

Clinical Nurse Educators' Experiences on Instructing Student Nurses With Disabilities (SWD's) in the Clinical Arena

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Abstract

Students with disabilities (SWD's) entering undergraduate nursing programs has increased over time. In this article, the authors describe the experiences of clinical nurse educators on instructing student nurses with disabilities (SWD) in the clinical arena. Fourteen clinical nurse educators participated in this qualitative study. All participants were involved in the direct instruction of student nurses in the clinical arena. Data collection consisted of one on one interviews with clinical nurse educators and the participants completed an interactive journal. The results that emerged from the data include the following: 1. Instructional strategies used by the participants in the clinical arena; 2. Curricula issues; 3. Balancing opposing needs of student learning and client safety; and 4. Challenges encountered by participants. In conclusion, the instructional strategies used by clinical nurse educators are informed by their values about teaching and learning, teaching experiences and nursing education.

Introduction

Background

Students with disabilities (SWD) entering college or university programs has increased over time [1]. This increased number of SWD's has also increased in those entering undergraduate nursing programs [2-4,1,5-6]. In this article, the authors describe the experiences of clinical nurse educators on instructing SWD's in the clinical arena.

Undergraduate nursing curricula consist of theoretical and practical components. The purpose of a practicum is to enable student nurses to integrate concepts taught in the classroom into actual practice and clinical nurse educators are solely responsible for instructing student nurses in the clinical arena.

Clinical supervision is an essential component in nursing education, as it enables learners to consolidate their knowledge and facilitate professional growth [7]. In nursing, clinical supervision is defined as a 'formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their practice, and enhance consumer protection and safety of care in complex clinical situations' [8, p. 15]. Clinical nurse educator's roles are as follows: to guide students in integrating theoretical concepts in practice; to guide students in planning care for the patient; to instruct students in practicing skills; engage students to critically think about how they care for their clients; and guide students in socializing into the nursing role.

Disability is understood as 'multidimensional (i.e. biological, psychological, social and environmental) and a universal phenomenon that considers the individual within the context of the environment as part of one's health continuum' [6]. In this study, the authors subscribe to a social conception of disability and raise concerns of using a biomedical model approach to disability in undergraduate nursing education. A social model of disability examines 'overall patterns of thought and action that collectively devalue individuals with disabilities and creates barriers' [5, p.13]; whereas a medical model of disability subscribes to the disability as a 'deficiency and medical illness' (p.13). Using a medical approach to disability in nursing has resulted in students and staff nurses being perceived as unable to become successful practitioners because of their perceived impairment and 'nursing faculty often assume that they are a potential

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liability and safety threat in nursing practice' [9]. The authors also found that the medical model of disability limits student nurses' access to nursing education programs.

In Canada, protections are offered to post-secondary students with disabilities through federal and provincial legislation. At the federal level, the Canadian Charter of Rights and Freedoms section 15(1) identifies the right of Canadians to be treated equally and explicitly identifies disability as a prohibited ground of discrimination with a right to accommodation. Although, each province and territory have their own respective Human Rights Code which detail protected areas, each code explicitly includes disability as a prohibited ground of discrimination and offers a detailed definition of what constitutes a disability [10-12]. Further, the duty to accommodate included in each act details the legal obligation to remove barriers and promote equitable participation. However, the duty to accommodate is not an absolute. For example, the Ontario Human Rights Code describes undue hardship as a justification to deny accommodation for reasons such as health concerns, safety concerns and financial cost.

Post-secondary institutions are legally obliged to develop and provide services to meet legal obligations set out under their jurisdictional Human Rights Code. This takes many forms and often includes services such as offices to support students with disabilities, provision of accommodations and policies. Various governments' agencies have created grants to assist in providing equipment needed for accommodations, such as an amplified stethoscope that a nursing student with hearing impairment may need. The obligation to provide accommodations extends to field education placements, including clinical placements for nursing students. However, this duty to accommodate cannot override bona fide essential requirements of nursing programs such health and safety of others. In undergraduate

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nursing education programs, SWD's need to self-declare their need for accommodation after acceptance into a program and follow the education institution's process to request accommodation [13,14].

Disability accommodation refers to "academic adjustment and auxiliary aids provided to enable students with disabilities to have access to education equivalent to that of their peers" [1, p. 34]. It is premised on the understanding of providing equal opportunity so that all students -with or without disabilities-have an equal opportunity of success. Furthermore, accommodations in higher education setting 'are meant to provide a student with access to the schools program and facilities equal to that of non-disabled students....The presence of the disability does not automatically qualify accommodation for a SWD. If the student's disability does not prohibit access to the education program, then no accommodation is necessary' (p. 35).

Aim of study

The purpose of this study was to explore with participants their experiences in instructing SWD's in the clinical placement area. The study addresses a gap in nursing education literature as the instructional experiences of clinical nurse educators is sparse [15] and the experiences of clinical instructors as it relates to this student population is minimal in the Canadian context.

The results reported in this article are a subsection of results from the larger parent study conducted by Epstein et al. [16]. The focus in this article remains on the instructional experiences of clinical nurse educators and has not been previously reported.

Method

Data collection

Data collection consisted of interviews and a short interactive journal.

A total number of fourteen participants were interviewed. Participants were interviewed individually; and each interview lasted for approximately 1-1\2 hours. Interviews were digitally recorded. The purpose of an interview is to enable researchers to gain understanding or insight into issues from a participant's perspective [17].

The interviews were semi-structured in nature and included both open-ended and close-ended questions. In developing the interview guide, the author used strategies such as ladder questions [18]. Ladder questions are an interview technique for selecting the most appropriate level of questions starting with the least invasive question first and proceeding to questions about deeper issues based on the premise that we need to build a safe relationship with participants prior to delving into more sensitive issues.

Participants also completed an interactive diary. Each participant was given an interactive diary to complete for duration of 7-10 days. The diary consisted of items related to demographic data such as education preparation, years in nursing practice; years in teaching in the clinical arena; and 2 visual scenarios. The scenarios related to instructing students in the clinical arena (e.g., how would you respond to a student who informally/formally identify with a disability during clinical?). After participants completed the diary, they were invited to participate in an interview.

After the fifth interview, the authors began examining the data for emerging concepts and developed new interview guides for subsequent participants. Data collection continued until all categories were saturated. In data saturation, new data collection ceases once the researcher does not obtain any new information to shift or extend the categories and thus redundancy is achieved [19].

Data analyses

The transcripts were examined without a priori codes and analysis of the data was conducted using Colaizzi's method [20]. Two of the study authors examined the data independently for emerging themes. Significant ideas and/or statements were extracted from the transcripts categorized and clustered into themes. Initial categories were expanded and contracted as each interview was coded. All data coded was re-checked against the initial transcripts to ensure accuracy of interpretation and relevancy.

Ethical consideration

The study received ethics approval from the Research Ethics Board at the participating university and college setting in Toronto, Canada. All participants received an information letter and a consent form prior to enrolling in the study. Consent consisted of both written and verbal consent. Verbal consent occurred prior to conducting the interview and ongoing consent was obtained throughout the interview process.

In order to protect the anonymity and confidentiality of the participants and the students that they instructed in the clinical arena, all identifying information of the participants and their students was delinked from the data prior to analysis. Further, the number of SWD's assigned to each participant has been generalised.

Participants

A purposive sampling method was used to recruit participants. The sample consisted of a total number of fourteen (14) clinical nurse educators. Most participants had taught for between eight-to-ten years in the clinical arena, and one participant taught for three years. All participants taught in undergraduate nursing programs and in a variety of undergraduate programs in the city. In addition, two participants taught in an accelerated nursing program (2 year BScN program); and one participant taught in a registered practical nursing program (RPN) to RN bridging nursing program.

Participants were involved in the direct instruction of student nurses in the clinical arena. Participants instructed student nurses in acute medical-surgical units, while some instructed students in less acute units. Participants instructed on average eight students in their clinical groups, and most participants encountered 1-2 students with disabilities over the semester. One participant indicated that "*I would say that I don't have a clinical group that doesn't have a student that needs accommodation*" (P5). Similar sentiments were expressed by all participants.

Participants instructed students with visible (vision impairment) and invisible (psychological) disabilities. Clinical instructors encountered students with the following forms of disability- Physical (vision, hearing impairment); Cognitive (Dyslexia, ADHD, memory lapses); Psychological (high anxiety). Dyslexia primarily affects verbal memory, verbal processing speed, skills in accurate and fluent word

reading and spelling and this can impact how the clinical nurse educators support the student nurse [21-23]. Anecdotal evidence suggests that SWD's are enrolling in higher numbers in undergraduate nursing programs, however the exact number of SWD entering these programs are difficult to determine due to several barriers that these students encounter such as stigma, denial of disability or failure to disclose a disability [16].

Results

In this section, the authors highlight the main themes that emerged from the data and provide exemplars to illustrate the theme. Four main themes emerged from the data and consist of the following:

1. Instructional strategies used by clinical nurse educator participants;
2. Curricula issues related to medication administration by student nurses;
3. Balancing opposing needs of student learning and client safety; and
4. The challenges encountered by the participants.

In the subsequent section, the authors discuss each theme and its implications for instruction in the clinical arena.

Instructional strategies used in the clinical arena

This section highlights the instructional activities of participants as it relates to SWD's and includes the most common strategies discussed by participants. They are: coaching; guidance in performing skills; guiding SWD's in self-reflection; and providing reassurance and emotional support. Further, in shedding light on the instructional activities of clinical nurse educators this result addresses a gap in nursing education literature.

In the first excerpt, the student had chronic back injury and required frequent and short breaks.

One of my students had a physical impairment that requires modification to her assignment related to breaks while she was in clinical. I received an email from the accommodation office that the student has an accommodation. I met with the student on-site to discuss the accommodation. I don't need to know her diagnosis. What I need from her is to let me know how I can help her learn. We sat down together, and she asked me that when I make her assignment, that I don't have her walk too far to her client's room. The assignment will not be too far apart, and that she can take small breaks instead of one chunk of a break. I allow her to take frequent breaks and she will let me know when she is off the unit. Once I know that this student requires accommodation, we work together and work out a plan on how to optimize her learning and her experience in clinical. The onus is on the student to let me know what strategies she requires from me and the kind of accommodation that she requires (P2).

Students may have an anxiety about performing a skill, or not doing a skill and sometimes that's where a space is needed. We have a conversation again, about what needs to happen, the areas they need to grow. They are not being attacked in the space or feel that they are being criticized. I also tell students often to go have breaks off the unit, because when they get away from the unit, they have time to self-reflect, out of that environment to do a proper self-reflection if they have for example, an anxiety attack (P8).

I develop a strategy; I really believe it's quite individualized. I've had students with vision problems, and I have a conversation with them about getting better spectacles. I've had students with severe panic attacks, and we look at breathing strategies and visualization strategies, and how they can practice at home with visualization (P5).

I always start my orientation by saying, "If you have a disability, I would really like you to come and talk to me about it. If you do then I can support you. I promise you I will give one hundred percent to do everything within my power to make your success possible." I really encourage them to talk to me. I think most students will find me to be very open and happy to help them. I think that my coaching is a gift (P14).

The above-mentioned excerpts denote the participants' realisation when they encounter a SWD. Nurse educators need to think about and devise strategies on how best to support the student in each situation. Several influencing factors such as the educator's knowledge of teaching, teaching experiences, nursing experiences inform the educator's approach and the strategies used in each situation. Participants also seemed to engage in reflection on and reflection-in-action which guided their instructional activities.

Curricula issues

The second theme that emerged from the data relates to the participants' concerns regarding the implementation of the undergraduate nursing curriculum in the clinical arena. Most of the issues stated by the participants relate to medication administration, a common nursing practice that all student nurses including SWD's engage in daily when providing patient care. This was a recurrent and ongoing issue identified by all participants in this study.

My student requires extra time to feel confident in her knowledge. She didn't disclose that she had anxiety problems to the accessibility center, so I had no information that she required accommodations. She did disclose this to me. I gave her the extra 30 minutes so that she could research her client. And that seems to work for her...Let's say one of her patients has medications at 8am, 10am, 12noon and at 2pm and so forth. We would administer every other medication and we make sure the nurse who has that patient knows which medications that she (sic-student) would give. For example, she (sic-student) would give the 8am medications and requires time to research the later medications and the patient's condition. This is important. We make a contract with the nurse; she (sic-student) will not give the 10 o'clock medications but will give the 12 o'clock medications. We work up to every medication time that is given and that she (sic-student) is responsible for all the patient care and documentation. She has been a wonderful addition. I work closely with her and every time she has a good outcome, we celebrate. We acknowledge her work while she is doing it. It seems to boost her confidence a little bit more. It has been a good learning experience for both of us (P2).

If they didn't disclose to me, I wouldn't know they have a disability. I have had students with disability, and I would ask them if they would like to be treated like every student. Everyone would say, yes please treat me like the others and with the same expectations. I would do my best if I encounter problems and I will let you know. Another way to help them is to look at the patient assignment. For example, I will not give him (sic-SWD) a patient who has 15 medications. I would probably give him a patient with 5 medications. It becomes a little easier when it comes to medication time to manage that time, within

the time frame to give medications. The knowledge, the process, everything will be the same for him (sic- student) to apply to the patient... I work hard with them (P1).

Medication administration is an integral aspect in student learning and how and when it is implemented in undergraduate nursing curricula has an impact on both the student nurse, the clinical nurse educator instructional activities.

In the next excerpt, a participant indicates her observations as it relates to instruction in the classroom and its effect on learning and nursing practice in the clinical arena.

I think that's another huge problem, is that they're being forced to memorize, not to understand the information. So when we talk about mode of action of the medication, or side effects or its implication, or the reason that the patient is on that drug, ninety percent of the students don't have any clue why the patient would be on that drug, even semester three!! It takes them till almost the end of semester three to begin to figure out why a patient (P5).

Similar sentiments were expressed by all study participants. There seems to be disconnect between how and when medication administration is taught and its corresponding pathophysiology. The instruction in pathophysiology should be closely linked to the instruction in medication administration in a more coherent, explicit and consistent manner. Also, the ability of the student nurses to understand this connection must also be considered and this result will be discussed further in the subsequent section.

This is an important result as participants taught in a variety of nursing programs and indicates clinical nurse educators concerns with certain aspects of the nursing curriculum in general.

Balancing opposing needs of student learning and client safety

The following three excerpts illustrate the emotional and ethical struggles that participants experienced as they make decisions related to balancing the learning needs of the student with the student's ability in providing safe client care.

If the student is struggling, sometimes you'll start to see that they're a little bit more reluctant to be hands on. They're so intimidated by the situation. I think you've got to look at their overall behavior - how they're presenting. Even before we begin administering medications, I take the student aside and go over their drug cards; and my expectations. I have to spend some extra time with the student, and it allows me to have insight into what I need to do... . Foremost, you have to make sure the patient's safe, that has to be number one priority. So, you must make sure that the patient is always safe, that there's never any danger to the patient (P9).

As nurses, we are trying to provide safe, competent care. I think that's fundamental, as a student and as nurse. We're working with real people and real health situations, and we must make sure that we're giving them adequate, appropriate care. I always emphasize with the students, that I'm never going to judge them, or criticize them or put them in a situation where they have; they feel they have to hide things from me, based on their accommodations. It's all about safe patient care. Course outcomes are very vague. You work with the student and help them progress to entry to practice requirements. I also tell my students that it may vary, based on clinical units, patient acuity, so it's really a

fluid clinical expectation, but they have to meet competencies to entry to practice (P8).

You have students who are very strong, who can work in a critical care area; and then there are nurses that have a different focus, maybe they're really are good at end of life care. I think that nursing is also a spectrum, you cannot put one checkmark that say "A, B and C." It's about safety, compassion, also providing, wholesome care and quality care. I don't think just having two patients and being excellent and just checking off the boxes makes you a nurse. I think it takes a little bit more analysis and the safety of patients. Bedside nursing may not be for everyone (P8).

The excerpts denote the participants' commitment to safe patient care as they guide the students in making decisions related to safe care of the client. Clinical nurse educators as health care professionals are obligated to fulfilling their professional responsibility by ensuring that students provide safe care to clients.

Challenges encountered by clinical nurse educator participants

This theme is important as it occurred repeatedly in the data and relates to several issues about curricula planning, implementing the curriculum in the clinical arena, and the lack of resources for clinical nurse educators. This result adds to the existing literature about the ongoing concerns encountered by clinical nurse educators.

Student and clinical nurse educator ratio

I've had days where I've had students who were absent due to illness and then I have about six students. It's a completely different learning, and the opportunities that I have to spend with students are also much more in depth and I feel that the learning is so much deeper when I don't have eight students (P11).

Similar sentiments were expressed by all participants and clinical groups consisted of eight student nurses on a consistent basis.

Lack of continuity in clinical settings

It's beneficial when you are able to return to a unit that you have previously been on or even had the opportunity to be on a particular unit for a longer period of time, because you get an opportunity to know the nurses, you get the opportunity to know the patient population, there's a significant amount of training that you need to do. It's essentially a crash course when you are a nurse who comes into a new unit, you have to learn the documentation, you have to learn the lay of the land, you have to know who the resource nurses and all the different staff members. You get an opportunity to build relationships and through those relationships, you can set up in-services for the students, there can be some unique learning opportunities that come from having time to establish relationships with some of the other healthcare members. So, that's a benefit to being on a unit a little bit longer, if the staff gets to know you, they trust you, they also come approach you with, some great learning opportunities for the students. Being comfortable with the documentation, the software, the technical stuff-medication administration dispensary. As an instructor when you are comfortable then you get to focus on your students in terms of helping them develop their nursing knowledge, skills, judgement (P7; P11).

Lack of timely communication

This term, I had one student who missed four clinical days. After two missed days I contacted the course leader, she responded with -to

complete a learning plan-which of course, I already done. Also, she (sic-course lead) said "I'll bring the student in and have a conversation". I don't understand why there isn't then a conversation with me, or an invitation to be at the same session so that we could collaborate with the student to help deliver a full plan. The statement from the lead is, we will let me know if there is anything else I can do. I think that the school really should take a proactive stance about making sure we collaborate on what's happening with the students (P5).

It leaves me at a disadvantage because I then don't know exactly what I can do to accommodate him, because if you don't know there's a disability, you don't need to know the specifics but you can say "do you need a little bit more time? Do you need me to review the process with you? Do you need me to help you set up a time schedule? What would be best suited to what you need?" I have done this in the past. But in, it's very important that the school offer a non-judgemental and positive approach so that the students don't feel that this is going to set them at a disadvantage (P5; P14).

The following excerpts relates to the lack of communication between the course lead and the participants and highlights the negative impact on the planning and instructional activities of the participants.

Discussion

In this study, participants instructed student nurses with similar types of disabilities reported in nursing literature [4,3,24]. For instance, participants encountered student nurses with physical (visual impairment); Psychological (high anxiety) and cognitive learning disability. Also, participants sought out resources to guide them instructing students in the clinical arena and similar results were reported by Sowers and Smith (2004) [25], White, [26], and Walker [14]. This study is part of a larger study conducted by Epstein et al. (in-press) [27] and the results of that study sheds important insights on the issues that SWD's encounter.

The results from this study indicate that most clinical nurse educators learn to teach on the job and that their knowledge of instruction is informed by their nursing experiences, their teaching experiences and their nursing education. Participants lacked knowledge of how to instruct or support SWD's and learned through trial and error and from the experiences of their peers. Clinical nurse educators engage in several ethical decisions and academic decisions on a frequent basis with minimal support or guidance from the course leads and education institutions [28]. Further, the learning experiences of student nurses in the clinical arena differ widely as they are influenced by several variables such as the knowledge and teaching experiences of the clinical nurse educator; academic support provided to the clinical educator and the situational context.

The results also indicate problems in the development and implementation of undergraduate nursing curricula in the clinical arena. For instance, problems related to the implementation of medication administration. It seems that student nurses were struggling with conducting an accurate head to toe assessment of their clients, collating and synthesizing relevant data about their clients in order to make an informed decision while learning to administer medications in a safe manner. It is imperative that clinical nurse educators become involved in developing and implementing undergraduate nursing curricula in clinical including *how* and *when* medication administration is introduced and taught to student

nurses. Jennings [28] recommends that nurse educators move away from the current Tylerian approach to curriculum development and pedagogy and adopt a progressive re-conceptual approach to the design, development and implementation of the undergraduate nursing curricula.

Nurse educators teaching in the classroom and clinical nurse educators grapple with how best to instruct SWDs. For instance, Arndt [29], a nurse educator, clearly articulates her learning in instructing students with varying abilities in the clinical arena. For example, in moving a client from the bed to chair, Arndt advocates using delegation to accommodate a student with physical disabilities. The authors concur with Arndt conclusion that "fairness is not achieved by treating everyone the same, but rather by giving each person what he or she needs" (p. 205).

Furthermore, the nursing profession should reconsider the competencies required for entry to practice. Instead of providing a detailed list of every possible physical, emotional and cognitive skill that the competencies currently reflect, the competencies should include 'the core attributes of the discipline such as caring, integrity, good interpersonal skills and cognitive abilities' [29, p. 205]. Matt, Maheady and Fleming [30] argue that the discipline should move from the *Technical Standards* to the *Essential aspects* of the job. Technical standards are 'the requirements for admission into and participation in the educational program' (pg. 462); whereas essential functions are those required to fulfill one's role as a nurse.

Moore [31] suggests that nurse educators view disability from a cultural diversity lens as it enables the educator to consider the possibilities in SWD's. Nurse educators by acknowledging and valuing diversity in the student population could influence students' understanding when caring for a diverse client population. Diverse life experiences provides a 'natural, built-in knowledge base for meeting the varying needs of diverse health care consumers: looking beyond people's disabilities to identify their abilities and uniqueness allows for recognition of the skills and abilities they have *because* of their disabilities, rather than *despite* them' (p. 198).

The results indicate that clinical nurse educators are concerned with student nurses' ability in providing clients with safe care. Balancing the learning needs of the student with the student's ability to provide safe client care is a struggle for both new and seasoned clinical nurse educators [15]. Meeks and Jain [1] report that schools 'must ensure that its safety requirements are based on actual risks, not on mere speculation, stereotypes or generalizations about individuals with disabilities' (p. 42). Educators should make informed decision based on current medical knowledge of the disability and accurately assess the probability of potential injury and whether reasonable policies and procedures mitigate the risk to clients.

Recommendations

Participants made several recommendations that would support them in improving their instructional methods such as more in-depth orientation including instructional strategies on supporting students with disabilities; more content on instructional techniques as most continue to learn to teach on the job; mentoring and communication and collaboration amongst the course leads, classroom faculty and clinical nurse educators. These suggestions are also supported by Griffiths et al. [32] and Horkey [33]. Mackay et al. [34] devised 'practice-development' workshops designed by clinical nurse instructors to meet their learning needs.

Study Limitation and Future Research

Data collection in this study did not include observational methods due to financial and contextual constraints. The authors suggest using observation methods as an additional data source in future studies.

In conclusion, clinical nurse educators instruct student nurses with a wide array of abilities and disabilities. Clinical instructors devise ways of instructing and guiding SWD's based on their values about teaching and learning, knowledge of teaching, nursing education and their nursing experiences.

Competing Interests

The authors declare that they have no competing interests.

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