learning.

Further, description of activities such as information giving, counselling, self care, health promotion, and promotion of adaptation and coping, indicate that nursing's teaching function may be more global than that described by the educational perspective (Bartlett, 1985a; Coutts & Hardy, 1985; Gottlieb & Rowat, 1987; Pender, 1987; Rovers, 1987; Wilson-Barnett, 1988; Wilson-Barnett & Osborne, 1983).

Biomedical perspective. Historically, this perspective has had a significant impact on the content of and approach to nurses' teaching. From this perspective, information giving regarding normal anatomy, pathology, and the disease process is common, with emphasis placed on treatment regimen description. The expectation is that when information is provided, patient compliance with therapy will result (Johnson, 1984; Linde & Janz, 1979; Lowe, 1970; Norris, 1982; Wilson-Barnett & Osborne,

1983). The assumption that knowledge results in compliance, as in the biomedical perspective, or changed behaviour, as in the educational perspective, has not been consistently supported by research (Bartlett, 1985b; Becker, Drachman & Kirscht, 1974; Cohen, 1981; Pratt, 1971; Wilson-Barnett & Osborne, 1983).

Nursing's adoption of the medical model is problematic because it does not serve nursing's purpose; it neglects nursing's view of the patient as a unique human being experiencing an illness, and the environment as significant in the care of the sick and the well (Baron, 1985; Benner & Wrubel, 1989; Meleis, 1985; Norris, 1982; Redman, 1988).

The appropriateness of teaching toward the outcome of patient compliance has been questioned (Aiken, 1970; Brody, 1980; Flaherty, 1985; Levine, 1970; Murphy, 1982; Redman, 1988; Rovers, 1987). Nurses' teaching for compliance can be seen as incongruent with nurses' view of the patient as well as with the patient-nurse relationship (Curtin, 1982; Flaherty, 1985; Storch, 1982). Curtin (1982) asserts that nurses view patients in "their wholeness--their completeness as human beings" (p. 86). The patient-nurse relationship is seen as being founded on the shared humanity of the patient and nurse (Curtin, 1982). Nurses' philosophy of care is one of "human advocacy" with the nurse attending to the patient's need for information, respect, participation, and access to health care, predicated on the nurse's view of the patient as a fellow human being worthy of respect (Curtin, 1982). Flaherty (1985) contends that the patient-professional relationship has the potential to provide a medium for the enhancement of patient autonomy. Cassell (cited in Flaherty, 1985) contends that success in the preservation of autonomy is achieved when

the patient requiring ongoing care manages with the least possible interference from their illness and treatment regimen.

Rather than teaching for the outcome of compliance, Aiken (1970) writes that viewing the goal of teaching in terms of assisting patients solve their own problems defines nurses' teaching function as a continuous process of helping patients cope with difficulties in their environment. Rovers (1987) suggests that in many teaching situations the most appropriate strategy is to provide patients with reasonable choices and assist them to judge decision alternatives. Flaherty (1985) affirmatively states that nurses of today "perceive themselves as advocates for patients and devote considerable effort to recognizing and upholding patients' rights to be involved in decisions about plans for their care and therapeutic regimes and to refuse prescribed treatment if, after they have been informed about possible consequences, they prefer not to be treated in particular ways" (p. 97).

Health promotion perspective. While some nursing authors see health promotion as an activity different from health education and aimed at the well population (Pender, 1987), others see it as a philosophical component of nursing's teaching function wherever it is practiced, irrespective of the health status of the client (Flynn & Giffin, 1984; Gottlieb & Rowat, 1987; Innes & Ciliska, 1985; Maher, 1987; Narrow, 1979; Rovers, 1987). Determining how health promotion can and should be defined as well as approached within the acute care setting, presents a new challenge to the understanding and practice of nurses' teaching function in that setting (Rovers, 1987).

Self-care, self-help, and wellness perspectives. Evident in the

American literature are nursing responses (Clark, 1986; Redman, 1975, 1988; Stanton, 1983) to changes in the American population's understanding of their rights regarding health information (American Hospital Association, 1972), and their role in their care and its outcome as evidenced by the rise of the self-care, consumerism, and wellness movements (Levin, 1978; McClary, Zahrt, Montgomery, Walker, & Petry, 1985). Before Canadian nurses, practicing in a different society and a different health care system, adopt approaches to patient teaching based on responses to American societal change, a thoughtful analysis of the stimulus for those approaches, their relevance to Canadian society and health care system, and their impact on the outcome of patient care is indicated.

Motivation for the American self-care and self-help movements have been described as the desire for the knowledge and skill necessary to take control of one's health and the view that one has the right, responsibility and capability to accomplish that goal, as well as reaction to the medicalization of health and health care (Levin, 1978; Redman, 1988). Defence against the high cost of using the privately-funded American health-care system must surely also act as a powerful motivator to these movements.

Violations of human rights, most often unintentional but occasionally intentional, occur in today's health-care system (Storch, 1982). These violations have the potential to motivate charges of dehumanized and depersonalized care to be levelled against health professionals and the health-care system generally (Storch, 1982). This has implications for the learner-teacher relationship, as well as for the content of teaching. For

example, litigative trends, particularly evident in the American literature, have the potential to change the nature of the patient-health professional relationship from one based on trust to one characterised by a defensive posture. Also, the potential exists for the increasing rationalization of both the teaching role and content taught, through the requirement for written professional standards and Acts legislating professional practice (Redman, 1988). Storch (1982) contends that a first step in avoiding these human-rights violations is for health professionals to develop awareness and understanding of the issues involved in patients' rights. This awareness and understanding can assist definition of the patient-professional relationship in such a way that it forms the cornerstone of humanized care.

The Consumers' Association of Canada published the resolution entitled Consumer Rights in Health Care (Canadian Consumers' Society, 1974). This four-point charter states that the consumer has the right: (a) to be informed, (b) to be respected, (c) to participate in decision-making affecting his or her health, and (d) to equal access to health care. This resolution was endorsed by the CNA (Mussallem, 1985).

In 1981, the CNA documented its recognition of the responsibility of the nursing profession to see that patient/clients rights are respected and protected by publishing the following position Statement on Consumer Rights in Health Care (CNA, 1981):

> All individuals, sick or well, have the right to be informed, the right to privacy, the right to be respected as individuals, the right to participate in decisions affecting their health.
> The Canadian Nurses Association believes that health professionals must commit themselves to respect and protect the health care rights of consumers. Nurses must speak both as individuals and as a group to identify and correct violations of these rights.

Viewing the person who seeks health care as consumer or patient/client has implications for the nature of the relationship between that person and the health-care professional. The nature of the social relationship between health-care professionals and their clients has been described as evolving from client-practitioner to consumer-provider, merely by the change in perspective initiated by the use of the term "consumer" rather than "patient/client" (Reeder, 1979). Many authors caution against substituting the term "consumers" for "patient/client," with some arguing that the former term detracts from the human and healing aspects of the health-care system, focusing instead on the more technical aspects (Storch, 1982).

Teaching Within the Acute Care Setting: Review of Research Literature

Although much confusion exists regarding terminology, in the nursing literature, the term "patient teaching" usually refers to teaching of the hospitalized individual and generally includes teaching of their family or significant others (Coutts & Hardy, 1985; Narrow, 1978; Pohl, 1979).

From the extensive nursing literature regarding nurses' patient teaching function, several research studies were selected for this literature review (Ackerman, Partridge, & Kalmer, 1981; Benner, 1984a; Brykczynski, 1985; Field, 1983; Gleit & Graham, 1984; Lee & Garvey, 1978; Lindeman, 1975; Lindeman & Van Aernam, 1971; Luker & Box, 1986; Palm, 1971; Pohl, 1965; Tilley, 1985). Each study makes a salient contribution to the understanding of nurses' patient teaching function within the acute care setting, and to how that function has been studied.

Pohl (1965). Pohl's (1965) landmark study entitled Teaching Activities of the Nursing Practitioner, was published as her dissertation

work toward a Doctorate of Education at Teachers College, Columbia University. Pohl's (1965) conceptualization of teaching as well as the teaching function in nursing from and "education perspective" can be seen as being influenced by her work at Teachers College as well as by the ANA study of the functions, standards, and qualifications of nurses being conducted around the time of Pohl's research. While teaching had been included as a function of every nursing practitioner by the ANA, clarification of that teaching function was required (Pohl, 1965). Pohl (1965) investigated the teaching activities of American nurses providing direct patient care in an attempt to: clarify nurses' teaching function, examine the scope of that function, and identify the basic nursing preparation required for that function. Fifteen hundred nurses practicing throughout the United States in the fields of private duty, general duty, public health, occupational health, and office nursing were surveyed by a mailed questionnaire.

Since it was anticipated that respondents might demonstrate a wide variance in their interpretation of their teaching function, it seemed important that teaching should be defined in the questionnaire. However, since one of the purposes of the study was to explore the practitioners' concept of their teaching function, stating the researcher's definition of teaching also presented a problem. To resolve this situation, two forms of the questionnaire were used. Half the study sample received a questionnaire with no definition of teaching, while the other half received a questionnaire stating the researcher's definition of teaching, making it possible to both obtain reaction to the researcher-stated definition of teaching, and to compare overall responses to the

questionnaire of those participants who had received the definition with those who had not. To address content validity, the questionnaire was reviewed by a panel of ten experts, each with expertise in one or more of the five nursing practice fields sampled in the study. The revised questionnaire was then pre-tested with fifty practicing nurses, ten from each of the five fields of practice. The final questionnaire revision was based on the pre-test respondents' answers and their comments regarding content and format of the questionnaire. Pohl (1965) acknowledges that study findings and conclusions were based on self-reporting of the respondent's teaching activities.

Most respondents felt that teaching is a responsibility of every nursing practitioner, that they enjoy and want to teach, and that teaching is as important as other aspects of their work. The majority of respondents expressed dissatisfaction with the quality of their teaching, and more respondents expressed dissatisfaction than satisfaction with the quantity of their teaching. Obstacles to teaching most frequently identified were: (a) inadequate preparation for teaching, (b) lack of time, (c) heavy work load and (d) inadequate staffing. To improve their preparation for teaching, Pohl (1965) states that subjects most frequently identified a course in teaching in basic nursing programs, and the need for education beyond the basic program. Suggesting how practitioners could better utilize their time, Pohl (1965) suggests that much of nurse's teaching can be done during the provision of nursing care, and that if nurses believe they must wait for teaching time free from other nursing duties, they may miss many teaching opportunities.

Two aspects of Pohl's (1965) over-all study findings have broad

implications for the development of nurses' teaching role: the nursing respondent's lack of clarity concerning the concept of teaching, and their feeling of a marked lack of preparation to fulfill their teaching function. Pohl (1965) contends that it is essential that nursing practitioners understand both the scope and the limitations of their teaching responsibilities. Pohl (1978) offered the following research-derived definition of the teaching function in nursing:

> ...the sum of all the activities by which the nurse helps the learner to understand and apply knowledge about health and illness. The term includes informal teaching as well as more structured activities (p. 2).

Based on her research findings, Pohl published the text The Teaching Function of the Nursing Practitioner (Pohl, 1978) to provide an educational resource for teaching in nursing. The text is written from the "education perspective" previously described in this review with material on the nursing process and its relationship to health teaching introduced in the third edition of the text.

Lindeman and Van Aernam (1971). These authors published a practice-based investigation comparing the effect of structured and unstructured preoperative teaching of deep breathing, coughing and bed exercises (surgical "stir-up routine") on: postoperative ventilatory function, length of hospital stay and postoperative analgesia requirements. A static group pretest-posttest design was chosen to avoid the potential confounding effect of having the same nursing practice group administer unstructured teaching to the control group while simultaneously administering structured teaching to the experimental group. Surgical patients admitted to the hospital from May 24 to June 18, 1970 (N=135), who met the study inclusion criteria, and who received unstructured

preoperative teaching comprised the control group. Unstructured preoperative teaching was defined as each registered nurse teaching what, when and how they thought was adequate and correct for their patient. The experimental group was comprised of surgical patients admitted from November 1 through 27, 1970 (N=126), who met the inclusion criteria, and who received structured preoperative teaching. This teaching consisted of registered nurses implementing a teaching approach standardized for content and method incorporating a "Sound-on-Slide" audio-visual presentation, a return demonstration by each patient, and a pamphlet explaining the instructions. Implementation of this teaching was preceded by the writing of a descriptive, effective stir-up regime procedure, and the conduct of a staff development program for all nursing personnel involved in the study.

The investigators found that: (a) the ability of subjects to deep breathe and cough postoperatively was significantly improved when structured preoperative teaching was used, (b) mean length of hospital stay was significantly reduced with structured preoperative teaching, and (c) no significant difference was found in postoperative analgesia use between control and experimental groups.

Regarding the finding of the effect of structured teaching on mean length of hospital stay, the researchers comment that because the difference was so large, it is difficult to attribute the finding solely to improved preoperative preparation and that perhaps other extraneous factors were operating. Lindeman and Van Aernam (1971) suggest that length of hospital stay and incidence of respiratory and circulatory complications be evaluated over a longer period of time in another study.

Regarding the finding referable to postoperative analgesia use, the researchers postulate that the insignificant findings may be attributable to the pattern of analgesia ordering by physicians in the study setting, and that further testing using a different research setting or a dependent variable is necessary as it is possible that structured preoperative teaching does decrease the patients need for postoperative analgesia. However, the value of structured preoperative instruction is clearly supported by this study. Further, nurses in this setting, teaching this content reported that the structured preoperative teaching approach was more effective, less difficult, less frustrating, more rewarding and required less time. Patient reaction to structured preoperative teaching was also positive. Patients reported that they felt they not only learned but could participate in their own recovery. In addition to the actual knowledge and skills gained by the patient, one wonders if the actual teaching relationship associated with the development and implementation of the structured teaching approach may have influenced the positive postoperative outcomes. For example, through the structured teaching approach, was a patient-nurse relationship established that enabled mutual commitment to and active participation in the goal of postoperative recovery?

This study has significance for nursing science and practice for several reasons in addition to the study findings. The idea for the study arose from practice-based questions posed by nurses practicing in the study setting. Expertise in research required to establish and carry out the study was provided by the hospital-based director of nursing research. The research itself involved the study of a nursing intervention carried

out by nurses within the context of their clinical setting.

Palm (1971). Palm (1971) conducted a study to determine if nurses give top priority to patient teaching over other aspects of nursing care during direct patient care. Two assumptions, arising from Palm's perspective as a Clinical Nurse Specialist, underpinned her study (Palm, 1971): before effective patient teaching in the clinical area can be expected, practicing nurses must assign top priority to that teaching; and incidental, informal patient contacts offer the greatest patient teaching opportunity for nurses. The study sample was comprised of 151 registered nurses who gave direct patient care in the medical-surgical areas of a large, private, general hospital in the American midwest. The research instrument consisted of 22 written vignettes of non-emergency situations of direct nursing care. The instrument had a reliability coefficient of 0.76. Although Palm (1971) states that validity was determined, she does not describe how that was done. Even though the vignettes were grounded in clinical practice and developed by a clinical expert, it must be noted that the instrument required nurses to exercise context-stripped clinical decision making.

Fifty-nine percent of the subjects assigned top priority to the patient education response. Nurses without a college education assigned significantly higher priority to patient education than nurses with higher education, a finding in conflict with that of Pohl (1965). No significant relationship was found between the priority nurses assigned to patient teaching and their unit of assignment, shift worked, professional journal reading habits, year of graduation (although older graduates tended to give top priority to teaching), years of nursing experience, or full- or

part-time employment (Palm, 1971).

Common factors in the vignettes were compared to determine those that enabled nurses to recognize patients' learning needs and utilize opportunities for patient teaching. An important finding was that when patients overtly expressed a learning need, nurses both recognized the need and initiated teaching. However, when the patient did not overtly express a learning need, nurses did not conduct patient teaching. Another interesting finding was that nurses tended to select teaching responses that explained care given to the patient but not those responses explaining changes resulting from surgery or preparing patients for self-care at home. Patient gender and classification of the health problem did not seem to influence nurses' teaching.

Palm (1971) suggests that nurses need to develop skill in identifying learning needs in addition to those overtly expressed by patients, and to appreciate that learning opportunities for both the patient and their family present themselves during informal contacts throughout aspects of daily nursing care. She challenged nursing educators by asking if they can properly prepare students to teach patients without preparing them to recognize patient learning needs and to identify informal teaching opportunities at the patient's bedside.

Lindeman (1975). Under the direction of Lindeman (1975), the Western Interstate Commission for Higher Education's [WICHE] Regional Program for Nursing Research Development conducted an national study to determine clinical nursing research priorities in the United States. The Delphi technique, was used to survey 433 experts (419 nurses and 14 nonurses knowledgeable about nursing practice and possessing an appreciation for

research). Four Delphi survey rounds were completed by 341 of these experts. The survey focused on three questions: "1) Is this an area in which nursing should assume primary research responsibility? 2) How important is research on this topic for the profession of nursing? 3) What is the likelihood of change in patient welfare because of research on the topic?" (Lindeman, 1975, p. 434).

The survey found that the majority of research areas identified in the questionnaire derived from the first round are areas that nursing should take research leadership in. Further, Lindeman (1975) found that despite some overlap, priorities for professional significance and social or patient welfare relevance are different. Regarding professional significance, highest priority was afforded to items concerning measuring the quality of care, role, nursing process, and the research process. Regarding patient welfare, several programs of research were identified in the items ranked in the top ten percent including patient education, nursing interventions related to stress, care of the aged, and pain. This innovative approach to research served to highlight the importance of a patient education research program for American clinical nursing research.

Also applying the Delphi technique, Dennis, Howes and Zelauskas (1989), surveyed 715 nurses within one American hospital's nursing department, to determine their nursing research priorities which could subsequently focus the development of a nursing research program within that institution. Clinical priorities determined included: patient education, prevention and treatment of pressure sores, pain management, and treatment of nosocomial infections.

Ackerman, Partridge and Kalmer (1981). As the first phase of the

Health Education Curriculum Development Project (HECDP), funded by the W.K. Kellogg Foundation and initiated by Johns Hopkins University, Ackerman et al. (1981) studied the role of baccalaureate education in the preparation of nurses to fulfill their role as health educators. This phase involved two parts, an extensive literature review and a survey of 266 NLN-approved baccalaureate schools of nursing.

Approximately 900 nursing and health education articles were reviewed to obtain a description of currently reported teaching activities of practicing nurses as well as the processes, skill and knowledge required to integrate health education into nursing practice. This review revealed that less than 20% of the articles were research-based, with most articles being either philosophical in nature, or descriptive of nurses' teaching activities. The two most commonly documented educational target groups were adults requiring medical or surgical interventions and women with maternal and child health concerns. Major educational goals identified by nurses were illness prevention and rehabilitation facilitation. Nurses most frequently reported practicing health education in the settings of the hospital or the outpatient departments. Rather than functioning as part of a multi-disciplinary team, the nurse was most commonly identified as the primary or only educator. Nearly half of the 900 articles were devoted to implementation of health education activities. Health education assessment and evaluation received more emphasis than planning. Minimally documented in the literature reviewed were the topics of behaviour modification, demonstrations, mass media, and community organization.

Following this extensive literature review, 266 NLN-accredited American baccalaureate nursing programs were surveyed with the goals of

determining the extent of incorporation of health education content into baccalaureate nursing curricula and obtaining curriculum information from programs giving evidence of health education content. Two assumptions underlying the HECDP that influenced the survey and the interpretation of its findings were: "1) nurses have a pivotal role in helping people learn to deal effectively with real and potential health problems; and 2) health education must be planned and systematically implemented" (Ackerman et al, 1981, p. 38). The project's operationalization of these assumptions are seen as congruent with the "education perspective" previously described in this review.

A striking finding among the 207 responding schools was the minimal attention paid by baccalaureate nursing curricula to the content, process and competence necessary to conduct health education. Not only does this finding have obvious implications for the adequacy of nurses' preparation to carry out their teaching function, it also has implications for how nurses conceptualize that function.

As part of the HECDP, Ackerman et al. (1981) surveyed the views of 390 practicing nurses and 53 nurse administrators employed in two hospitals and two public health settings regarding health education activities as a function of nursing. Health education was generally valued by both groups. Interestingly, they identified the practice setting (work conditions and job-related interactions) as having greater influence on their teaching activities than their attitudes or level of educational preparation.

Gleit and Graham (1984). Also interested in how nurses are educated to carry out their teaching role, Gleit and Graham (1984) conducted a study to determine patient teaching content and types of assigned readings used

in baccalaureate nursing programs. In Gleit and Grahams' (1984) view, education for nurses' teaching role involves the key concepts of: learning theories, principles of teaching, teaching role of the nurse, health belief model, relationship of values to teaching, relationship of self-concept to teaching, responsibility of client for meeting learning needs. These key concepts are congruent with the "education perspective". Exposure to reading resources supportive of that concept of nurses' teaching role is posited as important to the internalization of that role. These assumptions can be seen as driving this study as well as interpreting its findings and should be born in mind when thinking about what this study has to contribute to the conceptualization of the teaching function in nursing and the educational preparation for that function.

A questionnaire was sent to 108 randomly selected schools of nursing across the United States. Of the 12 items comprising this questionnaire, two are discussed in Gleit and Grahams' (1984) research report. Findings from the 90 usable responses indicated that although most schools reported that they included key teaching concepts in their curricula, evidence of assigned readings to provide the content was not reported. In fact, less than one half of the nursing programs reported the use of resources including the actual role and functions of nurses as health teachers. In the researchers' view, teaching based on exposure to general and specialty nursing textbooks often results in teaching as telling, information dispensing, or skill demonstration, rather than "learning in the affective domain, such as consciousness raising or changing attitudes about health behaviour, a higher level of the cognitive domain" (Gleit & Graham, 1984, p. 27).

Field (1983). Reporting on her doctoral dissertation work, Field (1983) presents research findings and methodological considerations of particular relevance to this literature review. Based on the assumption that practice, the core of any profession, must be studied within the contextual setting it occurs, Field (1983) utilized ethnography as the research approach to describe four nurse's perspectives of nursing. The social psychology framework of symbolic interaction in the tradition of Becker, Geer, Hughes and Strauss (cited in Field, 1983), and Blumer (cited in Field, 1983) formed the conceptual framework for the study. Four public health nurses, working in a western Canadian urban community setting, volunteered to be study subjects. Field (1983) conducted the ethnography over five months, utilizing participant-observation, formal and informal interviews, client records, and clinic reports to collect data.

Field (1983) found that each of the four nurses held unique models of nursing that guided her practice. The most significant factor influencing the model of nursing developed by each nurse seemed to be the values each nurse held regarding her own lifestyle and experiences (Field, 1983).

The influence of each nurse's model of nursing on her understanding and conduct of patient teaching is evident. For example, describing one of the nurse's model, Field (1983) writes:

> Kate saw herself as giving priority to those things that interested her outside of nursing. When she approached clients she did so in the belief that they would give priority to the things that interested them, so she looked for needs which the client identified as the priority. Her hospital experience (in a cardiovascular unit) had made her believe that prevention of illness was important. Her concern with exercise and nutrition as a means of illness prevention became evident in her work in the schools, which again reflected her own personal interest in nutrition and involvement in athletic activities.

Methodological considerations of particular interest in Field's (1983)

report include: (a) her contention that nursing practice is central to the profession of nursing and must be studied within its contextual setting, (b) her discussion of the method of ethnography and her description of its utilization in her study of nursing practice, and (c) her analysis of the strengths and limitations of the ethnographic approach for nursing research.

Benner (1984a). Particularly relevant to this literature review is the work of Benner (1984a) who, in her context-based interpretive study of nursing practice, described the "teaching-coaching function" as one of the domains of nursing. Benner's (1984a) work came out of the Achieving Methods of Intra-Professional Consensus, Assessment, and Evaluation (AMICAE) project, an American, federally funded project to develop methods of evaluation for seven schools of nursing and five hospitals in the San Francisco Bay Area.

Benner (1984a), contends that what is missing from the study of nursing practice is the study of the knowledge embedded in clinical nursing practice, that is, what nurses learn from their clinical practice. Theoretical nursing knowledge is differentiated from clinical or experiential knowledge:

> Experience, ...is the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory. Theory offers what can be made explicit and formalized, but clinical practice is always more complex and presents many more realities than can be captured by theory alone (Benner, 1984a, p. 36).

Since the clinician's knowledge is embedded in perceptions rather than precepts; clinical nursing knowledge must therefore be studied in the context within which it occurs.

Applying the Dreyfus Model of Skill Acquisition, Benner (1984a)

identified and described five levels of competency in clinical nursing practice. These levels are: novice, advanced beginner, competent, proficient, and expert. The level at which an individual functions is dependent on the experience with the situation in which the behaviour is demonstrated. That is, a nurse may function as an expert in her usual setting, but as a novice in an unfamiliar one.

Interviews with and participant-observation of over 1200 novice and expert nurses (Benner, 1984a, p. xxv) were used to collect data about nurses' clinical knowledge embedded within the context of their clinical practice. These data were analyzed using an interpretative strategy based on Heideggerian phenomenology.

Thirty-one competencies emerged from the analysis that were then classified into seven domains, one of which was the teaching-coaching function. Other domains include the helping role, the diagnostic and patient-monitoring function, effective management of rapidly changing situations, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices and organizational and work-role competencies.

Brykczynski (1985). Brykczynski (1985) expanded Benner's work by using the domains of nursing as a model to study the knowledge embedded in the clinical practice of Nurse Practitioners working in Ambulatory Care settings.

Teaching is seen by Benner (1984a) and Brykczynski (1985) as fundamental to nursing practice and therefore is a critical domain to be researched within the context in which it is carried out and in which it is influenced.

Tilley (1985). Perceptions of patients and nurses in two Canadian hospital settings concerning the nurses's role in patient education were studied by Tilley (1985). The convenience sample comprised thirty-eight matched nurse-patient dyads, 23 dyads from Hospital 1 and 15 dyads from Hospital 2. All 38 nurses in the sample were full-time staff nurses. Of the 26 patients in the sample, 23 had the diagnosis of acute myocardial infarction while three had the diagnosis of a respiratory disease. The two study settings differed both in organization and in structural context of patient education delivery. Hospital 1 setting was a 38-bed cardiology unit where patients had homogeneous diagnoses, and where resource personnel and materials were available to assist nurses to integrate patient teaching into their daily work. Hospital 2 was a 36-bed general medical ward where nurses had to organize and deliver patient teaching to a diverse patient population and without the available resources to support that effort. Two instruments, a Nurse Questionnaire and a Patient Interview Schedule, were developed and pilot-tested by the primary investigator. Evidence of content validity of the instruments is provided.

Tilley (1985) found nurses' and patients' perceptions of the nurse's patient education role to be incongruent. Results point to the need for nurses to develop a clear definition of their role in patient education, to validate patients' wishes for teaching, and to examine organizational factors influencing nurses conduct of their patient teaching role. Regarding nurses' patient teaching role, Tilley (1985) suggests that nurses' "coaching" function in helping patients cope with illness, as described by Benner (1984a), be refined. Also suggested is clarification of nurses' role in assisting patients obtain information they desire from

other health care team members, including assisting patients to identify the information they would like to learn from other team members and how to formulate questions that enable obtaining that information. Tilley (1985) points out the importance of nurses validation of patient preference regarding educational approach (e.g. group or individual teaching), timing of teaching, and type of information the patient can deal with during various stages of illness and recovery. Regarding the contextual influences on nurses' patient teaching activities, Tilley (1985) suggests that both structural and organizational characteristics of the setting be considered for their effect on teaching activities and outcome.

Luker and Box (1986). These British nurse-researchers utilized participant observation on two British Nightingale-style nursing wards to study registered nurses' responses to teaching end-stage renal patients to manage life on Continuous Ambulatory Peritoneal Dialysis (CAPD). Additional data were collected from observations at the setting's out-patient clinic and at multi-disciplinary CAPD meetings. Underlying this study was the assumption that opinions held by nurses regarding CAPD treatment might, over time, have an influence on this treatment and patients' response to it.

Findings indicated that the most influential factors governing how nurses in this study responded to patients treated with CAPD were the type of patient selected for the treatment and the ward workload. Rather than being seen as individuals, patients in this study comprised part of the ward collective with nurses having to priorize competing demands on their time exerted by the members of that collective. Since patients receiving

CAPD treatment and its associated teaching requirements, were seen as causing additional work, these patients and their teaching needs were less likely to be viewed enthusiastically by the nurses.

This study offers valuable insight into the notion that contextual factors influence the structure, process, and outcome of patient teaching, as well as offers support for the use of participant observation as a useful method to study nurses' teaching function.

Teaching Specific to Individuals Hospitalized With Chronic Obstructive Pulmonary Disease or Myocardial Infarction

Rehabilitation, or restoring the individual to their optimal level of health within the constraints of their disability (American Thoracic Society [ATS], 1981), is commonly identified as the goal of care and teaching for hospitalized individuals with COPD (ATS, 1981; Davido, 1981) and with MI (Bcogaard, 1984; Greenland & Chu, 1988; Provikoff, 1983; Raleigh & Odtohan, 1987). Redman (1988) outlines the following assumptions underlying the concept of rehabilitation:

> 1. There is no cure.
> 2. The patient is not a passive recipient; maximum success depends on client initiative.
> 3. Rehabilitation does not focus on the pathological processes but on modification of patient behavior to increase functional capacities and performance in the presence of infrequently modifiable pathologic processes (p. 11-12).

The approach to and content of teaching is dependent on the stage of illness during hospitalization (Pravikoff, 1983; Wilson-Barnett, 1983) and readiness to learn (Moynihan, 1984; Rovers, 1987). Wilson-Barnett (1988) found considerable evidence to support the effectiveness of a more interactive and counselling-based teaching approach in assisting patients cope with infirmity and chronic illness. Content taught to both groups of

patients is described as specific to understanding and managing specific aspects of their therapy as well as patient and family adaptation to chronic illness and health maintenance (Briody, 1984; Fletcher, 1987; Gaglione, 1984; Howard, Davies, & Roghmann, 1987; Keeling, 1988; Pinneo, 1984; Stanley, 1978; Taylor, 1986; Tilley, Gregor, Thiessen, 1986; Traver, 1975).

Because rehabilitation is often continued in the community, the importance of linking the patient with community teaching and health-care resources is identified (Caffarella, 1984; McGinty, Chase, & Mercer, 1988; Pravikoff, 1983; L.M. Smith, 1979; Steele & Ruzicki, 1987; Wilson-Barnett, 1988). Wilson-Barnett (1988), in fact, is emphatic that continuity of care be valued in the acute care setting. She contends that only when a small group of nurses are consistently assigned to the same group of patients can the potential for continuity of care be maximized. Further, Wilson-Barnett (1988) contends that ward nurses see "their patients" as out-patients as only then can those nurses really learn about recovery events as well as the effects of their teaching.

Summary of Literature Review

Teaching is seen by the nursing profession as well as by individual practicing nurses as an important and valued nursing function for which adequate preparation is both desired and required.

Justification for further research in the area of nurses' teaching function exists based on this review of practice-based and selected research literature. Particularly indicated is research that would clarify the conceptualization of nurses' teaching within actual nursing practice. Evidence exists that the long-dominant educational perspective of and the

medical model influence on nurses' teaching function, may not be appropriate to the actual practice of teaching within nursing. A view of a "teaching-coaching function" has been described (Benner, 1984a; Brykczynski, 1985) with the suggestion that this view merits further study (Tilley, 1985).

Further, teaching is clearly influenced by the context within which it is conducted. Teaching, like nursing is relational, and therefore cannot be adequately described by research strategies that omit context and content of nursing and teaching functions (Benner, 1984a; Field, 1983). Review of research literature reveals evidence that interviews and participant observation can provide a useful approach to the context-based study of nurses' teaching function (Benner, 1984a; Brykczynski, 1985; Field, 1983; Luker & Box, 1986). Interpretive or hermeneutical phenomenology has been useful in the exploration and description of the lived experience of practicing nurses, including their teaching-coaching function (Benner, 1984a; Brykczynski, 1985).

Conceptual Framework

The teaching-coaching domain of nursing described by Benner (1984a) provided the conceptual framework for this study. It is appropriate because Benner's (1984a) description of the teaching-coaching function was derived from research using an interpretive methodology to discover and describe clinical nursing knowledge from the perspective of its practitioners. That study is congruent with the method and purpose of this study.

Benner (1984a) contends that looking only at information giving and formally planned teaching sessions, oversimplifies nursing's teaching

function. The more significant patient learning lies in coping with illness and mobilizing for recovery. In teaching to facilitate that learning, nurses offer not only information but "ways of being, ways of coping, and even new possibilities for the patient by means of the perspectives and the practices that are embedded in good nursing care" (Benner, 1984a, p. 78).

Within nursing's teaching-coaching domain, Benner (1984a) identified five "competencies" or components. These include: (a) timing, or the capturing the patient's readiness to learn, (b) helping patients integrate implications of their illness and recovery into their lifestyles, (c) determining the patient's interpretation of their illness, (d) providing an interpretation of the patient's condition and giving a rationale for tests and treatments, and (e) coaching the patient--making approachable and understandable culturally avoided aspects of their illness (Benner, 1984a). The main tasks of the coach include (a) interpreting unfamiliar diagnostic and treatment demands, (b) coaching the patient through alienated stances, (c) identifying changing relevance, and (d) ensuring that cure is enhanced by care (Benner, 1985b).

Four of the competencies described by Benner (1984a) were expanded by Brykczynski (1985) through her study of the clinical practice of Nurse Practitioners in ambulatory care settings. The first competency, timing, was expanded by integrating the notion of motivating the patient to change. The second competency, helping patients integrate the implications of illness and recovery into their lifestyle was expanded by adding "teaching for self care" through helping patients alter their lifestyle to accommodate changing health care needs and capacities. Added to the

competency, determining the patient's interpretation of their illness, was the notion of negotiating agreement concerning how to proceed when priorities of patient and health care provider conflict. For the coaching function, Brykczynski (1985) identified the overall goal of eliciting active patient participation in care.

These competencies are not seen as exhaustive or even comprehensive; rather as requiring further testing, addition and refinement (Benner, 1984a). For this study, the teaching-coaching domain and the competencies described by Benner (1984a) and expanded by Brykczynski (1985) were not used as a rigid approach to collecting or categorizing data but rather as a sensitizing framework from which the study of practicing nurse's understanding of their teaching function could be approached.

Summary

In this chapter, practice-based and selected research literature was reviewed to determine how nurses' teaching function has been defined, described, and studied. From this review, a conceptual or sensitizing framework for this study, was identified (Benner, 1984a; Brykczynski, 1985). The next chapter presents the method of this study.

CHAPTER 3: METHOD

This chapter describes the study method. Interpretive or hermeneutical phenomenology and ethnography are identified and discussed as the specific qualitative research approaches used. The purpose and benefit of a pilot project conducted prior to this study are discussed as is the notion of investigator as instrument. The study setting and sample are described. Then, the procedures and methods of data collection and analysis are discussed. A presentation of ethical considerations underpinning the study concludes the chapter.

Research Approach

Qualitative research methods are acknowledged as appropriate for nursing research (Benner, 1984a, 1984b, 1985a; Field, 1981; Field & Morse, 1985; Leininger, 1985; Melia, 1982; Munhall & Oiler, 1986; Oiler, 1982; Parse, Coyne, & Smith, 1985). A qualitative approach was appropriate for this study because (a) the problem of interest concerned gaining an understanding of nurses' lived experience of their teaching function within the context it occurs, the acute care hospital setting; and (b) the emphasis was on understanding nurses' teaching function from the perspective of the nurses involved (Cobb & Hagemaster, 1987). The specific qualitative approaches used in this study are interpretive or hermeneutical phenomenology and ethnography.

Interpretive or Hermeneutical Phenomenology

The interpretive approach provides the philosophical stance and method of the study. Rooted in the work of Heidegger (1962) and Taylor (1971), and interpreted by Benner (1984a, 1984b, 1985a), Benner and Wrubel (1989), and Dreyfus (1983), the interpretive approach is presented as an

alternative method for the social sciences (Benner, 1985; Dreyfus, 1983; Polkinghorne, 1983; Rabinow & Sullivan, 1979; Taylor, 1985). Supporting the use of the interpretive method in nursing research is evidence of understanding gained through its application to the study of human problems of interest to nurses (Benner, 1984a, 1984b; Brykczynski, 1985; Chelsa, 1988; Schilder, 1986).

Fundamental to hermeneutical phenomenology, is Heidegger's concern with the philosophical question of what it is to be human. In his view, understanding constitutes the way humans are in the world (Polkinghorne, 1983). In this instance, understanding refers to the "comprehension of meaning" (Polkinghorne, 1983, p. 217). Lived meaning, in turn, refers to how personal meanings both come out of and are part of the situation as it experienced by the person (Benner & Wrubel, 1989).

Being-in-the-world is the term Heidegger used to describe "how people are involved in situations through their concerns, skills, and practical activity" (Benner & Wrubel, 1989, p. 407). According to Heidegger, people understand or have an immediate grasp of a situation according to its meaning for them. That is, humans are self-interpreting beings (Benner, 1985; Benner & Wrubel, 1989; Dreyfus, 1983; Taylor, 1971). Several aspects of our humanness make this immediate grasp possible. The phenomenological view of that humanness, of what it is to be a person, includes the aspects of embodied intelligence, background meaning, concern, and the situation.

Embodied intelligence, the first aspect of the phenomenological view of the person, refers to our bodily-way-of-knowing. It implies mind-body unity, differentiated from the mind-body split contended by Husserl, the founder of phenomenology and Heidegger's teacher (Benner & Wrubel, 1989;

Dreyfus, 1983). Included in embodied intelligence are a wide range of capacities from maintaining posture and moving one's body without conscious thought; to habitual, cultural activities such as maintaining appropriate physical distance in social settings; to complex skills such as those of the expert nurse (Benner, 1984a; Benner & Wrubel, 1989).

Embodied intelligence allows people to live in the world with ease and comfort because it provides the person with a nonreflective grasp of a situation according to its meaning for the self (Benner & Wrubel, 1989; Schilder, 1986). What that meaning might be is described in the following discussion of the second and third aspects of the view of humans, background meanings and concern.

Background meaning, according to Heidegger, is what a culture, subculture, and family gives a person from birth (Benner & Wrubel, 1989). It is a way of understanding the world; what is real for the person (Benner, 1985; Benner & Wrubel, 1989; Dreyfus, 1983). Although there is individual variation in how cultural background meanings are taken up, the range of possibilities are determined by each culture. In this way, culture forms both the constraints and possibilities for what it is to be human. As Heidegger asserts, humans are self-interpreting, but this interpretation is based on socialization into a culture (Allen, Diekelmann, & Benner, 1986: Dreyfus, 1983). Taylor (1979) called this situated freedom.

Background meanings cannot be made completely explicit. They can be understood in part, however, by studying how people depict them in their language and actions (Dreyfus, 1983). Like embodied intelligence, background meanings, enable life to proceed smoothly without conscious thought.

The third aspect of what it is to be human involves the notion that things matter to people. Because of this, people become actively involved in the world. Heidegger called this way of being involved, concern (Benner & Wrubel, 1989). Concern is a uniquely human way of being in the world. As Heidegger (1962) argues, both an object and a person can be "in" in a spatial sense. For example, both a chair and a person can be in the room. However, only the person can be "in" in the existential sense, the sense of being involved, such as, being in love. This existential notion of "in", is concern.

Concern also constitutes an essential component of human existence (Dreyfus, 1983) because "although embodied understanding and background meaning can account for how the person can be in the world and grasp meaning directly, concern accounts for why" (Benner & Wrubel, 1989, p. 48). In the phenomenological view of the person, concern is defined qualitatively, in terms of the meaning for the person. Consequently, how concern is lived can be described.

The fourth aspect of the phenomenological view of the person involves the situation, specifically, the context of the situation--its timing, meanings, and intentions (Benner, 1984b). The person brings to the situation: background meaning, embodied intelligence, and concern. Meaning is constituted by the transaction of the person and the situation (Allen et al., 1986). In this way, the person both constitutes and is constituted by the situation (Benner 1985; Benner & Wrubel, 1989).

Embodied, self-interpreting people live in a dynamic real-world context. As this context changes, previously unnoticed background meanings, habitual body understandings, and concern no longer act to

facilitate smooth functioning. Consequently, people become aware of these aspects and reflect on them. This breakdown of smooth functioning is known as stress. One situation that is nearly always associated with this breakdown is illness. It disrupts bodily understanding, background meanings, and concern. As well, the person may find themselves in the unfamiliar and threatening context of a hospital (Benner & Wrubel, 1989).

A second key component of interpretive or hermeneutical phenomenology involves the emphasis on language. According to the Cartesian view of humans held by Husserl, individuals have a subjective representation of their worlds, of objective reality. Therefore, language is restricted to a method of depicting reality (Taylor, 1982). The Heideggerian view of what it is to be human opens new possibilities for understanding human expressions and therefore, meanings (Taylor, 1985).

Taylor (1982) contends that, through language, humans achieve three distinct functions. First, language allows us to formulate things, to bring them into focus and define their boundaries. This facilitates our development of an articulated view of the world. Second, language allows us to put things into public space. This space acts as a common vantage point to bring us together in the act of viewing the world. There are different types of public space, varying from private conversations between two people, to formal, institutional public space such as that of Parliament. Third, language acts as a medium for us to set out our human concerns and the discriminations that define them (Taylor, 1982). In summary, language both "imbues and informs experience. It does not exist apart from thought or perception, for it generates and constrains the human life world" (Munhall, 1989, p. 25). In this study, nurses' language

acted to formulate nurses' experience of their teaching function, to put that function in a public space permitting nurses as participants and investigator as interpreter to view that function from a common vantage point, and to set out their concerns around nurses' teaching function.

A third key component of interpretive or hermeneutical phenomenology involves the view of knowledge. Two types of knowledge are identified: theoretical knowledge, or "knowing that", and practical knowledge, or "knowing how" (Benner, 1984a). Many skills, for example riding a bicycle, are acquired through "know how" without "knowing that". Further, for many common everyday activities, we are unable to provide a theoretical account for our practical knowledge. Benner (1984a) argues that viewing knowledge in this way identifies the possibility that some of our practical knowledge may elude scientific formulations of theoretical knowledge. Further, Benner (1984a) contends that "'know-how' that may challenge or extend current theory can be developed ahead of such scientific formulations. Therefore, knowledge development in an applied discipline consists of extending practical knowledge (know-how) through theory-based scientific investigations and through the charting of the existent 'know-how' developed through clinical experience in the practice of that discipline" (Benner, 1984a, p. 2). Of interest in this research, was the study of existent "know-how" embedded in nurses' clinical practice of their teaching function.

In interpretive or hermeneutical phenomenology, "the task is to uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualized, trivialized, or sentimentalized (Benner, 1985, p. 6). Consequently, this method studies the person in the

situation, that is, in context (Benner, 1985; Dreyfus, 1983). Participants reveal their lived experiences through their language and everyday practices within the context they occur. The investigator, as interpreter, attempts to determine commonalities in meanings, situations, and practices of the participants (Benner, 1985; Benner & Wrubel, 1989). When participants can recognize and validate the interpretation, Benner (1985) contends that the interpreter has been successful. This study explored and described the lived experience of the teaching function of nurses participating in the study, as they carried out that function within the context it occurred.

Ethnography

In the interpretive and cultural anthropological tradition of Geertz (1973, 1979), the second research approach, ethnography, shaped the design of this study. Ethnography was used to collect a "thick description" of nurses' teaching function in the context it was practiced and experienced. The aim was to look beyond the more evident behaviors associated with the practice, to identify underlying meanings and intents.

Assumptions Underpinning the Study

Congruent with a qualitative research approach, the following assumptions underpin this study:

1. Science can be viewed as "a human activity in which the subject as knower is central" (Polkinghorne, 1983, p. 242). Knowledge of a lived experience can become known through the individual's descriptions of the meaning of the reality for them (Smith, 1989).

2. Individuals who share a common cultural and language history have a background of common meanings that allows understanding and interpretation

(Benner, 1984a, 1984b, 1985a).

3. Data cannot be observed from a neutral (value-free and unobtrusive) stance (Taylor, 1982).

4. Nurses have a role in teaching patients.

5. Nurses will openly discuss their understanding of their teaching function referable to their patients.

6. Nurses behaviour during the conduct of their patient teaching role is observable.

Pilot Study

As Burns (1989) contends "to become an effective qualitative researcher, one must serve an apprenticeship or seek mentoring from one experienced in the specific type of qualitative research" (p. 46). Preceding this study, a 64 hour pilot project (Young, 1989) was conducted to gain experience with the ethnographic approach and to study nursing practice within the context of the study setting. As this pilot project formed part of the investigator's Master of Nursing program, it was conducted under the direct supervision and guidance of the investigator's thesis sponsor who also conducts ethnographic and interpretive research in nursing within the setting. In addition to the practical experience gained employing the ethnographic approach, the pilot project offered the investigator an opportunity to clarify and validate observations with a nurse researcher who is knowledgeable and experienced in both the method and the setting utilized in this study.

Further, conduct of the pilot project in the study setting enabled nurses in that setting to become familiar with the ethnographic approach to research as well as with the investigator's style of implementing that

approach. This facilitated nurse participants' comfort with the ethnographic approach, and their candidacy in sharing their understanding of their teaching function during the conduct of the actual study.

Investigator as Instrument

The investigator was known to the nursing and medical staff of this ward as both a colleague and an investigator. During the five years preceding attendance at graduate school, the investigator collaborated with the staff of the study setting in the care of patients with respiratory illness through her role as respiratory nurse clinician. During the year prior to this study, the staff also came to know the investigator as a student researcher during the conduct of the pilot project in the study setting.

Familiarity with the investigator as a clinician as well as with the research approach used in this study facilitated the comfort and candidacy of the participants, rather than contributing to observer bias. Further, the investigator's clinical pre-knowledge enabled data collection and analysis from the position of a culture shared with the nurse participants.

Study Setting

The study was conducted in a 26 bed, acute-care nursing ward of an 800 bed, tertiary care, university-affiliated teaching hospital located in western Canada. The hospital, consistent with its founding religious order, has a strong historical tradition as a "community of service", providing health care that is humanistic, holistic, and caring in orientation; patient and family centered; and responsive to the ever changing health-care needs of the society it serves. The hospital also has

a tradition of respecting the health-care personnel working within its "community". Guiding the present-day enactment of that tradition is the hospital's stated Mission, Aims and Objectives (1980).

The caring philosophy established by the founding order and guided by the hospital's Mission, Aims and Objectives (1980) is congruent with the Nursing Division: Statement of Philosophy (1989). In that statement, nursing is defined as the:

> professionalization of the human capacity to care, expressed through compassionate and trusting relationships; developed from a sound base of knowledge and skill; fostering sensitivity to the ethical and moral in daily activities, and a commitment to fulfill obligations entailed in specific nursing roles. (Nursing Division Statement of Philosophy, 1989, p. 1).

Specifically related to nurses' teaching function, the Statement of Philosophy (1989) asserts:

> We support a patient-centered system of nursing which transcends the limits of institutional boundaries; provides continuing care in hospital, home and community; encourages and facilitates self-care and a family centered approach to treatment; provides education and information to enable patients and families to become partners in their care and to make informed decisions (p. 2).

The study ward is comprised of 13 semi-private patient rooms. Based on the nature of patient needs, bed occupancy, and patient length of stay, the ward was categorized as the hospital's most acute medical nursing unit. Except in rare instances, the ward had 100% bed occupancy. Patients' average length of stay on the ward was 8.2 days. At the extremes of the "average" stay were some patients who stayed a few days, and those who stayed for an extended period, including some whose stay exceeded one year.

The ward's nursing team was comprised of the head nurse (HN), assistant head nurse (AHN), staff nurses (SN), nursing orderlies (NO),

ward clerks (WC), and one nursing aid (NA). The SN group consisted of 19 RNs, 9 full-time and 10 part-time; and 4 LPNs, 1 full-time and 3 part-time. One NA and one NO worked weekday, daytime shifts. One other full-time and two part-time NOs worked on other shifts. One full-time WC was assigned to the weekday, daytime shift. Three part-time WCs were assigned to the evening and weekend shifts.

Staffing during the day shift included four RN's, one LPN, one NA, and one NO. To the extent possible, each nurse's patient assignment was kept the same over the period of consecutive days worked, generally two to four 12-hour shifts for the RNs and three to five 8-hour shifts for the LPNs.

Occasionally, when the nursing staff determined that a patient's nursing care needs would be best met by the approach to providing nursing care known as primary nursing, it was employed as an alternate method of patient assignment. This exemplifies the openness demonstrated by nurses on this ward to adapting their system of nursing care delivery based on assessment of individual patient need, balanced with an assessment of what was reasonable and possible, given the overall ward situation.

Sample

If a qualitative question is asked, Morse (1986) suggests that nonprobability sampling be employed. In qualitative research, adequacy of the sample is determined by the quality, completeness, and amount of information gathered, rather than by sample size (Morse, 1986). For this study, 15 nurse participants and 10 patient participants constituted the convenience sample. In retrospect, a smaller sample size of 10 to 12 nurses, and 5 to 6 patients (provided patients with both diagnoses were represented) would have been sufficient to gather adequate quality,

completeness, and amount of data.

Nurse Participants

Of the nurses, thirteen nurses were SNs who provided direct care, including teaching, for patient participants. The other two nurses were the HN and AHN. They were included in the sample because during the pilot project, they were observed taking an active part in teaching patients as well as in setting and monitoring standards for that teaching.

Nurse participant inclusion criteria were: (a) the nurse was a full- or part-time member of the ward's bedside nursing staff who was assigned to care for a consenting patient during the day-time shift, or the HN or AHN of the study ward; and, (b) the nurse gave consent to participate in the study. Demographic data were collected, providing a description of nurse participants (see Appendix A).

Experience in nursing. Although the sample of nurse participants represented a wide range of years of nursing practice experience (1.25 to 24 years), a reasonably even distribution of experience levels was represented (see Table 1). Since graduation, 12 of 15 nurses reported that they had not taken any extended periods of time away from their practice. Reasons given by the 3 nurses who had done so, related to family and personal obligations rather than dissatisfaction with their nursing experience (see Table 1).

The most common areas of nursing experience since graduation included medical nursing or closely related areas (see Table 1). Five of 15 participants reported that their entire experience since graduation as nurses (ranging from 1.25 to 7.5 years) had been with the study ward.

Table 1

Nurse Participants' Experience In Nursing

Category	Number
Total nursing experience in years	
1 to 5	9
5.1 to 10	3
10.1 to 15	2
15.1 to 20	--
20.1 to 25	1
Interruptions in continuous nursing practice	
No	12
Yes	3
Maternity leave	2
Armed forces service	1
Areas of nursing practice experience	
Study ward	5
Other medical wards	4
Geriatric wards	4
Maternity ward	1
Small rural hospital	1
Community nursing	1

Experience and employment status in the study ward. Length of time nurses worked in the setting ranged from 0.6 years to 13 years (see Table 2). This range was comprised of a fairly evenly balanced distribution of nurses' clinical practice experience levels. In this way, the sample was representative of the total population of nurses working in the setting, reflecting the balance of nurses with more experience and those with less. This experiential level balance was beneficial because the more experienced nurses could care for patients with complex needs while supporting less experienced nurses as they gained the experience necessary to develop the confidence and skills essential to clinical practice. The less experienced nurses, in turn, brought their enthusiasm and new ideas to the clinical setting. The majority of nurse participants worked full-time (see Table 2).

Nursing education. Most participants were diploma-prepared registered nurses, with a small representation of licensed practical nurses, and one baccalaureate-prepared registered nurse (see Table 3). Three nurses reported having additional nursing education courses.

Table 2

Nurse Participants' Length of Experience and Employment Status In Ward

Category	Number
	Experience working in study ward in years
<1	2
1 to 5	8
5.1 to 10	3
10.1 to 15	2
	Current employment status
Full-time	11
Part-time	4

Table 3

Nursing Education

Category of education	Number
Basic nursing education	
Licensed practical nurse	3
Registered nurse-diploma	11
Registered nurse-degree	1
Additional nursing education	
Nurse management courses	2
Allergy and audiometry course	1

Patient Participants

Of the ten patient participants, two patients had the medical diagnosis of COPD while eight had the diagnosis of MI. One patient participated in the study during two admissions to the ward. Originally admitted with the diagnosis of MI, the patient requested that he continue to participate in the study during his readmission for recurrent chest pain.

Patient participant inclusion criteria were (a) the patient was hospitalized with the medical diagnosis of COPD or MI, as documented by

the attending medical staff in the patient's record, (b) the patient spoke and understood English, and (c) the patient gave consent to participate in the study. Demographic data were collected, providing a description of patient participants (see Appendix B).

Patient participants' demographics by admitting diagnosis. The 8 patients admitted with the medical diagnosis of MI ranged in age from 39 to 73 years (see Table 4). Both patients admitted with COPD were in their mid-seventies (see Table 4).

Of the patients admitted with MI, two are female and six are male. One female and one male patient were admitted with COPD.

Employment status of patients at the time of admission with their MI included four who were retired with two of those actively engaged in volunteer activities, one who was a homemaker, three who were employed outside the home (see Table 4). Both patients with COPD were retired (see Table 4). One of these patients was able to manage housekeeping activities while the other was unable to do so.

Three of the ten patients lived alone including one who is single, and two who are widowed (see Table 4). The remaining seven patients lived with their spouse (see Table 4). Of those seven couples, four had teenage or adult children living at home. All patient participants lived in the city where the study hospital is located.

Table 4

Patient Participant's Demographics By Admitting Diagnosis

	Admitting Diagnosis	
Demographic	MI	COPD
	Age in years	
30 to 39	1	--
40 to 49	1	--
50 to 59	1	--
60 to 69	3	--
70 to 79	2	2
	Employment status	
Retired	4	2
Homemaker	1	--
Employed		
Outdoor physical labour	2	--
Supervisor	1	--
	Marital status	
Single	1	--
Married	7	--
Widowed	--	2

Formal education. Despite attention being paid to asking the question, "what was your last formal schooling", in a straight-forward, non-judgmental, and diplomatic manner, nearly all patients were apologetic about what they consistently described as their limited formal education. Many expressed extreme discomfort with their formal school experience. Several related that they felt handicapped throughout their lives because of limited access to formal education, particularly in the advanced grades of school, and definitely in post-secondary education. Others felt uncomfortable with "school-like" settings because it recalled for them, difficult personal experiences especially related to scholastic achievement in school. Consistently, patients related that through learning associated with everyday life, they had successfully made their living and contributed to society, including raising families.

Six patient participants reported formal schooling from grade 8 on (see Table 5). The remaining four patient participants reported "little formal schooling" (see Table 5). Of this group, one participant moved from Europe to South America to Canada, learning two new languages in addition to English. Another participant studied at bible school as an adult and then carried out missionary work for thirty-five years which necessitated living within a new culture and learning a new language. A third participant learned a trade through an apprenticeship system, eventually becoming a supervisor and teacher of others.

Table 5

Patient Participants' Formal Education

	Admitting Diagnosis	
Education	MI	COPD
Little formal schooling	3	1
Grade 8	1	--
Grade 10	1	--
Grade 12	2	1
Community College	1	--

All patients admitted with MI were observed reading various personal reading materials ranging from newspapers, pocketbooks, to pictorial magazines. Reported formal schooling was consistently unrelated to the level of complexity of materials patients were observed reading. Neither patient with COPD was observed reading during the entire data collection period. Family members validated that although both patients had been avid readers in the past, currently the patients found reading physically taxing. Even when they were rested, these patients commented that they found it difficult to concentrate enough to read.

Current hospitalization. All patients with MI were admitted through emergency, transferred to the coronary care or intensive care unit for two to three days, then transferred to the study ward. One patient had been transferred to another medical nursing ward prior to being transferred to the study ward. Both patients with COPD were admitted through emergency and transferred directly to the study ward.

The usual length of stay for patient with MI was 10 to 12 days, with one patient's stay unusually long at four weeks. One of the patient with COPD was hospitalized on the ward for three weeks before being transferred to a surgical ward. The other patient with COPD had been hospitalized on the ward for seven months preceding data collection and remained on the ward after its completion.

Experience with previous hospitalization. All patient participants had previously been hospitalized, with all but three hospitalized within the past ten years. Half of the patients had been previously hospitalized in the study hospital. Four of the 10 patients' previous hospitalizations had been for reasons related to their current condition.

Patient's understanding of their condition at hospitalization. Of the eight patients admitted with MI, six patient's understanding of their present condition corresponded with the nature and severity of the medical diagnosis recorded in the patient's chart. The other two patients understood that there was a problem with their heart, but were awaiting definitive explanation from their physician to specify the nature of that problem. In both cases this information was documented in their chart but had not yet been communicated to the patients.

Of the two patients admitted with COPD, both expressed the understanding that they were hospitalized because of difficulty with their breathing. Congruent with the recorded medical plan, one patient related that because of no longer being able to manage independently at home, it was necessity to remain in hospital until transfer to a long-term care hospital could be arranged. The other patient related the understanding that hospitalization had been necessary because "it got so bad that I couldn't breath anymore. I couldn't even eat". According to the medical record, this patient had a diagnosis of very severe COPD which was exacerbated because of pneumonia. The patient stated that at first the doctors thought home oxygen would be needed but, much to his relief, subsequently decided that would not be necessary.

The patient was confused about upcoming surgery to correct a prostatic problem discovered on admission. In the patient's view, his problem was difficulty breathing. Consequently, repeated explanations by nursing and medical staff were required before the patient could accept surgery.

Data Collection and Analysis

Congruent with a qualitative approach, data collection and analysis

occurred simultaneously. For the sake of clarity of presentation, data collection and analysis are discussed separately.

Data Collection

Once approval to conduct the study was obtained and prior to its initiation, the investigator met with the HN and AHN, and then the nursing staff, and the medical housestaff of the ward, to explain the study. Part of the process of gaining permission for access to the study setting involved the review of the investigator's research proposal by both the director of medical nursing and the medical service-chief for the area. Their knowledge and support of the study, as well as that of the HN and AHN, greatly facilitated the conduct of this study.

Potential study patients were identified by the HN, or her delegate (see Appendix C), through reviewing the ward's Nursing Kardex and the patient's hospital record to determine patients who met the inclusion criteria. The HN, or her delegate, then approached the patient to request their permission for the investigator to discuss the study with them. At the direction of the HN, or her delegate, the investigator approached the patient to invite them to participate in the study. This approach provided a method of protecting patients' right to consider participation without coercion, that is, patients could decline to participate without having to face the investigator directly. Nurses assigned to consenting patients during the day-time, weekday shift were then invited to participate in the study.

Data collection procedures involved an ethnographic approach employing participant observation, spontaneous conversations with patient and nurse participants during the course of fieldwork observation, and one scheduled

interview with each nurse. Triangulation of data collection methods (Sandelowski, 1986) including observation as well as interview was chosen because "some of the expert's most valuable clinical knowledge is so taken for granted that the expert will not describe it" (Benner, 1982, p. 15).

Participant observation provided a method of data gathering that allowed data to be gathered directly within the context that nurses' teaching function occurred. Observations were conducted during the weekday, daytime shift over a ten week period, totaling 325 hours. During week six, a "time out" of four days was taken away from fieldwork observations. Taking this time away from data collection allowed the investigator to catch up on fieldnote recordings and more importantly, to reflect on the massive amount of data that had been collected by that date. As such, it proved an immensely helpful methodological strategy facilitating the investigator's completion of data collection and analysis.

Nurses and patients were observed as they interacted during nursing care. Other consenting health care team members were also observed as they interacted with those patients. Fieldnote recording of observational, methodological and theoretical notations as described by Schatzman and Strauss (1973) was done during, or as close to the time of observation as possible.

These single-spaced, handwritten notes filled eight large notebooks.

As part of fieldwork observations, Nursing Notes of patient participants' records were reviewed to determine documentation by nurse participants of their teaching activities conducted with these patients. Patient teaching materials available in the study setting, as well as

hospital Missions, Aims and Objectives (1980), the Nursing Division: Statement of Philosophy (1989), and the hospital's quality assurance program and charting guidelines referable to patient teaching were reviewed.

After the nurse-patient interaction had been observed, one scheduled interview was conducted with each nurse. These interviews were conducted at a time mutually convenient to the nurse participants and the investigator. To the amazement and great appreciation of the investigator, all nurse participants generously used either break times during their workday or volunteered their off-duty time for the conduct of these interviews. Interview times ranged from forty-five minutes to two and one-half hours, with a median time of one hour.

Both scheduled and unscheduled interviews were approached as "a conversation between interviewer and participant that evokes the participant's lived experience, seeking shared understanding" (Weber, 1986, p. 66). Most nurses commented that discussion of patients and their teaching was facilitated by the common experience with patients shared by the nurse and investigator because of the study and/or previous clinical practice.

Scheduled interviews were also facilitated by the use of an Interview Guide (see Appendix D). The question in the guide that best facilitated discussion was the broad, open-ended question used to open the interview. That question was generally phrased, "please tell me about what it is like for you to teach your patients, how you help them learn". Often, the phrase "what teaching patients means to you" was added to this initial opening question.

Congruent with a qualitative approach, the Interview Guide was refined during the conduct of the study (Cobb & Hagemaster, 1987; Melia, 1982; Weber, 1986). Most commonly this refinement consisted of exploring the nurse participants' experience with their teaching function through their many paradigm cases and exemplars. Benner (1985a) describes a paradigm case as one that stands out as such a strong instance of a particular pattern of meanings that other similar cases can be recognized. Exemplars are like a paradigm case although smaller (Benner, 1985a). This approach was particularly helpful when nurses defined patient teaching from the perspective of the educational model and as such, felt they either did not carry out patient teaching or did not do so adequately. However, through their conversation describing exemplars and paradigm cases, a rich data regarding nurses' teaching function was collected.

Scheduled interviews were audio-taped and later transcribed. A copy of that transcription was provided to each nurse participant within three days following the interview, with the invitation that they review the transcript and make additional or clarifying comments or deletions. Nurse participants freely discussed the contents of interview transcripts but no nurse asked that any additions, clarifications, or deletions be made. Even though the investigator had prepared nurses for the difference they would notice when reading a transcription of spoken language compared to reading written language, many nurses commented on that difference.

Data Analysis

Data was analyzed using an interpretive or hermeneutical approach based on Heideggerian phenomenology (Heidegger, 1962; Palmer, 1969; Benner, 1985a). Benner (1985a) describes hermeneutics as a systematic

approach to text interpretation; systematic analysis of the whole text, of parts of the text, and comparison of the two interpretations for conflicts as well as for understanding of the whole in relation to the parts, and vice versa. Although interpretive analysis fits the description of the constant comparative method described by Glaser and Strauss (1967), it differs in that its intent is to identify meanings and content rather than to induct theoretical terms (Benner, 1984b). Multiple instruments, multiple stages of interpretation, and consensual validation are used to achieve bias control for the interpretation (Benner, 1984b).

Verbatim transcriptions of fieldnotes and audio-taped interviews constituted the text for analysis in this study. "Thick description" (Geertz, 1973) provided through the collection of field observations and interview data (Mitchell, 1986) provided multiple examples of nurses' teaching behaviour. This approach to triangulation of data collection permitted confidence in the interpretation, deterring the interpreter from placing too much significance on a single example (Benner, 1984b).

Four stages of data analysis described by Benner (1984b) were used to guide interpretation:

1. The complete text was independently read and studied by the investigator with the purpose of gaining a sense of it as a whole. Notes of initial questions and interpretations were made. That text included participant-observation fieldnotes as well as the transcriptions of 15 scheduled, nurse-participant interviews.

2. Excerpts of text were studied to identify themes, paradigm cases and exemplars referable to nurses' teaching function. Benner (1985a) describes these three interpretive strategies; thematic analysis, and

identification of paradigm cases and exemplars, as facilitating both discovery and presentation of interpretation. Thematic analysis is useful for the presentation of common meanings. A paradigm case is one that stands out as such a strong instance of a particular pattern of meanings that other similar cases can be recognized. An exemplar is like a paradigm case, although smaller. Three major themes, several paradigm cases, and many exemplars were identified from the data.

3. Aspects of nurses' teaching function were compared with interpretations of the text as a whole.

4. The material generated in the previous stages was reread numerous times and studied with the aim of identifying competencies within the teaching function, generating further interpretations, and validating previous interpretations.

Consensual validation was obtained by comparing the investigator's interpretations, with those of the thesis sponsor for this study, who is experienced in interpretive methodology. At the completion of the study, findings were shared with the group of nurse participants and resulted in their validation of the findings. The written report of study findings includes sufficient text excerpts to permit readers to participate in consensual validation.

Ethical Considerations

Ethical underpinnings of qualitative methods that derive from a reverence for the subjective, self-determined, self-described realities of individuals and groups guided this study (Munhall, 1988; Punch, 1986). Approval to conduct the study was sought from the Ethical Review Committee of the University of Manitoba School of Nursing (see Appendix E) and

through the Nurse Researcher Access process of the study hospital (see Appendix F). The study began following receipt of approval from both sources.

A verbal and written explanation of the study including the rights and roles of study participants, was given to all nurses (see Appendix G) and patients (see Appendix H). Written consent was obtained from nurses (see Appendix I) and patients (see Appendix J) prior to their inclusion in the study. Each nurse and patient participant was given a copy of their signed consent. Verbal explanation of the study was given to family or other health team members who came to visit study patients. Verbal permission to observe the interaction of family or health team members with study patients was obtained from the parties involved.

Confidentiality was maintained by designating each study participant in fieldnotes, on audio-tape cassettes, and in transcribed data, by a code number known only to the investigator. Following the formal defence of this thesis study, the key to the code number system for study participants was destroyed. During the study, fieldnotes, audio tapes of interviews, and transcribed data were kept by the investigator in a locked file. Only the investigator and the thesis committee had access to these data.

Participants were not identified as suffering any ill effects as a result of their involvement in this study. Instead, both patients and nurses described a sense of satisfaction at having participated in a study with the potential for improving future patients' nursing care. Patients gained an awareness that research is being conducted by nurses and that results of that research have the potential to improve future patients'

nursing care. Nurses participating in the study were keenly interested in the process of conducting this type of research. Consequently, considerable time was spent in discussion with the nurses around issues of nursing research and its implications for nursing practice. Also, openly discussing their teaching function facilitated nurses' clarification of their understanding of that function. Further, nurses received validation that their nursing practice generally, and specifically that of their teaching function, was not only recognized, it was also valued and made public through this study. In these ways, new possibilities were opened for nurses to view both their practice and the role of nursing research in that practice. To the investigator, observing these benefits to participants in the study, was one of the most gratifying aspects of conducting this study.

In addition to ethical considerations that could be stated a priori, the role of participant-observer required that the investigator use "common sense and good manners" (Schatzman & Strauss, 1973, p. 145) as well as ethical practices common to both research and nursing (Robinson & Thorne, 1988) to determine when individual situations should not be observed. Respect for study participants as fellow human beings constituted the paramount ethical consideration of this study.

Summary

This chapter discussed the study's method. Interpretive or hermeneutical phenomenology was described as providing the philosophical background and method while ethnography provided the design for the study. Characteristics of the study setting, and of the nurse and patient participants comprising the study's sample were presented. The approach to

and procedures for data collection and analysis were described as were the ethical considerations underpinning the study. The next chapter presents the study findings.

CHAPTER 4: FINDINGS

This chapter presents the findings of the study. Three major themes were identified in the data. These themes include: (a) the setting: contextual influences on nurses' teaching function, (b) nurses' description of their teaching function, and, (c) nurses' clinical practice of their teaching function. Each theme is discussed individually in the following chapter.

The Setting: Contextual Influences on Nurses' Teaching-Coaching Function

Contextual factors constitute the first major theme identified in the data as influencing nurses' teaching function. Studying this function within the context it occurred, revealed that nurses practice within a context that is not only influenced by nurses, but that also influenced how they shape and perform their practice, including their teaching function. The interpersonal environments are the key contextual elements influenced by nurses, and influencing nurses' practice, including their teaching function.

The Interpersonal Environment

The first key contextual element influencing how nurses' teaching function involves the ward's interpersonal environment. That environment was characterized by the interaction of a large number of individuals representing a multitude of health-care disciplines as they collaborated in the provision of patients' care on the ward. Shaping and sustaining that complex interpersonal, interactional environment while, in turn, being influenced by it, was the nursing culture of the ward.

Caring: The Dominant Feature Of the Nursing Culture Of the Ward

Patient-centered caring by the nursing staff for patients of this ward was the outstanding feature of this ward's nursing culture. This approach to nursing was exemplified by the philosophy and nursing practice of the head nurse (HN). Identifying the primacy of the patient as both the focus and purpose of the nursing staff on this ward, and caring as the nursing link to that care, the HN describes the standard she set for her staff:

> The patient has always been my primary focus and I've tried to instill that into the staff. The patient's well-being, their safety, that they are getting quality care--the best that we can deliver, that's what I'm after. And everything else is secondary. That I've tried to convey to the staff from day one.

An example of the caring nature of the nursing culture on the ward is evident in the following fieldnote record of the HN's interaction with a patient that occurred one morning during nursing rounds (NR). A newly admitted patient informed the HN that he had been "waiting all night" to see her. He was extremely anxious about being admitted to hospital with a possible heart attack and desperately wanted to telephone his daughter who lived in a neighboring province. This had not been possible to accomplish when the patient was admitted the previous evening because the ward's portable telephone was not working and the patient's condition required that he remain on bedrest. The night nurses had explained to the patient that the HN would be around in the morning and would arrange for him to speak with his daughter. On learning this from the patient, the HN responded:

> It is perfectly reasonable that you would want to speak with your daughter. We will see that you can call her. We can push you in your bed out to the desk as there is a phone there that you can use. When would be best for you to call your daughter?

Through the process of helping this patient resolve his major concern, he

had also learned that the nursing staff were not only committed to helping him but were prepared to go to great lengths to do so. Because of their commitment to patient-centered caring, not one of the staff found this approach to facilitating the patient's communication with his daughter, unusual or burdensome. Congruent with the nursing culture of this ward, this example of extra-ordinary expenditure of time and energy in fact, represented "routine" nursing care on this ward.

Following the leadership of the HN, the assistant head nurse (AHN) and nursing staff implemented and strengthened the ward's nursing culture of caring. As one of the members of the multi-disciplinary team associated with the ward commented:

> I find the nurses here are great! They are, on the whole, extremely interested in the patients and their care--very, caring.

Although each SN was given the responsibility for the nursing care of their assigned patients for their shift, the commitment to the care of and interest in the patients extended beyond that formal assignment. For example, one nurse was observed speaking with an elderly patient who had accidentally fallen and fractured her hip the previous week. When the nurse was asked if she was assigned to that patient she replied:

> No, I was just checking in to see how Mrs. ___ is doing. I was looking after her last week when she fell and broke her hip.
> She is doing really well now. Back to usual.
> You feel really badly when something like that happens. It was something that you couldn't help but you still feel badly. She's fine now though, thank goodness.

The depth of commitment the nursing staff are capable of is evidenced through the description of the approach to care of a very ill patient who became a paradigm case (Benner, 1985) for the entire staff. The patient's initial surgery had been compounded with complication after complication

necessitating nearly one year of hospitalization prior to her transfer to the study ward. When the patient came to the ward, she was gravely ill with multiple, complex needs. The patient's situation so violated the sense of what the nurses believed was just and right regarding the health care-patient relationship, the entire staff committed themselves to "winning" for this patient. Once the patient was able, the nursing staff transferred their sense of commitment to "winning", to the patient herself, actively employing their teaching function to engage the patient in her own recovery:

> Nurse Participant: I mean we were so (laughter) you know, nursing, we're kind of an odd brood in a way. Since we got her from another area--when she arrived on our she ward was so critically ill. I can remember the doctors saying--`she's our sickest patient'.
>
> Well, nursing knew that the moment we got our eyeballs on her, we knew she was very, very sick. And bang! Just like that, our nurses said--`let's go for this one'!
>
> They were going to win regardless. (laughter) And that's the kind of effort that was put into her. `We are going to see that this woman gets out of here on her own two feet'! And that was the attitude that they had and they weren't going to stop at anything.
>
> Once ___ [first name of patient] was able to, you know, once she was rational and alert and coherent and everything, she just latched right onto the plan that we had for her. The staff would tell her, not to overwhelm her, but--`this is where we're going and we want you out of here for Christmas day at least'.
>
> She came to us in October and I never thought she would leave here for months--not even go out for an hour's pass. But, she went out to work in less than a year!

Across the membership of the nursing team, a range of the sense of commitment to patients existed. This was evident in their discussion regarding their view of the nature of the feedback they received about patients following their discharge from the ward. For example, discharge was seen by some nurses as the time to end their relationship with the patient as they were either able to take on their own care or were referred to the appropriate community resources. Other nurses maintained a

more prolonged connection with patients, wondering how they were doing at home, and in the case of some nurse participants who had become particularly attached to certain patients, visiting those patients at home.

Humour: A support to caring. Frequently, laughter was shared among the ward staff. No nursing theory known to the investigator identifies the place of humour in nursing. In decontextualized theories; humour, spontaneity, emotion, all that makes life and nursing dynamic and enjoyable, are not represented. What then is the role of humour and laughter in nursing?

On this ward, humour was frequently observed as a method of easing the discussion of problems thereby making their negotiation less threatening, more amenable to resolution. This seemed especially important in the context of the interaction of the multiplicity of individuals involved in the process of providing care on this ward. Openness, respect, and communication must be maintained for caring to exist and care to proceed. Day by day, creating and maintaining a ward environment that permitted caring, learning, and the provision of quality care, was accomplished by the HN and AHN. Humour acted as an essential ally to that process.

Humour also acted as a commonly used method of coping with the frustrations and inadequacies of the physical environment. One example concerns the use of humour that united staff as they faced the common frustrations related to the extremely cramped conditions of the nursing station, prior to its renovation. The following sign was posted on the back of the hallway sign indicating the ward's nursing station. As this sign was only visible to those sitting in that area, it constituted a

private joke, shared by staff:

___ (ward name) NURSING STATION
MAXIMUM SEATING CAPACITY
200
FOR RESERVATIONS, CALL ___ (Ward Clerk) AT ___.

The caring-healing environment. Through their culture of caring and in association with their 24 hour presence, the nurses provided an environment of care and comfort for their patients. Nurses caring approach combined with their constant presence, facilitated nurses' "knowing" the patients in all their dimensions, as fellow human beings as well as patients. This caring environment was seen as a healing environment, characterized by nurses' respect for the dignity of patients as individuals and the provision of nursing care that involved working in partnership with patients and families to assist them obtain the care they needed, and advocating on their behalf when necessary.

Extending the caring environment to members of the nursing team. The caring environment was extended to the staff. Individuals and their contributions to patients' care were both respected and valued, and their collaboration in patients' care was actively invited.

Caring for staff of the ward was very much a part of the management style of the HN and AHN. Being treated in this sensitive manner and seeing it as the norm for the ward, the staff followed through with it in their interactions with both patients and other staff as the following illustrates:

> The day orderly did not attend morning report. As soon as the Head Nurse saw him in the hallway, she gave him a pleasant smile and greeted him: "Good morning ___, how are you today"?
>
> Later that day, this same orderly brought the relief orderly who would be a "Constant Care" for a confused and wandering patient, into the patient's room and introduced the patient to the orderly by saying: "Mrs. ___, I would like you to meet ___. He is just

> going to sit with you today. I hope you have a very nice day today". He then made sure the new orderly was comfortably seated beside the patient and engaged in conversation with her before he left the room.

The philosophy of caring for patients as well as staff was strongly supported by the director of medical nursing for the ward. Just as the HN was able to care for her staff, she felt supported and cared for by her immediate "boss", the director of medical nursing, stating:

> I have been very fortunate to have a really decisive leader, a lady who is not afraid to speak up for anyone--very, very supportive. She is just worth so much to me.

Extending the caring environment to the multi-disciplinary team. Informal discussions with the various members of the multi-disciplinary team of the ward regarding their view of how that team functioned and their role on that team revealed a consistent picture of the team as well as its relationship to enabling members to collaborate in the provision of patients' care. The HN and AHN were seen as largely responsible for the creation and fostering of this caring, collaborative climate wherein individual team members and their contributions to patients' care were actively welcomed and highly valued. Expressing the general sentiments of team members, one member commented:

> I really like coming to this ward. The staff here are so welcoming to us. It is a real team effort.
>
> There is a real openness that makes it easy to help the patients. You work with the patients and their family while you are working with the nurses. They share information and you feel comfortable doing so too.
>
> Everyone is here to look after the patients. There is no one-upmanship because everyone is comfortable in their position. Whoever has the expertise assists the patient.

Although the team members took their responsibilities toward the patients and their care very seriously, the caring environment of the ward and the frequent use of humour enabled team members to have a great deal

of fun in the process of providing patient care. Reflecting the common experience of team members, another member stated:

> I met with ___ (HN) daily to discuss patients and attended the weekly discharge planning rounds.
> It worked just great for me. I can't thank ___ (HN) enough. I feel perfectly free expressing my view, making my suggestions plus, it is fun!

Nurses' central role in coordinating patient care within this complex interpersonal environment was clearly evident. That role involved: coordinating inter-disciplinary team functioning; acting as information exchangers and relayers; acting as patient advocate to the multi-disciplinary team and health care system; monitoring patients' understanding of and response to their illness, hospitalization, and treatment plan; and, structuring and maintaining both the physical and interpersonal ward environment. That this complex and vital role was performed is credible, but that it was done from the patient-centered, caring perspective characteristic of the nursing culture of the ward, was exemplary.

Having described the nursing culture of the ward, it is important to understand the nursing team who practiced within that culture. The next section describes the members comprising that team: their roles, how they perceived their team, and how they gathered and exchanged information referable to patients' care, including their teaching.

The Nursing Team of the Ward

Members of the nursing team included the HN, AHN, staff nurses (SNs), nursing orderlies (NOs), ward clerks (WCs), and the nursing aid (NA). All team members were responsible to the HN who was responsible to the director of medical nursing. She; in turn, reported to the vice-president

of nursing of the hospital.

The head nurse. The HN graphically described her role as "multi-, multi-faceted". The uncertainty of daily events as well as their complex and all encompassing nature, required that she employ tremendous flexibility, maturity, and an ability to priorize and delegate, in order to accommodate the everyday demands of her role. Consequently, the HN stated she often thought of herself as "an octopus with about thirty thousand arms and each arm having a function".

The HN's philosophical stance underpins her management style. Committed to patients and their needs, and viewing caring as the link to meeting those needs, she tells her staff:

> I won't stand for any fooling around. They will hear from me about any behaviour that is not in the patient's best interest--that would make a patient's stay worse or uncomfortable, or that isn't for the patient.

Congruent with her belief in the importance of establishing a caring environment, she was extremely supportive of her staff who saw her as fair, mature, and non-partisan. She fostered a climate of open communication with her staff, appreciating their concerns and valuing their input. She was circumspect in dealing with problems and realistic about the boundaries and limitations inherent in the practical world of clinical nursing.

In setting the standard for patient teaching, the HN was adamant that patients receive the teaching they require. Her expectation of her staff was not that they know or teach "all", but rather that they teach what they could. She identified as imperative, that staff ensure that appropriate resource people were consulted to assist with teaching those areas beyond the nursing staff's expertise.

The assistant head nurse. Spontaneous and open in her approach, the AHN freely shared her wonderful sense of humour. She highly valued the leadership and vitality of the HN and was extremely supportive of and loyal to the HN and her approach to patient-centered caring. Overall, the AHN was a significant therapeutic force for patients and staff on this ward.

Teamwork: The head nurse and assistant head nurse. Initially, it was not clear why the roles of both HN and AHN were necessary. Over time, observations revealed that the HN and AHN function as a strong leadership and managerial team for the ward. Regarding their administrative functions, both are involved with day to day administrative duties such as replacing "sick calls" and making patient care assignments as well as with long range administrative duties such as completing staffing hours and performance appraisals, planning for long-term ward objectives, and administering the ward's nursing budget.

Regarding their patient care-leadership function, both assess patients, communicate with the multi-disciplinary team, and set and evaluate standards of nursing care. A clear demonstration of this patient care-leadership function involved daily NRs made by the HN and AHN. Each morning, following nurses' shift-change report, the HN and AHN made NR to each patient on the ward. Describing her purpose in conducting these rounds, the HN stated:

> You make rounds to see the patients every day. You're the patient's advocate. You're trying to get all the information you can from them. You want your patients to know what the plan is for them--do they understand results of their tests? Have they been given information? You want to hear their frustrations, you want to hear their compliments.

In addition to her stated purpose, the manner in which the HN

conducted NRs, revealed her patient-centred focus and caring approach. After introducing herself to the patient she explained her role in relation to that patient and how she could be of assistance to them. She established a sense of informality and trust by asking the patient if she could call them by their first name and inviting them do so when speaking with her. When visiting each patient, she further demonstrated her patient-centered caring through giving patients her complete attention. As patients and the HN got to know one another, patients gained a sense that the HN, and through her leadership, all the nursing staff, were there to support them through their illness and hospitalization. This support translated into a strong sense of empowerment of patients.

Not only did the HN and AHN actively invite patients' expression of their concerns and requests, they used that information to work with the patient to enable them to receive the care they needed. Information gathered from the patients was used by the HN and AHN to define problems, to set a plan of action, and/or to identify the need to consult with medical or other health-team members. Their patient-centeredness and caring was further exemplified through their framing of identified problems as they were experienced and expressed by the patient, that is, from the perspective of the patient.

Patient teaching was an integral part of NRs conducted by the HN and AHN. Based on information they gathered from the patients about their experience with and response to their disease and illness, the HN and AHN actively taught patients about their illness and how the nursing and multi-disciplinary health-care team would do their best to assist them. The HN and AHN helped patients become aware of the caring environment of

the ward, establishing the patient as an active partner in their own care while making it known that the nursing team would advocate on patients' behalf to assist them obtain the care they required. Planning for discharge was also a key component of NRs. This included verification of the patient's physical readiness for discharge, explanation of how discharge teaching such as that regarding medications would occur, explanation of what assistance was available for the patient once they were discharged and how that assistance could be arranged, and establishing details of how patient would actually get home. Overall, during NRs, teaching within a relationship of caring functioned to empower patients.

The staff nurses. Bedside nursing care of patients was provided by the SNs, who were either registered nurses (RNs) or licensed practical nurses (LPNs). While the SNs were assigned to the care of their own patients, they also worked as a team, helping one another with nursing care as they had time, exchanging information about and experience with the care of patients on the ward, and supported one another through the "ups and downs" associated with working on the ward.

The nursing aid and orderlies. One NA and one NO were permanently assigned to work weekday, daytime shifts. Through their commitment to patient-centered care and their constance on the ward, these two staff members provided an invaluable contribution to patients' care of the ward.

Frequently, nurses commented on the need for adequate auxiliary and support staff during evenings, nights, and on weekends. This was identified as essential to facilitate the use of nurses' time for nursing purposes, including their teaching function.

The ward clerks. One WC was assigned to work the weekday, daytime shift. Not only is she extremely competent in her assigned duties, she is also interested in and knowledgeable about patients and their care, and courteous and considerate toward nursing and other health-care team members. Consequently, she acted as a strong ally to the culture of caring on this ward. Also working within the nursing team were WCs who worked during the evening and on the weekend.

Nurses' knowledge of and sense of trust in the ward's nursing team. Pervading the nursing team of the ward, was a sense of trust that others, and in particular, those "in charge", were doing their part, and would negotiate with members of the larger multi-disciplinary health-care team on behalf of patients and nurses. This trust was related to understanding how the nursing team worked, learning one's place in the "scheme of nursing things", and generally feeling part of that nursing team. Even to relative newcomers to the ward, a sense of trust in the ward's nursing team was evident, based on the considerate treatment they received and on their observation of outcomes of the nursing team's work. This knowledge of and trust in the nursing team had a significant, positive impact on individual nurse's ability to carry out their nursing work.

Gathering and Sharing of Information Within the Nursing Team

Information exchange within the nursing team of this ward was characterized by the openness with which it occurred; by relying most commonly on informal, verbal methods, and less commonly on formal, frequently written, methods of exchange; and having as the most common ultimate goal of this information exchange, the centrality of the patients and the facilitation of their care. Nursing team members were constantly

attuned to both gathering and sharing information about their patients and their care.

Information about patients that SNs were consistently observed gathering and sharing included: the multi-disciplinary, medical, and nursing team plan of care for the patient; what individual team members had told or taught the patient; how they understood their plan of care; and what the patient thought about that plan. A multitude of information gathering approaches combining both formal and informal approaches, were used by SNs.

Formal information gathering and exchange. Information about patients on the ward was available to members of the ward's nursing team from several formal sources. Most commonly those sources included written documents or formal rounds, all requiring that nursing team members expend considerable time and effort to pursue. The most frequently consulted written information sources were patients' charts, specifically: the nursing history, progress notes, and medical history found therein; and the nursing kardex.

Many types of formal rounds were held on the ward. Some of these rounds were attended only by the HN and/or AHN, while others were attended by any nursing team member who was able to do so. Due to the very active and constant demands of providing bedside care, it was impractical for SNs to attend morning ward rounds (WR). Maintaining a team approach required that mechanisms for getting pertinent information to the SNs be used. A communication board, kept at the nursing station, was used to record aspects of patients' care discussed in WRs that SNs should be aware of, such as a new or changed physician's order. However, if an order or aspect

of a patient's care arose during rounds that required a SN's immediate attention or necessitated discussion with and/or feedback from a SN, the HN or AHN would speak directly with the nurse. SNs would also share information they had discovered about patients with the HN and AHN, who could share it with the team during WRs or during discharge planning rounds.

Informal information exchange about patients. Several methods of informal information exchange were used by the nursing team. They were both highly developed and utilized as they provided considerable information while fitting into the time-pressured worklife of nurses. These methods generally involved discussions among the nursing team members and occurred both on the ward and elsewhere. No instance of violation of patient's confidentiality was observed during the nursing team's informal discussions. Learning about the multiplicity and pervasiveness of informal information exchange, demonstrated its tremendous significance to the provision of nursing care, including nurses' teaching function. Describing commonly used information gathering methods, one nurse commented:

> You end up, over breaks we end up talking--"Mr. so and so in [room] 42. I had him last week". You get back and forth information. Its great!
> Sometimes at change of shift when we're charting, we happen to mention about a patient. Its not as in depth as we would like it. But you get an idea. And then if you have time, you put it in the kardex.

In terms of content exchanged and outcome regarding patient care, the informal exchange went far beyond that of actual information exchange. This informal process also acted as a medium for the nursing team to plan individual patient's care and to obtain consistency in the team's approach

to that care. It also fostered committment to patients and their care while facilitating the establishment of standards of nursing care and caring that formed the ward's nursing culture.

Informal information exchange was also associated with members of the nursing team exchanging their knowledge and experience as well as their values, beliefs, and assumptions about nursing. Frequently, this fostered the learning and professional growth of other nursing team members. An experienced nurse, describing an incident wherein she informally shared her knowledge of a patient in addition to her nursing experience and values with a less experienced nurse, illustrates how this exchange improved the patient's care while enlarging her colleague's understanding of nurses' teaching function:

> I said to ___ [patient's nurse], he is a post-MI patient. His wife died the day before he was admitted. She hadn't known that. She told me she had given him a Heart Talk book. When she asked if he had read the book, he said--`no, I only got to the first page', and then he started to cry.
>
> I said to ___ [patient's nurse]--"maybe you could write a nursing order to put his MI teaching on hold right now until its appropriate. Maybe he can just be followed in the community". Because he's <u>definitely</u> not ready to learn because of his high stress level just now. He wouldn't remember. But if you sent him home with the Heart Talk book and a few resources, then information is available for him when he is ready.

"<u>Overhearing" from "behind the curtain</u>". An ubiquitous and extremely effective information gathering technique used by nurses involved "overhearing" other's conversations about or with patients. This informal method of information gathering fitted perfectly with the time-pressured worklife of the members of the nursing team and with their constant presence in the ward. However, beyond the obvious convenience and availability of this approach to information gathering, nurses use of this approach demonstrated that they were highly motivated to gather current

information to assist them in providing nursing care. As one nurse participant put it:

> Other stuff, is you know--over-hearing (laughter).
> Keeping your ears open when you're at the desk (laughter). You're charting about your patient and you try to listen in.
> And then you kind of know when you are with a patient and other team members come in to see the other patient in the room. So you kind of go to the other side of the curtain and listen (laughter).

Sharing information with patients from "behind the curtain". Patients, as well as nurses, gathered considerable information, and in fact received patient teaching through overhearing nurses teaching others, frequently, from "behind the curtain" of the patient in the next bed. As one nurse related:

> I think they even learn a lot just from observing you too.
> Like, sometimes they hear what you're telling, if there are two MI patients, you're talking to one patient, the other one is listening behind the curtain (laughter).

Information gathering about the content of teaching. Functioning independently and as a group, the nursing team gathered and exchanged information about what to teach their patients. One approach, a Cardiac Manual, devised by the nurses on this ward was used to provide and exchange information referable to the teaching of patients with cardiac illness. Not only did this approach act as an information resource for the ward's nursing team, it was also available to nursing teams of other wards. The nurses were in the process of developing a similar manual for respiratory patients which they expected would be completed within the year.

A significant method of learning about patient teaching content involved experiential learning gained through the process of nursing the patients. As new or unfamiliar situations presented themselves to the

nurses, they utilized all available resources to learn about that aspect of care and its implications for teaching the patients. A large component of the nurses' experiential learning involved learning along with as well as from patients during the process of caring for them. For example, following an investigative procedure, nurses frequently asked patients about the procedure; what happened, how it went, and what the doctor told them about the findings of the test, thereby augmenting the nurse's knowledge while assisting patients to review their experience.

Nurses not only practiced nursing within the context of a nursing team, they also carried out that practice within a context characterized by the interaction of a large numbers of individuals representing the multitude of disciplines constituting the ward's multi-disciplinary team. Just as nurses contributed their part to the total care provided patients by that multi-disciplinary team, so they contributed their part to patients' teaching.

Teaching as Part of a Complex Nursing and Multi-disciplinary Team

While nurses consistently acknowledged teaching as an independent nursing function, they both understood and conducted that patient-teaching function as members of an intricate health-care team. Nurses valued the contribution other members of the multi-disciplinary team made to patients' care. As one nurse commented:

> I think the multi-disciplinary approach is really good in this hospital because even if you think you're just doing a little bit, so is the physiotherapist and so is the home care nurse and so is the head nurse and so are the housestaff. I think that combined, a lot of it really comes together and prepares the patient.

Nurses actively sought the involvement of multi-disciplinary team members whose skills directly addressed problems nurses identified

through their assessment of patients. In the following exemplar, a nurse related how she involved the social worker to assist the patient with an identified problem:

> I admitted a patient in his forties with weight loss, not yet diagnosed. The doctors were pretty sure it was cancer of the lung.
> When I asked him if he was working, he said yes. I thought, okay, he's going to be in here for awhile. So, I asked him if he had sick time, he said he wasn't sure.
> I consulted the Social Worker to get UIC [unemployment insurance] involved. It turned out that his company did not have sick benefits but that he was entitled to UIC benefits. The Social Worker got all that sorted out for him so he didn't have to worry about the financial concerns while they were trying to diagnose his cancer.
> It worked out beautifully.

Collaborative teaching by the nurses and other health-team members characterized the multi-disciplinary team's approach to patient teaching. Frequently, nurses cited the collaborative approach they shared with the clinical pharmacist (CP) in teaching patients about their medications, as one nurse commented:

> I notice, we do discharge teaching with the pharmacist.
> She goes in and teaches them their medications. But if you go in every time you hand out their pills and say--"this is your coated aspirin. The reason you're taking is to keep, to prevent blood clots", or whatever.
> And then when the pharmacist goes in to teach them, they recognize the pills. `Oh yes, I've been taking that since I've been in here'. You know, they understand better.

This collaborative approach to teaching was in turn, validated by the CP:

> What is <u>really</u> great is when the patient has been receiving medications for a few days, the nurses show the patients the medications and say--`can you tell me what these medicines are and what they are for?' That way it really reinforces the medications and lets us know what the patients know and understand.
> I find most nurses are really good at that. It really helps when I come to do the discharge teaching because the patient is familiar with the medications and feels comfortable, reassured about taking them.

The CP provided an active and highly valued educational resource for

patients and members of the multi-disciplinary team. Attending daily WR to learn about the patients on the ward, the CP also acted as a consultant regarding the pharmacologic aspects of patients' care. As the CP was frequently on the ward and was extremely open to sharing her expertise, the nurses frequently consulted her as an educational resource for questions they had about their patient's medications. In turn, she appreciated learning about information the nursing staff had about the patients that would assist her in teaching them.

Another example of the collaborative approach to teaching involved pastoral care. Pastoral care team members brought specific aspects of spiritual care to the patients' care. Those aspects related to the traditional "religious functions" as well as the counselling, supportive function related to life situations relevant to the patient's present illness and other life events. They also recommended post-discharge follow up such as counselling or support groups to patients who had issues that could not be resolved during hospitalization. The pastoral care team kept a kardex on the ward, related to patients' spiritual care. This also provided information to the nursing team. In the view of the pastoral care worker specifically assigned to the ward, the nurses were, through their caring, very much a part of providing spiritual care to the patients. He outlined his perception of several aspects of how nurses' teaching function related to the spiritual care of the patients and their families and facilitated his discipline's ability to provide that dimension of care. A key support involved nurses making patients and families aware of Pastoral Care services and what they have to offer. Nurses also informed them about specific areas of religious care related to illness, care, and

dying.

The nurses also actively collaborated with specialist nurses associated with the ward. These nurses included the bed coordinator nurse; two clinical nurse specialists in medical nursing, one who focused on general medical nursing and one who focused on patients with auto-immune deficiency syndrome; an endocrinology nurse clinician; a nutrition nurse clinician; a respiratory nurse clinician; a nurse educator; and, a nurse from the Victorian Order of Nurses who was also referred to as the home care nurse. Collaboration around patient teaching was characterized by a sense of patient-centered teamwork. SNs monitored patients' learning over time, sharing their assessment with the nurse specialists who responded in kind. SNs also reinforced teaching conducted by the nurse specialists, and when indicated, requested that nurse specialists review aspects of teaching with the patient and family. This nursing collaboration was valued by both SNs and nurse specialists because of its resultant benefit to patients' care and for the learning it provided both groups of nurses. The specialist nurses learned in-depth, current knowledge of the patient gathered by the SNs during the patient's present admission. SNs learned information about the patients gathered by the specialist nurses over time and in settings beyond that of the acute care ward, such as the out-patient clinic or the community.

Through nurses' introducing health-team members to patients and their families by explaining what those members had to offer them, patients and families' understanding and acceptance of those team members was facilitated. For example, the dietitian expressed that she found the team approach extremely supportive of her work. It was her impression that

frequently patients have a stereotypical view of "a dietitian", seeing them as constraining usual eating patterns by setting limits on eating habits. However, the dietitian found that patients and families on the ward were assisted to accept and trust the information the dietitian shared with them because the nursing staff explained to them that the dietitian was a part of the team providing care and outlined how she could be of help to them.

Being aware of the expertise each team member could bring to patients' care, nurses also guided patients toward various members of the team who could provide the expertise they required. This was not done from the stance of "one-upmanship" or devaluing any team member's contribution. Rather, it represented congruence with the multi-disciplinary team philosophy, "whoever has the expertise helps the patient".

Further, nurses actively taught patients how to seek assistance for their own care and learning from team. For example, regarding teaching patients about WRs, a nurse described:

> We tell patients what to expect when the doctors come in for rounds. Like for our service, we'll say--"they'll be around first thing in the morning. A whole gang will be in to see you and talk to you. If you have any concerns or anything, you can mention to them tomorrow. Or if you have any questions, you know. Like specifically, if you have a question like--`how long do you think they're going to keep me here'? You can address them to the group when they are in for rounds".
>
> But for off-service ... off-service patients tend not really to be neglected, but they're not first on the list unless they're really unstable. So when the service comes to see them, sometimes (laughter) it can be in the afternoon. So, you can warn them, like--"your doctor works on the other desk. So the doctors that work with him that come around to see you, don't usually come around until a little bit later".

Nurses also acted as the patient and families' advocate in relation to multi-disciplinary team functioning. For example, recognizing that

patients who were "off-service" may not have an opportunity to speak directly with the housestaff during morning WRs, nurse participants would advocate on the patient's behalf to have their request addressed.

Serving to reinforce other multi-disciplinary team member's teaching were "follow up" sessions conducted by nursing team members. During these sessions nurses monitored how the patients understood the information and how they accepted it in relation to their own lives. Frequently, nurses supplemented the teaching of other members of the multi-disciplinary team. While the physician in the following exemplar had informed the patient that he would be having a specific test, the nurse describes how she supplemented this information:

> All that the patient knew was the word "Stress Test". He had no idea what was going to happen to him. He didn't know that he was going to have a heart monitor on or what "Stress Test" meant.
> Just simply explaining that--"they want to see the reaction of your heart to activity". And in simple terms, how that is done. Just simple explanation like that gives them the picture.

Nurses' "monitoring" of patients' response to their therapeutic regimen was both recognized and valued by other multi-disciplinary team members. In the view of one of the physicians, because nurses interact with patients on an interpersonal, caring level, they are closer to patients. Also, in his opinion, because nurses listen well and have more exposure to patients through the provision of direct nursing care over a 24 hour period on an ongoing basis, they gather a wealth of information about the patient that is often unknown to the rest of the team. From his perspective:

> As a physician, one deals with the medical issues on the table. If that is dealt with, other issues will fall into line.
> But, that may not be so--if the patient and the [medical] plan are not getting along. Physicians need to know if that is the case. They may not unless the nurse tells the physician because

> the nurse is usually the one who gets that information. If the nurse doesn't speak up, the team approach is lost.

In turn, nurses valued collaboration with members of the multi-disciplinary team because of the resources they provided to the nursing team by virtue of the knowledge and skills of their discipline.

Experience in nursing and in working within the nursing unit, was directly related to knowledge of how the nursing and multi-disciplinary teams functioned. That knowledge, in turn, related directly to how nurses taught patients about the functioning of those teams, and to how nurses were able to advocate with those teams on patients' behalf.

The Physical Environment

The second key contextual element influencing how nurses' teaching function involves the physical environment. The ward, a 26 bed acute care medical nursing unit, is comprised of 13 semi-private patient rooms located along either side of a central hallway. Placed along the west wall of that hallway were an assortment of carts and chairs. One large cart contained the ward's daily laundry supplies. A smaller cart contained emergency equipment. Three laundry hampers were interspersed along the hallway. Occasionally, a bright yellow cart containing supplies for a patient on "isolation technique" due to a suspected or actual case of infectious disease, was placed outside a patient room.

A combination medication, clean supply, and kitchen room was located at the midpoint of the ward. This room was away from the high traffic of the central hallway and nursing station. However, while nurses were pouring medications, other staff members frequently came into the room to use the microwave or the refrigerator, or to obtain sterile supplies of the supply cart that was located within the medication area.

Beside the medication, clean service, and kitchen area is the dirty service room. In its approximately 1 m by 1.5 m space are housed the bedpan flusher, a sink beside which were stacked used supplies to be returned to the Central Supply area, a large garbage can for wet garbage, a laundry hamper, usually several intravenous poles, and frequently, a commode chair.

On the other side of the medication, clean service, and kitchen area are the staff washroom, the shower room, and the tub room. The shower room and tub room contained one shower and one bathtub respectively. The bathtub and shower were shared with the patients of the adjoining medical nursing ward.

There was no patient or visitor lounge on the ward. Visitors and ambulatory patients were frequently observed sitting in an alcove adjacent to the elevators located at the entrance to the adjoining nursing ward.

The nursing station or "desk" was located at the south end of the central hallway. It could best be described as the "hub" of the ward. Every health team member who came to the ward made at least one stop at the desk. Discussion of patients by consulting health-care team members including physicians, generally occurred in this area. The small area of the nursing station was constantly congested with various team members, creating noise and activity that impacted on the ability of the HN, AHN, and WC to concentrate on their work. However, they were consistently courteous and welcoming to the various team members who collected there, receiving similar responses from them. A stairwell, enclosed by glass doors and located immediately east of the nursing station, frequently acted as an extension of the nursing station as various staff and team

members sat in the stairwell to chart or discuss patients.

Changes Occurring Within the Physical Environment

Two major changes occurred in the setting during the conduct of the study and can be seen as having some impact on its findings. The first change involved the construction of a new nursing station, conference room, and medication room in the area adjacent to the south entrance of the ward. Previously this area contained the ward's conference room, second staff washroom, and the HN's office. The conference room had been used to hold the nurses' shift-change report, discharge planning rounds, medical sign-out rounds, as well as various ward-associated meetings and educational sessions. It was also the area where the SNs did the majority of their daily charting. However, during the period of data collection, this key area was unavailable to the ward staff. Consequently, the activities that had formerly been conducted in the conference room were carried out in the ward's tub room. This room, approximately 1.8 m wide by 2.5 m long, contained a bathtub, shelves for bathing supplies, several straight-backed chairs, and an over-bed table which held the tape recorder used for the nurses' report.

The actual renovations had relatively little impact on the nurses and their teaching function. No complaint was heard about the temporary but rather significance inconvenience associated with the appointments and use of the tub-conference room, although staff and other multi-disciplinary team members frequently joked about this. Overall, there was a sense of excitement among the nursing staff concerning "their" new desk, medication room, and conference room.

The move to the new nursing station occurred on the seventh Monday of

data collection. Once the new nursing station was completed, renovations began to convert the original nursing station into a patient and visitor lounge. The medication, clean supply, and kitchen area was to be converted into a nutrition centre and an office for the HN.

Occurring simultaneously with the changes associated with renovation of the physical structure of the ward, was a monumental change that significantly impacted on the nurses and their provision of nursing care. That change involved "going live" with computerization of transcription of doctors' orders and documentation of nurses' care planning. Amazingly, the nurses successfully moved into their new nursing station on the same day that computerization was instituted.

Despite the extensive effort the nursing division had put forth in their attempt to prepare the nursing staff for "computerization", and the valiant efforts of the nurses to attempt to adapt to this new technology, it appeared, at least during the first two weeks of operation, that the technology was not sophisticated enough to support the complex human behaviour it was intended to "computerize". As a result, during the period of observation, introduction of this new technology had an profoundly negative impact on how nurses communicated and organized their nursing care, and placed incredible stress on the nurses as they carried out that care, including their teaching function.

Summary

Contextual elements, specifically the physical and interpersonal environments, constitute the first major theme identified as influencing and in turn, influenced by nurses' practice, including their teaching function. Two changes within the physical environment, the more

significant being "going live" with computerization, were identified as having an impact on the practice of nurses' teaching function. The interpersonal environment, characterized by the complex interaction of a large number of nursing and multi-disciplinary team members, was shaped and mediated by the culture of caring of the nursing team of this ward. To enlarge the exploration and description of the lived experience of nurses' teaching function, the next section presents how nurses participating in this study described their teaching function.

Nurses' Description of Their Teaching Function

The second major theme identified in the data is nurses' description of their teaching function. Without exception, nurses described their teaching function as a highly valued and integral part of their nursing practice.

Teaching "Ongoing" Throughout Patients' Hospitalization

Congruent with patients' learning, teaching by nurses was seen as a constant and continual process, occurring on a 24 hour basis, "ongoing" throughout patients' hospitalization. Speaking for all nurses, one commented:

> Patient teaching begins from the time the patient walks in the door until they leave. You're teaching constantly.

Further, teaching was seen by nurses as completely integrated into their daily practice. In one nurse's experience:

> Sometimes you can be just going in the room, and maybe you just happen to be picking up the urinal and they ask a question, and you answer. Its more or less just as we go along, you know, ongoing. You have to slip it in when you can. So, if you can teach during the bath, great.
>
> I think most of the teaching is spontaneous. I don't think you can just specifically say--at eleven o'clock in the morning I'm

> going to do cardiac teaching with this person. When something arises where you feel that they should be learning, or as they ask questions, that's when you do your teaching.
>
> I think teaching hits home more when it occurs with the activity that's related to what you're teaching about.

In fact, nurses described their teaching function as being so embedded in their practice, they were often not conscious that they were teaching their patients. In addition, because of nurses' informal and relational approach to teaching, and the degree to which that function was embedded into everyday practice, patients were often unaware that teaching was going on.

Scope of Teaching Within Nursing: "Anything and Everything"

Consistently, nurses described their teaching function as broad in scope, responsive to the individualized learning needs of each patient. Teaching was seen as involving "global content", well beyond the "single need" referable to the patient's diagnosis. Describing the scope of nurses' teaching function, one nurse stated:

> Teaching is all encompassing. It can be anything and everything.
>
> You really need to be sensitive to ... make it a global thing. There can be specific illness-related learning needs addressed but there is so much more than that.
>
> I mean, we need to know about what's happening at home. Is there something we can do to change their getting in or out of a tub even? Is there something we can do to make it safer or easier for the patient? We need to know those things. We have to pick up on it.

Teaching was also seen as highly individualized, based on each patient's unique needs. Meeting those needs involved nurses individualizing both the content as well as the method and timing of teaching:

> Sometimes it can be a one answer. Sometimes a sit down session. Sometimes it can be like--`what did you tell me last when you were in here'? So you reinforce it again.
>
> With our patients, its individual. I mean regarding what

teaching is done, and how the teaching is done--how often, how much reinforcement.

Teaching Toward the Purpose of Enablement: For Healthy Living and Peaceful Dying

Within this setting, nurses conducted their teaching-coaching function toward the purpose of enabling patients and their families to restore, maintain, and promote their health; to cope with illness; and to die in peace. Firmly underpinning their teaching practice was the approach of promoting healthful living, and dignified, peaceful dying; that is, health promotion as a philosophical stance, irrespective of the health status of the client.

Doing One's Best, Given the Circumstances

Nurses were acutely aware that although they tried to do the very best they could for their patients, circumstances within the real world of clinical nursing mediate what is actually possible to accomplish. Particularly with experience, nurses develop a sense of what is realistic to expect of themselves as well as of what to expect of patients. Expressing the view of the majority of nurses, one nurse commented:

> I guess we try to do the best we can. Otherwise we try to do too much and burn out for sure (laughter). You learn with experience.

An example of "doing one's best, given the circumstances", could be seen when patients were unexpectedly discharged. Generally on this ward, discharges were well planned including the setting of a projected discharge date. Occasionally it was necessary to discharge patients with little or no advance warning. This created considerable stress for members of the nursing team, particularly if the discharge occurred during the evening or at weekends. Unanticipated discharges inevitably left nurses

feeling that even though they had done the best they could, the patient had not received the same quality of teaching and ease of discharge, that is, had not been as fully "enabled" for discharge, as would have otherwise been the case. Following is an exemplar that one nurse related:

> With Mr. ___ [elderly, confused patient requiring indwelling urinary catheter], the doctors decided all of a sudden he was going home, one evening. They really needed the bed so they had to discharge him.
>
> He didn't have urine bags and he has an indwelling catheter. We had to get special bags from Urology. I hadn't seen the leg bags he was going home with so the nurses from Urology had to explain to me how to wash them out and everything.
>
> I didn't know if he had enough bags at home, so all I could do was leave a message for Monday for ___ [WC] to call to see that Home Care arranged for him to have bags and all the stuff he needed.
>
> His son came in to pick him up. I couldn't even talk with his wife because she was at home. And his son didn't want to go pick her up because they live out of town a ways.
>
> So sometimes things aren't quite ready, the way you'd like them to be. But you just do the best you can anyway.

Patient Profiles: Teaching Patients With Chronic Obstructive Pulmonary Disease (COPD) or Myocardial Infarction (MI)

Nurses consistently described teaching patients admitted with COPD and those MI as very different in terms of content taught as well as approach to teaching. The physiological and psychological effects of these two disease categories resulted in qualitatively different illness experiences, in addition to the moderating affect of individual variation. As one nurse noted:

> Teaching patients with COPD is different from teaching patients with MI. Their COPD isn't going to change. They're not going to be breathing normally in a couple of days, ready to go home with normal breathing.
>
> Mrs. ___ [patient with COPD] said today--`I'm always short of breath'. That's something she has to live with now. She goes on her oxygen whenever she goes out. That's hard. Its hard to give someone hope ... that way.
>
> Because if you have an MI and are going for an angioplasty, you'll go to Intensive Care after and then you'll come back here

and ... hopefully the blockage will all be fine, and ... you'll be much better.

Consistently, in the nurses' view, experiencing COPD: a chronic, "ongoing", progressive disease characterized by remissions and exacerbations, resulted in the patient developing a long-standing "illness history" that may have involved multiple admissions and considerable teaching along the way. Further, due to the exacerbated nature of their symptoms on admission, these patients were generally dyspneic, fatigued, possibly confused, and often discouraged and/or threatened by the need for readmission and/or the need for additional ongoing therapy such as home oxygen. Consequently, at least until the acute phase of the disease process was over, these patients generally required teaching geared to helping them through the immediate demands of each day of their admission. Frequently mentioned priority learning needs included learning and practicing effective sputum clearance, and managing debilitating dyspnea. Once the acute phase had resolved, it became crucial for these patients to begin to exercise to the limits of their physical condition in order to recondition their muscles, including those used for breathing. Dyspnea and fatigue often presented tremendous physical and emotional barriers to patients' participation in exercise. This necessitated ongoing guidance by nurses concerning the setting of realistic expectations regarding goals for exercise and considerable encouragement regarding patients' meeting those goals. Further, because of the often extensive "illness history", teaching was more commonly geared to the evaluation and reinforcement of patients' previous learning. Nurses consistently described that evaluation as a process of observing patients' actions and conducting casual discussions to determine how patients integrated previous teaching into

the practical aspects of their everyday lives.

In the nurses' view, experiencing an MI, generally a sudden event that may or may not have been preceded by warning signs such as chest pain with exertion, resulted in a patient with no, or limited, "illness history" who, having faced an acute, dramatic, unfamiliar, and possibly life-threatening event, generally felt well for the remainder of their hospitalization. Because of the acute nature of the disease, patients suffering an MI were frequently very interested in learning as much as they could about regaining and protecting their health, and had the energy to participate in that learning. Psychological response following the experience of a MI was described as varying from being too anxious to learn, to being anxious but able to learn, to being open and highly-motivated to learn. Occasionally patients were unable to accept that they had in fact suffered a MI. In those instances, nurses tried to support the patient and family, making learning resources available to them within the limits set by the patient, and arranging where possible, for community follow up of the patient.

However, most patients admitted with MI were described as physically able to participate in learning and motivated to do so. In sharp contrast to patients with COPD, once the acute event of the MI was over, these patients frequently needed guidance about not "overdoing" their reconditioning program. However, patients suffering their second or third MI tended to be seen as more like patients with COPD, in that they had an "illness history" with its attendant prior teaching and learning.

Summary

This section presented the second major theme identified in the data,

nurses' description of their teaching function. Consistently, nurses described their teaching function as a highly valued and integral part of their nursing practice. Occurring "ongoing", throughout patients' hospitalization, its scope includes "anything and everything". The fundamental purpose of teaching was described as patient and family enablement--for healthy living and peaceful dying. Nurses also described coming to terms with the notion that although they try to do the best they can for their patients, contextual circumstances mediate what is actually possible to accomplish. Finally, nurses consistently described patient admitted with COPD and those with MI as having qualitatively different illness experiences necessitating a different approach to teaching as well as requiring different content. The next section presents an interpretation of nurses' actual practice of their teaching function within the acute care setting in which it occurred.

Nurse Participants' Clinical Practice of Their Teaching Function

The third major theme identified in the data is nurses' practice of their teaching function. All five competencies or components identified in the sensitizing framework, the teaching-coaching domain described by Benner (1984a), were identified in the practice of nurses' teaching function within this setting. One of the competencies identified by Benner (1984a) was expanded in this study. Three additional components were identified in nurses' practice of their teaching function within this setting.

The following five competencies, identified by Benner (1984a), were also part of the teaching function practiced by nurses within this

setting: (a) timing, or the capturing the patient's readiness to learn; (b) helping patients integrate implications of their illness and recovery into their lifestyles; (c) determining the patient's interpretation of their illness; (d) providing an interpretation of the patient's condition and giving a rationale for tests and treatments; and, (e) coaching the patient--making approachable and understandable culturally avoided aspects of their illness (Benner, 1984a). Expanding the competency, "timing, or the capturing the patient's readiness to learn" described by Benner (1984a), were several other dimensions related to time. Consequently, that competency has been renamed "time, timing, and teaching" to more appropriately describe how it was practiced by nurses within this setting. In addition to the competencies described by Benner (1984a), nurses' practice of their teaching function in the setting involved the following three components: (a) establishing the teaching-caring relationship; (b) evaluating: ongoing monitoring of responses; and, (c) family-involved teaching and coaching. Following is a discussion of each of these eight competencies.

Establishing the Teaching-Caring Relationship

The first competency, establishing the teaching-caring relationship, was consistently observed in nurses' practice of their teaching function. Within this setting, nurses' teaching function was identified as requiring but also reinforcing a caring nurse-patient relationship. As one nurse described it:

> I think if you explain, or teach what you're doing with the patients on an ongoing basis, their anxiety level just relaxes.
> They trust you more. They come to you. They ask you why they [physicians and other health-care workers] are doing things.
> And its exciting. You're building something with this person. And, you know, it works out great!

Congruent with the nursing culture of the ward, the primacy of the patient underpinned this teaching-caring relationship. Approaching communication within this relationship from the stance of respect for and openness to patients, facilitated patients' expression of their learning needs:

> Just speaking with the patient and making them feel that--"yes, I am concerned about you". And make them feel comfortable and that--yes, they can talk to you. And that you aren't judgmental or critical.
>
> Its so important, how we approach this whole thing.
>
> If we go in there and we say--"well ... you're expected to read this book. If you have any questions, just ask us". Well, nobody, I'll bet you, nine out of ten patients will not say boo.
>
> First of all, they'll be embarrassed if they do have a question that may be very simple for someone else.
>
> Secondly, they don't want to know. Maybe its somebody who has had a heart attack. They might be terrified of finding out what really has happened. There's all kinds of issues there.
>
> I think, we really have to be very careful how we approach patients.

Helping Patients Engage With the Teaching-Caring Relationship

Consistently, nurses employed various strategies to foster patients' engagement in their care and learning. Often these strategies were very creative. Frequently, the mediating effect of humour was employed:

> If its somebody who is going to become agitated by what you're teaching, I would not go in there and sit down and make a point of teaching them (laughter) because I think they should have the information (laughter).
>
> If I have a patient like that, most of the time I'll say--"I would like you to hear this because I think this is good for you". Or, I may say--"humour me and listen to me for a minute and then I'll leave and leave you alone" (laughter). Which I have many times.
>
> At least you're doing your part. You're not taking the easy way out. And, you never know, some people are totally different on the inside than they are on the outside.

Getting to know patients as individuals: Gaining a perspective of their worlds. Consistently, nurses described and demonstrated the importance of getting to know patients as individuals in order to

facilitate their engagement in the teaching-caring relationship. This process involved learning about patients' "stories": how they usually responded to major and stressful life events; how they were currently dealing with their situations; and, who was "there for them". Understanding patients' "perspectives" gave nurses a view of how those perspectives shaped patients as people and how they contributed to their understanding of their current situations.

Getting to know patients as individuals was most commonly approached by nurses from a non-intrusive stance. Underpinning that stance was a respect for patients' right to privacy, and sensitivity to the need of individuals to develop trust in a relationship before feeling comfortable communicating on a personal level. Further, nurses acknowledged the individuality of both patients and nurses, accepting that patients may feel more comfortable talking with particular nurses simply on the basis of individual preference. Clinical application of this approach is evidenced in this nurse's description of her approach to taking the nursing history on a patient's admission:

> A lot of information comes from the nursing history. And with talking with the patient while you are taking their history.
>
> Some patients hold back though. You can tell when you're doing their history, if they're reluctant, they'll just answer with the minimum, just a few words.
>
> You sort of hate to pry. So, you figure, well maybe after they've been here awhile, ... maybe they'll open up a bit more.
>
> Sometime its just, how do they say that between two people? Like a ... a rapport. Sometimes its closer with a different person. So, you don't take it personally, you just sort of know that some people get along with others better than with other people.
>
> I don't like to push patients. I know I wouldn't like it and I don't feel right doing it to others.

Nurses' Perception of Roles Within the Teaching Relationship: Nurses' and Patients' Rights and Responsibilities

Consistently, nurses saw teaching as occurring in a helping relationship wherein patients and their needs were paramount, and where nurses provided whatever information they could for patients. Nurses viewed this information as a "guideline" or resource to be shared with patients for their consideration rather than their "compliance". Expressing the consistent view of nurses, one nurse commented:

> We should at least address all the issues and they can take from it what they want.

The notion of the professional as the teacher and "knower", and patients as recipients of that knowledge, was alien to the nurses. Instead, nurses viewed patients as active partners in their care and the caring relationship. Several nurses stated that they thought of teaching as "sharing" as opposed to teaching in a formal or academic sense. Speaking for the group, one nurse commented:

> Its more like a sharing. You may have the information that they need. You say--"what do you <u>want</u> to know"? You know--"how can we help you"?
>
> More than--"this is what we're going to cover, and when we're done, I'll ask you these questions. And you'll tell me what you know".

In addition to sharing knowledge, the sharing approach itself was seen as facilitating patients "opening up" discussion of their personal experiences.

Further, discussing issues from the patients' perspective provided nurses with the opportunity to offer positive reinforcement for approaches patients identified to promote their healthy living, or to suggest alternate approaches if the discussion indicated this was necessary.

Acting on her view that it is the professional's responsibility to respect the "rights" and dignity of the patient, one nurse described

reframing the patient-professional relationship from that of control to that of sharing and collaboration. This resulted in a positive teaching relationship, facilitating the engagement of both the patient and nurse in learning and teaching:

> Its <u>really</u> funny that we react almost negatively to some patients who take control to learn as much as they can. I think we feel threatened maybe, and maybe we're the ones who are feeling we're loosing control.
> But you know, they do have the right to ask questions. They do have the right to ask for a second opinion. We should be supportive and we should give them as much information as they want.
> Once you recognize that, its easier to deal with. You go--"oh great! This is somebody who is willing to learn. He's not going to get upset when you go in and talk about things".

Nurses took their teaching responsibility seriously. Particularly if teaching involved content that concerned patient safety or was otherwise vital to their health, nurses constantly monitored patients' understanding and found ways patients could accept and integrate teaching. As one nurse related:

> If the patient is taking Nitroglycerine because he's got a cramp in his toe, I mean, we're not going to just say--"you know, you've had your teaching, now you take from that what you want."
> We'll go back and say--"sir, this is not why Nitroglycerine has been prescribed for you. Let's review again".

Generally, nurses held the belief that there are only a few patients who truly do not want to "hear" teaching. In their view, most patients who seem to be unreceptive to teaching, are in actual fact unable to engage in learning. Nurses consistently and actively tried to determine why patients did not "hear" teaching. They also had a large repertoire of methods from which they drew in their attempt to find an approach acceptable to each patient. This is exemplified in the following nurse's comments:

> Sometimes it may be just the way that I worded it. Maybe its not the right way. So sometimes I'll come back later and talk. Also,

> maybe they're just not in the mood to listen at the time.
> If they really don't seem to be interested you can ask the doctor to come and explain. I've done that a couple of times--asked someone's physician to come and explain because I don't feel that they understand.
> Or, you ask them if they have particular questions. Because maybe you're not answering what they want to know (laughter).
> You just have to try different methods.

Consistently, nurses were skilled in differentiating "unable to hear" patients from those rare patients who "don't want to hear". They were extremely sensitive to meeting the needs of both categories of patients. Further, nurses were observed going to extreme lengths before they conceded that a patient truly did not want to "hear" teaching. As one nurse related:

> Usually, and its rare that, that happens. But if it does, and if the patient consistently demonstrates that behaviour, day after day. And it doesn't matter what different methods we have used to try to talk with that patient. Then, I believe we have to accept that.
> I think its important to say--"fine, its one hundred percent sure that you're not willing to discuss this. That's your business. But its our business to make sure that if you run into difficulty you know where to go or what to do. Or you know where to go and get help".
> I think as health-care givers, we have to accept the fact that we're not going to win every time we go into a patient's room.

Patients who did not want to accept teaching or some aspect of treatment were not labelled as "non-compliant" or abandoned. Rather, nurses attempted to find some grounds for compromise, or failing that, advocated on the patient's behalf by representing the patient's decision to the multi-disciplinary team.

Nurses' Understanding of Patients' Perception of Nurses Within the Nurse-Patient Relationship

Many nurses discussed their perception that patients trust that nurses will act on the information patients bring forth to facilitate patients'

care. Nurses were aware that such information was often sensitive and personal, and would be considered private in other circumstances. They also acknowledged that, by virtue of being hospitalized, patients' usual social roles were frequently altered and social defenses lessened. Consequently, nurses consistently demonstrated that they honored the trust underlying their professional relationship with patients. They valued information communicated by patients and their families, seeing it as a significant method of learning about patients and their needs and used that information to facilitate patients' care.

Time, Timing, and Teaching

This second competency, also described by Benner (1984a), is expanded through data gathered through observation of nurses' practice of their teaching function within this setting. Two dimensions of time: time and teaching, and timing and teaching, were identified in the data as comprising this competency.

Time and Teaching

Time: necessary to establish a teaching-caring relationship. Consistently, nurses identified the importance of building a relationship over time. The process of "getting to know the patient as an individual", fundamental to the individualization of patient's care, requires time:

> I find that having the patient for one day is just not my cup of tea because they're people and you can't individualize if you don't know them ... I find that I really have to get to know the personality too. I can't just walk in and teach. I can't nurse that way either.

Time: For patients to learn. Nurses were acutely aware that patients, by virtue of being hospitalized and often facing extreme physical and emotional stress, frequently could not learn as readily as

they would in health. Compounding this compromised ability to learn was the frequent need for patients to learn about complex and threatening aspects that were usually out of the realm of their everyday experience. Consequently, patients frequently required increased time to learn. They also required time to come to terms with the implications of that learning. Further, the sheer complexity of learning needs and the existence of other more pressing concerns to which patients must devote their energies compounded the inadequacy of time for learning. Consequently, nurses consistently identified the importance of knowing the total "picture" of the patient, including what assumed priority regarding their learning. The following exemplar emphasizes this point and also reveals the complex real-world context in which nurses practice their teaching function. In this exemplar, a young patient received the diagnoses of cancer and of diabetes during one period of hospitalization. Received alone, each diagnosis would have been associated with multiple and complex learning needs. Received simultaneously, the diagnoses proved overwhelming. Recognizing that learning to deal with the life-threatening diagnosis of cancer took priority over any other learning, the nurse proceeded to provide emotional support to help the patient come to terms with that diagnosis.

Given the reality of patients' short length of stay in hospital, some patients clearly did not have enough time during their hospitalization to learn. Recognizing this reality, nurses exercised many effective strategies to quickly determine patient and families' learning priorities. Then they took steps to obtain the resources from among team members necessary to meet those needs. Citing the example of cardiac patients, one

nurse noted:

> Because the cardiac patients aren't here very long, you only have time to address certain things that they want more information about.
>
> If they want more information about their diet, you can refer more to the dietitian for that. You get the people involved for what they specifically want to talk about.

Time: For nurses to teach. Insufficient time was the most significant and commonly identified block to teaching identified by nurses. The conditions of nurses' worklife and in particular, those related to workload pressures, were consistently identified as imposing time limitations on their teaching function, impacting their ability to carry out that function and the satisfaction with which they did so. The sense of insufficient time for teaching was particularly troublesome to less experienced nurses. Describing a common view, one nurse commented:

> For the acuity of the patients on our ward, we don't have enough time to spend teaching them. I find with teaching, its probably the thing that gets left. If you're busy, and you're running from room to room filling IV's or doing treatments, you try to do what you can while you're at the bedside.
>
> I think sometimes teaching tends to be more hurried than is appropriate for the patient. You may be handing out the meal trays and thinking--"this person is going for an Angiogram, I wonder how much information he has gotten from the doctors"?
>
> You just try to go through the procedure with them. If they have the Heart Talk book there, they've actually got a picture of the heart you can show them. But you may not have time to ... run and get the Cardiac Resource Manual to show them--"this is a picture of where the catheter goes".

Timing and Teaching

Timing: Capturing patients' readiness to learn. Assessing patients' readiness to learn: how open they are to teaching, and where they are in the course of their hospitalization and in dealing with the issues that presents, were consistently recognized by nurses as crucial to effective teaching. Being in tune with the totality of patients' experience and

their response to their illness and treatment was seen as crucial to the accurate timing of teaching. For example, one nurse related:

> The gentleman yesterday, his big thing was his Stress Test. As far as he was concerned, that was his only thing to think about.
> In that case, its not a good idea to go in and start teaching signs and symptoms of a heart attack when he's worried--'if I don't pass the Stress Test, I don't know what's going to happen to me'.
> It was easy to go in after his Stress Test. His whole mind was cleared, he was so relieved. He was more receptive then.

Nurses' proactive stance in helping patients "get ready" for learning. Nurses, in particular those with more nursing experience, not only assessed patient's readiness to learn, but took an active stance in helping patients get ready to learn. This proactive approach involved communicating to patients, in an open and supportive manner, that learning is part of care and recovery. Giving patients permission to discuss issues related to their learning needs and reassuring them that the nursing staff were there to help them, effectively established a climate that facilitated patients' readiness for, and engagement in learning:

> I think we have to encourage the patients that it is okay to talk about this, and even though they may not perceive it as being a problem or concern, it is still important information for them to have. And they can do with it as they wish. As long as they don't feel that we're being to assertive, too aggressive in trying to force our information down their throat. And that, this is only a guideline for them.

Experienced nurses also assessed qualitative differences in readiness for learning. Constantly monitoring these differences facilitated the nurses' choice of the type and amount of teaching, and often the approach to teaching. One nurse described how, when patients' readiness to learn is hindered by their anxiety, she rations the amount of teaching, gearing it specifically to basic information aimed at reducing anxiety. At this stage, her teaching approach involves being very patient, spending time

with the patient, and using their response to teaching to gauge when to give more information. Once patient comfort is attained through this "basic teaching", the nurse's experience was that patients are "ready" for more complex, "in depth" teaching.

Timing: Establishing a teaching-caring relationship in anticipation of critical learning needs. Nurses frequently described incidents where they actively established a relationship with a patient and their family in anticipation that such a relationship would be needed to facilitate their future complex and/or critical learning. The greater the nurse's nursing and life experience, the greater the information pool from which the nurse could draw for this anticipatory preparation and guidance. A nurse's exemplar relating this anticipatory teaching-caring follows:

> We had a young man on our ward for tests. Tests, and more tests. They could find nothing but we were suspecting cancer.
> So I made it a point to get to know him as a person because I thought this man was going to need some emotional support. Its a good thing I did because he did need lots of emotional support. And so did his wife. The day that he found out that he had cancer.

Teachable moments and minutes. Since learning that patients needed to do involved learning about coping, and how to mobilize for recovery or a peaceful death, their learning needs presented themselves on an ongoing basis, as their hospitalization and treatment evolved. Teaching on the spot, as the learning need presented itself, was identified by nurses as both very helpful to patients, given the nature of their learning needs, and pragmatic for nurses, given their worklife conditions. Further, rather than teaching in a lengthy concentrated "sit-down" session, teaching in "minutes", on an ongoing basis, was often all a patient with decreased energy, considerable physical and emotional stress, or advanced age, could manage.

Assisting Patients To Integrate the Implications Of Illness and Recovery Into Their Lifestyles

This third competency, originally identified by Benner (1984a), was also identified in this study. Fieldwork observations clearly support the notion that learning about one's disease, treatment, and coping with illness is a part of learning to accept and attain a new definition of health necessitated by the presence of that disease and illness experience. Further, a collaborative relationship characterized by openness to patients' perspectives, willingness to explore and negotiate options, and a willingness to support patients' decisions regarding their own life, clearly facilitated nurses assisting patients to integrate the implications of illness and recovery into their lifestyles.

For example, experiencing a heart attack at any age is associated with significant implications for one's recovery and future lifestyle. In the following exemplar, a nurse describes the devastating effect on her patient who experienced a heart attack at the age of twenty-eight. Recognizing the tremendous stress this young man was under and the major lifestyle changes he faced, the nurse conducted her teaching from the stance of collaboration and support as opposed to control and prescription. Through suggesting that the patient make whatever "modifications" he could with the understanding that whatever he could manage would be "acceptable", this nurse opened possibility to this young man even in the face of extreme adversity:

> To look at him you wouldn't think there was a thing wrong with him. And that's the way he felt inside. `I feel well. I look well. And don't tell me that most of my heart is gone and I have to change my lifestyle.' Well, of course, you're going to be in denial a greater length of time than the average individual.
>
> Yet, he <u>knew</u>, he knew he was going to be ... he said--`well, I

> can understand that maybe some things will change.' But you know, he also ... he was playing hockey when he had this. And I mean hockey was a big part of his life.
>
> He wanted to learn but was frightened. Frightened to hear the information that he was given. So ... he wanted to hear, but he didn't want to hear.
>
> And so, I think the bottom line that we had outlined for him is that, ... at least if he modified some of the things he was doing, that was acceptable.
>
> It can be very difficult but we have to be extremely flexible with these patients.

Interpreting New Bodily Responses

Illness is frequently associated with new bodily responses that are often confusing to the patient and may be frightening to them. Learning how to adjust one's lifestyle, both in hospital and after discharge, was commonly seen as involving learning about what those new responses meant and the range of options available to respond to them. Fundamental to this learning, however, was the notion that the individual was still a whole person who could go on living a meaningful life.

Heart disease, for example, may be associated with a new bodily response to activity, that of chest pain. Patients hospitalized with heart disease need to learn that although changes in their usual activity are required and that they do need to rest, the possibility exists for independence and activity within guidelines for safe care during rehabilitation. As patients progress along their recovery, they have the support of the health-care team to monitor with them, their bodily responses to treatment and exercise. As one nurse related:

> Its kind of reassuring them that getting up to the bathroom will be okay and reminding them what the symptoms are. Going over with them how they felt initially when they had the attack. And what would they do if it recurred again? And ... if you get up and have chest pain, that the doctors are here, the nurses are here. And you tell us right away.
>
> These kind of little things, ... basically just reassuring them that--"yes, you have to make some changes in your lifestyle. You

> have to make some changes while you're here in the hospital. You have to adjust, but you don't have to stop living completely".

Frequently, nurses would assess that patients' interpretation of bodily responses were incomplete or inaccurate thereby leading the patient astray as to how to cope with those responses. In another exemplar a nurse describes how, through conversation with her patient, she recognized that the patient's misunderstanding of her shortness of breath detracted from her ability to cope with that response. Basing her teaching on the patient's experience with shortness of breath, rather than giving the medical explanation of lung disease and its relationship to shortness of breath, facilitated the nurse's ability to provide the patient with accurate information that she could apply in her daily activities enabling her to cope with her shortness of breath. As that nurse concluded:

> People's perceptions are interesting sometimes. You know, we just try to ... straighten out their thinking a little bit. So they're ... more prepared.

Teaching Based on Sharing the Experience of Integrating the Implications of Illness and Recovery Into One's Lifestyle

Personal experience with illness clearly enhanced nurses' ability to understand patients' experiences and to teach from a realistic perspective. As one nurse related:

> Its hard. If you've always done or had something but then are told that you can't have or do that, well--"that's my independence". You don't want somebody else telling you that you can't have something.
>
> So I always say--"try to follow this as much as you can. And if, ... if you feel like you <u>really</u> need to have something, then have a little bit. Like, if you really want a chocolate bar, just have a bite. Then just don't have any more. And, try not to do it all the time.
>
> I mean I don't follow (laughter) my diet all the time. And its silly because sometimes you're just not that hungry or ... you don't feel like eating that much. And its ... you know, a hard thing.

Eliciting and Understanding the Patient's Interpretation of Their Illness

Also identified by Benner (1984a), this fourth competency was clearly part of nurses' teaching practice. Not only did nurses respect patients' interpretation of their illness, they were exquisitely attuned to eliciting and highly motivated to understand those interpretations. Ongoing, through their everyday practice, nurses listened to patients' conversation and questions, and observed patients' behaviour to gain an understanding of the interpretation of their illness.

Through the following exemplar a nurse describes how, having gained the patient's interpretation of his illness including a recommended dietary change, she enabled him to integrate that change into his lifestyle. Through her openness to the patient and her willingness to explore his perception of the change, she was able to offer him a different interpretation, one that was flexible and reasonable, and therefore acceptable to him:

> I had a patient, and East Indian fellow, who was admitted with heart disease. We just starting talking. It turned out that he was just very, very anxious about his diet.
>
> He said--`you know, I've been eating this way for so many years'.
>
> He just basically didn't want to stop eating the stuff that he liked and that he had grown up with. He said it was part of him. He just couldn't see himself never eating ... whatever. And he had a big family too, eight children and he was just worried about how his wife was going to do it. And so, we just talked about it.
>
> I'm not quite sure if the dietitian had been in and told him he had to do that, that, and that. I don't think so. I think he was probably reading the Heart Talk book and took it, like, word for word.
>
> And so, I told him about his diet ... it was a restricted sodium, restricted cholesterol ... I told him that you have to do the best you can but ... you still keep part of your lifestyle too.
>
> And he said--`well, what's moderation? And what's a little bit'?
>
> I mean, I didn't have all the answers for his questions and I

> told him that I wasn't a dietitian. But ... that I had the advise for the general type of lifestyle ... that I thought would be good for him. Everything has to be in moderation. But, if Sunday dinner is the big family dinner, then do the best he could. Try for moderation.
>
> The next day he was going home. We talked about it again. He was a new person, much less stressed out.

Frequently, patients volunteered their own interpretation of their experience. This was commonly observed after patients returned to the ward following a stressful test or procedure. Not only did patients want to talk out their experience, many times they seemed to need to do so. Nurses were aware of this need, attributing it to patient's need for emotional release following stressful events. Reviewing their perception of the experience helped patients "put it in perspective". Further, through sharing the experience, patients validated that they had, in fact, survived the event.

Gaining an understanding of patients or families' interpretation of their illness also served to enlarge nurses' ability to help other patients. In the following paradigm case, a nurse describes how understanding a husband's interpretation of his wife's dying, forever changed that nurse's perception of the experience of dying. In this way, new possibilities were opened for the nurse to help other patients and families achieve comfort in dying:

> I'll just tell you of an experience I had in a home with a dying lady when I worked with ___ (private nursing agency). When I got to the home, all I knew was that the lady had cancer of the gallbladder and that she was dying. She was young, I think in her forties, maybe fifty.
>
> When I got there, she was not well at all. Her husband had her in the family room propped up on the couch with all her drains and everything. But the lady herself, ... I don't think she knew who I was at all.
>
> She needed to have her dressing changes so her husband helped me. While I was changing the dressing, he talked to her the whole time. And he would say--`its okay dear. I know its, that its hard

and I know its painful ... but I love you and I am here'. And he just talked and talked and talked.

She died ... while we were doing the dressing. And after ... he shed no tears. But ... he said--`we've been through this death, my wife and I, many times'. It was just so amazing, like he explained it to me--`giving birth is hard, hard work, and so is dying. It is a lot of hard work. And you have to work through it'.

He just made my eyes pop open. I just thought--I've known this man for about an hour and a half and I'll never forget him as long as I live. Because he had such a different way of looking at dying and death. ... Like, he just talked to her. And he just told her it was okay. You know, he held her hand and hugged her. Whereas so many people stand at arms length. You know, they're afraid to come close to the person.

It can be a beautiful thing. To be there ... you would have really appreciated it, you really would have. Like I ... it was just ... I can't explain it. I just am ... dumfounded when I ... think back to the way he dealt with it and how he ... he made her so precious. Her life was everything. But, he made her more precious because he also loved her in death.

I often think of that now, when somebody is dying, you put yourself in that bed and you think all these people are standing there and you know, you would probably just want somebody to just come and hold your hand, or put their arm around you or something. And this man did.

Providing an Interpretation of the Patient's Condition and Giving a Rationale for Procedures

This fifth competency was also identified by Benner (1984a). Through fieldwork observations and in discussion with nurses and patients, it was clear that individuals hospitalized in this acute care setting faced learning about significant changes in role, environment and routine life events. Also, nurses were aware of the scope of this learning and its impact on patients and their recovery. Further, nurses were sensitive to the fact that learning occurred while patients (and often their families) were in a state of decreased energy, and increased physical and emotional stress. As part of their everyday practice, nurses constantly taught patients about hospitalization; being a patient; and about their disease, illness, and care. Empowering patients with this information enabled them

to cope with their illness, hospitalization, and preparation for discharge, or for their dying.

Teaching About Hospitalization and Being a Patient

On admission, nurses oriented patients to their new physical surroundings. Beyond simple information giving, teaching on admission also involved establishing a "caring relationship". This involved promoting patients' comfort with their new environment, establishing that the nurses sincerely wanted to help the patient, and reassuring the patients that it was "okay" for them to ask for that whatever help they required. Nurses not only taught patients that it was "okay" to ask for help, they actively taught them how to do so.

Teaching patients about hospital routine as they unfolded, made the unfamiliar familiar. This enabled patients to feel comfortable with those events and often facilitated a sense of mastery in dealing with them.

Teaching patients about resources within the hospital and framing that information in terms of "resources available to help", not only enlarged patients' sense of possibility for and support of treatment and recovery, it also linked those resources to the patient in a relevant and supportive manner. Patients were therefore enabled to engage with available "resources". As one nurse put it:

> I think its important that patients know and understand what kind of resources are available to them as far as, you know, social workers, dietitians, pastoral care, etc. being in the building. They need to know what is available to them because the hospital in itself, is such a strange place to most people.

Teaching patients about events in advance of their happening prepared the patient for what to expect. It also provided an approach for nurses to personalize the event or procedure by explaining how it would be of

benefit to the patient. This facilitated patients' acceptance of the event or procedure. Even more significant, through this anticipatory teaching, nurses reviewed with the patient how they could cope with the event and instilled confidence that they would cope with it.

As also noted by Benner (1984a), nurses not only provided patients with information, they also offered new ways of being, ways of coping, and new possibilities for patients, all of which enabled patients to deal with the process of receiving care. The following exemplar illustrates how a nurse not only explained a test to her patient but also helped him cope with the anxiety-provoking process of waiting to receive that aspect of care:

> Being ... thirty-nine, and having a heart attack. That's scary ... that's really scary. And then having to wait for the crazy angio. Just every day thinking--`well, there's only two more days now and ...'. Its scarring him more, I think.
>
> On Sunday we went over a bit more teaching than I did on Saturday. But today I was more joking around with him ... because I didn't want to be all teaching.
>
> I thought, today I'll be a little bit more ... easy going. If he has questions then he could just ask them. I didn't want him to be scared.
>
> He seemed to really respond to that. It sort of lightened him a bit. Like--`I'm still an okay person. I can have laughs'. I wanted him to know that its okay, enjoy yourself (laughter).

Teaching Patients About the Nature of Their Disease

Teaching patients about their disease and the prescribed medical treatment plan, at least for the initial explanation, was consistently seen by nurses as the premise of the medical staff. Nurses saw their role as one of clarification and validation of the patient's understanding of what the physician had discussed. For example, a nurse describes how she determined that although the physician had explained the procedure to the patient, he required further information and reassurance about that it:

> When I asked if he knew, it seemed that he knew partially what was going to happen. So I showed him the diagram and it just seemed it explained it. It sort of fell through in his mind. He could sort of understand it and he said felt better about it.

Other aspects of the nurses' role referable to teaching patients about their disease involved advocacy on behalf of patients to help them obtain additional or clarifying information. Nurses also offered guidance regarding how patients could seek further information.

Teaching In Preparation For Going Home

Teaching in preparation for patients' discharge, starting on admission and continuing throughout the patient's hospitalization, was a consistent goal of the nursing team of this ward. Teaching to enable patients to live safely and comfortably at home while regaining or maintaining their health, required that nurses teach patients on an ongoing basis, how to mobilize for their own recovery. Discharge teaching also required extensive and intensive reassurance and anticipatory planning.

Fundamental to nurses' view of successfully discharging patients, was the knowledge that patient and their families felt capable of coping with that discharge. Instilling a sense of confidence in patients and families that they were capable of managing at home was seen as crucial to their comfort with discharge. In the following exemplar, a nurse describes how using a matter-of-fact approach to performing a totally foreign but crucial skill, provides the patient with knowledge and skill as well as the confidence necessary to manage that procedure at home:

> I try not to make people paranoid when they have to learn a specific task. Like, when patients have to learn something like doing a straight catherization, don't make them paranoid about the procedure. The risks of the procedure.
> You know (laughter) not,--"you're going to be really prone to

> having a bladder infection, or kidney infection. You should wash those hands for one minute, or two minutes (laughter). Scrub really well (laughter)", or whatever.
>
> Instead, talk about good hygiene and be positive--"Once you've learned how to do it, you're going to feel comfortable with it. And you are going to be able to manage this at home".

Nurses also actively monitored patients and families' comfort with going home. When it was felt that a patient or family was uncomfortable with plans for discharge, nurses actively sought to determine the reason for that discomfort. Then they helped patients and their families overcome whatever obstacles were causing discomfort about going home.

The Coaching Function:

Making Culturally Avoided Aspects of an Illness Approachable and Understandable

While much data was collected identifying this sixth teaching-coaching competency, the majority concerned coaching patients and their families toward comfort and peace in dying. In this way, a different aspect of the competency as described by Benner (1984a) is brought forth, although the dimensions of the competency are the same.

Teaching For the "Bigger Picture": Coaching the Patient Toward Comfort and Peace In Dying

Death and dying are part of the reality of clinical nursing. Making this culturally avoided aspect of illness approachable and understandable was a challenging but vital aspect of nurses' coaching function. In a paradigm case, teaching "for the bigger picture", a nurse described how she coached her patient to a peaceful death. The patient, a man who had been treated for a form of cancer in his early twenties, had now, in his early thirties, developed a serious complication of that treatment, resulting in failure of his lungs. Because of this and the associated

strain on his heart, he became critically ill necessitating hospitalization. Having no other method of treatment to offer him, he was "evaluated" for heart-lung transplantation. Even this was unavailable because it was determined that, in his case, it was anticipated that the surgical procedure would be impossible.

Through her engaged caring, her complete openness to and acceptance of the patient, this nurse conveyed to the patient that she not only understood what he was attempting to deal with, but that she was present for him, offering her assistance and inviting him to chose what help he felt he needed. Her attempt to normalize the situation, making life more familiar and therefore less frightening, despite his critical emotional and physical status, made this young man's dying comfortable and peaceful:

> I was just ... trying to make him feel comfortable ... it was just the way it was with us, we were like pals, sort of thing. You know, things weren't going well for him and I just wanted it to feel more normal, sort of thing.
>
> I think its hard for a young guy in that position ... you need time to think--but then there's too much time to think. I don't think he was ready at first to really talk about things so I used to spend a lot of time goofing around with him. We sort of had a similar sense of humour. I used to play lots of cards with him. If he wanted to talk, I'd listen, if he didn't, we played cards.
>
> Actually, I came in the night before he passed away. I came in and I stayed there all night, just with him. Originally, I came in because they were short staffed, but as it turned out, there were students on. They had all my patients so I just sat with him all night.
>
> He was very afraid. He knew he was dying. You know, if you can't breath very well, its got to be the worst way to go! ... He was so afraid. Like, he was and he wasn't. He was afraid ... of the more physical not being able to breathe, but he wasn't afraid of dying anymore.
>
> I don't know what its like to be dying, but I think it would have made a difference if he had been just sitting there alone all night. The night before he died.
>
> ... That's something I'll always remember because I really do think ... like at the time, it was important. Just .... to sit there with him. ... I think it probably, was good for him. I don't really think of it as teaching, but in a way it is--teaching for the bigger picture.

Evaluating: Ongoing Monitoring of Learning

The seventh competency, evaluating: ongoing monitoring of learning, is a component of nurses' teaching function found in addition to that described by Benner (1984a). Congruent with the ongoing nature of patients' learning needs and nurses' approach to teaching, evaluation of that learning and teaching was conducted by nurses through the ongoing monitoring of patient and families' responses. Monitoring of patients' learning was thoroughly integrated into the practice of everyday nursing care. Consequently, evaluation could be conducted over time as nurses had contact with patients, and as teaching and learning occurred. Further, integration of this approach to monitoring learning was pragmatic in terms of nurses' worklife.

Monitoring: The Indirect Approach to Evaluating Learning

Consistent with the teaching-caring relationship, nurses' evaluation of patients' learning was approached from an informal, indirect, and non-threatening stance. Formal evaluation involving any semblance of "testing" the patient and their learning was consistently seen by nurses as inappropriate to their teaching function and the teaching-caring relationship. Representing the view of most nurses, one nurse commented:

> People get annoyed or put on the spot, it makes them nervous if you point blank ask them--"so what did you learn"?
> There are ways of gathering that information without them even realizing what you are doing. Just through conversation and casual--"hi, how are you? How are you doing"? The indirect approach.
> Like, I always ask the patient for whom diet is important--"what do you eat at home"? Or maybe their tray is there and I'll say--"oh that looks pretty disgusting (laughter). ... If you were at home now what would you be eating"? Just sort of ask them in that sort of sense ... build it into the conversation.

Nurses also constantly observed patients' behaviour for evidence of

integration of learning into their everyday lives as the following documents:

> Nurse: That's great Mr. ___. That's a good habit to get into. Using your puffer before you go for a walk like that.
> Patient: Well, my doctor told me, its just like putting on your overcoat. You don't wait until you're outside where its forty below to put it on. Put it on before you go out (laughter).

The informal, indirect approach of monitoring responses facilitated the mutual exploration and individualization of learning. For example, through setting "real-life scenarios" for patients, nurses placed learning within the context of patients' personal experience. This form of personalized, anticipatory planning, assisted patients to "think through" how they could integrate teaching once they were at home. One nurse describes this commonly used approach:

> If you give them the daily ... life routine and ... maybe set them a bit of a scenario. Something they can relate to. You are asking about them and their life and how things are and what they do.
> Just getting them telling you about ... even things like, I'll just say--"show me ... or what you do if this were the situation". You know in a more ... open ended way.

Feedback From Patients

Patients frequently provided direct feedback regarding their evaluation of teaching they had received. The following fieldnote excerpt describes one such patient's comments. As was the case with most patients, this patient's feedback was related to the practical applicability of teaching he had received and its usefulness in enabling him to manage his own life. The patient had been hospitalized on the ward following his MI. A few days after his discharge, he developed chest pain and was subsequently readmitted to the intensive care unit. When he was readmitted to the ward, he told the nurses:

> Yes, I had pain again. I took three Nitros but the pain didn't

> ease off. So I told my boys to call the ambulance. They had quite a set too with the drivers because they wanted to take me to ___ [another hospital]. But my boys told them they had to bring me here, because you people have all my files and know what my problem is so there wouldn't be any delay getting help.

This patient did not seem upset about the necessity for readmission. Instead, he felt good about the fact that when his condition indicated, he knew exactly what to do to get the help he needed. His comments to the investigator were:

> I told my boys that you would be here studying things and when I saw you, I was going to tell to tell you--the system works! I got the information I needed to work along with you folks to give me the help I need. So I thought you would want to put that in your report.

Evaluating Enablement: The Outcome Measure of Teaching

Since the purpose of nurses' teaching was seen as enablement of the patient, the measure used for evaluation was the comfort and degree to which the patient and/or family had been enabled to integrate that learning into their lives. Assessment of patients and families in terms of what was required for safe, comfortable living balanced with what they were capable of coping with, was consistently described by nurses as the "very bottom line" of what patients and families need to learn. The following exemplar highlights this, as a nurse described the special learning needs of an elderly couple. For them, the "bottom line" criterion to measure teaching effectiveness was that they were enabled to safely manage the husband's gastrostomy at home:

> An elderly man was to go home with a gastrostomy. His wife was to do the feeding. I was trying to teach the husband during the day because it was on him. He did quite well. And then when his wife came in, we showed her. It took more than two days to explain to her how to do it and for her to feel okay with it because she was a bit anxious.
>
> Actually though, you couldn't have high expectations of either of them. When you get old, you don't want somebody home that's

> sick. Its enough for them to care for themselves. So your goals have to be set differently.
>
> I was quite pleased though, because eventually they were able to go home and safely do the man's gastrostomy feeding. I don't really know how much they understood about it but at least they went home able to manage.

Through conversation engaged in during the provision of nursing care, another nurse describes how she reviewed with the patient, what she saw as important aspects of learning. Through her evaluation, the nurse determined that both she and the patient felt comfortable with the patient's learning. Through helping the patient priorize the information she needed to know, and reassuring her that she was doing well with her learning, the nurse further enabled the patient to select what was relevant to and possible for her:

> I was talking to ___ [patient]. She's read the book [patient-teaching reference book for heart patients], three times I think. And she's familiar with what she's read.
>
> So I went over the Nitro teaching. I just told her as long as she knows about the Nitro, when to use it and how, that's the most important. The rest is more for ... interest sake. I mean, if she can absorb it fine, but not to be hyper about it. Because she is a bit anxious at times.
>
> So she explained to me about the Nitros and I think she's pretty safe with that.
>
> So, the rest ... she said that Physio hasn't been there yet but there is a consult to them. And she spoke with dietary, and she'll see the pharmacist about her medications. So she feels comfortable.

"Connecting" and "Getting Through": Other Yardsticks For Evaluation

"Connecting" with patients and families through the teaching-caring relationship and "getting through" to them in terms of being able to enable them through teaching, were common yardsticks nurses used to evaluate nurses' teaching effectiveness and patients' learning. In addition to providing nurses with a method of evaluating their practice, nurses' recognition and utilization of these criteria exemplified their

understanding of the integral relationship of the nature of the teaching-caring relationship and the effectiveness of their teaching-coaching practice. One nurse outlines how the sense of "connecting" and "getting through" promoted a positive evaluation of the teaching-caring relationship established with the patient and her family and of the teaching the nurses had conducted:

> After she went home she suffered pulmonary emboli. Apparently, she was just predisposed to emboli because of all the abdominal surgery.
>
> The family said--'We brought her back here because we know that you know her'.
>
> There was no problem with the wound. It was the pulmonary emboli. And when we checked her wound, ... everything was great. It was going along great. It was nice knowing that we got through that way.
>
> So I think we connected that time.

Following Up

Consistently, nurses acted on information they received during the monitoring of patients' learning. In instances where nurses felt patients were unclear about teaching, nurses were aware that the reason could lie with the nurses' teaching or evaluation as well as with the patients' learning. Being committed to the patient and their learning, nurses went to amazing lengths in their attempt to ensure that patients' learning needs were met:

> Sometimes a person who, you thought understood can be totally confused the next day. Overnight, something happened. When you talk to the patient or hear from the family ... they don't seem to have understood a word you said.
>
> Whether its anxiety, or fear ... or maybe you weren't as simple as you thought you were, in your explanation ... or you just didn't appreciate the fact that they didn't understand. You know it could be your way .. not listening to them.
>
> If I find that a patient is quite confused about what I had tried to explain, I go over it again. And, try to change it (laughter). Reinforce it.
>
> Just see what they know. ... If they don't, I mean if it comes to a point where you really can't, maybe you can ask someone else

to go and try. If they're still getting the similar results, maybe its time to talk to the family too.

Family-Involved Teaching and Coaching

This eighth component, found in addition to that described by Benner (1984a), concerns a valued and integral part of nurses' practice, the involvement of family in patients' care. In this setting, patients defined who constituted "family". Nurses recognized that although the patient was the person who was sick, the experience also had a significant impact on the family and/or significant others. Families not only needed to learn about patients' illness, treatment, and recovery; they also needed to learn how to become involved and engaged in patients' care and recovery. Just as nurses' teaching function was aimed at enabling the patient, it was also aimed at enabling families' understanding and acceptance of patients' illness, care and recovery; and to engage in it.

Teaching, particularly about aspects of healthy lifestyle, were frequently as relevant to family members as to the patient. This provided an additional impetus for family-involved teaching. The approach of "getting the message out to as many people as possible" was also adopted by patients, particularly those who had heart disease and had read the Heart Talk book. Nurses both valued and encouraged this action by the patients:

> We have patients who come to us and say--'would you mind if we had one more of those books? I'd like to give it to my neighbor or brother. They should know what is in that book'.
> It is very positive for them because they feel that they can do a little teaching along the way too.

Family: The Patient's "Support Group"

Family were seen by nurse participants as being in an excellent position to offer crucial support to patients' teaching because of their

knowledge of and relationship with the patient. Teaching carried out in collaboration with the family was often made more meaningful and acceptable to the patient because of the family's unique ability to interpret information to the patient. The family could also act as the patient's advocate, representing the patient's concerns to members of the nursing or multi-disciplinary team. Further, with the help of the family, patients often felt more comfortable "opening up" to the nursing staff thereby facilitating nurses' understanding of the patients' needs and wishes.

Following discharge, family support was seen as encouraging the patient to integrate suggestions for healthy living and recovery into their lifestyle, and helping in instances of deterioration in patients' health status. Expressing the common view of nurses, one nurse related:

> We tell patients that its so important for their spouse to know what a heart attack is, what to expect, and that there probably will be some changes. Even emotionally when they are at home in the convalescent phase. Then they will know--"this is okay. Like you're not going to break in half or something". Otherwise their spouse may be very, very worried and concerned that, 'wow, something is going wrong here and maybe I should take this one back to the hospital', or whatever. So they know what's going on. At least they are aware of signs and symptoms of angina and what to do.
>
> There <u>should</u> be, I feel there should be a second party, <u>always</u>, for our patients. When its something new to them, there needs to be someone else who knows what to do if things go wrong.

<u>Inviting Family Involvement</u>

While the nurses valued and encouraged family-involved teaching, the process of inviting that involvement was based on consultation with the patient. If the patient supported family-involvement, they were asked to identify which family members and in what capacity they could be involved.

Through the process of consulting with patients and inviting family

involvement, nurses frequently gained a valuable understanding of patients and families' perception of family dynamics and of their overall relationship. Frequently, nurses acted as a "bridge" between the patient and family, helping them to become involved with one another:

> Initially, you have to spend some time with the family especially if you sense that there is a need there. Often you find with elderly and their children sometimes they have kind of drifted apart. If you spend a little bit of time with them, you can make both of them a lot happier. Sort of bridge the gap.

While all nurses valued family-involved teaching, both nursing and experiential knowledge influenced the degree to which nurses actively sought to involve families. For example, a nurse who was relatively new to nursing reported that she was just beginning to develop the confidence necessary to interact with family groups. In clinical practice, this nurse was very open to and supportive of family members when they were present and when they actively sought her out. However, she rarely actively sought out family members or mobilized them to be involved in patients' teaching. As nurses gained more experience in nursing, and/or drawing from their life experience, they both described and were observed taking a more active stance in getting to know families and involving them in patients' care.

Nurses also described that moving from the experience of providing direct bedside nursing care to six or seven patients, to that of assuming "charge" responsibility for the overall nursing care of all the patients on the ward, resulted in a different and more concentrated exposure to families. This new perspective expanded their perception of family-involved care and teaching.

Despite nurses' valuing family-involved teaching and their active

attempts to engage families, the realities of clinical practice were such that it was not always possible to implement ideal family-involved teaching. In those instances, most nurses accepted that they would do the best they could to involve families, trusting that through the "nursing teamwork" on the ward, more ideal family-involved teaching would be attended to. Observations validated that this was so.

Facilitating Families Understanding Of Patients' Illness, Care, and Recovery; and Acceptance Of Patients' "Changed" Situation

Family-involved teaching served to foster families' understanding of the patients' situation during hospitalization and any changes required on their discharge. These changes ranged from alterations in patients' physical, emotional or mental condition; to changes in lifestyle; to the introduction of health-care services and/or equipment in the home. Gaining this understanding facilitated families' acceptance of these changes as well as their impact on both the patient and family members. Consequently, both families and patients were enabled to integrate these changes into their lives while respecting the personhood of the patient and promoting healthy family relationships:

> I think its really important that families have things explained to them when the patient is discharged. Like what the patient can do, and how to exercise and so on. Then they can kind of watch out for the patient if they don't want to watch out for themselves.
>
> Its an adjustment for the whole family ... because maybe your father shovelled grain all his life. Well its a big change in his lifestyle if he can't do that anymore.
>
> And you've got to be able to accept the change in him. Like he has to change his lifestyle but you still have to accept that there is something changed about him. He's accepted and, sort of, that its not a new <u>him</u>, its just a new way he has to do things in life.
>
> The surrounding people have to accept it. He maybe can't do what he used to, but still appreciate what he <u>does</u>. Don't push him aside just because he can't shovel grain anymore.

Family-Involved Coaching

In the following exemplar, a nurse describes how she makes a culturally avoided aspect of illness, approachable and understandable to the family. Based on her belief in the importance of physical nearness and actual contact for healing, the nurse describes how she teaches the family about the need for and role of touch in the communication of caring. Through her openness to the family and patient, she is able to gain the family's perspective of the patient and what is unfamiliar and frightening to them. Encouraging the family to engage in normal, everyday facets of care, the nurse attempts to normalize the situation. Integral to her coaching behaviour, is the active demonstration of approaches family could use to engage in the patient's care, sustaining the family until they could gain enough comfort, confidence, and experience to develop their own approaches. Through her teaching about the role of therapeutic touch in healing, this nurse not only exemplifies valuing of and caring for the person regardless of disease, illness, or situation; she also teaches the family how to engage in this type of valuing and caring:

> Part of looking after patients too is physical contact. Visitors are often scarred. They walk into the room and they are scarred to go close to the bed because the patient is sick. Not realizing that even though they are sick they are still people.
>
> The patient feels that. They can sense a warm and a cold feeling, and a feeling of fear. So patients sense the visitor is scarred, they sort of think--`well they're scarred to do this, so maybe I won't bother them with this problem', as opposed to--`I <u>should</u> bother them with this problem because I've got my feelings and they are the ones that have to help me do it'.
>
> You have to realize, getting close to them helps them relax and is part of support. You don't realize you are giving support but it is a part of support because you feel just by touching--like shaking the hand of somebody you feel like there is some friendship or caring. Touching is more of a warm, receptive feeling. Sort of--`I don't care if you are sick, you haven't changed. You are still somebody to me no matter what your illness is'.

> If you keep close to the patient and touch them, and get the family members helping you, sometimes even if you just get them to just brush the patient's hair. They'll think well, they're still the person they were before just a little something has changed.
>
> You teach them without them knowing. If you bring it in as an everyday thing, they can do it. You have to be the leader and show the example. If they're scarred, they'll do it the same way you did it because that's the only way they can see how. But once they have done it a few times, then they will get into their own way of doing it.

Summary

The third and final theme identified in the data involves nurse's clinical practice of their teaching function. That function, as it was practiced within this ward, involved the following eight competencies: (a) establishing the teaching-caring relationship; (b) time, timing, and teaching; (c) assisting patients to integrate the implications of illness and recovery into their lifestyles; (d) eliciting and understanding the patient's interpretation of their illness; (e) providing an interpretation of the patient's condition and giving a rationale for procedures; (f) the coaching function-making culturally avoided aspects of an illness approachable and understandable; (g) evaluating: ongoing monitoring of responses; and, (h) family-involved teaching and coaching.

This chapter presented the findings of the study. Three major themes comprise the findings. The themes are: (a) contextual influences on nurses' teaching function; (b) nurses' description of their teaching function; and, (c) nurses' clinical practice of their teaching function. The next chapter discusses these findings.

CHAPTER 5: DISCUSSION AND CONCLUSION

The findings presented in the preceding chapter will be discussed in relation to the central question asked in this study. That question was, how do nurses, practicing in an acute-care setting, define and practice their teaching function with adults hospitalized with the medical diagnosis of chronic obstructive pulmonary disease (COPD) or myocardial infarction (MI)? In this study, data collected addressing that question identified three major themes. The first theme, contextual factors influencing nurses' teaching function within the acute-care setting, will be discussed. This will be followed by a discussion of the second and third themes, how nurses described, and how they practiced that function, within the acute-care setting. Then, the significance and limitations of the study, and recommendations for further investigation, will be presented. Finally, concluding statements complete the chapter.

Contextual Factors Influencing Nurses' Teaching Function

Several contextual factors were identified as influencing nurses' teaching function within this study setting. The dominant contextual factor was nurses' culture of patient-centered caring. A second factor related to nurses' conduct of their teaching function as part of a complex nursing and multi-disciplinary patient-care team. Other contextual factors, identified throughout the three major themes, included conditions of nurses' worklife and trends occuring within acute health care.

Teaching Within the Context of a Patient-Centered Culture of Caring

The dominant contextual factor influencing nurses' teaching function as practiced within this setting was nurses' culture of patient-centered caring. Caring, and its centrality to nurses' practice, including their

teaching function, can be understood in terms of the phenomenological notion of concern (Benner & Wrubel, 1989; Dreyfus, 1983).

Concern, or what mattered to nurses practicing within this setting and determining why they were involved in their world as they were, accounted for the assumptions and values underpinning their culture of caring. Congruent with that described by Curtin (1982), nurses' culture of caring was characterized as one of "human advocacy" with the nurse attending to the patient's need for information, respect, participation, and access to health care, predicated on the nurse's view of patients as a fellow human beings worthy of respect. Fundamental to that culture was nurses' committment to the primacy of patients and their families. Arising from and integral to their patient-centered, caring approach to practice, was nurses' committment to their teaching function. Committed to assisting patients meet their learning needs, nurses addressed the learning needs they could and advocated for patients to have other learning needs addressed by members of the multi-disciplinary team.

Within the culture of patient-centered caring, openness of communication, and fairness and respectfulness in interpersonal relationships represented norms. As this related to nurses' teaching function, the teaching-learning relationship was seen by nurses as characterized by collaboration and sharing, with patients and nurses as active partners. Information was freely shared with patients just as it was among members of the nursing and multi-disciplinary team.

Through their culture of patient-centered caring, nurses created an environment committed to the healing of patients and their families. Staff were also nurtured by this environment. As staff made their contribution

to patients and families' care, they did so within an environment that both welcomed and valued their personal and professional contributions. This acted to facilitate staff's committment to and enjoyment of the process of providing care and promoting healing within this caring environment.

The centrality of caring to the practice of nursing has been described by other nurse authors (Benner, 1984a; Benner & Wrubel, 1989; Leininger, 1978; Roach, 1987; Watson, 1985). Watson (1985) describes caring as the "core" of nursing. In her view, caring constitutes the essence of nursing regardless of how nursing is conceptualized or practiced. Leininger (1978), based on many years of study of transcultural nursing, contends that "the most unifying, dominant and central intellectual and practice focus in nursing is caring" (p. 13).

Roach (1987), asserts "that caring is essentially the human mode of being, that to be truly human is to care" (p. vii). Caring is therefore not unique to any profession. It can, however, be seen as unique in a profession. Regarding caring as a concept in nursing, Roach (1987) states that "all the attributes used to describe nursing have their locus in caring" (p. 47). The professionalization of caring involves affirming caring as the human mode of being and developing the capacity to care. Professional caring may be expressed through five categories of human behaviour which Roach (1987) calls the "five C's" of caring. "In compassionate and competent acts; in relationships qualified by confidence; through informed, sensitive conscience; and through commitment and fidelity, specific manifestations of caring are actualized" (Roach, 1987, p. 68).

Benner (1984a) presents the thesis that caring is central to human expertise, curing, and healing. Extending that thesis, Benner and Wrubel (1989) contend that nursing is "a caring practice whose science is guided by the moral art and ethics of care and responsibility" (p. xi). They further state "that caring as a moral art is primary for any health care practice" (Benner & Wrubel, 1989, p. xi).

Teaching as Part of a Complex Nursing and Multi-Disciplinary Team

A second contextual factor influencing nurses' practice of their teaching function involves teaching within the context of a complex nursing and multi-disciplinary team, characteristic of the world of acute-care nursing. While nurses consistently acknowledged patient teaching as an independent and valued nursing function, they both understood and conducted that function as members of an intricate, patient-centered team.

Studying nurses' practice of their teaching function within the context it occurred identified that different aspects of nurses' teaching function were addressed through the various roles nurses played within the nursing team. Nurses were aware of how their individual roles within the nursing team contributed to patients' teaching. They were also aware of how nurses, as a team, contributed the nursing perspective to patients' teaching. Nurses' culture of caring fostered nurses' understanding and valuing of the different nursing roles. It also facilitated the nursing team's patient-centered teaching.

In addition to being aware of their nursing role in patients' teaching, nurses were also keenly aware of how teaching from the nursing perspective was a part of the larger "whole" of teaching provided by the multi-disciplinary team. Aware that they did not function in "splendid

isolation", nurses accepted that they did not have the sole responsibility for teaching patients "everything". Length of experience working within the ward and in nursing generally, was related to nurses' degree of knowledge of team functioning. The greater nurses' knowledge in this area, the greater their ability to participate in the total picture of patients' teaching. Also, the greater this knowledge, the greater nurses' ability to teach patients about the team and its functioning, and to advocate for patients with that team to facilitate patients' obtaining the teaching they required.

The multi-disciplinary team extended beyond the physical boundaries of the hospital. Linking patients and families with community health resources were several mechanisms within the hospital. For example, multi-disciplinary, patient-centered discharge planning rounds facilitated the identification of necessary supports and resources, including those for teaching, required by patients and families on discharge. Within this multi-disciplinary approach, nurses and in particular, the head nurse (HN) and assistant head nurse (AHN), took an active part in involving the appropriate team members to arrange patients and families' community support.

Mechanisms for feedback from the community concerning how patients and families managed following discharge from hospital were present but limited. Although rare, this feedback was identified as significant to nurses because it provided a form to evaluate their teaching. It also enlarged nurses' understanding of patients' illness experiences, recovery, and ongoing coping patterns.

Worklife Conditions and Ongoing Trends Impacting On the Context of Acute-Care Within Which Patients Learn and Nurses Teach

Other contextual factors, identified throughout the three major themes emerging from these data and integral to nurses' description and practice of their teaching function, involved the conditions of nurses' worklife, and trends occuring within acute-health care including the context of this study setting.

Impact of nurses' worklife conditions on nurses' teaching. Conditions of acute-care nurses' worklife had a significant impact on nurses' clinical practice. Aspects of nurses' worklife influencing nurses' teaching function included nurses' 24 hour presence, workload, patient assignment methods, administrative expectations, and professional leadership.

The first aspect of nurses' worklife involves their 24 hour attendance of patients. As a team, nurses used this time to create an environment of caring that promoted healing. Individually and collectively, nurses used their time to develop teaching-caring relationships and to conduct teaching on an "ongoing" basis, as patients' learning needs arose and "teachable moments and minutes" occurred.

Studying workload, the second aspect of nurses' worklife, identified several factors influencing nurses' perception of that workload and its impact on nurses' teaching function. These factors included discretionary time available to nurses, the actual number of assigned patients, patient acuity levels, number of consecutive days nurses were assigned to patients, and availability of nursing aid and orderly support to free nurses from non-nursing duties thereby providing time to teach.

Within this setting, the intricate interrelationship of time, caring, and teaching was obvious. Nurses described and demonstrated that teaching that is more than telling requires time. Also, time was seen as necessary for the repeated interchanges wherein coaching and clarification could occur and for the building of a teaching-caring relationship.

Insufficient time was the most commonly identified block identified by nurses as impeding their ability to carry out their teaching function. However, nurses' perception of the inadequacy of their teaching during occasions when their time for teaching was reduced because of increased workload was generally incongruent with the amount and adequacy of teaching they actually conducted. This observation exemplifies nurses' commitment to patient-centered care and caring, including teaching, that persisted even in the face of periods of heavy workload.

The third aspect of nurses' worklife involved patient assignment. Nurses were generally assigned to care for six or seven patients during each shift. Several nurses commented that they frequently noted that when their assignment consisted of six rather than seven patients, they experienced a notable difference in the time available for teaching. However, the most significant factor determining nurses' time for teaching was the acuity level of assigned patients. The higher that level, the less time nurses had to teach.

Consistently, nurses identified the essential factor of being assigned to patients over a period of time as crucial to establishing the teaching-caring relationship. Nurses did not comment on the difference between being assigned to a patient for an eight- or a twelve-hour shift to establishing this relationship. However, the question arises that as

eight-hour shift rotations are associated with a greater opportunity for more consistent nurse-patient assignment over time, is eight hour work scheduling more facilitative of nurses' establishing teaching-caring relationships, and of conducting patient teaching, than twelve hour work scheduling?

The fourth aspect of nurses' worklife involves administrative expectations and professional leadership. Documentation of nurses' teaching was significantly impacted by administrative expectations. Observing the complexity of nurses' teaching function and the degree to which it is integrated into everyday nursing care, the difficulty of documenting the scope and depth of this function takes on a new and challenging perspective. Given current quality assurance trends based on the premise that if an activity is not documented it is assumed that it has not been done, the question arises, how can nurses' teaching function be accurately and realistically documented?

Within this setting, where patient teaching was a fundamental and integral part of everyday nursing care, most documentation referable to patient teaching recorded only discrete activities of information sharing, and even then, principally that of sharing theoretical knowledge or "knowing that" (Benner, 1984a). Even more significant, however, is the observation that current approaches to documentation of nurses' teaching function within this setting as well as other acute-care settings, are inadequate in that they neither reflect the purpose of that function nor the teaching-caring process through which that purpose is achieved.

Within this study setting, nursing leadership was identified as playing the major role in the quality of nurses' worklife. During the

study, the investigator observed nursing leadership roles underpinned by a strong sense of patient-centered caring as a nursing philosophy, and a sound understanding of what nursing is and how nursing is practiced. In particular, the primacy of the HN's patient-centered focus and the strong clinical leadership she provided, clearly identified the pivotal role of the HN in establishing and fostering a patient-centered culture of caring, and facilitating a healing environment in which teaching was integral.

Traditionally, the HN role has been comprised of a principal clinical leadership focus and a secondary administrative focus. Through this strong clinical focus, HNs with a commitment to patient-centered caring and a clear sense of what constitutes nursing, have the potential to establish a caring nursing culture and an healing environment. However, current trends in the evolution of the HN role indicate a move toward increasing emphasis on the administrative focus of the role. As this trend continues, will it result in the diminution or exclusion of the HN's clinical leadership role thereby reducing or eliminating the mechanism for the establishment of a caring nursing culture and a healing patient-care environment? This question raises other questions concerning the impact of such a change on the quality of care provided to patients, including their teaching; and, on the professional development of nurses providing direct nursing care. For example, what would the nursing culture and the nursing care of an acute-care setting look like under the leadership of a HN whose focus is administrative rather than clinical? Where will future nursing leadership come for the establishment and fostering of a culture of caring and a healing environment? Who will role model caring and healing, and support nurses working at the bedside to develop their caring, healing work?

Trends impacting on the context of acute health care within which patients learn and nurses teach. Three significant and interrelated trends discussed in the first chapter of this report as impacting acute health care were also identified within this study setting. Just as in other settings, these trends influenced how patients learned and nurses taught in this setting.

The first trend involves increasingly complex care being carried out during shortened hospital stays. This was observed as the norm in this acute-care setting. Shortened stays resulted in less time for patients to learn and for nurses to teach. Further, acutely ill patients were hospitalized for the acute phase of their illness with convalescence and rehabilitation occurring at home. This pattern of early patient discharge resulted in a context of care characterized by an increasing level of patient acuity associated with increasingly demanding levels of care.

Patients, often faced with multiple, complex, and/or threatening learning, required that nurses be constantly attuned to their situation in order that they could assist patients to priorize their learning as well as cope with what were often overwhelming learning needs. Actively helping patients get ready to learn was also a significant component of nurses' teaching. Recognizing that some patients did not have time, or for other reasons, could not learn in hospital, another consistent aspect of nurses' teaching involved ensuring that patients and families were taught how to seek help and teaching following discharge.

The trend toward shortened hospitalization was particularly evident with patients admitted to the study setting with the diagnosis of MI. Consequently, nurses employed strategies to identify quickly patients'

priority learning needs and then align patients with the appropriate learning resources. Patients admitted with the diagnosis of COPD had a much longer period of hospitalization but because by the nature of their disease, were acutely ill for a longer period of hospitalization. During their protracted acute illness, these patients typically had decreased energy to learn.

The second trend, the advent of high technology health care, was in continual evidence in this acute-care setting. As a result, the potential for information overload of patients was everpresent. Congruent with nurses' culture of caring, teaching acted as a key approach to assisting patients to understand their care and treatment, to participate in decision-making relative to that care and treatment, and for the giving of informed consent. Within this setting, teaching including patient advocacy throughout the health care experience, was identified as an important aspect of care necessary to prevent experiences of dehumanization, alienation, and loss of control that can be associated with "high-tech" health care.

Another dimension of the trend toward high-tech health care involves the increasing rate that patients are discharged from hospital requiring this type of care in their homes. Patients admitted with the diagnosis of COPD were frequently faced with this type of complex learning regarding "high-tech" home care, such as, home oxygen therapy. To assist patients with what was frequently extremely complex learning essential to managing this high-tech care at home, nurses worked with the multi-disciplinary team, contributing their nursing perspective to patients' teaching, but also coordinating teaching conducted by the multi-disciplinary team.

One patient's experience exemplifies another dimension of the trend toward high-tech health care. That dimension involves the increasing number of individuals with chronic illness who, having reached the end-stage phase of their illness, are unable to manage at home. Consequently, they require a setting that can provide assistance with activities of daily living, health care supervision, and when necessary, medical treatment. However, as in this patient's situation, patients frequently must remain in acute-care hospitals for extended periods because more appropriate facilities are unavailable. As a result, this group of patients are delayed from experiencing the quality of life associated with the more home-like setting of an extended care facility, and acute-care beds are used by patients who do not require them.

The third trend, that increasingly complex, high-tech care is associated with the development of an increasingly complex hospital organization including a complex, multi-disciplinary team was evident in this study setting. How nurses practicing within the study setting worked within the framework of such a patient-care team, and facilitated the coordination of multi-disciplinary care, is documented in the preceding section.

Summary of Contextual Factors Influencing Nurses' Teaching Function

Several contextual factors were identified as influencing nurses' teaching function within this study setting. The dominant contextual factor identified was nurses' culture of patient-centered caring. A second factor was nurses' conduct of their teaching function as part of a complex team. Other factors were conditions of nurses' worklife and trends occuring within acute-health care.

Findings of this study support the notion that teaching, like nursing, is relational and therefore both requires and contributes to a caring relationship, that is, the teaching-caring relationship. Supporting the notion of the centrality of caring in teaching and nursing, and the interconnectedness of caring, healing, and nursing, is the phenomenological concept of concern. Further, the centrality of caring to teaching and nursing has been described by other nurses authors.

Nurses' Description and Practice of Their Teaching Function

An understanding of practicing nurses' lived experience of their teaching function was gained through studying how nurses' described that function and through observing how it was practiced by nurses within the context of the acute-care setting. The purpose and process of nurses' teaching function were identified. Also identified was how, in the clinical practice of acute-care nursing, nurses' teaching function differs from both the dominant educational perspective in nursing and that of the biomedical perspective. The domain of nursing's teaching-coaching function as described by Benner (1984a) was identified as offering a useful sensitizing framework for this study. The assumptions underpinning that framework and the competencies within it were congruent with the findings regarding nurses' teaching function in this study.

Purpose of Nurses' Teaching Function

One of the most significant findings emerging from the data is that nurses' purpose in teaching patients and families is to enable them to restore, maintain, and promote their health; to cope with illness; and to die in peace. Conceptualizing the purpose of nurses' teaching function in terms of enablement, changes the role of the nurse from one of teacher as

prescribed in nurses' dominant and traditional education perspective, to one of enabler, consistent with a helping relationship. Within this setting, facilitation of patient and family engagement in their own health enablement was pivotal to nurses' enabler role. In this way, nurses' description and practice of their teaching function was congruent with nursing theorists' notion that both teaching and nursing involve a helping relationship with the objective of developing independence in the individual.

Firmly underpinning this purpose of teaching for enablement was nurses' goal of promoting healthful living, and dignified, peaceful dying; that is, health promotion as a philosophical stance, irrespective of the health status of the client. In this acute-care setting, what constituted health had several "definitions". These included definitions held by patients, by health-care professionals, and those arrived at through patient-professional collaboration. Within this setting, learning about one's disease, treatment, and coping with an illness constituted a significant part of learning to accept and attain a new definition of health necessitated by the presence of disease and the experience of illness. Exploration of the meaning of illness to patients and families, and sharing of health-care professionals' knowledge regarding disease and the illness experience, promoted patient-professional collaboration regarding the defining of "health".

Nurses' Perspective of Teaching: Differentiated From That of the Biomedical Perspective

Nurses described their teaching function as distinct from that prescribed by the biomedical perspective. Teaching from the framework of

that perspective was seen as inappropriate for nurses because it does not support nurses' view of patients as unique human beings experiencing illness as well as having disease, and receiving treatment in an unfamiliar environment. Also, conducting teaching from the perspective of avoiding health "risks" was seen by many nurses as "blaming the victim", associated with the potential of causing patients to feel guilty and devalued, and therefore, disabled.

In light of the complexity and individuality of patients' learning needs, standardized teaching content consistent with the disease-oriented medical model, was seen by nurses as inappropriate for their teaching function. Given nurses' purpose of teaching toward enablement, the scope of teaching in nursing within this setting was identified as including "anything and everything". In other words, nurses saw the scope of their teaching function as involving teaching referable to anything that was of concern to patients and families, and/or that was necessary to enable them toward healthy living or peaceful dying.

The notion of teaching for "compliance", congruent with teaching from the biomedical perspective, was identified as incongruent with nurses' teaching function because of the inconsistency of that notion with nurses' view of the patient and the nurse-patient relationship. The assumption that knowledge given results in compliance, as in the biomedical perspective, or changed behaviour, as in the educational perspective, was foreign to practicing nurses' working with individual human beings. Acknowledging that "textbook cases" are found in textbooks and not in the practical world of nursing, nurses accepted each patient as unique, acknowledging that negotiation and personal choice are fundamental to

nurses' clinical practice of teaching.

Teaching From the Educational Perspective: Academic Preparation Versus Praxis

One nurse participant reported receiving no academic preparation for nurses' teaching function during basic studies to become a Licensed Practical Nurse. All other nurses reported receiving academic preparation conceptualizing nurses' teaching function from the traditional educational perspective. Congruent with that conceptualization, nurses consistently reported they had been taught to view teaching as structured, and to a lesser extent informal activities, based on educational principles such as setting learning objectives, choice of teaching methods, and evaluation of change in learner behaviour and teacher effectiveness. Also, congruent with the traditional educational perspective, nurses reported they had been taught to conduct teaching according to the steps of the nursing process: assessment, planning, implementation, and evaluation.

Without exception, nurses adamantly reported that they found the traditional educational perspective inappropriate for their patients and for the practice of their teaching function within the acute-care setting. Formal and/or lengthy teaching sessions were poorly tolerated by patients with decreased energy and/or increased physical or emotional stress. Further, the formal, academic approach associated with teaching from the educational perspective was perceived by many nurses as associated with creating stress for patients, particularly those for whom formal schooling was remote or associated with negative experiences. Also, the premise that professionals "teach" from their agenda rather than in response to patients' needs, was incongruent with nurses' view of what is helpful to

patients.

Teaching from the educational perspective was consistently identified as inconsistent with nurses' worklife conditions. Although elements of the steps of the nursing process were observed during nurses' practice of their teaching function, observation of nurses' practice of their teaching function identified that an interactional and relational process was used, not a linear one. For example, assessment of learning needs often occurred while teaching addressing other needs was occurring. Also, while teaching was being carried out, simultaneous evaluation in the form of monitoring, occurred.

Contrasted with their academic preparation for their teaching function, nurses described and demonstrated how, in their practice, they conceptualized and conducted that function. In practice, teaching was both thought of and carried out as an integral part of nursing care, thoroughly embedded in everyday nursing practice and consequently occurring on an "ongoing" basis. Beyond being pragmatic vis a vis the nature of nurses' worklife, this "ongoing" approach to teaching was congruent with patients' constant and everchanging learning needs.

Because teaching was so thoroughly embedded in nurses' practice, they were often unaware that they had, in fact, been teaching their patients. Also, patients were frequently unaware that teaching had occurred because of the informal and relational approach nurses used in their teaching. This latter observation offers some explanation of why previous studies of patients' perception of nurses' teaching, in which teaching was conceptualized from the educational perspective (Adom & Santiago Wright, 1982; Bullough, 1981; Jarvis, 1970; Linehan, 1966; Pender, 1987;

Pfisterer, 1975; Summers, 1984; Tagliacozzo, 1965; Tilley, 1985), found that patients reported that they perceived nurses as carrying out minimal teaching.

The Practice of Nurses' Teaching Function: Congruent With the Domain of Nursing's Teaching-Coaching Function

For this study, the teaching-coaching domain described by Benner (1984a), provided an extremely helpful sensitizing framework. Its underlying assumptions and identified competencies were congruent with findings emerging from the study data.

As Benner (1984a) contends, looking only at information giving and formally planned teaching sessions oversimplifies nurses' teaching function. The more significant patient learning lies in coping with illness and mobilizing for recovery, that is, teaching toward enablement of patients and their families for healthy living or peaceful dying. In teaching to facilitate that learning, nurses offered not only information but "ways of being, ways of coping, and even new possibilities for the patient by means of the perspectives and the practices that are embedded in good nursing care" (Benner, 1984a, p. 78). Teaching content was related to what was familiar to patients' personal experience and relevant to their own health. It also involved sharing with patients, practical knowing "how" in addition to theoretical knowing "that" (Benner, 1984a).

Validating Benner's (1984a) work, is the identification, within the study setting, of all five competencies of Benner's teaching-coaching domain. Expanding Benner's (1984a) work, is the identification of three additional components and the enlargement of one of the competencies identified within the teaching-coaching domain.

Summary of Nurses' Description and Practice of Their Teaching Function

The second and third major themes emerging from the study data identified how nurses' within this acute-care setting, described and practiced their teaching function. Combined with the contextual influences on nurse's conceptualization and conduct of their teaching function, these themes provide an understanding of nurses' lived experience of their teaching function from the perspective of nurses practicing within this study's acute-care setting. Also identified was the usefulness and congruence of Benner's (1984a) domain of nursing's teaching-coaching function as a sensitizing framework for this study. The remaining sections of this chapter present the strengths and limitations of this study, and recommendations for further research.

Significance of the Study

The major significance of this study is its contribution to the clarification of nurses' teaching function through the description of that function as it is understood and practiced by nurses in the clinical setting (Benner, 1984a; Field, 1983; Melia, 1982). Describing this function within the context of the clinical setting, and from the perspective of practicing nurses gives a public voice to the "tacit knowledge" (Polanyi, 1978) of practicing nurses referable to their teaching function. This voice can contribute to nurses' dialogue concerning the study, refinement, educational preparation for, and clinical application of nurses' patient teaching function. The ultimate aim of this dialogue is to strengthen the quality of care provided by the profession of nursing. In this way, the findings of this study have significance for nursing practice, education, administration, and

research.

Consistent with a qualitative research approach, the study was intended to portray the lived experience of nurses' teaching function from the perspective of nurse participants. Readers of the study report are free to make independent judgments about the transferability (Sandelowski, 1986) of the findings, that is, whether they provide understanding of the teaching function as it is experienced by other nurses in other settings.

Limitations of the Study

To address the purpose of this study and to allow rigour of conduct within the time available for its completion, nurses observed during the weekday, day-time shift were studied. Since all nursing staff of the study setting rotate to the day-time shift, all of these nurses potentially had the opportunity to participate in the study.

The convenience sample was determined by the fact that only two patients with the diagnosis of COPD were available to participate in the study during the period of data collection. A balance of patient participants with the diagnoses of MI and COPD may have yielded more completeness of data (Morris, 1986). Inclusion of the patients' perceptions of nurses' teaching function would offer additional understanding, as has been shown by others (Adom & Santiago Wright, 1982; Jarvis, 1970; Linehan, 1966; Pender, 1987; Pfisterer, 1975; Summers, 1984; Tagliacozzo, 1965; Tilley, 1985). Conducting a rigorous study including these perceptions would require more time than was available for this study.

Recommendations for Future Investigation

Findings of this study identify several areas requiring further

investigation. Recommendations for future research include the exploration of patients and families' experience of illness as well as issues of nursing practice, administration, and education referable to nurses' teaching function.

Research is required that explores patients and families' experience of illness over time. Integral to this, is research that addresses how nurses' teaching can enable patients and their families to understand and cope with their illness experiences. Research addressing these issues should be conducted from the perspective of patients and families, and from that of practicing nurses, and should include learning during hospitalization and following discharge.

In addition to research that explores patients and families' experience of illness over time, research is required that explores how the collaborative efforts of hospital and community can facilitate discharge planning toward the goal of patient and family enablement. Understanding patients and families' perception of what is helpful and necessary learning could be further augmented by collaborative research conducted by representatives of the multi-disciplinary team, hospital to community.

Further research is required to explore the relationship of caring, as the fundamental component of nursing, to the outcome of patient and family healing. Placing this caring-healing relationship within the acute-care context, identifies the need to study the relationship of caring, healing environments to the patient and family outcome of healing. Integral to this, is the need to explore the role of nursing leadership in establishing and maintaining caring, healing environments for patients,

families, and nursing staff.

Current approaches to documentation of nurses' teaching function do not accurately record that function. Specifically, the teaching-caring process involved in nurses' teaching function is not reflected. Additionally, current documentation approaches neither accurately document patient and family enablement, the intended outcome of nurses' teaching function, nor allow measurement of satisfaction with that outcome. For example, evaluating patient and family enablement becomes problematic when one takes into account that much of the outcome of the teaching conducted by acute-care nurses can not be adequately evaluated until patients and families are discharged from hospital. Qualitative research approaches studying the process and outcome of nurses' teaching function, in addition to enlarging understanding of nurses' teaching function, may facilitate development of appropriate methods of documenting that function.

Finally, as Benner (1984a) contends, further study of the richness of knowledge embedded in various aspects of nurses' clinical practice is required. This research would contribute to the identification of what constitutes the clinical practice of nursing. It would also allow nurses to study and refine that practice, to study how to teach that practice to student and novice nurses, and to value that practice through making public nurses' tacit knowledge (Polanyi, 1978) embedded in their clinical practice.

Conclusion

This study explored and described nurses' lived experience of their teaching function as it was practiced within the acute-care nursing context. Three major themes were identified in the data. The first theme

identifies contextual factors influencing nurses' teaching function. The second and third themes identify how nurses' described, and how they were observed practicing, their teaching function.

A key finding of this study is the identification of the purpose of nurses' teaching as the enablement of patients and families to restore, maintain, and promote their health; to cope with illness; and to die in peace. Firmly underpinning this purpose is nurses' overall goal of promoting healthful living, and dignified, peaceful dying. Fundamental to patients and families' enablement is the exploration of the meaning of illness to patients and families, and sharing with them, health-care professionals' knowledge about disease and the experience of illness.

Conceptualizing the purpose of nurses' teaching function in terms of enablement changes nurses' role from that of teacher, as prescribed in nurses' traditional education perspective, to that of enabler, consistent with a helping relationship. Further, teaching toward enablement is identified as different from teaching toward knowledge for behaviour change as in the educational perspective, or for compliance with a prescribed medical regimen as in the biomedical perspective.

A second key finding of this study is the identification of nurses' culture of patient-centered caring as the dominant contextual factor influencing nurses' teaching function. Underpinning this culture is nurses' committment to the primacy of patients and their families. Nurses' teaching function is identified as arising from and integral to, nurses' practice of patient-centered caring. Teaching, like nursing, is relational and therefore both requires and contributes to a caring relationship, that is, the teaching-caring relationship.

The centrality of caring to nursing and teaching is described by other nurses. Benner (1984a), for example, identifies caring as central to human expertise, curing, and healing. Benner and Wrubel (1989) contend "that caring as a moral art is primary for any health care practice" (Benner & Wrubel, 1989, p. xi). The phenomenological concept of concern also supports the notion of the centrality of caring in teaching and nursing, and the interconnectedness of caring, healing, and nursing.

Results of this study validate Benner's (1984a) teaching-coaching domain as an appropriate sensitizing framework for the conceptualization and study of nurses' teaching function. As Benner (1984a) contends, looking only at information giving and formally planned teaching sessions oversimplifies nurses' teaching function. More significant patient learning lies in coping with illness and mobilizing for recovery, that is, teaching toward enablement of patients and their families for healthy living or peaceful dying.

In this setting, nurses described and were observed practicing their teaching function as thoroughly embedded in everyday nursing care. Beyond being pragmatic vis a vis the nature of nurses' worklife, this "ongoing" approach to teaching was congruent with patients' everpresent and changing learning needs. Nurses approached teaching through discussion and sharing in an informal, relational manner. Content taught was placed within the realm of patients' personal experience, and involved sharing practical knowing "how" in addition to theoretical knowing "that" (Benner, 1984a).

Use of a qualitative research approach facilitated the exploration of nurses' experience with the practice of their teaching function. Interpretive or hermeneutical phenomenology provided the philosophical

stance underpinning the study while ethnography, in the interpretive tradition, provided the design. The sample consisted of fifteen nurse and ten patient participants. Nurses included the head nurse, assistant head nurse, and thirteen bedside nurses. Patients included two who were admitted with the medical diagnosis of chronic obstructive disease and eight admitted with the diagnosis of myocardial infarction.

The major significance of this study is its contribution to the clarification of nurses' teaching function as it is understood and conducted by nurses practicing in the acute-care setting. Revealing practicing nurses' tacit knowledge about their teaching function identifies expertise embedded in clinical nursing practice. Once made public, this expertise can become part of the dialogue about nurses' practice of their teaching function. It can also contribute to the identification of necessary educational preparation, administration support, and nursing leadership, required for the practice of nurses' teaching function. Recommendations for future research include the exploration of patients and families' experience of illness as well as issues of nursing practice, administration, and education referable to nurses' teaching function.

APPENDICES

APPENDIX A

Demographic Data of Nurse Participants

To provide some information about yourself as a nurse, could you please answer the following questions:

1. How long have you been a nurse?

2. Since graduation, have there been any periods of interruption of your nursing practice (eg. maternity or educational leave, or travel)?
   If so, why and for how long?

3. What areas have you worked in since graduating from your nursing education?

4. How long have you worked on this ward?

5. Do you work you full- or part-time on this ward?

6. What is your nursing education:
   LPN:
   RN-Diploma:
   RN-Degree:
   Other courses:

Thank you.

Code _____

APPENDIX B

Demographic Data of Patient Participants

1. What is your understanding of your present condition?

2. Have you ever been a patient in hospital before?
   If so, when, for how long, and why?

3. Who lives at home with you?

4. What is your home like--that is, is it an apartment? a bungalow? a two storey house? a trailer?

5. What was your last formal schooling?

Thank you.

From patient's hospital chart:

6. Date of admission to this hospital:

7. Date of admission to this ward:

8. During this admission, other wards hospitalized on:

9. Medical diagnosis:

10. Age:

11. Sex:

12. Marital status:

13. Current work status:

14. Place of residence:

Code _____

APPENDIX C

Letter to the Head Nurse of the Study Setting

_____, Head Nurse
St. Boniface Hospital
409 Tache Ave.
Winnipeg, Manitoba R3H 2A6

Dear _____,

As we discussed informally during the summer, I would like to conduct my Master of Nursing Thesis study, An Interpretive Study of Nurses Teaching-Caring Practice, on your ward. Both St. Boniface Hospital and the Nursing Ethics Committee of the University of Manitoba have given me permission to proceed with my study in your area.

The purpose of the study is to learn what it is like for nurses to teach and coach their patients through hospitalization. To conduct the study, I will use the observational method I practiced during my fieldwork experience on your ward, earlier this year. The period of observation will be two months.

Prior to beginning my study, I would like to meet with you and your nursing staff to explain the study and the rights and responsibilities of nurse and patient participants, as well as answer any questions you or your nursing staff may have regarding the study. Could you please call me at 453-5571 to arrange a convenient time for me to meet with you and your staff?

During the study, I plan to observe interactions between ten patients on your ward--five hospitalized with the medical diagnosis of Chronic Obstructive Pulmonary Disease and five with Myocardial Infarction (or as many patients as can be observed in two months), and nurses assigned to care for them during the day-time. To protect patient privacy and freedom of choice regarding participation in the study, I ask you, or your delegate, to assist me with identification of patient participants. This would involve you, or your delegate, approaching patients on your ward who you feel could participate in the study and who meet criteria for the study, to ask their permission for me to speak with them about my study prior to inviting them to participate.

During the conduct of the study, please feel free to discuss with me any concerns or questions you have. If, for any reason you wish to speak with my study supervisor, Dr. Erna Schilder, she can be reached by phoning the School of Nursing, University of Manitoba (474-9664).

Thank you for you cooperation and assistance. I look forward to hearing from you, and to conducting my study in your area.

Sincerely,

(Miss) Susan Young, RN, BN
Master of Nursing Student
University of Manitoba.

cc. Dr. E. Schilder.

APPENDIX D

Interview Guide for Nurse Participants

Through this study I am interested in learning about what it is like for nurses to teach and coach their patients through hospitalization. I would like to hear your views on that. Perhaps you could start by telling me what it means to you to teach and coach your patients and what purpose you think it serves for your patients.

Prompts--the intent of the following questions can be used to clarify understanding of what the nurse discusses or to indicate aspects that the nurse may want to comment on. Wording of the questions will incorporate phrases the nurse uses:

1. When you were caring for _____ (study patient), how did you know when to teach/coach him/her?

2. Was it important to you to find out what your patient thought about his/her condition?
   If so, how do you go about this?
   If not, why?

3. How did you know what to teach or how to coach your patient (for example, about his/her condition, treatment in hospital, or preparation for discharge)?

4. How did you find out about his/her usual lifestyle/routine and how their condition and recovery would affect that?

5. How did you know that your patient understood what you discussed with him/her?

6. Generally, how important is it for the patient and family to feel they can manage recovery and care at home?

7. Can you tell me about ways that indicate to you that a patient you have cared for has done okay at home following discharge?

8. Can you tell me about a patient (or patients) with whom you felt your teaching/coaching went really well?

9. What about a patient (or patients) you found really difficult to teach/coach?

10. Thinking about ____ (study patient), how do you feel about the teaching/coaching you were able to do with him/her? Was the teaching/coaching you carried out with ____ (study patient), normal or different from what you usually do with your patients?

11. Do you have any other comments? Thank you.

APPENDIX E

University Ethics Committee Approval

The University of Manitoba

SCHOOL OF NURSING

ETHICAL REVIEW COMMITTEE

Proposal Number N#89/14

Proposal Title: "Nurses' Perceptions of Their Teaching-Coaching Function with Adults Hospitalized with Chronic Obstructive Pulmonary Disease or Myocardial Infarction."

Name and Title of Researcher(s): Susan Young, R.N.
Master of Nursing Student
University of Manitoba

Date of Review: September 11, 1989

Decision of Committee: Approved: Sept.11/89 Not Approved: _____

Approved upon receipt of the following changes:

Date: Sept. 14th 1989.

T. George, R.N., Ph.D. Chairperson
Associate Professor
University of Manitoba
Position

NOTE:

Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

APPENDIX F

Study Setting Access Approval

Hôpital Général - St. Boniface - General Hospital
409 Tache Avenue,
WINNIPEG, MANITOBA R2H 2A6
(204) 233-8563

September 20, 1989

Ms. Susan Young

Winnipeg, Manitoba
R

Re: Research Access Approval

Dear Susan:

I am pleased to inform you that access has been approved for your thesis research project entitled:

> Nurses' perceptions of their teaching-coaching function with adults hospitalized with chronic obstructive pulmonary disease, or myocardial infarction.

You may proceed with data collection as outlined in your proposal.

Please feel free to contact me if the services of the Nursing Research Space at SBGH can be of help to you, or if I can facilitate your project in any way.

Congratulations on your worthwhile project. Would you provide us with a copy of your final report?

Sincerely,

Eleanor J. Adaskin, RN, PhD
Director of Nursing Research
Tel. 235-3480

APPENDIX G

Explanation of the Study for Nurse Participants

My name is Susan Young. I am a Registered Nurse and a student in the Master of Nursing Program at the University of Manitoba. As part of my nursing program, I am conducting a study on this ward to learn what it is like for nurses to teach and coach their patients through hospitalization. This Hospital as well as the Nursing Ethics Committee of the University of Manitoba have given me their permission to carry out this study.

You are invited to participate in this study. If you agree to do so, I will observe you over several days as you care for one patient hospitalized on this ward who has also consented to participate in the study. Other health care team members may also be observed as they care for the patient. I will take notes of what I observe. Each study participant is welcome to read notes made about observations of their interactions. No one else on the ward will be permitted to read notes about observations that do not involve them. I will review consenting patients' hospital records for documentation of their medical diagnosis and nursing care.

I will talk with you informally as well as conduct one interview to discuss your thoughts about teaching and coaching your patients. The interview will last about one-half to one hour. It will be held at a time and location convenient to you and me. I will tape record the interview and then will give you a typewritten copy to read and make comments. I will also ask you to take about five to ten minutes to complete a questionnaire that will give me some information about you.

Participation in this study is voluntary. Whether or not you participate, your position as a nurse will not be affected in any way. If you choose to participate, I will ask you to read the consent form and will answer any questions you may have regarding the study. Your signature on the consent form indicates your willingness to participate in the study. You will be given a copy of your signed consent form.

You information will be confidential and anonymous. Your name will not be used in written notes, on the cassette tapes, or in any public report of the study. Instead, a code number (eg. 21) will be assigned to each study participant. The list with the coded numbers and names will be kept in a locked filing cabinet and will be accessible only to me.

There may be no direct benefits to participating in this study but the study results may help nurses give better care to other patients in the

future. You will be invited to attend a presentation of the findings when the study is completed. As a result of being interviewed and observed during participation in this study, you may experience some loss of privacy. You are free to answer only those questions you wish, to ask that I not observe you during a particular instance, and to withdraw from the study at any time.

If you have any questions you have about this study, I can be reached on the ward or at . If you wish to speak with my study supervisor, Dr. Erna Schilder, she can be reached by phoning the School of Nursing, University of Manitoba (474-9664). You are welcome to keep this explanation.

Thank you for your time and attention.

APPENDIX H

Explanation of the Study for Patient Participants

My name is Susan Young. I am a Registered Nurse and a student in the Master of Nursing Program at the University of Manitoba. As part of my nursing program, I am conducting a study on this ward to learn what it is like for nurses to teach and help their patients while hospitalized. This Hospital as well as by the Nursing Ethics Committee of the University of Manitoba have given me their permission to carry out this study.

Your name was suggested by one of the nurses taking care of you as someone who might be interested in this study. I would like to invite you to participate in this study.

If you agree to participate, I will be observing some of the ward's nurses as they care for you for several days while you are a patient on this ward. Other health care team members may also be observed as they care for you. These observations will be made during the daytime. I will take notes as I observe. You are welcome to read the notes I make. No one else on the ward will be permitted to read notes about observations that do not involve them.
I will ask you to take ten to fifteen minutes to answer several questions that will give me some information about you as a patient that I may not find elsewhere. I also ask permission to review your hospital chart.

Participation in this study is voluntary. Whether or not you decide to participate, your care will not be affected in any way. If you choose to participate, I will read a consent form with you and if you have any questions, please feel free to ask me about them. Your signature on the consent form indicates your willingness to participate in the study. You are free to withdraw from the study at any time, without harm to you or your care. You will be given a copy of your signed consent form.

There may be no direct benefits to participating in this study but the study results may help nurses give better care to other patients in the future.

You may experience some loss of privacy through being observed. If you find that the observation is disturbing at any point, you are free to ask me not to observe. There will be no health risks to participation in this study.

You are assured of confidentiality and anonymity. Your name will not be used on written notes or in any public report of this study.

I will be happy to answer any questions you have about this study. I can be reached at .. If you wish to speak with my study supervisor, Dr. Erna Schilder, you can call her at the School of Nursing, University of Manitoba (474-9664). You are welcome to keep this explanation.

Thank you for your time and attention.

APPENDIX I

Consent Form For Nurse Participants

DESCRIPTION OF THE STUDY:

Susan Young, a Registered Nurse and a student in the Master of Nursing Program at the University of Manitoba, is conducting a study on this ward to learn what it is like for nurses to teach and coach their patients during hospitalization. I am invited to participate in this study.

PROCEDURES:

If I agree to participate, my participation will include:

1. Susan will observe me over several days as I care for one patient hospitalized on this ward who has consented to participate in the study. These observations will be made during the daytime.

2. Notes will be taken by Susan about her observations. I am welcome to read notes concerning observations that involve me. No one else on the ward will be permitted to read notes that do .

3. Susan will talk with me informally as well as conduct one interview to discuss my thoughts about my teaching and coaching of patients. The interview will last about one-half to one hour, depending on how much I have to say. It will be held at a time and location convenient to me and Susan. The interview will be tape recorded. I am free to ask that any part or parts of the interview not be taped. I will be given a typewritten copy of the interview so that I can make additional or clarifying comments or deletions.

4. I will also take about ten minutes to complete a questionnaire asking about me as a nurse.

BENEFITS AND RISKS OF PARTICIPATING IN THIS STUDY:

There may be no direct benefits to participating in this study but the study results may help nurses give better care to other patients in the future. I will be invited to attend a presentation of the findings when the study is completed.

I may experience some loss of privacy through participation in this study as a result of being interviewed or observed. I am free to answer only those questions I wish, to ask that I not be observed during a particular instance, and to withdraw from the study at any time.

CONFIDENTIALITY:

I am assured of confidentiality and anonymity. My name will not be used on written notes, on the cassette tape, or in any public report of

this study. Instead, a code number (eg. 21) will be assigned to each study participant. The code list will be destroyed at the end of the study. Transcribed notes and interviews will be saved for possible future teaching or analysis purposes but my name can not be identified in these transcriptions.

INVITATION TO QUESTION:

If I have questions about the study, I may reach Susan on this ward or at . If I wish to speak with her study supervisor, Dr. Erna Schilder, I may call her at the School of Nursing, University of Manitoba (474-9664).

VOLUNTARY PARTICIPATION:

Participation in this study is entirely voluntary. Whether or not I decide to participate, my position as a nurse will not be affected in any way. If I decide to participate and then later want to withdraw, I am free to do so without any harmful effect.

My signature on this form indicates that I have discussed this study with Susan and have read a written explanation of it, that I have read this form, and that I give my consent to participate in this study.

_____ _____

Signature of Nurse Signature of Investigator

Date:_____ Date:_____

I wish to receive a final report of this study:

Yes_____ No_____

Mail to:

APPENDIX J

Consent Form for Patient Participants

DESCRIPTION OF THE STUDY:

Susan Young, a Registered Nurse and a student in the Master of Nursing Program at the University of Manitoba, is conducting a study on this ward to learn what it is like for nurses to teach and coach their patients through hospitalization. I am invited to participate in this study.

PROCEDURES:

If I agree to participate, my participation will include:

1. Observation of some of the ward's nurses as they care for me during several days while I am a patient on this ward. Other health care team members may also be observed as they care for me. These observations will be made during the daytime.

2. Susan will take notes about her observations. I am welcome to read notes concerning observations that involve me. No one else on the ward will be permitted to read these notes.

3. About ten to fifteen minutes will be taken to talk with Susan to help her complete a questionnaire about me. I am welcome to read the completed questionnaire.

4. I permit Susan to review my hospital chart.

BENEFITS AND RISKS OF PARTICIPATING IN THIS STUDY:

There may be no direct benefits to participating in this study but the study results may help nurses give better care to other patients in the future.

There will be no health risks to participation in this study. I may feel some loss of privacy through being observed. If I find that the observation is disturbing at any point, I am free to ask Susan not to observe.

CONFIDENTIALITY:

I am assured of confidentiality and anonymity. My name will not be used on written notes or in any public report of this study. The code list will be destroyed at the end of the study.

INVITATION TO QUESTION:

If I have any questions about the study, I may reach Susan on this ward or at . If I wish to speak with her study supervisor, Dr.

Erna Schilder, I may call her at the School of Nursing, University of Manitoba (474-9664).

VOLUNTARY PARTICIPATION:

Participation in this study is entirely voluntary. Whether or not I decide to participate, my care will not be affected in any way. If I decide to participate and then later want to withdraw, I am free to do so without any effect on my care.

My signature on this form indicates that I have discussed this study with Susan and have read a written explanation of it, that I have read this form, and that I give my consent to participate in this study.

Signature of Patient	Date	Signature of Investigator	Date

I wish to receive a final report of this study: Yes_____ No_____
Send to:

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