Nursing homes as learning environments:

A study of experiences and perceptions of nursing students and supervising nurses

Mari Wolff Skaalvik

A dissertation for the degree of Philosophiae Doctor

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FORORD

Min interesse for sykehjem som læringsmiljø for sykepleierstudenter bygger på mange års erfaring som sykepleielærer. Arbeidet som sykepleielærer omfatter blant annet teoretisk undervisning og undervisning og veiledning av studenter i deres praksisstudier. Mine erfaringer fra praksisveiledning har jeg i all hovedsak fra sykehjem. Jeg erfarte tidlig at praksis i sykehjem er komplisert og sammensatt dersom læringsmålene skal nås. God planlegging og organisering er forutsetninger for studentenes læring i praksis, og det berører og utfordrer studenter, ledere og sykepleiere i praksisfeltet og lærere.

Som sykepleielærer har jeg møtt sykepleierstudenter som har uttrykt at praksis i sykehjem opplevdes som vanskelig. En hektisk hverdag gjorde at det ofte ble liten tid til å stille spørsmål og reflektere over egen praksis Mange studenter uttrykte at de så på praksis i sykehjem som lite utfordrende og som noe de bare ”måtte komme gjennom”. Studentutsagn om at ”det er jo bare stell” tyder på at utfordringene er mange for å styrke sykehjem som læringsmiljø. Samhandling i situasjoner som stell, måltider, sosialt samvær og rapport må rammes inn av utforskende og kritisk refleksjon i dialog med erfarne utøvere av faget for at studentene skal oppleve et positivt læringsmiljø. Jeg har også opplevd at studenter, mens de har hatt sykepleiepraksis i sykehjem, har snakket om konkrete pasientsituasjoner som interessante og berørende. Deres kritiske og til dels negative oppfatninger om praksis i sykehjem bygde på erfaringer om begrenset plass for utforskning av og diskusjon om sykepleiefaglige problemstillinger i pleie og omsorg for eldre.

Mitt mål med forskningen som presenteres i denne PhD-avhandlingen, er at den skal være et bidrag til å synliggjøre hvordan et utvalg av sykepleierstudenter og kontaktsykepleiere

erfarer læringsmiljøet. Forhåpentlig kan avhandlingen bidra til økt bevisstgjøring om hvilke faktorer som har betydning for et positivt læringsmiljø i sykehjem. Konkrete pleie- og omsorgssituasjoner er bærebjelker i læringsprosessen når utøvelsen av sykepleie skjer i et læringsmiljø som vektlegger et godt samspill mellom sykepleier og student. Dette utdypes ut fra data om studentenes ønske om å lære mer om og å praktisere personsentrert omsorg for personer som lider av demenssykdom. I avhandlingen presenteres også en artikkel som bygger på data fra en spørreskjemaundersøkelse for et større antall sykepleierstudenter som evaluerte det kliniske læringsmiljøet i henholdsvis sykehjem og sykehus.

Et positivt læringsmiljø har betydning dersom rekruttering av sykepleiere til eldreomsorg skal styrkes og kvaliteten i omsorgen for eldre bli bedre. Forskning har vist at studenter etter avsluttet sykepleierutdanning ofte vender tilbake til steder der de har hatt positive praksiserfaringer. De eksisterende rekrutteringsproblemene av sykepleiere til eldreomsorg skyldes blant annet mange studenters negative holdninger til eldreomsorg som fremtidig karrierevei. Et stigende antall eldre gjør det imidlertid viktig å styrke interessen for sykehjem som et faglig interessant arbeidsfelt slik at flere kan tenke seg sykehjem som fremtidig arbeidsplass.

TAKK

Denne avhandlingen har blitt til fordi sykepleierstudenter og sykepleiere har vært villige til å delta i min forskning. Takk til dere alle.

Mine to veiledere, førsteamanuensis Nils Henriksen og førsteamanuensis Hans Ketil Normann ved Avdeling for sykepleie og helsefag (ASH), Universitetet i Tromsø, har vært til stor støtte faglig og personlig. De har oppmuntret, gitt meg del i sine kunnskaper og gitt konstruktiv kritikk. Takk til dere for inspirerende diskusjoner underveis i arbeidet med studien. Dere besitter faglig dyktighet og er gode fortellere, noe som har brakt smil og latter inn i arbeidsdagene.

En takk rettes til kollegaer ved Avdeling for sykepleie og helsefag ved Det helsevitenskapelige fakultet, Universitetet i Tromsø. Et inspirerende arbeidsmiljø betyr mye! Bente Ervik har vært min "romkamerat", og det har vært en glede faglig og sosialt. At hun tok seg tid til å lese tekst for meg, var nyttig og inspirerende.

Jeg vil også takke kollegaer ved sykepleierutdanningen, Avdeling for hels- og omsorgsfag. Dyktige kollegaers engasjement for utdanning av sykepleiere inspirerer. Gode venner har betydd mye for meg under arbeidet med avhandlingen. Uten Liv-Berit Knudsens faglige støtte og praktiske hjelp ville arbeidsprosessen vært tung. Ellers vil jeg nevne Rolf Andersen, Solveig Heimdal, Kristin Skaalvik, Anne Margrethe Støback, Anne Grethe Talseth og Nils Aarsæther. Det trengs så mange slags overskudd for å forske. Takk til joggedamene Anne Margrethe, Eva Britt, Karina, Kirsti og Åshild. Bevegelse og samtale har gitt energi. Åshild Fause har gjennom vennskap, engasjement og faglighet løftet meg fremover. Jeg vil jeg rette

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SAMMENDRAG

Avhandlingen bygger på 12 sykepleiestudenters erfaringer og oppfatninger om sykehjem som læringsmiljø for praksisstudier i eldreomsorg, og hvordan et utvalg på 407 norske sykepleierstudenter evaluerer læringsmiljøet i sykehjem og sykehus. Videre har jeg intervjuet 11 sykepleiere om deres syn på læringsmiljøet i sykehjem.

Levealderen i Norge ventes å øke, og man må regne med at fremtidens kommunale helsetjeneste vil stå overfor store utfordringer. Flere studier viser at få studenter ønsker eldreomsorg som fremtidig karrierevei, og det er dokumentert at sykepleierstudenter ofte vender tilbake til steder hvor de har hatt positive praksiserfaringer.

Forskningen er gjennomført ved hjelp av kvalitative og kvantitative metoder. Artiklene I, II og III bygger på datamateriale fra feltobservasjoner, feltnotater og intervjuer med sykepleierstudenter og deres kontaktsykepleiere i 2006/2007. Dette datamaterialet er analysert ved hjelp av innholdsanalyse og fokuserer på: læringsmiljø (I), læring av personsentrerte tilnærminger til personer med demenssykdom (II) og rapporten som en potensiell læringssituasjon (III). I artikkel IV presenteres et utvalg av norske sykepleierstudenters evalueringer av det kliniske læringsmiljøet i henholdsvis sykehjem og sykehus fra 2009.

Studiens funn viste varierende erfaringer og oppfatninger vedrørende læringsmiljøet i sykehjemmene. Avhandlingen viser at det eksisterer utfordringer innenfor de områdene de fire artiklene omhandler. Et godt læringsmiljø inkluderer veiledning, tilbakemelding, faglige diskusjoner og kritiske refleksjonsprosesser i et inkluderende faglig fellesskap. (I). Det var variasjoner i sykepleierstudentenes og kontaktsykepleiernes oppfatninger med hensyn til læring av pleie og omsorg for pasienter med Alzheimer's sykdom. Sykepleierstudentene erfarte begrenset læring av personsentrerte tilnærminger i pleie og omsorg for pasienter med Alzheimer's sykdom. Kontaktsykepleierne oppfattet sykehjemmet som et praksissted med rike muligheter for å lære personsentrert omsorg (II). Funnene viser at muntlige rapporter kan utgjøre en viktig læringssituasjon. Dette gjelder spesielt hvis studentene engasjeres i faglige diskusjoner med personalet. Funnene peker på tiltak for å styrke muntlige rapporters læringsverdi for sykepleierstudenter (III). Data fra spørreskjemaundersøkelsen viste at sykepleierstudenter evaluerte sykepleiepraksis i sykehjem alt overveiende mer negativt enn de som evaluerte praksis i sykehus (IV).

Søkeord: Læringsmiljø, personsentrert omsorg, muntlig rapport, sykepleierstudent, sykehjem.

ABSTRACT

The thesis is based on the experiences of 12 nursing students and 11 supervising nurses about how they view nursing homes as a learning environments for clinical studies in care for older people, and how a selection of 407 Norwegian nursing students evaluate the learning environment in nursing homes and hospitals.

The living age is expected to increase in Norway, and it is expected that the municipal health services in the future will face big challenges. Several studies show that few students want care for older people as a future career path, and it is documented that nursing students often return to places where they have had positive clinical experiences.

The research is carried out by using qualitative and quantitative methods. Articles I, II and III are based on data material from field observations, field notes and interviews with nursing students and their supervising nurses in 2006/2007. This data material is analyzed by using content analysis and focuses on: Learning environment (I), learning of person centered approaches to persons with Alzheimer's disease (II) and the oral shift report as a potential learning situation (III). In article IV there is a presentation of a selection of Norwegian nursing students' evaluation of the clinical learning environment from 2009 in nursing homes and hospitals respectively.

The research shows that there exist challenges within the topics studied in the 4 articles in this thesis. A good learning environment includes supervision, feedback, professional discussions and critical reflection processes in an including professional community (I). There were variations in the nursing students' and contact nurses' perceptions as regards to learning of care for patients with Alzheimer's disease. The nursing students experienced limited learning of person centered approaches in nursing and care for patients suffering from Alzheimer's disease. The contact nurses perceived the nursing home as a practice place with rich possibilities to learn person centered care (II). The findings show that oral reports can constitute an important learning situation. This is particularly the case if the students are engaged in the professional discussions with the staff. The findings also point at measures which might be taken to strengthen the learning value of oral reports for nursing students (III). Data from the questionnaire survey showed that nursing students who responded in referring to clinical practice in nursing homes were predominantly more dissatisfied than those who referred to clinical practice in hospitals (IV).

Key words: Learning environment, person-centred care, oral shift report, nursing student, nursing home.

LISTE OVER ARTIKLER

Denne avhandlingen er basert på følgende artikler refereres til i teksten med henvisning til deres romertall.

I Skaalvik MW, Normann HK, Henriksen N. (2009) Nursing students' experiences of nursing homes as learning environments. *Manuscript submitted for publication*.

II Skaalvik MW, Normann HK, Henriksen N. (2009) Students experiences in learning of person-centred care of patients with Alzheimer's disease as perceived by nursing students and supervising nurses. *Journal of Clinical Nursing. Manuscript accepted for publication 27.10.09.*

III Skaalvik MW, Normann HK, Henriksen N. (2009) To what extent does the oral shift report stimulate learning among nursing students? A qualitative study. *Journal of Clinical Nursing. Manuscript accepted for publication 31.10.09.*

IV Skaalvik MW, Normann HK, Henriksen N. (2009) Clinical learning environments and supervision: experiences of Norwegian nursing students. A questionnaire survey. *Manuscript submitted for publication*.

Artiklene som er akseptert for publisering er trykket her med tillatelse fra tidsskriftet.

INTRODUKSJON

Det er global oppmerksomhet omkring mangelen på sykepleiere som ønsker å arbeide innenfor eldreomsorgen (Tailor *et al.* 2007). Avhandlingens hovedtema er læringsmiljøet i sykehjem for sykepleierstudenter som gjennomfører praksisstudier[1] i eldreomsorg. Sykepleierstudenters erfaringer fra praksis i sykehjem er med på å påvirke deres holdninger til eldreomsorg som fremtidig arbeidsplass (Ryan *et al.* 2008). Sykehjem som praksissted[2] innebærer spesielle utfordringer ettersom pasientgruppen i sykehjem er uensartet og har flere sykdommer eller sammensatte diagnoser (Kleppe 1999). Spesielle utfordringer knytter seg til omsorg for pasienter med demenssykdom (Norbergh *et al.* 2006, Robinson & Cubit 2007).

Demografisk utvikling i Norge

Levealderen i Norge ventes økt i årene fremover. Andelen eldre over 67 år stipuleres til å øke fra 13 % i 2006 til 25 % av befolkningen i 2050 (Birkeland *et al.* 1999). Antall eldre over 90 år ventes å øke fra ca 40 000 i 2010 til 138 000 i 2060 (Statistisk sentralbyrå 2006). I 2005 mottok mer enn 200 000 personer kommunale omsorgstjenester i form av hjemmesykepleie eller institusjonstilbud. Mer enn 40 000 bodde i alders- og sykehjem, og nesten 50 000 bor i omsorgsboliger eller andre boliger tilpasset omsorgsformål (Helse- og omsorgsdepartementet 2005-2006). I 2007 hadde 27 % av de over 80 år institusjonsplass eller omsorgsbolig med heldøgns bemanning (Statistisk sentralbyrå 2007).

Demens er den største diagnosegruppen i pleie- og omsorgstjenesten (Sosial- og helsedirektoratet 2007). Antall personer med demenssykdommer er beregnet å fordobles fra 65 000 i 2007 til 135 000 i de kommende 30-40 år (Sosial- og helsedirektoratet 2007).

[1] Ordene ”praksisstudier” og ”praksis” brukes som en fellesbenevnelse for undervisnings- og læringssituasjoner der studentene arbeider med sykepleiefaglige problemer og utfordringer i praksis.
[2] Ordet ”praksissted” henspeiler på institusjonen eller området av helsetjenesten der studenter gjennomfører praksisstudier.

Anslagsvis 80 % av de rundt 40 000 pasientene i norske sykehjem har demenssykdom (Helse- og omsorgsdepartementet 2007-2008). De sammensatte sykdomsbildene hos pasienter i sykehjem og den krevende omsorgen for pasienter med demenssykdom (Norbergh *et al.* 2006), gjør at behovet for tilstrekkelig antall kompetente sykepleiere er stort. Med bakgrunn i disse tallene og prognosene må man regne med at fremtidens eldreomsorg innebærer store pleie- og omsorgsutfordringer.

I Stortingsmelding 25 (Helse- og omsorgsdepartementet 2005-2006) står det at utdanningskapasiteten på høgskolenivå må være høy, og at dette spesielt gjelder utdanning av sykepleiere og vernepleiere. En prognose anslår at det i Norge trengs ca 230 000 årsverk i den kommunale omsorgstjenesten frem mot 2050 (Helse- og omsorgsdepartementet 2005-2006), noe som vil si en fordobling sammenlignet med i dag. En studie av Kloster *et al.* (2007) viser at eldreomsorg ikke er en attraktiv arena for nyutdannede sykepleiere. Internasjonale studier (Happell 1999, Heslop *et al.* 2001, Söderhamn *et al.* 2001, Williams *et al.* 2006) viser tilsvarende resultater ved at eldreomsorg var det minst ønskede arbeidsområdet etter endt utdanning. De som ønsket å arbeide innenfor eldreomsorg uttrykte imidlertid en genuin interesse for eldre mennesker, og de mente at arbeidet med eldre gir faglige utfordringer.

Høy utdanningskapasitet er viktig, men kan ikke løse fremtidens omsorgsutfordringer for eldre dersom nyutdannede sykepleiere ikke ønsker å arbeide innenfor eldreomsorg. Dokumentasjon viser at sykepleierstudenter ofte vender tilbake til steder hvor de har hatt positive praksiserfaringer (Edwards *et al.* 2004). Dette understreker studiens betydning ved at den utforsker hvordan sykepleierstudenter oppfatter læringsmiljøet i sykehjem og hvordan et utvalg norske sykepleierstudenter evaluerer læringsmiljøet i sykehjem og sykehus.

Funnene kan brukes til å styrke bevisstheten om hvor viktig et godt læringsmiljø i sykehjem er.

Sykepleierutdanning i Norge

Norge har hatt formalisert sykepleierutdanning siden 1868. I 1948 kom loven om treårig enhetlig sykepleierutdanning (Evensen 2003). Fra 1960-tallet har det skjedd en oppgradering av yrkesrettede utdanninger gjennom flere utdanningsreformer, og en akademisering av sykepleierutdanningen er en konsekvens (Smeby & Vågan 2008). Historisk sett har Norsk Sykepleierforbund vært sentral i en økt vektlegging av teoretisk og vitenskapelig kunnskap i sykepleierutdanningen (Martinsen & Wærness 1979). I 1996 ble en felles lov for høgskoler og universiteter vedtatt (Kirke-, utdannings- og forskningsdepartementet 1993). I loven ble det slått fast at det i sykepleierutdanninger skal utføres faglig utviklingsarbeid og gis undervisning basert på forskning og erfaringsbasert kunnskap. Kravet om forskningsbasert kunnskap har blitt ytterligere poengtert i rammeplanen for sykepleierutdanning (Kunnskapsdepartementet 2008).

Utdanning av sykepleiere i Norge har historisk sett gjennomgått store endringer. Utdanningens teoriandel har økt på bekostning av praksisandelen. I løpet av vel 50 år er praksisandelen i sykepleierutdanning blitt redusert fra 4/5 av utdanningstiden til 1/3. I forbindelse med ny rammeplan for sykepleierutdanningen i 2000 ble praksisandelen økt (Fause & Michalsen 2001). Sammen med fagmiljøene har Norsk Sykepleierforbund i den senere tid understreket betydningen av å styrke praksisstudiene gjennom en videreføring av sykepleiefagets praktiske kunnskapstradisjon (Karseth 2004). Innholdet i dagens utdanning utgjør 180 studiepoeng fordelt på tre år med 60 studiepoeng pr år. Teori og praksis utgjør 90 studiepoeng hver av utdanningens totale lengde.

Formål og mål for sykepleierutdanning i Norge

Formålet med sykepleierutdanning er å utdanne yrkesutøvere som er kvalifisert for sykepleiefaglig arbeid i alle deler av helsetjenesten, både i og utenfor institusjoner (Kunnskapsdepartementet 2008). Et overordnet mål er å utdanne reflekterte yrkesutøvere som setter pasienten i sentrum. Gjeldende rammeplan for sykepleierutdanningen beskriver formål, områder og omfang for praksisstudier (Kunnskapsdepartementet 2008). Det er en målsetting at de ulike kunnskapsområdene i utdanningen skal integreres i praksisstudiene. Praksisstudiene og ferdighetstreningen er obligatorisk, og praksisstudiene skal knyttes til utdanningens hovedemner. Områdene for praksisstudier er:

1. Spesialisthelsetjenesten innen medisin
2. Spesialisthelsetjenesten innen kirurgi
3. Psykisk helsearbeid og psykiatri
4. Eldreomsorg og geriatri
5. Hjemmesykepleie
6. Ferdighetstrening, forberedelser til og refleksjon over praksisstudier

(Kunnskapsdepartementet 2008)

Når det gjelder praksisområdene 1-5, skal minst tre av områdene ha en varighet på 8 uker. I den lokale fagplanen skal det gis en nærmere beskrivelse av innhold, fordeling, sekvenser, retningslinjer og spesifikke mål for praksisstudiene (Kunnskapsdepartementet 2008).

Føringene i rammeplanen overlater til utdanningsinstitusjonene å fastsette plassering av sekvensene i utdanningsprogrammet ut fra ”*tilgjengelig veiledning i praksis og fagdidaktiske valg*” (Kunnskapsdepartementet 2008, s.10). Med dagens mangel på sykepleiere i sykehjem og de føringer rammeplanen gir når det gjelder omfang av tid i veiledede praksisperioder,

kan en risikere at praksis i sykehjem bli redusert til et minimum. Økt rekruttering av sykepleiere til sykehjem har betydning for et styrket læringsmiljø (Kirkevold & Kårikstad 1999).

I rammeplanen (Kunnskapsdepartementet 2008) er forutsetningene for praksisstudier angitt. Det forutsettes at studentene skal få jevnlig veiledning, oppfølging og vurdering, og at praksisstedets sykepleiere har ansvar for den daglige veiledning og oppfølging. I de kontrakter som skal utarbeides mellom utdanningsinstitusjon og praksisfelt heter det at "*Avtalene skal sikre at veiledningsarbeidet er tydelig lederforankret i ulike ledd, og at den inngår som en del av øvrig virksomhet*" (Kunnskapsdepartementet 2008, s.11). Dette organiseres på ulike måter. I sykehjemmene som inngår i denne studien (I-III) hadde studentene kontaktsykepleier.

Læring og læringsperspektiver

Begrepet læring har ulike definisjoner. Illeris definerer læringsbegrepet slik:

> "*Læring må forstås som alle de processer der fører til en varig kapacitetsændring – det være sig av kroplig, erkendelsesmæssig, psykodynamisk (følelses-, motivations- og holdningsmæssig) eller social karakter – og som ikke udelukkende drejer sig om biologisk modning eller aldring*" (Illeris 2002, s.23).

Læring er både en individuell prosess og en prosess som inkluderer omgivelsene. Læring ses som en helhetlig integrert prosess som består av samspillende enheter; de kognitive, psykodynamiske og sosiale dimensjoner. Den kognitive dimensjonen inkluderer erkjennelsesmessige forhold og en motorisk del. Til den psykodynamiske delen hører følelser, holdninger og motivasjon med. Den sosiale dimensjonen inkluderer alle direkte og indirekte samfunnsmessige forhold (Illeris 2000). Illeris' definisjon av læring fremhever at forandring som resultat av læring, berører en persons kunnskap og holdninger. Et slikt

perspektiv er viktig fordi sykepleiepraksis har betydning for holdninger til eldreomsorg som fremtidig arbeidsplass (jfr. Edwards *et al.* 2004).

Læring har siden begynnelsen av det 20. århundret blitt forstått ut fra i all hovedsak tre ulike perspektiver: det behavioristiske, det kognitivistiske og det relasjonelle (Imsen 1997, Tveiten 2008). Det behavioristiske perspektivet vektlegger kunnskap som noe objektivt gitt, og definerer læring som endring av atferd. Å lære knyttes an til prøving og feiling (Frøyen 1998). Kognitivismen kom som en reaksjon på de positivistiske og behavioristiske perspektivene som lå til grunn for tilnærmet all læringsforskning fram til 1960 (Bråthen 2002). Læringsforskning ut fra et kognitivistisk syn bygger på et rasjonalistisk kunnskapssyn hvor læring forstås som persepsjonsprosesser, hukommelsesprosesser, tankeprosesser og språklige prosesser. I kognitiv læringsteori vektlegges individet og det individuelle læringsarbeidet. En slik individualisering har blitt kritisert av flere, blant annet Dysthe (1999), Spouse (2000) og Säljö (2001), som skriver om fellesskapets betydning for læring.

Konstruktivismen vokste frem ut fra et perspektiv om at studenter konstruerer kunnskap gjennom etablering og revisjon av mentale strukturer. Som pedagogisk gren går konstruktivismen tilbake til Piaget, som av mange betraktes som opphavsmannen til ideen om å være aktiv i egen læring og kunnskapsutvikling (Piaget 1972, Noddings 1995). Det legges vekt på individuell og sosial aktivitet ved at læringens innhold, mening og betydning trer frem i samhandling med andre og med språket som verktøy for å bearbeide kunnskap (von Glaserfeld 1987).

Sosiokulturelt perspektiv på læring

Et sosiokulturelt perspektiv på læring har etter hvert fått en solid posisjon innenfor pedagogikken, både nasjonalt og internasjonalt (Greeno 1997, Dysthe 2001, Bråthen 2002). Perspektivet er utgangspunkt for synet på læring som presenteres i avhandlingen og hvilke faktorer som støtter opp om sykepleierstudenters læring i praksis.

> *"The goal of a sociocultural approach is to explicate the relationships between human action, on the one hand, and the cultural, institutional, and historical situations in which this action occurs, on the other"* (Wertsch, del Rio & Alvarez 1995, s.11).

Læring ses som en aktiv prosess som skjer i tilknytning til sosial interaksjon og kulturell kontekst i et læringsmiljø der det foregår autentiske aktiviteter.

I boken "Tenkning og tale" (2001) beskriver Vygotsky sosiokulturell læringsteori som et alternativ til behavioristisk og kognitiv læringsforståelse. Læring forstås i dette perspektivet som en del av den menneskelige virksomhet basert på interaksjon mellom mennesker og deres omgivelser (Säljö 2001, Bråthen 2002). Vygotskys tenkning har fått en sentral plass i utdanning ved at man i læring vektlegger samspill mellom tilgjengelige ressurser for tenkning og handling (Säljö 2001). Dette åpner blant annet opp for spørsmål knyttet til hvordan sosiale praksiser blir gjort tilgjengelige for nye deltakere. Læring er i sosiokulturell læringsteori knyttet til deltakelse i praksisfellesskapets virksomhet. Studentene lærer ikke bare et innhold, men sosialiseres inn i en fagkultur (Dysthe 2001).

Vygotsky bruker begrepet "den nærmeste utviklingssonen" (the zone of proximal development). *"This is the distance between the actual development as determined by independent problem solving and the level of potential development determined by problem solving under adult guidance or in collaboration with more capable peers*" (1978, s.86-87). I tanken om den nærmeste utviklingssonen er den hjelp og assistanse som er tilgjengelig for

studenten sentral for å skape et støttende miljø for læring. Dette kaller Vygotsky "stillasbygging". For sykepleierstudenter som gjennomfører praksisstudier kan inkludering i pleiefellesskapet, akseptasjon, veiledning og faglige diskusjoner ses på som komponenter i "stillaset".

Vygotskys begrep "den nærmeste utviklingssonen" og "stillasbygging" (1978), kan ses sammen med tankene til Bakthin som sier at grunnleggende mening alltid blir skapt i dialog. Bakthin (1986) skrev om at ytringer har en referensialitet (et innhold), en ekspressivitet (den som ytrer seg har en følelse for eller gjør en emosjonell vurdering av det han/hun ytrer seg om) og en adressivitet (den ytringen er tenkt rettet mot). Meningsskaping, kunnskapsutvikling og læring i praksis skjer når konkrete erfaringer løftes frem gjennom dialog. Dysthe skriver at "*Språket brukar vi både for å forstå og tenke for oss sjølve og for å uttrykke det vi forstår til andre"* (2001, s. 49). Vi står her overfor betydningen av refleksiv dialog som en del av læring i praksis (jfr. Schön 1983, 1987).

Det sosiokulturelle teorifeltet er preget av mangfold ved at flere tradisjoner eksisterer side om side med ulike tolkninger av grunnideene til Vygotsky (Dysthe 2001). Dialogismen (Wertsch 1991) og Vygotskys teorier om forholdet mellom språk og tenkning, individ og kollektiv, menneske og kultur (2001) er sentrale perspektiver i en utforskning av faktorer som har betydning for læringsmiljøet i praksis.

Læring i sykepleiepraksis

Frem til ca 1980, da sykepleierutdanningene ble en del av høgskolesystemet, foregikk opplæringen av sykepleierstudenter som mesterlære i et praksisfellesskap (Fause & Michalsen 2001). Mesterlære innebærer at læring skjer ved at studenten gis adgang til å delta og handle i relevante praksissituasjoner under veiledning av en mester (Martinsen 1990,

Nielsen & Kvale 1999). Mesterlære har fire karakteristika; praksisfellesskap, tilegnelse av profesjonell identitet, "learning by doing" og evaluering gjennom praksis (Nielsen & Kvale 1999). Begrepet "learning by doing" kan tilbakeføres til filosofen og pedagogen John Dewey (1974). Det vektlegger relasjonen mellom kunnskap og handling, og samspillet mellom enkeltindividet og vilkårene i omgivelsene – og da spesielt de menneskelige omgivelsene.

Begrepet mesterlære er satt søkelys på av flere (Martinsen 1989, 1990, Wackerhausen 1993, Fly 1994, Rasmussen 1999, Munk 2002) ut fra at ikke alle "mestere" er gode veiledere i praksis, noe som vil resultere i at studentens utbytte av å gå sammen med "mesteren" begrenses. Historisk sett har mesterlære vært kjennetegnet av en autoritær og undertrykkende karakter (Rasmussen 1999). Wackerhausen (1999) peker på at man i en dynamisk og foranderlig verden må være oppmerksom på mesterlærens potensielt iboende konservatisme dersom kritisk, teoretisk refleksjon ikke integreres i læringsprosessen.

Situert læring ble introdusert som læringsmodell av Lave & Wenger (1991). Ordet "situert" viser til menneskelig praksis som deltakelse i en autentisk handlingskontekst (Lave & Wenger 1991, Cope *et al.* 2000). Situert læring fremstilles som en kontrast til abstrakt læring, som skjer i klasserom og borte fra den konteksten der kunnskapen har sin anvendelse (Dreier 1999). Quinn (2000) skriver at læring i praksis er eksperimentell og betraktet som mer meningsfull enn det som skjer i klasserommet. En norsk studie (Espeland & Indrehus 2003) viste at norske sykepleierstudenter var mer tilfredse med den kliniske delen av utdanningsprogrammet enn den teoretiske delen i studiet. Slike funn rapporteres også i studier gjennomført av Kyrkjebø *et al*. (2001) og Brammer (2006).

Forneris & Peden-McAlpine (2006) beskriver hvordan kontekstuell læring gir muligheter for kritisk refleksjon over de ulike situasjonene som erfares i konteksten. Slike muligheter må utnyttes dersom læring i praksis skal oppfylle sitt potensial og bidra i studentenes læringsbestrebelser (Stockhausen 2005).

Vygotsky (2001) påpeker at læring skjer innenfor sosiale rammer og at mye av det vi lærer, lærer vi av andre. Studentenes læring og kunnskapsutvikling påvirkes derfor av den posisjon de har innenfor pleiefellesskapet. Begrepet legitim, perifer deltakelse brukes av blant andre Lave og Wenger (1991) for å tydeliggjøre relasjonen mellom studenter og eksperter. Begrepet omtaler prosessen der studenter (nykommere) gradvis blir en integrert del i et pleiefellesskap. Da trenger studentene å inngå i samarbeid, samhandling og dialog knyttet til gjøremål og aktiviteter. Wenger (1998) skriver at meningsfull læring innebærer at studentene aktivt bidrar i arbeidet i avdelingen. Utfordringen er at deltakelsen i pleiefellesskapet ikke resulterer i at studentene bare fungerer som arbeidskraft. Det har betydning at studenten gis anledning til refleksjon sammen med erfarne utøvere av faget dersom ”daning” fremfor ”tilpassing” skal skje (jfr. Hellesnes 1994).

I de senere år har læring i praksis blitt viet stadig større oppmerksomhet (Heggen 1995, Hargreaves 2003, Papp *et al.* 2003, Chan 2004 a & b, Tiwari *et al.* 2005). Flere studier (Chapman & Orb 2000, Bashford 2002, Channel 2002, Elliot 2002) viser at studenter opplever praksisstudier som utfordrende med hensyn til læring. Beck (1993) fant at studenter kunne oppleve engstelse i møtet med de mange utfordringene i praksis.

I forskning om læring i praksis vektlegges ulike forhold. Westad Hauge (1996) konkluderer med at miljøet i avdelingen sammen med egeninnsats, følelsesmessig engasjement og en

interessert og faglig dyktig veileder har betydning. Heggen (1995) peker på den betydningen det har at studentene inkluderes i arbeidsfellesskapet og gis anledning til å samhandle med en mester.

Sykepleierutdanning i Norge har siden 1980-tallet tatt opp i seg Schöns (1987) og Martinsens (1989, 1990) perspektiver på læring i praksis. Schön (1983, 1987) opererer med tre nivåer av refleksjon: "Knowing in action", "reflection in action" og "reflection on action". "Knowing in action" innebærer å kunne vite mer i handlingen enn man umiddelbart kan sette ord på. Slik kunnskap i handling er spontan og uten bevisst overveielse. "Reflection in action" har en kritisk funksjon og gir umiddelbar betydning for handling i den aktuelle situasjonen. "Reflection on action" innebærer å reflektere i ettertid over utført handling for å etablere en dialog mellom tenkning og handling. Dette forutsetter et læringsmiljø kjennetegnet av samarbeid og samhandling mellom student og kontaktsykepleier.

Martinsen (1989) skriver at:

> *"Håndverkslæringen skal gjøre sykepleieren dyktig til å være i omsorgens motsetninger, i en mangetydig og komplisert virkelighet, som vi ikke kan kontrollere, men som vi følelsesmessig lever og deltar i. Det er å få fagets tause kunnskap i kroppen. Det er å få fagets teorier og prosedyrer "innskrevet i kroppen"* (1989, s.70).

Martinsen vektlegger betydningen av at studenter lærer gjennom råd fra og faglige diskusjoner med en mester.

Læring i praksis er ofte assosiert med "learning by doing" (Dewey 1974). Perspektivet er utilstrekkelig hvis det innebærer at læringssituasjoner blir oversett ut fra manglende oppmerksomhet og gjenkjennelse (Lambert & Glacken 2005). Læring i praksis må derfor ikke overlates til tilfeldighetene, og det kreves dedikert, kvalifisert personale som støtter opp

om studentenes læring. Kontaktsykepleierne må være tilgjengelige, samhandle og samarbeide med studentene, slik at deres læringsbehov og faglige utbytte imøtekommes (Bezuidenhout *et al.* 1999). Slik kan det etableres et positivt læringsmiljø som støtter og verdsetter studentene som lærende.

Organisasjonskultur

Kulturen i en organisasjon har betydning for hvordan den skaper, deler og bruker kunnskap. Sykepleiekulturen utgjøres av dens historie, tradisjoner, ritualer, myter, rutiner og fortellinger og underbygger antagelser og verdier (Hill *et al.*2003). Suominen *et al.* (1997 s.186) skriver at:

> "*Culture finds expression in learned, shared and inherited values, in the beliefs, norms and life practices of a certain group, guiding their processes of thinking, decision-making and action. Past events and the anticipation of future are both reflected in the culture*".

Sykepleiekulturen kommer til uttrykk i sykepleierens handlinger, innflytelse, utførelse, holdninger, beretninger og samhandlinger i relasjon med andre (Cronin & Rawlings-Anderson 2004 s.29). Brooks & Brown (2002 s.344) skriver at:

> *"Culture comprises a series of cultural schema or collective knowledge structures, which are socially constructed and rely on negotiation, consensus and agreement for their sustenance. They are communicated and maintained through the socialization process and in everyday interaction, through ceremonies, rituals, myths, and symbols*".

Kulturen i sykehjem utgjør en del av det læringsmiljøet studenter møter. Organisasjonens kultur har betydning for dens kunnskapsutvikling og læring, og kulturen vil påvirke organisasjonens praksis. Kulturen i sykehjem vil derfor i stor grad legge grunnlaget for hvordan sykepleierstudenter erfarer og oppfatter læringsmiljøet. Kulturens betydning for studenter som gjennomfører praksisstudier i sykehjem kan uttrykkes gjennom Scheins (1985 s.7) definisjon av kultur som en prosess som skapes gjennom samhandling:

> ”*Et mønster av grunnleggende antakelser – skapt, oppdaget eller utviklet av en gruppe etter hvert som denne lærer å mestre sine problemer med ekstern tilpasning og intern integrasjon – som har fungert tilstrekkelig bra til at det blir betraktet som sant og at det læres bort til nye medlemmer som den rette måten å oppfatte, tenke og føle på i forhold til disse problemene*”.

Læringsmiljø

Bloom (1964 s.187) definerer begrepet læringsmiljø som:

> “*…the conditions, forces, and external stimuli which impinge upon the individual. These may be physical, social, as well as intellectual forces and conditions. We conceive of a range of environments from the most immediate social interaction to the more remote cultural and institutional forces. We regard the environment as providing a network of forces and factors which surround, engulf, and play on the individual. Although some individuals may resist this network, it will only be the extreme and rare individuals who can completely avoid or escape from these forces. The environment is a shaping and reinforcing force which acts on the individual”).*

Papp *et al.* (2003) beskriver et klinisk læringsmiljø som: ” *The clinical environment encompasses all that surrounds the student nurse, including the clinical setting, the staff, the patients, the nurse mentor and the nurse teacher.”* (s.263). I denne avhandlingen er relasjonen pasient/ student og student/sykepleielærer ikke vektlagt. Begge de nevnte definisjonene av læringsmiljø anses som fruktbare ettersom de fanger opp det mangfoldige i hva som utgjør et læringsmiljø, og at læringsmiljøet har stor betydning for individet som inngår i det.

Quinn (2000) skriver at læring i praksis er mer relevant og meningsfull enn læringen som skjer i klasserommet. De samme synspunktene finner en hos blant annet Rogers (1969), Knowles (1990), Schön (1983, 1987), Papp *et al.* (2003) og Myrick *et al.* (2006). Dersom deres synspunkter legges til grunn, er betydningen av innsikt og forståelse for faktorer som virker inn på læringsmiljøet åpenbar.

Det er gjort flere studier av læringsmiljøet i sykehusavdelinger, og disse er i all hovedsak gjort i Storbritannia og Australia (Fretwell 1980, 1983, Lewin & Leach 1982, Dunn & Hansford 1997, Bjørk 2001, Chan 2004a). I Norge har Heggen (1995) skrevet boken "Sykehuset som "klasserom". Praksisopplæring i profesjonsutdanninger". Bjørk (2001) har gjennomført studien "Sykehusavdelingen - et miljø for læring?". Nordiske studier om studenters læring i praksis har i all hovedsak vært opptatt av veiledning som en faktor i sykepleierstudenters praksisstudier (Christiansen 1991, Mogensen 1994, Saarikoski & Leino-Kilpi 1999, 2002, Bjørk & Bjerknes 2003, Saarikoski *et al.* 2007). Felles for studiene er at betydningen av praksis vektlegges, og at læringsmiljøet har stor betydning for læringsutbyttet. Det er ikke funnet nyere nordiske vitenskapelige studier om sykepleierstudenters opplevelse av læringsmiljøet i sykehjem.

Internasjonale studier om praksis i sykehjem er gjort av blant andre Adams (2000), Happel (2002), Rogan & Wyllie (2003), Banning *et al.* (2006) og Kerridge (2008). Funnene i disse studiene er ikke entydige, men de peker alle på spenningsfeltet mellom studenters holdninger til arbeid med eldre og hvordan de erfarer læringsmiljøet i sykehjem. En studie av Hartigan-Rogers *et al.* (2007) om sykepleierstudenters oppfatninger om klinisk praksis inkluderte informanter som hadde praksis i eldreomsorg. Studien viste at verdifull læring skjedde når studentene opplevde støtte i utøvelsen av pasientomsorg. For øvrig viste studien at studentene, uavhengig av praksissted, opplevde det som avgjørende at læringsmiljøet var kjennetegnet av støttende relasjoner.

De mellommenneskelige relasjonene fremheves som avgjørende for utviklingen av et positivt læringsmiljø (Dunn & Hansford 1997, Papp *et al.* 2003, Edwards *et al.* 2004, Levett *et al.* 2009). Studentenes læring avhenger av at læringsmiljøet er støttende og kjennetegnet av respekt, gjensidig tillit og akseptasjon (Nolan 1998, Midgley 2006, Henderson *et al.*

2006). For at læringsmiljøet skal bidra til læring, har det betydning i hvilken grad det er etablert strategier og tilnærminger som understøtter studentenes læringsprosess og faglige utbytte (Watkins 2000, Matsumara *et al.* 2004, Ranse & Grealish 2007).

Kontaktsykepleierne er viktige ressurspersoner i læringsmiljøet. Kvaliteten i veiledningsrelasjonen innebærer å bidra til studentens læring gjennom støtte, tilbakemeldinger og vurdering og å være en god rollemodell (Kilcullen 2007). Sykepleiere med kompetanse, vilje og tid til å dele sin profesjonelle kunnskap gjennom samarbeid med studentene i utøvelse av sykepleie, er en forutsetning (jfr. Spouse 1996). Uten kompetente kontaktsykepleiere kan studentenes læring av sykepleie bli preget av passiv tilpasning uten kritisk refleksjon (Eraut 1994). Delt kunnskap, faglige diskusjoner og samhandling i meningsfulle læringssituasjoner som det reflekteres over, gir et godt læringsmiljø med involverte og aktive studenter (Hawthorn *et al.* 2009).

For at kontaktsykepleierne skal bidra til et positivt læringsmiljø, må forholdene legges til rette for det i en hverdag som er kjennetegnet av mange gjøremål (Hutchings *et al.* 2005, Lambert & Glacken 2005). Det har stor betydning at ledere er oppmerksomme på forholdene som utgjør læringsmiljøet. Ledere har en viktig oppgave i å stimulere til og styrke kontaktsykepleiernes deltakelse i studentenes praksis og engasjement i å inkludere studentene i et vidt spekter av læringserfaringer (Bezuidenhout *et al.* 1999, Saarikoski & Leino-Kilpi 2002, Vallant 2004, Zilembo & Monterosso 2008).
I et trygt og støttende læringsmiljø har det betydning at studenter og kontaktsykepleiere forstår hverandres respektive roller, og at studentene inkluderes i miljøet (Heggen 1995, Nolan 1998). Levett-Jones *et al.* (2007) viser i en studie at opplevelsen av tilhørighet er avgjørende for en positiv og utbytterik praksis.

I en studie av Brown *et al.* (2008) om sykepleierstudenters synspunkter på sykepleie til eldre, benyttes benevnelsene "*impoverished environments of care and learning*" og "*enriched environments of care and learning*" (s. 1220-1221). Det som benevnes som "*impoverished environments*" kjennetegnes av et uhensiktsmessig fysisk miljø, manglende ressurser og utstyr, personale med manglende kunnskap og ferdigheter, dårlig lønn og arbeidsforhold for de ansatte og underbemanning. Studien viser at "*impoverished environments"* kan resultere i at studentene får negative oppfatninger av sykepleie til eldre. Det kan konkluderes med at personalets holdninger til arbeidet og eldre i særdeleshet og et konsistent og dynamisk lederskap (Lockwood-Rayerman 2003), er avgjørende for et positivt læringsmiljø.

Et "enriched environment" er i følge Brown *et al.* (2008) kjennetegnet av at studentene opplever trygghet, får oppnevnt en veileder og føler seg velkomne og inkluderte på praksisstedet. Videre legger studiens informanter vekt på betydningen av at praksisstedet inspirerer dem gjennom "*excellent standards of care*" og positive holdninger overfor eldre. Personalets holdninger til arbeidet generelt og til arbeid med eldre spesielt, et dynamisk lederskap og god kommunikasjon fremheves som avgjørende for et "*enriched environment"*. Benevnelsene "enriched" og "impoverished" som beskrivelser av læringsmiljø oppfatter jeg som hensiktsmessige for temaet i studien. Det er spesielt interessant hvordan studien til Brown *et al*. (2008) knytter sammen "care" og "learning" som områder som konstituerer hverandre. Denne sammenhengen gjenfinnes i min studie ved at studentene som erfarte praksissteder med personsentret pasientomsorg opplevde at læringsmiljøet var personsentrert overfor dem som studenter (II).

Sykehjem

Sykehjem er en del av den kommunale helsetjenesten i Norge. I Norge ble sykehjem formelt utformet på 1950-tallet, og hadde røtter tilbake til den tidligere institusjonaliserte fattigforsorgen (Hauge 2004). Historisk sett har omsorg for eldre utviklet seg fra å være familiebasert til å bli institusjonalisert i form av alders- og pleiehjem som tilholdssted for hjelpetrengende eldre som ikke hadde familie å falle tilbake på (Daatland 1999).

Ut fra en voksende kritikk av alders- og pleiehjemmene som "oppbevaringsinstitusjoner" for gamle som ikke greide seg på egen hånd (Hauge 2004), ble det på 1950-tallet etablert sykehjem som skulle innebære en mer aktiv tilnærming i tilbudet til eldre i form av aktiv behandling. Intensjonene om sykehjem som aktive behandlingsinstitusjoner viste seg å være vanskelig å iverksette (Hauge 2004), og sykehjemmene utviklet seg til institusjoner for langtidsopphold. Ideologien om sykehjem som behandlingsinstitusjoner endret seg i retning av en oppfatning om at sykehjem skulle være en institusjon der noen eldre skal leve i den siste fasen av livet. Dette kaller Hauge (2004) bostadsfasen, og det fremheves at sykehjem skal ha et hjemlig og privat preg (NOU 1992, Sosial- og helsedepartementet 1996-1997, Jacobsen 2008).

I dag har sykehjem to uttalte funksjoner; de skal være bolig og hjem for eldre og det skal tilbys behandling der (Hauge 2004). Dagens sykehjem står overfor en rekke oppgaver, og det er politisk enighet om at sykehjemmene skal styrkes med blant annet flere årsverk generelt og sykepleiere spesielt (Helse- og omsorgsdepartementet 2005-2006). Tilbudet i sykehjem skal styrkes for de som trenger det mest, og tiltak rettes spesielt mot de svakeste gruppene som bor i sykehjem (Helsetilsynet 2003). Sykehjemmene skal tilby individuelt tilpasset pleie, omsorg, behandling, rehabilitering og avlastning. Det forutsetter at man i

kommunehelsetjenesten har det nødvendige antall kvalifisert personale (Helse- og omsorgsdepartementet 2005-2006).

Praksis i sykehjem

Pleie og omsorg for eldre innebærer å forholde seg til sammensatte sykdomsbilder, ulike behov for pleie (Joy *et al.* 2000) og personsentrert omsorg og pleie (Kitwood & Bredin 1992, Dewing 1999, 2000, 2004, Normann 2001, McCormack & McCance 2006). Det er viktig å imøtekomme pasientenes sosiale behov innenfor rammene av sykehjem som institusjon (Hauge 2004). De fleste eldre i sykehjem bor der til sin død, og det er en utfordring å gi døende en omsorg som imøtekommer fysiske, psykiske og åndelige behov (Bondevik 1999). Det at ca 80 % av pasientene i sykehjem har demenssykdom gjør omsorg for eldre ekstra krevende og stiller høye krav til kompetanse. Flere studier (Wade & Skinner 2001, Chen *et al.* 2002, de la Rue *et al.* 2003) viser at det er viktig å legge til rette for at studenter erfarer at pleie og omsorg for eldre er faglig utfordrende og lærerikt. Det er avgjørende at studentene får hjelp, støtte og veiledning fra gode rollemodeller (Chow & Suen 2001, Tuohy 2003, Perry 2009) for å oppnå innsikt og forståelse for de faglige utfordringene pleie og omsorg for eldre representerer. Det er viktig at studentene ikke eksponeres for dårlig praksis og dårlige standarder, slik at det gir en negativ oppfatning av sykehjem som potensiell fremtidig arbeidsplass.

MÅL FOR FORSKNINGEN

Målet er at forskningen som presenteres i avhandlingen skal skape forståelse og interesse for hvilke forhold som har betydning for et godt læringsmiljø i sykehjem. Forskningens mål belyses gjennom utforskning av hvilke forhold studentene erfarer som viktige for et godt læringsmiljø (I). Hvordan oppnåelse av konkrete læringsmål har betydning for opplevelse av læringsmiljøet belyses gjennom studentenes erfaringer med læring av personsentrerte tilnærminger overfor pasienter med demenssykdom (II). Videre løftes det frem erfaringer med og oppfatninger om muntlig rapport som en potensiell læringssituasjon (III). Hvordan et utvalg norske sykepleierstudenter evaluerer læringsmiljøet i henholdsvis sykehjem og sykehus fremkommer av resultatene fra en spørreskjemaundersøkelse (IV).

Avhandlingen består av fire artikler, som hver har følgende spesifikke tema:

Artikkel I Å beskrive og belyse hvilke erfaringer og oppfatninger sykepleierstudenter og kontaktsykepleiere har av læringsmiljøet i tre sykehjem.

Artikkel II Å beskrive og belyse erfaringene sykepleierstudenter og kontaktsykepleiere har om læring av personsentrert sykepleie til pasienter med demenssykdom i et undervisningssykehjem.

Artikkel III Å beskrive og belyse sykepleierstudenters og kontaktsykepleieres erfaringer med og oppfatninger av rapport som potensiell læringssituasjon i sykehjem.

Artikkel IV Å kartlegge sykepleierstudenters evaluering av de kliniske læringsmiljøene i sykehjem og sykehus i sykepleierutdanningen.

METODE

Studiens utgangspunkt var en kvalitativ tilnærming basert på feltarbeid og kvalitative forskningsintervju (I-III). Etter hvert som det kvalitative datamaterialet ble analysert, skapte det en interesse for å utforske sykepleierstudenters erfaringer med det kliniske læringsmiljøet ved hjelp av en kvantitativ undersøkelse (IV).

Utvalg, metoder og beskrivelse av feltet

Studien omfatter fire delstudier (I-IV). I tabell 1 sammenfattes antall deltakere, datainnsamlingsmetoder og hvordan data er analysert.

Tabell 1 Oversikt over metoder brukt i studiene I-IV.

Studie nr.	Deltakere	Datainnsamlingsmetoder	Analysemetoder
I	12 sykepleierstudenter 11 kontaktsykepleiere	Feltobservasjoner Intervju	Kvalitativ innholdsanalyse
II	7 sykepleierstudenter[3] 6 kontaktsykepleiere[4]	Feltobservasjoner Intervju	Kvalitativ innholdsanalyse
III	12 sykepleierstudenter 11 kontaktsykepleiere	Feltobservasjoner Intervju	Kvalitativ innholdsanalyse
IV	Sykepleierstudenter (n=407)	Spørreskjema	Kvantitativ analyse; kji-kvadrattest, t-test, multippel lineær regresjonsanalyse

Rekruttering av informanter fant sted ved en høgskole og i tre sykehjem i Norge (I. II, III). Sykepleierstudentene og deres kontaktsykepleiere ble informert muntlig og skriftlig om studien og spurt om de var villige til å delta i prosjektet (Vedlegg 1 og 2). Sammen med informasjonsskrivet fulgte samtykkeerklæring som ble levert til undertegnede. En mannlig og elleve kvinnelige sykepleierstudenter deltok i studien. De utgjorde det antallet femte semesters studenter som på tidspunktet for gjennomføring av studien hadde ti ukers eldreomsorgspraksis. Studentene var fra 22 til 35 år med en gjennomsnittsalder på 27 år.

[3] Sykepleierstudentene er et uvalg av det totale antall (n=12) sykepleierstudenter som inngår i studien.
[4] Kontaktsykepleierne er et utvalg av det totale antall (n=11) kontaktsykepleiere som inngår i studien.

Alle hadde seks ukers erfaring fra sykehjem i første studieår med fokus på grunnleggende sykepleie.

Elleve sykepleiere som var oppnevnt som kontaktsykepleiere for studentene i praksisperioden deltok i studien. De hadde hver ansvar for veiledning og oppfølging av én student, bortsett fra én sykepleier som veiledet to studenter. Kontaktsykepleierne var fra 27 til 56 år med en gjennomsnittsalder på 37,5 år. Deres erfaring fra eldreomsorg var fra ett til 19 år med et gjennomsnitt på 5,5 år. Alle var kjent med rollen som kontaktsykepleier.

Artiklene I og III baserer seg på alle 12 femte semesters sykepleierstudenter på tidspunktet for feltarbeid og intervju (2006). Artikkel II inkluderer studentene som hadde praksis i sykehjem A (n=7)[5] og deres kontaktsykepleiere (n=6). I artikkel III studentenes kontaktsykepleiere (n=11) inkludert. Feltobservasjoner inngår i artiklene I-III.

Lederne ved de tre sykehjemmene ble informert om prosjektet skriftlig og muntlig, og ga tillatelse til gjennomføring av feltarbeid i forbindelse med prosjektet (Vedlegg 7). Studien ble godkjent av Norsk samfunnsvitenskapelig datatjeneste (Vedlegg 7).

Sykehjemmene

Sykehjemmene som er inkludert i studien (I-III) ble benyttet som praksissteder for sykepleierstudenter på regulær basis, og var de sykehjemmene som ble benyttet for praksisstudier i eldreomsorg da studien ble gjennomført. Ett av sykehjemmene (A) som inngår i studien var et undervisningssykehjem. Undervisningssykehjem er kjent fra USA under betegnelsen "Teaching Nursing Home" (TNH) og har eksistert siden 1963 (Mezey *et al.* 1988, Chilvers & Jones 1997). I 1999 iverksatte Sosialdepartementet

[5] Omtales under neste underoverskrift.

”Undervisningssykehjemsprosjektet” (USP) i Norge i tråd med Nasjonal plan for etablering av ressurssentre for undervisning, fagutvikling og forskning i den kommunale helse- og sosialtjenesten (Kirkevold & Kårikstad 1999). Fire undervisningssykehjemsprosjekter (USP) ble etablert i de fire universitetsbyene Bergen, Oslo, Tromsø og Trondheim (Helse- og omsorgsdepartementet 2008). I 2008 var det etablert 25 undervisningssykehjem i Norge (Helse- og omsorgsdepartementet 2008). Fag- og kompetanseutvikling, kvalitetsforbedring i omsorgen for eldre, heving av omsorgsarbeidets faglige prestisje for å bedre rekrutteringen, stimulering til økt interesse for klinisk forskning og utvikling av gode praksis- og læringsmiljøer for helsefaglige og medisinske studenter er vektlagt i målsettingen for USP (Kirkevold & Kårikstad 1999).

I sykehjem A praktiserte syv studenter fordelt på fire avdelinger, to studenter i tre avdelinger, og én student praktiserte i en fjerde avdeling. To sykepleiere hadde videreutdanning i henholdsvis eldreomsorg og demensomsorg. I sykehjem B praktiserte én student i en avdeling for pasienter med demenssykdom. I denne avdelingen hadde to av sykepleierne videreutdanning i omsorg for pasienter med demenssykdom. Én student praktiserte i en generell sykehjemsavdeling.

I sykehjem C praktiserte tre studenter. Sykehjemmet var lokalisert i et helsesenter og inkluderte en sykehjemsenhet og en sykestue. Studentenes kontaktsykepleiere arbeidet i både sykehjems- og sykestueenheten etter en oppsatt turnus. Studentene fulgte sine kontaktsykepleieres turnus med hensyn til vakter i henholdsvis sykehjems- og sykestueenhet. Studentene som praktiserte i sykehjem C deltok og utførte i større grad enn studentene i sykehjem A og B sykepleieprosedyrer knyttet til medisinering, sårskift og intravenøs behandling.

I de generelle sykehjemsavdelingene (6 av 7) i de tre sykehjemmene anslo sykepleierne at rundt 80 % av pasientene hadde demenssykdom. Dette er i overensstemmelse med data i en rapport fra Helse- og omsorgsdepartementet (2007-2008). Det fantes ingen pleietyngdestatistikk for sykehjemmene. Sykepleierne rapporterte at alle pasientene trengte hjelp til personlig hygiene. Forholdstallet ansatte/pasienter var 3/9 ved sykehjemmene.

Artikkel IV bygger på en spørreskjemaundersøkelse omtalt somClinical Learning Environment and Supervision Scale + Nurse Teacher (CLES+T)) (Vedlegg 6) blant sykepleierstudenter ved fem norske høgskoler. Respondentene til studie IV ble rekruttert fra fem strategisk valgte høgskoler i Norge. Spørreskjemaet CLES+T er utviklet og validert av Saarikoski & Leino-Kilpi (2002), Saarikoski *et al.* (2005, 2008) som ga tillatelse til oversettelse og bruk av det i Norge (Vedlegg 7). Det er første gang spørreskjemaet brukes i Norge. Spørreskjemaet ble oversatt og validert ut fra prosessen beskrevet av Polit & Beck (2008) med oversettelse fra engelsk til norsk, og så tilbake til engelsk av to innbyrdes uavhengige oversettere som behersket begge språk. En referansegruppe bestående av fagpersoner ved Universitetet i Tromsø bearbeidet spørreskjemaet etter oversettelse. En pilotutprøvingav skjemaet ble gjennomført blant 14 studenter i en helsefaglig bachelorutdanning som inkluderer praksis i helseinstitusjoner. Denne resulterte i mindre justeringer av skjemaet.

Spørreskjemaet inneholder spørsmål om bakgrunnsdata (alder, kjønn, praksissted, semester og utdanningsår). I tillegg omhandler spørsmålsstillingene læringsmiljø, veiledningsrelasjonen og sykepleielærernes rolle i praksis. Sykepleielærernes rolle inngår ikke i denne studien, men vil bli gjenstand for en egen artikkel.

Det ble sendt skriftlig informasjon om undersøkelsen til dekanene ved fem høgskoler med sykepleierutdanning og en forespørsel om tilgang til navn og adresseliste til studentene, noe som ble innvilget (Vedlegg 7). Denne delen av studien ble godkjent av Norsk samfunnsvitenskapelig datatjeneste.

Spørreskjemaundersøkelsen ble gjennomført våren 2009 og totalt 1397 studenter ved sykepleierutdanningene ved de fem høgskolene fikk tilsendt spørreskjemaet som de ble bedt om å besvare ved å ta utgangspunkt i den sist gjennomførte praksisperioden (Vedlegg 3). På grunn av flytting uten oppgitt ny adresse ble 168 spørreskjema returnert. Dermed har 1229 studenter mottatt skjemaet. Det ble mottatt 511 utfylte spørreskjema og foretatt én purring. Svarprosenten ble 41.6 %.

Feltarbeid med observasjon og feltnotater

Deltakende observasjon er en metodisk tilnærming som tar sikte på å etablere en felles erfaring mellom forskeren og de som utforskes (Hammersley & Atkinson 1996). Forskeren bruker tid sammen med sine informanter og observerer det som skjer. Graden av deltakelse i informantenes hverdag kan favne fra ren observasjon til total deltakelse (Hammersley & Atkinson, Wadel 1991). Rendyrket observasjon uten samtaler med informantene innebærer en fare for at forskeren ikke får innsikt i deres hverdag og erfaringer. Full deltakelse gir en risiko for at forskeren ikke oppnår den nødvendige analytiske distanse (Wadel 1991).

Innledende observasjoner før studentenes praksis ble gjennomført over en periode på to uker i ett av sykehjemmene - i hovedsak på dagtid, men med enkelte kveldsvakter. Hensikten var å revitalisere eget kjennskap til sykehjem som praksissted og læringsmiljø. I de to ukene med feltarbeid inntok jeg en rolle der jeg vekslet mellom ren observasjon og aktiv deltakelse ut fra hvordan jeg oppfattet de ulike situasjonene jeg var i.

Videre observasjoner ble i all hovedsak gjennomført på dagtid i løpet av studentenes praksisperiode (2 puljer á 10 uker) fordi studentene for det meste gjennomførte sine studentvakter på dagtid. For hvert sykehjem og hver avdeling var jeg til stede på minimum to kveldsvakter. Observasjonstiden pr dag varte fra 4-7 timer med start fra vaktens begynnelse. Forskerrollen kan best beskrives som delvis deltagende observatør. Jeg tilstrebet at min tilstedeværelse ikke skulle være ubehagelig for studenter og personale og deltok i de situasjonene studentene inngikk, i bortsett fra personlig pleie til pasienter når jeg vurderte at dette ikke var etisk forsvarlig.

I løpet av studentenes praksisperiode ble observasjoner i de tre sykehjemmene utført ut fra et tidsomfang tilpasset antall studenter i de respektive sykehjemmene. Disse observasjonene utgjorde totalt 55 dager i to perioder med praksis (32 dager i sykehjem A, 9 dager i sykehjem B, 14 dager i sykehjem C).

I oppstartsfasen var det viktig å bygge trygge relasjoner til alle ansatte i forskningsfeltene. Det var et mål at ingen skulle oppleve min tilstedeværelse og gjennomføring av studien som en belastning. Dette prøvde jeg å ivareta ved å være bevisst min egen forskerrolle og være åpen omkring hensikten med min tilstedeværelse. Jeg informerte om når jeg skulle være tilstede i de ulike sykehjemmene og avdelingene i form av skriftlige oversikter. Min opplevelse var at de ansatte viste interesse for prosjektet og aksepterte min tilstedeværelse på en positiv måte.

Ut fra intensjonen om å studere læringsmiljøet i sykehjem, var observasjon av konkrete samhandlings- og kommunikasjonssituasjoner en sentral innfallsvinkel. Innledende og

påfølgende feltobservasjoner ble også gjennomført i fellesarealer som dagligstue og korridorer, i tillegg til i vaktrom når rapporter, legevisitter og andre aktiviteter pågikk der. Når jeg var til stede i sykehjemmenes fellesrom presenterte jeg meg og min rolle for pasientene som var der, når dette føltes naturlig. Ettersom mange av pasientene hadde kognitiv svikt, ble min rolle ikke alltid forstått, og jeg ble flere ganger oppfattet som en av personalet selv om jeg bar privat tøy. I noen situasjoner løste jeg dette ved å hente en pleier som kunne imøtekomme pasientens henstilling til meg. I andre situasjoner brukte jeg meg selv som utdannet sykepleier eller medmenneske i samtalesituasjoner der det var etisk forsvarlig. Gjennom alle observasjonsperiodene ble det tatt fortløpende feltnotater som ble skrevet ut ved hjelp av teknikken beskrevet av Schatzman & Strauss (1973). Feltnotatene handlet om hva som ble sett, hørt og sanset. Metodologiske notater dreide seg om hvor observasjonene ble utført, hvor jeg befant meg, sammen med hvem og om jeg var aktiv eller passiv i situasjonen. Noen notater omhandlet teoretiske assosiasjoner og spørsmål knyttet til mine feltnotater. I tillegg ble det gjort personlige notater som omhandlet egne følelser fra situasjonene i feltene. Disse notatene ga grunnlag for å vurdere i hvilken grad egne følelser og oppfatninger virket inn på det observerte (jfr. Polit & Beck 2008). Feltnotatene fungerte som et viktig grunnlag for utforming av intervjuguide (vedlegg 4 og 5) og analyse av data som fremkom gjennom intervjuene (Malterud 1996). Feltnotatene ble skrevet ut daglig for å ivareta nærhet i tid til det som var observert og notert.

For feltforskere er det viktig å unngå en besøksrolle. Jeg deltok derfor i uformelle samtaler og kaffepauser som innfallsvinkler for å etablere en trygg relasjon. Wadel (1991) sier om besøksrollen at den er uheldig fordi den gjør det vanskelig å komme ”back stage” slik Goffman (1992, s.197) beskriver det:

”*Vi finner ofte et område bak kulissene, hvor opptredenen forbedres, og et fasadeområde hvor opptreden fremføres. Adgang til disse områdene er kontrollert for å hindre at publikum*

får titte bak kulissene og hindre at utenforstående slipper inn til en opptreden som ikke er myntet på dem".

Jeg erfarte at deltakelse i uformelle sammenhenger resulterte i at jeg ikke forble "front stage", og informanter og aktører så ut til å akseptere min tilstedeværelse og rolle. Ved noen anledninger opplevde jeg å bli tildelt en "ekspertrolle" ved at jeg ble spurt om "svar" på ulike faglige spørsmål. Jeg unngikk denne posisjonen ved å vise interesse for spørsmålet, men uten å gi konkrete svar.

Intervju

Artiklene I-III bygger på analyse og tolkninger av semistrukturerte intervjuer med sykepleierstudenter og deres kontaktsykepleiere tatt opp på lydbånd og skrevet ut ordrett som tekst. Utforming av intervjuguide (Vedlegg 4 og 5) ble påbegynt i løpet av de to første ukene med observasjoner forut for studentenes praksisperiode. Den ble videre bearbeidet, videreutviklet og ferdigstilt i tiden frem mot gjennomføring av intervjuene. Intervjuguiden som lå til grunn for intervjuene omfattet tematiserte innfallsvinkler rettet mot ulike forhold knyttet til læringsmiljø i sykehjem ut fra egne erfaringer som lærerveileder i sykehjem, tidligere forskning, innledende og påfølgende feltarbeid i sykehjemmene.

Tekstene ble analysert av meg og analysene ble etterpå diskutert med medforfatterne. Diskusjonene av analysene førte til mer innsiktsfulle fortolkninger og i noen tilfeller til nye fortolkninger. Vi diskuterte til konsensus om fortolkningene ble oppnådd. På denne måten bidro mine veiledere til analysenes troverdighet. Enhver tekst kan forstås på ulike måter. Det understreker betydningen av grundige diskusjoner i analysene slik at man finner støtte i datamaterialet og teoritilfang for at en tolkning av teksten er mer troverdig enn en annen tolkning. Man må like fullt være klar over at en tolkning aldri kan ses på som objektiv (Kvale 1997, Polit & Beck 2008). Tolkningen må derfor ses i lys av tolkernes forforståelse

(Kvale 1997). Artikkelforfatternes samarbeid og grundige diskusjoner ut fra ulike innfallsvinkler resulterte i grundige analyser, noe som styrker påliteligheten.

Det studentene fortalte i intervjuene og analyse av feltnotatene ble brukt som utgangspunkt for intervjuene med kontaktsykepleierne. Intervjuene fant sted på de respektive sykehjemmene mot slutten av studentenes praksisperiode. Intervjuene varte fra 40 til 70 minutter.

Sykepleierstudentene og deres kontaktsykepleiere ble i intervjuene bedt om å fortelle om sine erfaringer med og synspunkter på læringsmiljøet i sykehjemmet der de hadde sin praksis. For enkelte informanter var det nødvendig at jeg utdypet begrepet læringsmiljø. Etter hvert som intervjuene skred frem, grep jeg fatt i informantenes utsagn ved at de ble bedt om å utdype utsagn og gi eksempler. Disse henstillingene var i utgangspunktet åpent formulert samtidig som de bygde på kjerneområder for læring i praksis av eldreomsorg. På den måten kan informantene ha blitt påvirket til valg av hva som ble løftet frem og vektlagt. Ut fra min erfaringsbakgrunn opplevde jeg både styrken og svakheten i min nærhet til forskningsfeltet, selv om jeg ikke kjente de tre sykehjemmene fra egen virksomhet som lærer. I intervjuene med studentene og sykepleierne var styrken at vi delte en del faglig kunnskap. Ut fra mitt kjennskap kunne jeg stille relevante oppfølgingsspørsmål for å forfølge tema som ble tatt opp. Svakheten var at jeg ut fra en tilsynelatende innforståtthet ved noen anledninger gikk for raskt over til nye innfallsvinkler. Min forforståelse og umiddelbare fortolkning kom i veien. Etter hvert i forskningsprosessen ble jeg mer bevisst slike problemer. I intervjuene med sykepleierstudentene som var verbalt aktive og formidlet rike data, var utfordringen å holde fast i temaet for intervjuene.

Intervjusituasjonene var preget av at informantene viste engasjement og interesse for studien. De var åpne og meddelsomme om sine erfaringer og oppfatninger om læringsmiljøet i sykehjemmene. Dette førte til rike beskrivelser av hva som ble sett på som viktige elementer for læringsmiljøet både med hensyn til organisatoriske, faglige og individuelle dimensjoner. Noen av informantene hadde ikke norsk som førstespråk. Det medførte at intervjuer måtte klargjøre benevnelser brukt i spørsmålsstillinger og innspill. Dette må ses på som en potensiell feilkilde. Min oppfatning er like fullt at disse informantenes utsagn har gyldighet, ettersom klargjøringene resulterte i rike beskrivelser og konkrete eksempler med relevans for studiens tema.

Intervjuene ble tatt opp på minidisk. Til tross for at informantene på forhånd var informert om dette, forsikret jeg meg før hvert intervju om at de aksepterte at minidisk ble brukt. Noen kommenterte innledningsvis at de opplevde det som uvant å snakke med en opptaker på. Etter hvert som vi ble opptatt av intervjusamtalen, så det ut til at opptakeren ble glemt. Dette ble av flere kommentert ved slutten av intervjuene når de uttrykte at de var overrasket over at de hadde glemt at samtalen ble tatt opp.

Intervjuene ble transkribert samme dag eller dagen etter gjennomføring og så nøyaktig som mulig. Transkribering fra tale til tekst innebærer en reduksjon ved at kroppslige uttrykk ikke fanges opp. Ettersom jeg la vekt på en lyttende holdning under intervjuene, ble ingen notater tatt. Jeg har derfor ingen data vedrørende kroppsspråk. For å kompensere for dette ble pauser registrert med prikkede sekvenser, fet skrift ble brukt der informantene la ekstra trykk på ord, utropstegn ble brukt for å gjengi intensitet og latter ble skrevet inn i parenteser. En åpen og fleksibel form var en styrke ved at den ga rom for de overraskende veier som et intervju kan ta og som tilfører viktige data (jfr. Paulgaard 1997).

Analyse

Etter transkriberingen ble intervjuene lyttet til og lest flere ganger for å få et helhetsinntrykk av teksten. Forståelsen av teksten har derfor fungert som en veieviser i den påfølgende analysen der teksten ble delt opp i meningsenheter (sammenstilling av ord eller meddelelser som har sammenheng med den samme sentrale mening) (jfr. Graneheim & Lundman 2004). Deretter ble meningsenhetene kondensert slik at teksten ble forkortet uten at kjernen i innholdet ble borte. Etter arbeidet med søken etter meningsenheter og kondensering, ble undertema, tema og hovedtema utviklet (jfr. Graneheim & Lundman 2004) Derfra dreide arbeidsprosessen seg om en pendling mellom essenser i materialet, teoretisk fordypning og studier av tidligere forskning.

Spørreskjemaundersøkelse

Bruk av spørreskjema er en vanlig metode for å få frem kvantifiserbare data.
Artikkel IV bygger på en spørreskjemaundersøkelse (Vedlegg 6) blant 407 sykepleierstudenter ved fem utvalgte sykepleierutdanninger i Norge. Spørsmålene skulle bidra til å kartlegge respondentenes evaluering av det kliniske læringsmiljøet. For de ulike spørsmålene var det gitt konkrete svaralternativer som det skulle velges mellom. Respondentene besvarte spørreskjemaet ut fra en fem-punkts Likert skala med svaralternativene 1) helt uenig; 2) delvis uenig; 3) verken enig eller uenig; 4) delvis enig; 5) helt enig. At spørreskjemaet som ble benyttet er brukt og validert i flere ulike sammenhenger, styrker bruk av resultatene undersøkelsen har gitt (Saarikoski & Leino-Kilpi 2002, Saarikoski *et al*. 2005, Saarikoski *et al*. 2007, Saarikoski *et al*. 2007).

Forskningsetiske krav og etiske vurderinger

Forskningsprosjektet som ligger til grunn for avhandlingens artikler ble godkjent av Norsk samfunnsvitenskapelig datatjeneste. Prosjektet ble lagt fram for Regional komité for

medisinsk forskningsetikk (REK), helseregion V, med bakgrunn i forskerens tilstedeværelse i tre sykehjem under feltarbeid. Prosjektet ble vurdert til å falle utenfor REK sitt mandat (Vedlegg 7). Styrerne ved de respektive sykehjemmene ga tillatelse til feltarbeid. Sykepleierstudenter og sykepleiere som deltok i intervjuer brukt i artiklene I, II og III, ga sitt informerte skriftlige samtykke før datasamlingen begynte (Vedlegg 1 og 2).

I artiklene (I-III) har jeg tilstrebet å gi en grundig og nøyaktig fremstilling av informantenes formidlede erfaringer og oppfatninger. Jeg har vektlagt å tydeliggjøre hva som er mine fortolkninger og hva som er teoretisk baserte drøftinger. Alle data er anonymisert ved at det som kan bidra til å identifisere utdanningsinstitusjonene, sykehjemmene og informantene er utelatt.

Sykepleierstudentene som deltok i spørreskjemaundersøkelsen og dekanene, ble lovet at alt materiale skulle behandles konfidensielt slik at data om høgskoler, praksissteder eller respondenter ikke skulle fremkomme. Informantene mottok skriftlig informasjon om studien og ble bedt om å delta ved å fylle ut og returnere spørreskjemaet (Vedlegg 3). Deres informerte samtykke ble gitt ved at de returnerte utfylt spørreskjema.

Metodologiske overveielser

I kvalitativ forskning er forskeren sitt eget forskningsinstrument (Polit & Beck 2008). Spørsmål om studiens troverdighet har derfor sammenheng med tydeliggjøring av forskerens egen rolle, relasjonen til forskningsfeltet og hvordan dette innvirker på funnene som presenteres (jfr. Fangen 2004). Dette er prøvd ivaretatt ved å klargjøre valgte forskningsmessige tilnærminger. Jeg har arbeidet for å ivareta den nødvendige distanse og en kritisk og analytisk holdning til forskningsfeltet og egen rolle. I artiklene I-III er troverdighet

forsøkt ivaretatt gjennom empirinære fremstillinger av datamaterialet og teoretisk begrunnede fortolkninger.

Bruk av flere metodiske innfallsvinkler gir forskjellige tilganger til forskningsfokuset (Polit & Beck 2008). Disse utfyller hverandre og er med på å berike det samlede materialet gjennom en utvidet forståelse av fenomenene som studeres. Bruk av flere metoder gir også en mulighet for å vurdere i hvilken grad det er konsistens og sammenheng mellom fenomenene som trer frem (Polit & Beck 2008).

Observasjoner og feltnotater fra sykehjemmene mens studentene gjennomførte sin praksis, bidro til å styrke studiens pålitelighet ved at datamaterialet fra intervjuer kunne sammenholdes med observasjoner og feltnotater. Det informantene fortalte meg i intervjuene samsvarte innholdsmessig i stor grad med egne feltnotater. Potensiell bias (jfr. Polit & Beck 2008) som et resultat av min egen forforståelse må tas i betraktning, selv om jeg tilstrebet en åpen holdning i intervjuene og i analysen av feltnotater og intervjudata.

Kvantitative data (IV) er skaffet til veie under forhold der det var avstand mellom forsker og respondenter. Hensikten med kvantitative metoder er å skaffe til veie så sikker og gyldig kunnskap om mulig om forhold som kan telles, veies og måles (jfr. Polit & Beck 2008).

RESULTATER

Resultatene for studiene I- IV oppsummeres og presenteres i egne underkapitler. I tabell 2 gis en oversikt over resultatene.

Tabell 2. Oversikt over resultatene i studiene I – IV

Studier	Tema	Sammenfattende resultater
I. Nursing students' experiences of nursing homes as learning environments.	Akseptasjon og verdsetting. Veiledning og læringsprosess. Faglige diskusjoner og læringsutbytte.	Et godt læringsmiljø inkluderer veiledning, tilbakemelding og kritiske refleksjonsprosesser i et faglig praksisfellesskap.
II. Students experiences in learning of person-centred care of patients with Alzheimer's disease as perceived by nursing students and supervising nurses.	Holdninger til tilnærminger i pleie og omsorg til pasienter med Alzheimer's sykdom. Oppfatninger om kunnskap med hensyn til personsentrerte tilnærminger. Synspunkter og perspektiver på læring av personsentrerte tilnærminger.	Studien viser variasjoner i sykepleierstudenters og kontaktsykepleieres oppfatninger med hensyn til læring av pleie og omsorg for pasienter med Alzheimer's sykdom. Sykepleierstudentene erfarte begrenset læring av personsentrerte tilnærminger I pleie og omsorg for pasienter med Alzheimer's sykdom. Kontaktsykepleierne oppfattet imidlertid sykehjemmet som et praksissted med rike muligheter for å lære dette.
III. To what extent does the oral shift report stimulate learning among nursing students? A qualitative study.	Muntlig rapport som en arena for faglige diskusjoner. Innholdet i muntlig rapport. Muntlig rapport som en læringskontekst.	Det ble funnet at muntlige rapporter kan utgjøre en viktig læringssituasjon. Dette gjelder spesielt hvis studentene engasjeres i faglige diskusjoner med personalet. Funnene peker på tiltak for å styrke muntlige rapporters læringsverdi for sykepleierstudenter.
IV. Clinical learning environments and supervision: experiences of Norwegian nursing students. A questionnaire survey.	Bakgrunnsdata Pedagogisk atmosfære. Veiledningsrelasjonen.	Data viste at sykepleierstudenter som responderte i henhold til sykepleiepraksis i sykehjem alt overveiende var mer misfornøyd enn de som responderte med referanse til sykepleiepraksis i sykehus.

Artikkel I

Sykepleierstudentene opplevde at læringsmiljøet i sykehjemmene der de gjennomførte praksisstudier i eldreomsorg var viktig for deres holdninger til sykehjem som potensiell fremtidig arbeidsplass. Fra intervjuene med sykepleierstudentene ble tre hovedtema knyttet til læringsmiljø funnet. Disse var: akseptasjon og verdsetting, veiledning og læringsprosess og faglige diskusjoner og læringsutbytte. Faglig og kritisk refleksjon som kjennetegn for et

godt læringsmiljø ble ansett som vesentlig for læringsprosessen dersom den ikke skulle resultere i passiv tilpasning til etablerte rutiner i omsorg for eldre. Funnene innenfor de tre hovedtemaene var sammensatte og varierte for informantene mellom sykehjemmene de praktiserte i. Informantene ga i intervjuene konkrete eksempler på hvordan de hadde erfart sykehjemmene med tanke på læringsmiljø.

Funnene viste at prinsipper og ansvar for veiledning av sykepleierstudenter var ulikt integrert i måten kontaktsykepleierne forholdt seg for å engasjere og inkludere studentene i praksis. Vektlegging av dialog og praktisk samhandling om konkrete pasientsituasjoner ble ivaretatt i varierende grad. Studenter som opplevde at de ble verdsatt som midlertidige deltakere i sykepleiegruppen erfarte at de samarbeidet tett med sin kontaktsykepleier i praktisering av sykepleie og i faglige diskusjoner om sykepleiefaglige spørsmål. Motsatsen var studenter som opplevde at de i stor grad praktiserte alene eller sammen med en medstudent, men uten systematisk og planlagt samarbeid med sin kontaktsykepleier. Kompetanse og bevissthet om kontaktsykepleierens rolle og funksjon som veiledere for sykepleierstudenter er viktig for å utvikle et godt læringsmiljø.

Artikkel II

Fra intervjuene med sykepleierstudentene (n=7) og kontaktsykepleierne (n=6) i et undervisingssykehjem ble det identifisert ulike oppfatninger om læring av personsentrert omsorg for pasienter med demenssykdom. Fra intervjuene med sykepleierstudentene ble tre hovedtema funnet. Disse omhandlet 1) holdninger vedrørende tilnærminger til pasienter med demenssykdom, 2) oppfatninger om kunnskapens betydning for personsentrerte tilnærminger og 3) synspunkter på hvordan man kan lære personsentrerte tilnærminger til pasienter med demenssykdom. Fordi undervisningssykehjemmet vektla omsorg for pasienter med demens i ulike prosjekter, hadde sykepleierstudentene forventinger om å lære mer om og å praktisere

personsentrert omsorg. De hadde forventninger om å møte et miljø der holdninger til og kunnskaper om personsentrert omsorg for pasientene skulle være praktisert og tematisert. De opplevde at de hadde begrenset læringsutbytte med tanke på personsentrert omsorg for pasienter med demenssykdom. De uttrykte at de ikke observerte eller erfarte systematiske personsentrerte tilnærminger. Deres forventninger var videre knyttet til å lære personsentrerte tilnærminger gjennom veiledning og samhandling med sin kontaktsykepleier i konkrete pasientsituasjoner.

Kontaktsykepleierne oppfattet at sykehjemmet representerte rike læringsmuligheter for personsentrert omsorg for pasienter med demenssykdom. Kontaktsykepleierne ga uttrykk for at læring av personsentrert omsorg finner sted gjennom daglig omsorg for pasienter med demenssykdom. De vektla ikke sin egen betydning i å synliggjøre personsentrert omsorg.

Artikkel III

Artikkelen beskriver og diskuterer hvordan sykepleierstudenter (n=12) og deres kontaktsykepleiere (n=11) i tre sykehjem oppfatter muntlig rapport som en potensiell læringssituasjon for sykepleierstudenter. Sykepleierstudentene beskrev ulike erfaringer med muntlige rapporter. Noen opplevde begrenset læringsutbytte fra muntlig rapport, mens andre opplevde at muntlig rapport både med hensyn til form og innhold var nyttig for egen læring. Rapportsituasjoner kan ha en funksjon for studenter når det gjelder følelsemessig støtte i forbindelse med erfaringer fra konkrete pasientsitasjoner. Funnene viser at muntlig rapport med en personsentrert tilnærming representerer en vesentlig læringssituasjon. Dette gjelder spesielt for de studentene som opplevde at muntlige rapporter inkluderte faglige diskusjoner som de deltok i. Korte, summariske rapporter begrenset mulighetene for studentenes læring ved at de ikke ga rom for samtale og diskusjon om konkret pleie og tilhørende sykepleiefaglige spørsmål. Studentene som hadde praksis i sykehjem B og i avdelingen som

var tilrettelagt for pasienter med demenssykdom, formidlet at de erfarte personsentrert omsorg i det daglige pleie- og omsorgsarbeidet og i de muntlige rapportenes innhold og form. Funnene viser at det er et utviklingspotensial med hensyn til muntlig rapport som en læringssituasjon. For at muntlig rapport skal fungere som en læringssituasjon, må den gis tilstrekkelig tid slik at det skapes rom for faglige diskusjoner. Tid er en viktig faktor for personsentrerte rapporter som legger vekt på både psykososiale og fysiske forhold i pasientpleien. Enkelte kontaktsykepleiere opplevde at det ikke var tilstrekkelig tid til grundige muntlige rapporter. Noen kontaktsykepleiere uttrykte usikkerhet om hva som skal inkluderes i muntlig rapport, mens andre gjorde bevisst bruk av muntlige rapporter for å fremme studentenes læring og faglige utbytte.

Artikkel IV

I spørreskjemaundersøkelsen evaluerte 407 sykepleierstudenter klinisk læremiljø, veiledning og sykepleielærers rolle i praksis (CLES+T, vedlegg 6). I artikkel IV er svarene fra studentene som refererte til praksis i sykehjem (n= 146) og sykehus (n=261) (Tabell 1) lagt til grunn for en sammenligning av de to gruppenes erfaringer og synspunkter med hensyn til ”*pedagogisk atmosfære*”, ”*avdelingsleders lederstil*”, ”*sykepleie på avdelingen*” og ”*veiledningsrelasjonen*”. Funn knyttet til ”*sykepleielærers rolle i praksis*” vil som tidligere nevnt bli gjenstand for en egen artikkel.

Analysen av spørreskjemaene ble gjort i Statistical Program for the Social Sciences, versjon 15.0. ut fra svaralternativene ”*delvis enig*” og ”*helt enig*”. I faktoranalysen av spørreskjemaene viste det seg at tre av variablene som hos Saarikoski *et al*. (2008) hørte til under ”*pedagogisk atmosfære*” ladet for underdimensjonen ” *sykepleie på avdelingen*”. Resultatpresentasjonen i avhandlingen presenteres i henhold til den nye faktor-strukturen ved

at de tre variablene er flyttet til en ny underdimensjon kalt "*sykepleie og læringssituasjoner på avdelingen*" (Tabell 2).

Med hensyn til "*pedagogisk atmosfære*" var det signifikante forskjeller for tre av seks variabler med mer negative resultater for gruppen fra sykehjem, bortsett fra for variablene "*jeg følte meg vel med å gå til avdelingen ved begynnelsen av vaktene*" og "*jeg følte meg vel med å delta i diskusjoner på møter (f. eks før vaktskifte*)" og "*personalet lærte seg navnet på studentene*" (Tabell 2).

For området "*avdelingsleders lederstil*" var det signifikante forskjeller med mer positive resultater for sykehus sammenlignet med sykehjem for tre av fire variabler (Tabell 2).

Statistisk signifikante forskjeller ble funnet for alle variablene (7) knyttet til den nye dimensjonen "*sykepleie og læringssituasjoner på avdelingen*" med mer positive resultater for sykehus (Tabell 2). De største forskjellene ble funnet for "*dokumentasjon av sykepleie*", "*det var tilstrekkelig med meningsfylte læringssituasjoner på avdelingen*", "*læringssituasjonene var sammensatte med hensyn til innhold*" og for "*avdelingen kan betraktes som et godt læringsmiljø*".

Alt overveiende evaluerte studentene i gruppen fra sykehus innholdet i veiledningsrelasjonen mer positivt enn gruppen fra sykehjem (Tabell 2). Det ble funnet statistisk signifikante forskjeller for fem av de åtte variablene. Studentene som refererte til sykehjem var minst fornøyd med variablene "*jeg følte at jeg fikk individuell veiledning*" og "*jeg fikk kontinuerlig tilbakemelding fra min veileder*".

Ut fra samlet score i spørreskjemaene var forskjellene mellom sykehjem og sykehus til fordel for sykehus, signifikante med hensyn til ”*sykepleie og læringssituasjoner på avdelingen*” og ”*innholdet i veiledningsrelasjonen*” (Tabell 3). Ut fra lineær regresjonsanalyse fremkom det at en positiv, stabil relasjon til én veileder, forekomst av spontan veiledning og klinisk praksis i sykehus fremfor sykehjem, viste en signifikant positiv sammenheng med variabelen ”*avdelingen kan betraktes som et godt læringsmiljø*”. (Tabell 4).

SAMMENFATTENDE FORSTÅELSE OG REFLEKSJONER

Hensikten med studien har vært å belyse hvordan sykepleierstudenter opplever sykehjem som læringsmiljø for praksisstudier i eldreomsorg. Studiens tema er inspirert ut fra egne erfaringer med utdanning av sykepleiere som har vist at problemstillingene og utfordringene er mange når det gjelder å legge til rette for at studenter opplever et godt læringsmiljø i sykehjem. En studie gjennomført av Bergland & Lærum (2002) viste at studenter i siste studieår oppga både organisatoriske og utdanningsmessige forhold som årsak til at de i fremtiden ikke ønsket å arbeide med eldre. De ønsket mer sykehuspraksis enn de hadde fått i løpet av utdanningen, og mange ønsket mer erfaring med ulike sykepleieprosedyrer som de mente å kunne få i sykehus Forhold som ressursmangel i form av for lite fagpersonale, tidspress, opplevelsen av et negativt arbeidsmiljø og negative erfaringer i sykehjem i løpet av utdanningen, ble nevnt som årsaker til at de ikke ønsket å arbeide i eldreomsorgen.

Holdninger til eldre er gjenstand for ulike studier (Söderhamn 2001, Kotzabassaki *et al*. 2002, Tailor *et al*. 2007), og ”ageism” er en benevnelse som brukes i enkelte studier (de la Rue *et al.* 2002, Herdman 2002, Cottle & Glover 2007). Det antas at det i Vesten kan være en sammenheng mellom negative holdninger til aldring og alderdom i samfunnet og

sykepleierstudenters og sykepleieres holdninger til å arbeide i med eldre (Herdman 2002, Cottle & Glover 2007). Dette påpekes i en studie av Moyle (2003) som beskriver at sykepleierstudenters oppfatninger av eldre preges av samfunnets myter om eldre og alderdom. Holdninger til eldre varierer ut fra kjønn, alder og kultur. Det er rapportert at mannlige sykepleierstudenter har mer negative holdninger til eldre pasienter enn kvinnelige studenter (Slevin 1991). Andre studier viser ikke slike forskjeller mellom kjønnene (Harris *et al.* 1988). En studie av Hweidi & Al-Obeisat (2005) viser at jordanske sykepleierstudenter har alt overveiende positive holdninger til eldre, og at voksne og mannlige studenter hadde mer positive holdninger til eldre enn kvinnelige og yngre sykepleierstudenter. Flere studier viser til den betydningen utdanningsinstitusjonene har når det gjelder holdninger til eldre og alderdom (Stevens & Crouch 1995, 1998, Rogan & Wyllie 2002, Burbank *et al.* 2006, Williams *et al.* 2006, Robinson *et al.* 2008). Forhold som har betydning er: hvordan studentene forberedes til praksisstudier i sykehjem, undervisningsinnholdet om eldre og aldring og hvilke holdninger som direkte og indirekte formidles angående eldreomsorg i teori og praksis. Et godt læringsmiljø i sykehjem kan bidra til læring, holdningsendring og motivasjon (jfr. Illeris 2000, 2002) for sykehjem som fremtidig arbeidsplass.

Ulike tiltak har blitt satt i verk for å gjøre eldreomsorg og spesielt arbeid i sykehjem attraktivt, og iverksettingen av undervisningssykehjemsprosjektet er en stor satsning i Norge. Bakgrunnen for etablering av undervisningssykehjem i Norge bygde på en enighet om at kvaliteten på sykehjemstjenesten trengte å bli styrket, og at det var nødvendig å rekruttere og beholde kvalifisert personell. Betydningen av et godt og stimulerende læringsmiljø ble pekt på som viktig for å motvirke eksisterende motforestillinger mot å velge sykehjem som fremtidig arbeidssted (Kirkevold & Kårikstad 1999). Edwards *et al*. (2004) og Abbey (2006) viser til den betydningen studenters erfaringer fra praksis har for fremtidig yrkesvalg.

Å legge til rette for et godt læringsmiljø

Læringsmiljø tematiseres ut fra funn knyttet til legitim perifer deltakelse (jfr. Wenger 1998) og inkludering i pleiefellesskapet (jfr. Spouse 1996, 2000, Säljø 2001) gjennom akseptasjon og verdsetting, veiledning og læringsprosess og faglige diskusjoner og læringsutbytte (I) og læringsmiljø og veiledningsrelasjonen (IV).

Alle sykepleierne som deltok i studien fortalte at de opplevde det som positivt å ha studenter i praksis, selv om de ga uttrykk for at oppgaven som kontaktsykepleier var krevende både faglig og tidsmessig. De anså sine respektive arbeidsplasser som gode læringsmiljø der studentene hadde muligheter for god læring av eldreomsorg (I). En studie av Beadnell (2006) viste at sykepleiere var positive overfor studenter til tross for arbeidspresset. Studier har vist at sykepleiere står overfor et økende arbeidspress og ansvar som kan hemme dem i å gi optimal veiledning til studenter (Corlett 2000, O'Malley *et al.* 2000). At studenter i sykehus i større grad enn i sykehjem erfarte systematisk veiledning fra en stabil veileder (IV), kan være et resultat av sykepleiermangel i sykehjem (Dolonen 2009). Den globale sykepleiermangelen (Helse- og omsorgsdepartementet 2005-2006, Price 2008) innebærer at sykepleiere utfordres av mange og store krav med hensyn til oppgaver og at omsorgen for pasientene gis forrang (Heath 2002, Kilcullen 2007). En god relasjon til en stabil veileder ser ut til å ha stor betydning for hvordan studenter oppfattet det kliniske læringsmiljøet (IV).

Lloyd-Jones & Akehurst (2000) beskriver i en studie at verdien av studentenes bidrag i praksis kompenserte for den tiden de ansatte brukte på veiledning og undervisning. Studentene som deltok i denne studien opplevde at personalet uttrykte takknemlighet for den innsatsen studenten bidro med i løpet av sine studentvakter (I). For noen studenter var det imidlertid slik at "doing" var fremtredende på bekostning av "learning" ut fra begrenset

veiledning og undervisning. Begrensede erfaringer med en stabil veiledningsrelasjon i praksis i sykehjem (IV) understøtter at "doing" da kan bli mer fremtredende enn "learning". O'Callaghan & Slevin (2003) peker på den betydningen det har at sykepleierstudenter i praksis ikke skal inngå som en del av den regulære bemanningen.

Studentenes erfaringer med hensyn til læringsmiljøet var varierende. Studentene som hadde praksis i sykehjem A var overveiende skuffet over de erfaringene de gjorde med hensyn til læringsmiljøet. Deres skuffelse kan forstås som et resultat av at deres forventninger etter et innledende informasjonsmøte da de startet på sin praksis, var urealistiske. Det er like fullt viktig å se studentenes erfaringer i lys av i hvilken grad målsettingen om å skape et godt læringsmiljø for studenter (jfr. Kirkevold & Kårikstad 1999) var innarbeidet i hverdagens praktisering.

Sykehjemmene B og C hadde ingen eksplisitt uttrykte målsettinger om å være gode læringsmiljø for studenter. Det var ikke spesielt vektlagt at ansatte skulle drive forsknings- og utviklingsarbeid. Studentene som praktiserte i sykehjemmene B og C uttrykte at de i hovedsak hadde positive erfaringer med læringsmiljøet (I). Disse studentenes erfaringer tyder på at en organisasjons uttrykte målsettinger om et godt læringsmiljø i seg selv ikke er tilstrekkelig for at det oppleves som godt av sykepleierstudenter. Utfordringen er at tiltak rettet mot et positivt læringsmiljø må bli en integrert del av hverdagen ved at tiltakene er innarbeidet i organisasjonens individer og i dens hukommelse (jfr. Wadel 1992). Ulikhetene i studentenes erfaringer kan forstås slik at et positivt læringsmiljø avhenger av de ansattes og i særdeleshet kontaktsykepleieres motivasjon for, holdninger til og engasjement i veiledning av sykepleierstudenter. Slike ulikheter fremkommer i den kvantitative

spørreskjemaundersøkelsen (IV) mellom studenter som hadde praksis i henholdsvis sykehjem og sykehus.

Sykehjemmene som inngår i denne studien er ulike. Sykehjem A er et undervisningssykehjem. Sykehjem B er en del av et helsesenter, og studentene fulgte sammen med sine kontaktsykepleiere en turnus som innebar en veksling mellom arbeid i sykehjemsenheten og en sykestueenhet. Varierte arbeidsoppgaver *kan* tolkes til å ha betydning for studentenes tilfredshet og dermed for opplevelsen av læringsmiljøet. Funnene i studie IV som viste at studenter i sykehus i større grad enn studenter i sykehjem opplevde at det var tilstrekkelig med meningsfylte læringssituasjoner på avdelingen og at disse var sammensatte med hensyn til innhold, understøtter et slikt perspektiv. I sykehjem C praktiserte én av studentene i en avdeling spesielt tilrettelagt for pasienter med demenssykdom**.** Pleie- og omsorg til pasienter med demenssykdom er krevende. I en avdeling med en forholdsvis homogen pasientgruppe[6], er det antakelig, til tross for sammensatte, individuelle pasientbehov, større mulighet til å gå i dybden for å kunne arbeide systematisk og reflektert, enn i avdelinger med en mer sammensatt pasientgruppe når det gjelder diagnoser.

Longo (2007) skriver om ”horizontal violence” som et uttrykk for når studenter opplever å bli holdt nede og ydmyket i kliniske praksisperioder. Griffin (2004) beskriver ”horizontal violence” som at studentene ikke ses på som et aktivum, men at personalet åpent ergrer seg over studentenes forstyrrelser i form av verbal eller non-verbal avvisning. Ingen av studentene i denne studien opplevde dette direkte. Indirekte opplevde enkelte studenter å ikke bli lyttet til eller at innspill ble oppfattet som kritikk (I). Levett-Jones & Bourgeois

[6] Her forstått som at alle pasientene hadde en demensdiagnose.

(2007) og Thomas & Burk (2009) har gjort funn som viser at studenter er sårbare for ”horizontal violence” i praksisperioder. Slike erfaringer vil kunne resultere i ”tilpassing”- fremfor ”daning”. Oppnås ”daning” kan det ses som resultat av samhandling og dialog (jfr. Hellesnes 1994) i et trygt og inkluderende praksisfellesskap (jfr. Levett-Jones & Lathlean 2009).

I spørreskjemaundersøkelsen inngikk ”pedagogisk atmosfære” som en av underdimensjonene for læringsmiljø (IV). Relasjonelle forhold, faglige diskusjoner og en positiv atmosfære vektlegges av respondentene i artikkel IV og samsvarer med funnene i artikkel I.

Et godt læringsmiljø er blant annet knyttet til avdelingsleders evne til å skape et godt klima som understøtter læringsprosesser (IV). Avdelingsleder må da være noe mer enn en administrator, og faglig ledelse og faglig utvikling må utgjøre viktige arbeidsområder (Lockwood-Rayermann 2003). Rollen som avdelingsleder er i følge en studie av Bezuidenhout *et al.* (1999) flersidig ved at den innebærer administrative, praktiske, utdanningsmessige og forskningsmessige oppgaver. I hverdagen er det ofte utdannings- og forskningsmessige oppgaver som må vike (Bezuidenhout *et al.*1999). I samme studie fremgår det at sykepleierstudenter har forventinger til avdelingslederens rolle med tanke på å bidra til utdanning og et godt læringsmiljø. Levett-Jones & Bourgeois’ studie (2007) viste at avdelingslederens rolle var avgjørende for om studenter opplevde at de fikk støtte, var velkomne og verdsatt i det kliniske miljøet. I feltarbeidene ble avdelingsledernes rolle overfor studentene observert som varierende. Variasjonen viste seg i spennet mellom én sterkt tilstedeværende leder som la til rette for læring i for eksempel rapportsituasjoner, og de andre lederne som i all hovedsak ikke hadde direkte kontakt med studentene. Disse

lederne var i begrenset grad til stede under rapporter og var opptatt med administrative oppgaver og møtevirksomhet. Funn i spørreskjemaundersøkelsen (IV) viste at variabelen "*tilbakemeldinger fra avdelingsleder kunne lett ses på som en læringssituasjon*" ikke var av vesentlig betydning. Dette kan bero på at ordningen med kontaktsykepleier innebærer at avdelingsleder kun har en indirekte funksjon og rolle overfor studentene.

Veiledning og læringsprosess

Å ta imot studenter for praksisstudier innebærer et ansvar for veiledning slik at studentene utfordres med hensyn til sin nærmeste utviklingssone (jfr. Vygostky 2001) gjennom kontaktsykepleiere som bidrar til stillasbygging (jfr. Vygotsky 2001). Noen sykepleiere er verken skolert for eller har lyst til å være kontaktsykepleier med veiledningsansvar (Zilembo & Monterosso 2008). Kontaktsykepleierne som inngikk i denne studien (I, II, III) hadde alle deltatt i innføringsmøter vedrørende veiledning av studenter, men ingen hadde deltatt i systematisk opplæring i veiledning (jfr. Chow & Suen 2001, Tiwari *et al.* 2005, Kilcullen 2007).

Når det gjelder synspunkter på læring, har uttrykk som "ansvar for egen læring" og tanken om "learning by doing" (jfr. Dewey 1974) fått gjennomslag. Uten et bevisst forhold til at læring i praksis forutsetter tilrettelegging, stillasbygging (jfr. Vygotsky 2001) og veiledning, kan resultatet bli manglende gjenkjennelse og bruk av potensielt skjulte læringssituasjoner på grunn av at de overses (White & Ewan 1991, Lambert & Glacken 2005). En stabil, god veileder kan bidra til fremming av en god læringsprosess ved jevnlig veileding og kontinuerlig tilbakemelding (Saarikoski & Leino-Kilpi 2002) (IV).

Mye av læringen i praksis er spontan og uforutsett, men planlegging og veiledning er nødvendig for å utnytte læringsmulighetene (Dean & Kenworthy 2000). Dette understrekes i

en studie av Brodie *et al*. (2005) som skriver at sykepleiere er nøkkelpersoner og veivisere i studentenes læringsprosess. De er kjent med konteksten (jfr. Lave & Wenger 1991) og pasientene studentene skal lære innenfor og i relasjon til. Kilcullen (2007) fant i sin studie at kontaktsykepleiere spiller en avgjørende rolle i å styrke studenters læring gjennom å gi støtte for læringsprosessen. Det kan kontaktsykepleieren bidra til gjennom sitt kjennskap til praksisstedet og ved å løfte frem læringssituasjoner som man ikke kan forvente at studentene kan finne uten hjelp og støtte. Löfmark & Wikblad (2001) fant i sin studie at negative holdninger hos sykepleiere på praksisstedet kan hemme læringen.

Studier av Granum *et al*. (1991), Havn & Vedi (1997) og Green & Holloway (1997) har vist at studenter i praksis erfarte fravær av veiledning i store deler av tiden. Funnene med hensyn til veiledning i denne studien varierte (I-IV). Ettersom forholdet bemanning/pasientantall var likt i de tre sykehjemmene, gir ikke slike forhold grunnlag for å trekke konklusjoner med hensyn til ulikhetene i den veiledningen studentene fikk. Kontaktsykepleiernes opplevelse av hverdagens mange gjøremål må likevel tas med i betraktning. Skolering i veiledning kan heller ikke vektlegges som forklaring for ulikhetene i studentenes veiledningstilbud. Ulikhetene i studentenes erfaringer med veiledning, kan bero på at graden av forpliktelse til veilederrollen var sterkere hos noen kontaktsykepleiere enn hos andre. Når det gjelder studiens kvantitative funn med hensyn til forekomst av veiledning (IV), understøtter de funn gjort av Havn & Vedi (1997) som viste at studenter i praksis i sykehjem var alene i 2/3 av tiden til forskjell fra 1/3 av tiden ved praksis i sykehus.

Saarikoski & Leino-Kilpi (2002) fant at en stabil, individuell veiledningsrelasjon var det viktigste elementet i klinisk praksis. Dette samsvarer med resultatene fra spørreskjemaundersøkelsen (IV).

Praksis kan innebære stress og engstelse for studentene (Elliott 2002) ved at de kommer til ukjente omgivelser der de ikke kjenner personalet, pasientene eller rutinene. Kontaktsykepleieren kan avhjelpe en stressende situasjon gjennom å hjelpe studenten til å bli kjent i det nye miljøet og gi systematisk veiledning. I studiene I-III varierte kontaktsykepleiernes relasjon til studentene mellom daglig samarbeid og systematisk veiledning til en praktisering av studentenes "ansvar for egen læring" og "learning by doing" uten systematisk veiledning, men med beskjed til studentene om at de var tilgjengelige for studenten "hvis det var noe".

Sykepleiere har ansvar for daglig veiledning og opplæring av elever og studenter i praksis (Kunnskapsdepartementet 2008). Ut fra den travle hverdagen i sykehjem er det naturlig at ansatte ser på pasientene og praktiske gjøremål som sin primære oppgave. Situasjonen i praksis er dynamisk og uforutsigbar og dermed vanskelig å ha kontroll over (Grealish & Trevitt 2005), noe som kan vanskeliggjøre etablering av systematisk oppfølging og veiledning av studenter. Kontaktsykepleiere kan derfor oppleve at de befinner seg i et krysspress mellom arbeidsrolle og veiledning av studenter (Hutchings *et al.* 2005). Det er en ufordring å integrere studentveiledning i utøvelse av daglige gjøremål. Oppfølging av sykepleiere som har veiledningsansvar ovefor studenter kan bidra til å styrke veiledningen (Danielsson *et al*. 2009).

Sykepleierne i studie I ga uttrykk for at de i all hovedsak så det som positivt å veilede studenter fordi de ga dem nye impulser. For noen studenter ble dette synliggjort ved at deres synspunkter og perspektiver ble lyttet til og lagt til grunn i pleie og omsorg for pasientene. Dette samsvarer med funn gjort i en studie av Zisberg *et al*. (2003) fra sykehus som viste at sykepleiere ga sykepleie med høyere kvalitet når det var studenter i avdelingen enn ellers,

fordi studenter genererer kunnskap, stiller spørsmål og bidrar til at sykepleierne lærer gjennom faglig selvbeskuelse. En veiledningsrelasjon kjennetegnet av likeverdighet, gjensidig interaksjon, respekt og tillit (IV) åpner opp for inkludering av studenter (I) som bidragsytere i praksis.

Å handle og reflektere

Refleksjon handler om å vurdere, tenke over og kritisk analysere erfaringer (Schön 1983, 1987, Nordtvedt & Grimen 2004). I studiene I-III hadde studentene ulike erfaringer når det gjaldt refleksjon som en del av praksis. Noen studenter erfarte ikke at deres kontaktsykepleiere la til rette for eller inngikk i refleksjonssamtaler. Disse studentene gjorde dette sammen og på egne initiativ. Dette står i kontrast til andre studenter som erfarte at refleksjon inngikk som en naturlig del av hverdagen i løpet av praksisperioden (I, II). Rom for refleksjon forutsetter at student og veileder har tid sammen. At studenter erfarte hyppigere og mer jevnlig veiledning i sykehus enn i sykehjem (IV) kan skyldes at de fikk muligheter til å tenke over og kritisk analysere erfaringer.

”Daning” er et resultat av læring (jfr. Hellesnes 1994). Dysthe (1999) skriver om dialog som en måte å fremme ”daning” på gjennom kritisk vurdering av konkrete erfaringer. Erfaringer må utforskes hvis ikke tilpasning til etablerte rutiner og praksiser skal skje på bekostning av ”daning” (jfr. Hellesnes 1994) gjennom kreativitet og kritisk refleksjon.

Wackerhausen (2002) skriver i boken ”Humanisme, proffesionsidentitet og uddannelse i sundhedsområdet” om profesjonsidentitetens dannelse og humanisme. Begrepet ”spørgekultur” brukes om de spørsmål ulike profesjoner stiller eksplisitt og implisitt i relasjon til pasientene, og at ”spørgekulturen” primært tilegnes gjennom tilstedeværelse og deltakelse i de undervisnings- og praksissammenhenger der den utfolder seg (jfr. Lave &

Wenger 1991). Studentene i denne studien erfarte ulike spørrekulturer. Noen erfarte en spørrekultur som synliggjorde interesse for pasientene som individer, deres levde liv, følelser og verdier, i tillegg til konkrete forhold knyttet til fysisk pleie. I disse avdelingene var de muntlige rapportene personsentrerte, og det ble gitt rom for studentenes spørsmål og innspill og for faglige diskusjoner (I, III). Andre studenter erfarte avdelinger uten en spørrekultur og med summariske og oppgaveorienterte rapporter (III). Praksisstudier i slike avdelinger innebærer en fare for at studentene tilpasser seg en "ikke-spørrende" kultur med begrenset refleksjon over praksis. En "ikke-spørrende" kultur gir begrenset rom for faglige diskusjoner som grunnlag for læring (I).

Elstad (1995) skriver at pleiepersonalet alltid har hatt begrenset tid til refleksjon over praksis, og viser til at rutiner og regler blir "*en tralt*" når daglige diskusjoner blir fraværende. Muntlige rapporter kan være en arena for faglig diskusjoner. Hamran (1996) skriver at moderniseringen av offentlig sektor medfører at pleiearbeidet effektiviseres og rammer tradisjonelle samarbeidsformer som for eksempel den muntlige rapporten. Hvis den muntlige rapporten får begrenset tid eller blir borte, vil pleiere og studenter som gjennomfører praksis miste et viktig forum for faglige diskusjoner, refleksjon og læring (jfr. "stille rapport") (Solvang 2005). Konsekvensen kan bli at en ikke ser pasienter for "*bare oppgaver*". Variablene "*avdelingens sykepleiefilosofi/grunnlagstenkning var klart definert*" og "*pasientene mottok individuell pleie og omsorg*" i studie IV, viste statistisk signifikante forskjeller med mer positive resultat for sykehus enn for sykehjem. Diskusjon om og refleksjon over sykepleiefilosofi og grunnlagstenkning oppfattes å ha betydning for den pleie og omsorg som gis, og dermed for læringsmiljøet. Eckenfels (2002) skriver med henvisning til legeutdanning at moralsk motivasjon, sosial ansvarsfølelse og moralsk bevissthet har

dårlige vilkår uten refleksjon over praksis. Det er ingen grunn til å tro at dette ikke også gjelder for sykepleierstudenter.

Å ha og være rollemodell

I boken "Pleiekulturen- en utfordring til den teknologiske tenkemåten" (1992) bruker Hamran benevnelsen "*Å gå sammen i stellet*". At en student "*går sammen*" med sin kontaktsykepleier innebærer samarbeid og samhandling, og kontaktsykepleieren vil være en rollemodell for studenten gjennom sin tilnærming i relevante pasientsituasjoner (jfr. Martinsen 1989, 1990). For de studentene i utvalget som samarbeidet tett med sine kontaktsykepleiere ga dette grunnlag for dialog og refleksjon over ulike tilnærminger og handlingsalternativer (I-III). Andre studenter "*gikk alene*" (I) og erfarte i begrenset grad læring i kraft av rollemodeller og påfølgende "*fagsnakk*" (jfr. Hamran 1992), noe som understøttes av at studenter i sykehjem i mindre grad enn i sykehus erfarte en stabil, god veiledningsrelasjon med gjensidig interaksjon (IV). Hvis veilederrollen ikke ivaretas på en tilfredsstillende måte kan dette gi uheldige konsekvenser (Clarke *et al.* 2003).

Happel (2002) skriver at omsorg for eldre ses på som lite utfordrende, kjedelig og er lite ansett blant sykepleiere, og skriver videre at slike negative holdninger vil ha innflytelse på sykepleieres holdninger til arbeid innenfor eldreomsorg. En mulig konsekvens er at sykepleiere som arbeider i sykehjem ubevisst ikke verdsetter eget arbeid. Det kan i så fall resultere i at kontaktsykepleiere ikke fremstår som gode rollemodeller for studentene (I), med faglig stolthet og synliggjøring av faglighet i utøvelsen av sykepleie.

Gjøremålsorientering og summariske muntlige rapporter (II, III) kan sammen med lav bemanning og tidspress være et uttrykk for at den negative statusen arbeid i eldreomsorg har (Kirkevold & Kårikstad 1999), er internalisert i enkeltindivider og i avdelingskulturen. I

slike avdelinger opplevde studentene ved flere anledninger, da de hadde planlagt å bruke tid på personsentrerte tilnærminger, å bli oppfordret av kontaktsykepleier til å gjøre i stand medisindosetter eller ta blodprøver (II). En slik prioritering av hva kontaktsykepleieren rådet studenten til å engasjere seg i, kan tolkes til at hun vurderte medisinsk-faglige oppgaver som mer interessante og nyttige for studentene enn for eksempel psykososial omsorg. Disse erfaringenes motsats fantes i avdelinger der pasientenes situasjon og studentenes læringsbehov ledet planlegging av gjøremålene, og der rapportene var grundige og personsentrerte med faglige diskusjoner og refleksjoner (I, III).

Å vise frem og lære personsentrert omsorg

I praksislæring er erfarne sykepleiere rollemodeller (Robinson & Cubit 2007) for studenter i deres sosialiseringsprosess. Hillestad (2000) påpeker at sykehjemspasienter ofte bruker lang tid på å svare på det de blir spurt om. Uten en bevisst personsentrert tilnærming til noen pasienters langsomhet i samtale og at samtale tar tid, risikerer man at pasientene kan oppleve ensomhet med udekte behov for sosial kontakt og samvær. For at studenter skal erfare og lære hvordan man kan imøtekomme sykehjemspasienters behov for samtale, trenger de å observere og praktisere tilrettelagt kommunikasjon med pasienter som trenger lang tid for å uttrykke seg i tråd med å lære av gode ”mestere” (jfr. Martinsen 1990, Wackerhausen 1999, 2002).

Sykepleierstudenter som observerte at pasienter med demenssykdom ble møtt på en vennlig, men flyktig måte (II), kan selv internalisere denne måten å forholde seg til pasientene på om de ikke har et bevisst og reflektert forhold til dette. For å lære personsentrerte tilnærminger trengs gode rollemodeller og veiledning (jfr. Robinson & Cubit 2007) ut fra konkrete situasjoner som blir gjenstand for refleksjon. Williams *et al.* (2008) skriver at personer med demenssykdom prøver å opprettholde sin opplevelse av å være en person, og knytter dette an

til å se på seg selv som kompetent. Å bli møtt med ”elderspeak”, kjennetegnet av overdreven omsorgsfull, kontrollerende og infantiliserende kommunikasjon, kan i følge Williams *et al.* (2008), resultere i at pasienter med demenssykdom utagerer og motsetter seg pleie- og omsorgshandlinger. Noen av studentene i materialet erfarte at personalet brukte ”elderspeak” i sin kommunikasjon med pasienter med demenssykdom. Kontrasten var studenten som erfarte personsentrerte tilnærminger gjennom rollemodeller som kommuniserte med pasienter med demenssykdom uten innslag av ”elderspeak”. Studentene som i begrenset grad erfarte personsentrerte tilnærminger praktiserte i generelle avdelinger med et sammensatt pasientgrunnlag og begrensede muligheter for å etablere skjermede samtalesituasjoner, bortsett fra i et reminisensrom som ikke var lokalisert nært sykehjemmets avdelinger. Det er like fullt overraskende at reminisensrommet ikke så ut til å bli benyttet i vesentlig grad.

Feltobservasjonene viste at fagutviklingsprosjekter med pleie og omsorg for pasienter med demenssykdom som tema, var vanskelige å gjenfinne i sykepleiernes samtalesituasjoner med pasienter med demenssykdom. Dette kan skyldes at enkeltpersoners individuelle læring og kunnskapstilegnelse ikke var internalisert eller blitt en del av organisasjonens hukommelse (jfr. Wadel 1992). Praktiseringen av personsentrerte tilnærminger til pasienter med demenssykdom i en skjermet avdeling kan forstås i lys av personalets anledning til å utvikle sine kunnskaper ut fra erfaringer med en forholdsvis homogen pasientgruppe.

Funn i studie IV viste at ”*avdelingens sykepleiefilosofi/grunnlagstenkning var klart definert*” og ”*pasientene mottok individuell pleie og omsorg*” var tydeligere oppfattet av studenter i sykehusavdelinger enn i sykehjem. I artikkel III rapporterte studenten som hadde praksis i en skjermet avdeling for pasienter med demenssykdom om grundige faglige diskusjoner knyttet til pasientene og omsorg for personer med demenssykdom generelt. En tolkning av disse

funnene kan være at spesialiserte sykehusavdelinger og skjermede avdelinger for pasienter med demenssykdom er mer homogene med hensyn til pasientgrunnlag og tilhørende pleie- og omsorgsoppgaver. Dette kan være med på å gjøre det lettere å etablere en sykepleiefilosofi som grunnlag for individualisert pleie og omsorg i slike avdelinger.

Å ta i bruk hverdagslige situasjoner for læring

Praksis i sykehjem fordrer ferdigheter og kompetanse ut fra pasientenes sammensatte og komplekse behov (Storey & Adams 2002). Dette står i kontrast til oppfatningen om at praksis i sykehjem kun dreier seg om å gi grunnleggende pleie uten krav om spesielle kunnskaper og ferdigheter (Richardson *et al.* 2001, Banning *et al*. 2006). Slike oppfatninger utfordrer kontaktsykepleiernes synliggjøring av eget arbeid som kunnskapsbasert overfor studentene (jfr. Wade & Skinner 2001). Lambert & Glacken (2005) gjør et poeng av at læring i praksis forutsetter gjenkjennelse og bruk av læringssituasjoner som uten spesiell oppmerksomhet kan bli oversett. I en studie av Kirkevold & Engedal (2006) fremkommer det at de fleste pasientene i norske sykehjem får god grunnleggende pleie og omsorg. Deltakelse i fritidsaktiviteter og fysisk aktivitet er mer oversett. Malmedal *et al*. (2009) viser i sin studie at sykepleiere i sykehjem rapporterer at pleie og omsorg til eldre i sykehjem ikke er tilfredsstillende. En undersøkelse gjennomført av SINTEF Unimed Helsetjenesteforskning (Hofseth & Norvoll 2003) viste at sykepleiere i den kommunale pleie- og omsorgstjenesten mente at pasientenes psykososiale behov er vanskeligst å ivareta. Manglende tid og kompetanse ble nevnt som årsaker til dette (Hofseth & Norvoll 2003). Stell og måltider er eksempler på situasjoner som kan innebære god læring for studentene dersom kontaktsykepleierne hjelper dem til å se disse situasjonene som noe mer enn daglige, praktiske gjøremål. Det forutsetter at kontaktsykepleierne aktivt tar i bruk sitt kjennskap til pasientene, sin innsikt og forståelse for faget eldreomsorg og studentenes læringsmål, i samarbeid og dialog (jfr. Bakthin 1986) med dem.

Rutiner er nødvendige, og noen rutiner er gode mens andre kan fremstå som dårlige. For å sikre kvalitet i pleie og omsorg til pasienter i sykehjem, er det viktig at man stiller spørsmål til rutinene. Elstad (1995) skriver at uten refleksjon og ettertanke kan situasjoner som utgjør en del av rutinene resultere i "mekanisk" og "tom" praksis og at avstanden mellom teori og praksis øker. Kontaktsykepleierne kan gjennom å ta i bruk hverdagslige situasjoner for læring sammen med studentene hjelpe dem til å se mennesket og sykepleiefaget i oppgavene. I studie IV var det statistisk signifikante forskjeller mellom sykehjem og sykehus for variablene som omhandlet meningsfylte læringssituasjoner og om avdelingen kunne betraktes som et godt læringsmiljø, med mer positive resultat for sykehus

Muntlige rapporter var en dagligdags situasjon i de tre sykehjemmene som inngår i denne studien (III). Studentenes erfaringer med hvordan den muntlige rapporten ble brukt som en situasjon for læring, varierte. Noen erfarte ikke rapportene som en situasjon for læring, mens andre opplevde at de bidro til læring og faglig fellesskap. Studie IV viste at studentene i sykehus i større grad enn i sykehjem erfarte en god informasjonsflyt i forbindelse med pleie og omsorg til pasientene og god dokumentasjon av sykepleie. Hamran (1996) skriver at det i pleiearbeidets tradisjonelle rutiner er nedfelt en helhetlig ansvarstenkning. Muntlig rapport har vært en del av en slik positiv rutine (jfr. Hamran 1996). Den pågående effektiviseringen av offentlig sektor påvirker også sykehjem. "Stille rapport" (Bø 2007) og elektronisk sykepleiedokumentasjon innføres i økende grad (Blix 2006, Bø 2007). I noen av avdelingene uttrykte kontaktsykepleierne at usikkerhet om innholdet i rapportene og begrenset tid var årsaker til korte og summariske rapporter (III). I disse avdelingene mistet studentene og personalet en viktig arena for refleksjon, ettertanke og faglige diskusjoner som et grunnlag for en helhetlig ansvarstenkning.

Implikasjoner for praksis

Funnene i denne studien peker på forhold som har betydning for hvordan sykehjem kan fremstå som mer positive læringsmiljø for sykepleierstudenter. Det er interessant at kvalitative funn (I-II) understøttes av den kvantitative spørreskjemaundersøkelsen (IV). Utfordringen er å forbedre læringsmiljøet i sykehjem. Det kan bidra til å styrke rekrutteringen av nyutdannede sykepleiere til fremtidig arbeid i sykehjem. Det er viktig at studentene inkluderes i pleiefellesskapet ved at de aksepteres og verdsettes som lærende med kunnskaper og ferdigheter som kan bidra til forbedring av praksis. Veiledning er en forutsetning for en positiv læringsprosess. Studentene må videre erfare at de får jevnlige tilbakemeldinger og støtte i læringsprosessen. Det å sette ord på kunnskaper og erfaringer gjennom refleksjon og faglige diskusjoner, er en kilde til læring. Dersom studentene skal videreutvikle sine kunnskaper, trenger de å samtale med en dyktig og faglig engasjert veileder om sine erfaringer.

For studentenes læringsutbytte har det betydning at kontaktsykepleierne tar utgangspunkt i de læringssituasjonene som finnes på praksisstedet og som er relevante ut fra praksisperiodens overordnete målsetting. I tillegg er det viktig at kontaktsykepleiere setter seg inn i studentenes individuelle læringsmål og legger til rette for at de erfarer læringssituasjoner knyttet til disse. Igjen står kontaktsykepleiere overfor utfordringen om å delta i praktisk sykepleie sammen med studentene slik at for eksempel personsentrerte tilnærminger som reminisensarbeid og validering overfor pasienter med demenssykdom kan observeres, bli praktisert og lært.

Praksis har stor betydning i utdanning av sykepleiere. Den gir studentene muligheter til å omsette teori i praksis. Praksis innebærer også en sosialiseringsprosess til sykepleierrollen.

Kontaktsykepleierne kan betraktes som døråpnere for studenters inkludering i praksisfellesskapet. Ut fra sykepleieerfaring og innsikt i praksisstedets innhold og rutiner har kontaktsykepleiere en unik anledning til å bidra til studentenes faglige utvikling ved å ta i bruk hverdagslige aktiviteter som situasjoner for læring. Den muntlige rapporten er en hverdagslig rutine som kan bidra til studenters læring. Muntlige rapporter er en potensiell situasjon for læring fordi den fyller ulike funksjoner av informativ, sosial og utdanningsmessig karakter. Grundige og personsentrerte muntlige rapporter kan bidra til å forme studentenes holdninger til sykepleierrollen og fagets normer og verdier.

Avsluttende refleksjoner

Hensikten med denne studien har vært å bidra til økt innsikt i hva som har betydning for at sykepleierstudenter skal oppleve et positivt læringsmiljø i sykehjem. Studien viste variasjoner i utvalgets erfaringer av sykehjem som læringsmiljø. Informantene i studiens kvalitative studier (I-III) som opplevde et positivt læringsmiljø, fremhever at de erfarte å bli inkludert i pleiefellesskapet, de samarbeidet tett med sine kontaktsykepleiere, mottok jevnlig veiledning og observerte og deltok i muntlige rapporter som var personsentrerte og ga rom for faglige diskusjoner og kritisk refleksjon. Det er en utfordring å legge til rette for at sykepleierstudenter som gjennomfører praksisstudier i sykehjem gjør slike erfaringer. Dette avhenger av flere forhold. Avdelingsledere må legge til rette for at kontaktsykepleierne ivaretar sin veiledningsfunksjon slik at studentene lærer. Holdninger til eldre og eldreomsorg i samfunnet spiller en rolle uttrykt som ”ageism” og den status arbeid innenfor eldreomsorg har. Her står en overfor samfunnspolitiske og utdanningsmessige utfordringer. Sykepleiere som arbeider innenfor eldreomsorg må få skolering i veiledning slik at de får kompetanse til å inngå i et lærende fellesskap med studentene i praktisk utøvelse, refleksjon og kritisk dialog. Utdanningsinstitusjonene må aktivt bidra til denne kompetanseutviklingen.

Hverdagen i sykehjem er krevende og travel. Det er en kjensgjerning at personalet i sykehjem opplever at bemanningen er for lav i forhold til pleietyngde og pasientenes psykososiale behov. De eksisterende problemene med rekruttering av sykepleiere til den kommunale helsetjenesten og spesielt til sykehjemmene, stiller store krav til politikerne om å legge til rette for at flere søker seg til denne delen av helsetjenesten. Data fra spørreskjemaundersøkelsen (IV) er analysert ut fra svaralternativene ”delvis enig” og ”helt enig”. Det betyr at deltakerne i studien jevnt over er fornøyde med det kliniske læremiljøet og veiledning. Studien viste stor statistisk signifikans for variabelen ”avdelingen kan betraktes som et godt læringsmiljø” i favør av sykehus. Det er derfor viktig at kunnskaper om forhold som har betydning for et godt læringsmiljø utforskes og tas i bruk for å styrke rekruttering av sykepleiere til sykehjem.

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ARTIKKEL I

Nursing Students' Experiences of Nursing Homes as Learning Environments.

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ABSTRACT

Nursing students' experiences of nursing homes as learning environments.

Background

Nursing students' clinical experiences are important with respect to their impact on attitudes towards care for older people.

Aims and objectives

The aim was to explore and discuss nursing students' experiences of nursing homes as learning environments. The objectives were to identify factors and provide information for measures to support recruitment of nurses to care for older people.

Methods

A qualitative study based on field work, field notes and qualitative research interviews with 12 nursing students.

Results

Three main themes with varying experiences and perceptions connected to learning environment were found:

- acceptance and appreciation
- supervision and learning process
- professional discussions and learning outcomes.

Conclusion

A good learning environment includes expert guidance, feedback and critical and reflective processes.

Key words: Clinical practice, learning environment, nursing students, nursing homes, care for older people.

What is already known about this topic

- The number of nursing students interested in working with older people has declined.
- Graduated nurses often return to practice in an area where they experienced a positive learning environment.

What this paper adds

- Acceptance and appreciation of nursing students are essential aspects of a positive learning environment in clinical practice in nursing homes.
- Professional discussions are a key factor for nursing students' learning process and outcomes.

Implication for practice

- Measures for positive inclusion of nursing students in the clinical environment must become an integral part of the daily life in nursing homes to develop a positive and stimulating learning environment.
- Informed and systematic knowledge must be the basis for improvements of the learning environment.

1. Introduction

Like the rest of the western world, Norway is experiencing a general ageing of the population (1) and an increasing need of strengthened care for older people. There is a global focus on the lack of nurses who provide care for older people (2*)* especially in nursing homes (NHs). This problem will increase in the future. There is political consensus in Norway to assign care for older people high priority. A need for 10 000 additional employees in community health services, one-third of whom are to be nurses, is stipulated by the Ministry of Health and Social Affairs, by 2009 (3). The recruitment of graduated nurses to work in nursing homes is evidently a strategy to reach this aim.

Clinical practice is an acknowledged part of nursing education (4). The quality of the clinical learning environment is essential for nursing students' clinical experience (5). Studies show that a positive atmosphere and supportive relationships in clinical settings are paramount (6). The learning process is supposed to be a refinement of skills (7) so that critical reflection rather than passive adaptation is the result. In clinical practice NSs have the right to receive expert advice and support, clinical teaching, supervision and assessment to facilitate learning. This is arranged for by appointing a supervising nurse (SN).

Nursing students' (NS) clinical experiences are important with respect to their impact on ageism and attitudes towards caring for older people. The number of students interested in working with older people has declined (8) as this field of work is seen as boring, un-stimulating and frustrating by NSs (9). Several studies show that clinical experiences have an impact on feelings towards older people (10) and

preferences regarding NHs as future workplaces (11). Happel & Brooker (9) found that negative dispositions towards gerontological nursing heightened throughout nurse training. Edwards, Smith, Finlayson & Chapman (12) have found that NSs often return to practice in a location where they experienced a positive learning environment.

A clinical learning environment includes everything that surrounds the NS, such as the clinical settings, the staff and the patients (13). Bergland (14) describes a learning environment as constituted by psychosocial, physical and organizational factors. The learning environment is described as "[…] the conditions, forces and external stimuli that affect the individual […]. We regard the environment as providing a network of forces and factors which surround, engulf, and play on the individual" (15 p. 87).

The theoretical framework of this study is based upon socio-cultural perspectives emphasising collaborative learning in practice communities (16) through dialogue and reflection (17). A positive learning environment is dependant on the SNs' commitment to supporting the NSs' learning, through systematic interaction and communication (13).

It is important to study the learning environment in NHs to identify factors underlying a positive learning environment as well as factors that may discourage nursing students from this line of work.

Aims and objectives

The aim of this paper is to illuminate and discuss nursing students' experiences and perceptions of nursing homes as learning environments. The objectives are to identify factors and provide useful information for measures to support recruitment of nurses to care for older people.

2. The nursing homes

The contexts of this study were three NHs in Norway used as sites for clinical practice on a regular basis throughout the academic year. The sample of the NHs was convenient (18) as they were the nursing homes used for clinical practice at the time of the study. No statistics existed for the workload of care in the three nursing homes. Nursing staff on the three sites described that all patients needed help in completing the activities of daily life.

At the time of the study one NH (A) had five wards, four of which are included in this study. Seven students had their clinical practice here; two students in each of the three wards and one student assigned to a fourth ward. In the second NH (B) one student practiced in a sheltered ward for patients suffering from advanced Alzheimer's disease (AD). In this ward some of the nurses had special training in care for patients with AD. Another student practiced in a general ward. The third NH (C) was located in a health care centre. The institutional portion of the centre comprised a nursing home ward and a general practitioner hospital (GPH). Staff worked both in the nursing home ward and the GPH ward based on rotation. Three students did their clinical practice here. They cared for patients based on the rotation to the ward which their SNs were assigned. In the GPH unit palliative care for older

patients was the major activity. These students performed nursing procedures to a larger extent than those practicing in the other wards.

In the general wards in the NHs, staff estimated that about 80% of the patients had cognitive impairment. This coincides with numbers given in a report from the Directorate for Health and Social Affairs (19) in Norway. There were no significant differences in the NHs regarding the staff/patient ratio (3/9) or physical and organizational factors. In Norway registered nurses generally amount to approximately half of the staff (20) in nursing homes.

3. Material and methods

A qualitative design (18) including field observations with field notes and qualitative research interviews (21), was used. Qualitative interviews provide the means to examine the subjective experiences and perceptions (22) of the students. Field observations contribute to reveal practice in a structural and cultural context (18, 22).

Rigour

Trustworthiness and rigour of this study were determined by considering credibility, dependability and transferability. Data are presented as themes (Table 2) evidenced by verbatim quotations explained by the researchers' interpretations. Furthermore awareness about the researcher's historicity was ensured by maintaining a journal including reflections, questions and understandings throughout the research process. Dependability was enhanced by co-authors checking and discussing analysis and interpretations until consensus was reached. Transferability was addressed through descriptions of the nursing home contexts and the participants.

Sample/Participants

All final year 5th semester NSs (n=13) in the university college who had ten weeks of clinical practice in care for older people at each of the three different NHs at the time of the study were included. One student dropped out, leaving 12 participants (n=12) (Table 1). All students had six weeks of clinical experience in general nursing in NHs during the first study year. Each NS had a supervising nurse (SN) except for two students who were supervised by one SN. The students organised their work-shifts in accordance with those of their SNs during the clinical placement. The SNs were registered nurses experienced with being appointed as supervisory nurses. Their average experience from working in the NHs was 4 years. The first author had no prior relationship with the students and did not hold any professional role in the students' clinical practice.

Insert table 1.

Data collection

Data collection was conducted in 2006. Prior to the students' clinical practice the first author spent two weeks in one of the NHs to get re-familiarized with NHs as sites for clinical practice for NSs. Field observations as part of the data collection in the NSs' practice periods were conducted over ten weeks divided between the three NHs according to the number of students at each site. The units for observations recorded in field notes were activities, collaboration and communication between NSs and SNs. The intention was to grasp, illuminate and interpret the meanings, patterns and structures of individuals in social processes (21). In writing out the field notes the technique described by Schatzman & Strauss (23) was used to give

observational, theoretical, methodological and personal notes. By the end of the clinical practice semi–structured interviews (24) were conducted with each participant who had given their informed consent.

An interview guide was developed with thematic questions concerning aspects of learning environments generated from literature review (13, 25, 26) and from the previous field observations. In the interviews the NSs were encouraged to elaborate their experiences regarding their learning environments. The interviews were undertaken by the end of the clinical placement for all participants. The interviews lasted 45 to 70 minutes. The interviews were taped and transcribed verbatim.

Data analysis

The interviews were analysed by qualitative content analysis (22). The texts were read and reread to grasp a thorough understanding of each individual interview. A condensation was performed to determine meaning units as constellations of words related to the same central meaning. Those were then condensed and 31 sub-themes were created (e.g. feeling appreciated vs. not appreciated, being supervised vs. practising alone, experiencing professional discussions vs. task orientation). The sub-themes were grouped into three main themes. The main themes that emerged were different experiences of “acceptance and appreciation”, “supervision and learning process” and “professional discussions and learning outcomes” (Table 2). The analysis of the interviews served as a basis for a selective approach (18) of pulling out the same themes inherent in the field notes. Field notes were analysed according to the procedure described by Hammersley & Atkinson (21) starting with broad descriptive categories, sorting the field notes in relation to persons, places, activities,

collaboration and communication. Field observations, field notes and interviews were used to enhance the validity of the study. The co-authors checked and discussed analysis and interpretations until consensus was reached.

Insert table 2.

Ethical considerations

This study was approved by the Norwegian Social Science Data Services. Written permissions for field observations from the heads of the NHs were granted. The participants received an explanatory letter about the study and were asked to participate. Informed, written consent was obtained from participants prior to the data collection. During field observations the first author aimed at protecting the participants against harm or stress and by respecting their autonomy. Confidentiality was granted and assurance was given that participation was voluntary with the right to withdraw from the study at any time without consequences or having to state a reason.

4. Results

All students reported low expectations prior to clinical practice in the nursing homes, but not towards caring for older people as such. Several interwoven factors were involved in how students experienced and perceived the learning environments in the NHs. The findings from textual data are presented in terms of the NSs' different experiences regarding the main themes and are illustrated with quotations from students and observations done by the first author.

Experiences of acceptance and appreciation

All students expressed expectations of being accepted and appreciated as members of the caring community so as to promote learning. One of the students (2) said: "The student role is vulnerable", a statement supported by a fellow student (1): "My SN, told me about students who had behaved badly and not acted according to her (SN's) expectations. I thought that I had better do things the way they wanted it". Another student (5) said "I feel totally invisible here, worthless…they don't want my opinions, and if I raise a topic it is seen as criticism".

In one instance a student was sitting in the living room with a patient suffering from AD. The patient became stressed and the student tried to calm her. A nurse saw this and said: "Take her to her room!". In the interview the student described the situation as humiliating for both the patient and herself in the effort to make it possible for the patient to participate in a social setting. The student (4) stated: "She should have supported me instead of interrupting without knowing the situation".

Students in other NHs described feeling accepted and appreciated and one (10) said: "I felt welcomed and included. They cared about me and my learning objectives". Another student (9) said: "I was positively surprised given what I have experienced in previous clinical practice".

The students elaborated these statements recounting instances in which they were consulted about their knowledge in different matters. This made them feel accepted and appreciated as knowledgeable if temporary members of the nursing community. These feelings were expressed by one student (10): "I really enjoy being here. They

care about us and have time for us.". Another student (11) said: "They take an interest in our opinions". A third student (12) stated: "We are being seen and listened to".

These expressions fit field observations made of an atmosphere where the students were acknowledged and appreciated as learners and contributors by all staff members and especially by their SNs.

Experiences and perceptions of supervision and learning process

On the first day in the NHs the students were welcomed by a staff member carrying responsibilities for allocation of students. Low expectations notwithstanding the students hoped that they would practice in NHs with staff members familiar with principles of supervision and clinical teaching. In one NH a student (3) said: "I was not so motivated for this clinical practice, but the information we got on the first day made me think that this could be a good placement. But this did not agree with how the clinical placement turned out". Another student (6) stated: "I have been responsible for everything I have learned here." A third student (7) said: "She (SN) says that I can always ask, and I do get answers to my questions, but I haven't experienced supervision in the way I am used to". Such phrases correspond with field observations of students practicing alone or with fellow students.

In this NH supervision was characterized as scarce. One student (4) said: "By the end of the day they say thanks for the help, adding that I have been clever, but I don't know what I have been clever at."

The curriculum states learning objectives for the clinical practice in care for older people. The NSs identified supplementary individual learning objectives. The learning objectives are supposed to guide the learning process and be subjects for supervisory conversations between the NS and the SN. A student (1) said the following about this: “We don’t talk much about my objectives”. Another student’s (5) experience: “I started to nurse immediately, and I have been with all the patients, but I have not had any in-depth proceeds with anything like I wanted”.

These descriptions corroborate field observations of students becoming a pair of extra hands. Established routines and tasks directed the students’ activities rather than their learning objectives. The learning process was not characterized by a supervisory relationship between the SNs and NSs.

In the other NHs students described the units as well prepared for having students. One (10) stated: “They have a plan about my being here”.

A student (8) practising in the unit for patients suffering from advanced AD, elaborated: “The SN takes an interest in my objectives and helps me to adjust them to the strengths of the ward”.

This student (8) told about a SN with high professionalism:“…sometimes shadowed for my possibility to figure out things by myself”. An active and committed SN was described by another student (11) as somewhat problematic: “My SN sometimes takes over when I need some more time”.

Additionally, wards with time for reflections, time-outs and ongoing ethical considerations, were highly valued. The students practicing in these wards were granted and appreciated the role as temporary, but strongly included members of the nursing community. One student (10) said: “They listen to me and ask for my experiences and opinions”. This was elaborated by another statement (12): “It is not the routines that design the days here, everything happens from the patients’ situations and how these influence the ward”.

These students described a learning process with the opportunity to interact and collaborate closely with their SNs each day. This was substantiated by a student (10) saying: “The SN asks what I want to do, and puts forward proposals from situations the ward represents in general and on specific days”. Another student (12) stated: “I feel there is a balance between operating independently and getting support and supervision”.

From field observations it was obvious that learning, rather than routines, guided the activities these students took part in. Furthermore, the supervisory role was given priority in how tasks were divided between staff. The students were explicitly reminded that their position was the learners’ and not to provide extra labour. They were involved in decision-making when asked about their knowledge and reflections. One (10) said: “I am challenged by my SN to propose alternative ways of caring for the patients”. The experiences of the students can be summarized by the assessment of one student (8): “We reflect together… and I have learned about caring for the elderly from that”.

In a ward in one of the NHs (B) a student (9) expressed a wish to and was granted the possibility of practicing independently rather than interacting closely with the SN as described in the guidelines for clinical placements. Field observations indicated that this student became an integral part of the workforce through independent practice, lacking the SN as a distinct supervisor. The student's learning process can be characterized as independent and to some degree observed as lonely.

Experiences and perceptions of professional discussions and learning outcomes

The students considered professional discussions and critical reflections as important for the learning process and for learning outcomes regarding issues in care for older people such as care for patients with AD, reminiscence work, communication and addressing behavioural disturbance. To this one student (2) commented: "On the whole I have not learned anything about caring for persons with AD". Another student (7) said: "I miss discussions …they don't ask about my opinion regarding care for older people".

In one of the NHs systematic in-service lectures was offered, but the students did not participate. One student (6) said:" One day we had planned to attend, but when the time came we had to keep watch in the ward while they (staff) had a meeting". Regarding learning outcomes a student (3) stated: "Well, I guess I have learned something… but overall it has been the same as in the first semester"**.** These statements corroborate observations of a ward culture where patient centred professional discussions were scarce and distribution of tasks was based on getting the work done rather than on how the learning outcomes of the students could be enhanced.

In the sheltered ward in one of the other NHs, the student (8) said: “Each day includes discussions and considerations… and both in the beginning and ending of a shift we sit down to discuss and reflect”. The first author experienced this through observing handovers and time-outs for explorative, critical and analytic discussions with a patient centred focus. In the general ward the student (9) said: “We have had lots of discussions. I don’t really remember about what”. This supports the field observations of somewhat superficial communication between the NS and this particular SN.

One student (11) expressed the following about the impact professional discussions had for learning outcomes: “I have really developed as a professional through this clinical practice”. This statement was based upon how the student had experienced and perceived a learning environment marked by professional discussions. Another student (10) narrated: “Discussions are part of the daily life; we discuss what matters for the patients as individuals…One day a patient was going to have a medical examination that we found ethically challenging, because she has AD and could not fully understand what it contained. We were all very anxious…and we were right to feel that way; the examination was done and it turned out to be like an infringement for the patient…However we talked it through, discussed the ethics attached, the necessity of the examination and we learned from it”.

This example corresponds with field observations of staff members creating time-outs when important issues arose. Students (8, 10, 11) making comments such as: “I have really learned about care for older people” confirmed how professional discussions and reflective dialogue had an impact on learning outcomes.

5. Discussion

The findings in this study reveal differences between NSs' experiences and perceptions of the learning environment in the NHs. The NSs expectations to clinical practice were strongly related to aspects of the reflective practitioner (24) in putting weight on reflection before and after action as a source for developing their currently knowledge about care for older people.

Wenger (16) defines practice as a community consisting of three dimensions: mutual engagement, a shared activity and repertoire. According to Heggen (4) the outcomes of practice are closely connected to which extent the NS is integrated into the practice community. This corresponds with findings showing the students' wishes to be involved, accepted and appreciated as members of the nursing community (12).

Some of the students did not experience the learning environment as accepting and appreciative of them as learners with. Feeling invisible and being afraid of "stepping on toes" contradict the fact that the students expected to be acknowledged as contributors through shared analytic, critical and reflective approaches.
Some NSs talked about SNs failing to take interest in their learning objectives and being unconcerned about efforts and actions initiated by them. Instead, they conveyed experiences of being criticized when breaking established patterns. By the end of the clinical period, these students felt the lack of a learning culture, as well as a paucity of research results concerning care for older people integrated into the nursing care practiced in the placement.

Presuppositions influence how a learning environment is experienced and perceived Negative or unrealistic presuppositions might have constituted a hindrance for how some of the NSs perceived actual learning opportunities as they reported a poor learning environment not exposing them to excellent standards of care for older people. Field observations, though, confirmed the negative experiences reported by some NSs of a clinical practice where the potential for collaboration among nursing students and supervising nurses and learning opportunities were unutilized.

As to acceptance and appreciation, the discrepancies in the findings deal with two perspectives from NSs. Some students reported being accepted and appreciated as supplemental contributors with new perspectives, knowledge and investigating approaches. The contrast is other students who endorsed a peripheral and lonely role, and reported trying to make the best of it through self-motivation and collaboration with fellow students. Socio-cultural learning theory and principles in situated learning (27) emphasize the significance of students being an integrated part of the practice community (4). Allocating students for clinical practice includes responsibility for creating a positive learning environment with SNs challenging and motivating the students in their process of learning care for older people. Supervision as supporting the learning process includes regularity in supervisory sessions and guidance of the students' attention towards relevant experiences and learning situations. Finding the relevant learning activities requires professional insights and use of knowledge about the patients and the ward. One cannot assume that the students have this competence. Furthermore the students need to be assisted to se the relationship between theoretical knowledge about care for older people and its implementation into practice. The students' knowledge of clinical practice is

constituted through advice from and professional discussions with an expert, as experienced and observed for some of the NSs. Other students experienced being part of the workforce. Even though not explicitly expressed, they perceived that this was appreciated by staff. They received positive feedback when assisting to get the work done. This may be based on the SNs assumptions that learning best occurs by doing (28) but without the additional supervision and reflection before and after clinical situations. These experiences correspond with studies reporting that NSs are alone in 2/3 of the situations practicing in NHs compared with NSs being supervised in ¾ of all situations in hospital practice (29). Havn & Vedi (6) found that NSs in nursing homes and home care reported to be treated as an "extra pair of hands". This implies that learning occurs in established patterns and not in an exploratory and investigatory manner. The findings show that there is a challenge of balance in the supervisory role between too much and too little. Too much, means instructing rather than encouraging the student to reflect before, in and after action (17), whereas too little means relying on the student to take responsibility for the learning process as observed for some students. Implementation of strategies and philosophies for supervision and clinical learning are addressed as important for the learning environment.

Along with practice skills and knowledge, the NSs saw professional discussions as a crucial element in clinical practice, especially those regarding ethical challenges that they were familiar with from literature studies and lectures at the university college. They wished to develop critical thinking and analytic skills as competences vital in caring for older people. If this is to happen, it is not simply a matter of increasing their experience by caring for a high number of patients. It requires professional

discussions combining theory and clinical experiences. That can result in adaptation and repetition of established routines without thinking them over (7). There were significant differences between students with respect to this. Some students experienced few if any systematic professional discussions with staff and experts on topics related to care for older people they wished to explore and learn more about. Others experienced that professional discussions distinguished their clinical practice as they were arranged for by staff when specific situations regarding e.g. communication with older persons arose.

In this study, discussions and reflective processes with experts were regarded by the NSs as a gateway to their learning outcomes in care for older people. This comprehension corresponds with the notion that expert knowledge must guide selection of learning activities as well as learning objectives related to the actual context.

The differences in experiences of learning about care for older people from professional discussions and subsequent learning outcomes may depend upon several conditions; for example experience of workload of care, routine and task orientation or a lack of a culture promoting profound professional discussions and continued learning. The strain of a continuous number of students entering the NHs for learning purposes may be a reason for the experienced lack of engagement in some of the NSs' clinical practice as this is time-consuming for staff perceiving the care for patients as their main obligation. Receiving students for clinical practice on a regular basis may be experienced as a burden by the nursing staff negatively affecting their capacity for including them into the nursing community. In addition individual

learning styles (30) must be taken into consideration as they will influence utilization of potentials in the learning environment.

Trustworthiness and limitations

Trustworthiness was established by using multiple methods in data collection (25) to investigate aspects regarding nursing homes as learning environments. These included observations, field notes and interviews. Interviews provided rich descriptions which added to the validity of the study.

The small sample and the qualitative approach in this study put limits to the transferability of the findings to similar settings. One site including a GPH and another site a shielded/sheltered unit for patients suffering from AD must be taken into consideration as these sites differ from general wards. Although the study examined three nursing homes in a Norwegian context and a small number of participants in a specific period of time, the findings may be applicable to other nursing students and similar contexts.

Conclusions

We found variations in nursing students' experiences and perceptions of their learning environments while caring for older people. The findings strongly indicate a deepening knowledge about how psycho-social aspects are important components to nursing students' perceptions of the learning environment in nursing homes. The experiences and perceptions of the professionalism in the learning environment are pivotal factors as students seek refinement in their learning process through critical

reflection and professional discussions as sources for learning the essence in caring for older people.

It may be interpreted that awareness of principles and responsibilities in developing good learning environments may not be fully established in some of the SNs' approaches to engaging students in clinical practice. It is important to acknowledge the challenge and responsibilities involved with articulating and visualizing nursing homes as good learning environments.

Further research into implementation of supervisory principles, learning philosophies and strategies into the practice realm must be addressed. Training in supervision, preparedness for receiving NSs for clinical practice and adjusted workload for SNs seem to be important factors in order to provide a good learning environment in NHs. These factors may contribute to NSs experiencing being included into the nursing community through acceptance and appreciation along with supervisory approaches supporting a learning process characterized by collaborative interactions and professional discussions.

Relevance to clinical practice

Educational policy-makers, nursing home managers and researchers must contribute to developing positive learning environments in nursing homes if graduated nurses shall be recruited to and retained in this part of the health care system.

Contributions

Study design: MWS, NH, HKN.

Data collection: MWS.

Data analysis: MWS, NH, HKN.

Manuscript preparation: MWS, NH, HKN.

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Table 1. Nursing homes and nursing students included in the study

	Ward	Students	Staff/patient ratio	Age	Gender
Nursing home A	1 2 3 4	1,6 4,7 5 2,3	3/9 3/9 3/9 3/9	23,24 35,22 30 21,22	F F F F
Nursing home B	1 2	8 9	3/9 3/9	32 24	M F
Nursing home C	1	10,11,12	3/9	22,25,42	F

Table 2. Examples of the process of qualitative content analysis

Meaning unit	Condensations	Sub-themes	Theme	Main theme
I feel totally invisible here.....worthless… they don´t want my opinions, and if I raise a topic it is seen as criticism	The student felt alone and not included	Feeling ignored	Being dissatisfied with the learning environment	Acceptance and appreciation
The SN takes an interest in my objectives	The student experienced supervision as part of the learning process	Being supervised	Being satisfied with supervising and learning process	Supervision and learning process
I miss discussions…they don't ask about my opinion regarding care for older people	The student felt that her knowledge was not acknowledged	Feeling a lack of professional discussions	Being dissatisfied with learning outcomes from professional discussions	Professional discussions and learning outcomes

ARTIKKEL II

Student experiences in learning person-centred care of patients with Alzheimer's disease as perceived by nursing students and supervising nurses.

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ABSTRACT

Aims and objectives

The aims and objectives of this paper are to illuminate and discuss the experiences and perceptions of nursing students and supervising nurses regarding the students' learning of person- centred care of patients with Alzheimer's disease in a teaching nursing home. This information is then used to develop recommendations as to how student learning could be improved.

Background

The clinical experiences of nursing students are an important part of learning person-centred care. Caring for patients with Alzheimer's disease may cause frustration, sadness, fear and empathy. Person-centred care can be learned in clinical practice.

Design

A qualitative study

Methods

The study was performed in 2006 using field work with field notes and qualitative interviews with seven fifth-semester nursing students and six supervising nurses.

Results

This study determined the variation in the perceptions of nursing students and supervising nurses with regards to the students' expertise in caring for patients with Alzheimer's disease. The nursing students experienced limited learning regarding person-centred approaches in caring for patients with Alzheimer's disease. However, the supervising nurses perceived the teaching nursing home as a site representing multiple learning opportunities in this area.

Conclusions

Nursing students perceived limited learning outcomes because they did not observe or experience systematic person-centred approaches in caring for patients with Alzheimer's

disease. It is important that measures of quality improvements in the care of patients with Alzheimer's disease are communicated and demonstrated for nursing students working in clinical practices in a teaching nursing home.

Relevance to clinical practice

Introduction of person-centred approaches is vital regarding learning outcomes for nursing students caring for patients with Alzheimer's disease.

Key words

Person-centred care, Alzheimer's disease, learning, nursing home, nursing student, teaching nursing home.

What is known about this topic:

- Nursing students feel uncertain about caring for patients with Alzheimer's disease.
- Knowledge about person-centred care of patients with Alzheimer's disease can be obtained through clinical practice.

What this paper adds:

- Nursing students need support to practice person-centred care of patients with Alzheimer's disease.
- Supervising nurses must articulate and demonstrate person-centred approaches in the care of patients with Alzheimer's disease in collaborative situations with the nursing students.

INTRODUCTION

Like the rest of the world, Norway is experiencing a general aging of the population (Statistics Norway 2005). In 2007, approximately 66 000 of the total population of 4.6 million Norwegians, had Alzheimer's disease (AD). As the population ages, this number is expected to increase (Statistics Norway 2005). Approximately 80% of roughly 40 000 patients in Norwegian nursing homes (NHs) have cognitive impairments such as AD (Directorate for Health and Social Affairs 2007).

The Norwegian nursing education is a three-year university college programme based on national guidelines (Ministry of Education and Research 2004). Normally theoretical studies serve as a preparation for clinical practice. The clinical experiences of nursing students (NSs) impact their preferences in their choice of future workplace (Bergland & Lærum 2002, Kloster *et al.* 2007). Edwards *et al.* (2004) found that graduating nurses often return to practice in areas where they had positive learning experiences as NSs. The clinical experiences of NSs regarding their knowledge of and attitudes toward caring for patients with AD are important (Robinson & Cubit 2007). Most knowledge concerning dementia care is obtained through clinical practices (Skog *et al*. 2000).

Patients with AD may have problems with both verbal and non-verbal communication (Normann 2001). They may engage in deviant behaviour, exhibiting characteristics such as aggressiveness, unpredictability and un-cooperativeness (Brodaty *et al.* 2003) and these behaviours are sometimes difficult to understand (Taft & Cronin-Stubbs 1995). The behaviour may be caused by the frustration these patients feel when they are unable to express themselves verbally (Normann 2001).

A study by Beck points out that NSs consider the care for patients with AD to be exhausting. Caring problems are connected to communication, disorientation, mood changes, anxiety and aggression (Bottril & Mort 2003). A study by Kim (2006) shows that NSs hold more negative attitudes toward elderly patients with AD than toward elderly patients in general. Dewing (1999) found that patients with AD are sometimes treated as 'non-persons.' Validation therapy (VT) (Feil1993) and reminiscence therapy (RT) (Butler 1963) are recognised as person-centred care techniques. The aim of the person-centred care techniques is to keep the personality alive despite cognitive impairment (Dewing 2000). Kitwood and Bredin (1992) showed that patient-centred care can be obtained if the nursing staff understand the patients' needs and engage in positive interactions with them. This requires that the nurses listen to the patients and that their perceptions are explored before actions are initiated. The knowledge and attitudes of supervising nurses (SNs) toward the care of patients with AD are important for the patients, as well as for the NSs learning to care for them.

Few studies have investigated the experiences of NSs in learning how to care for patients with AD. Investigations of the attitudes of NSs toward patients with AD indicate that the students experience several emotions, such as frustration, sadness, fear and empathy (Beck 1996). Robinson & Cubit (2007) found that the complexities in caring for patients with AD, in conjunction with pre-existing ageist attitudes, can result in NSs having a negative experience in their clinical practice. This undermines the importance of supporting NSs in person-centred approaches under supervised circumstances.

Aims and objectives

The objective of this paper is to illuminate and discuss the experiences and perceptions of NSs and SNs regarding the students' learning of person centred-care of patients with AD in a

teaching nursing home (TNH) to make recommendations as to how student learning may be improved.

Methods

A qualitative design (cf. Polit & Beck 2008) including field observations with field notes and qualitative research interviews (cf. Hammersley & Atkinson 1990) was used in this study. Qualitative interviews examine the subjective experiences and perceptions of individuals (Graneheim & Lundman 2004) and field observations reveal practice in a structural and cultural context (Polit & Beck 2008). At the end of the clinical practice, semi-structured interviews (Kvale 2001) were conducted with each participant. A search of relevant literature was conducted in Cinhal, ProQuest and PubMed using the key words: Alzheimer's disease, elderly care, learning, nursing home, nursing student, person-centred care and teaching nursing home

Sample/participants

The NSs were in the final year of study and had 10 weeks clinical practice in care for the elderly in a TNH. The students received lectures on person-centred care in preparation for their clinical practice in their third and final year of study. The lectures focused on validation and reminiscence therapy. The supervising nurses had the opportunity to participate in domestic teaching (DT) on person-centred care of patients with Alzheimer's disease.

During the first study year, all students (n=7) had six weeks of clinical experience in nursing homes. They were exposed to patients with AD in this clinical practice, but did not have theoretical knowledge, as they were learning basic nursing skills. The SNs (n=6) who participated in this study were appointed as SNs for the NSs in a one-to-one relationship

except from one SN who supervised two NSs. The SNs conducted the assessment of the students' learning outcomes along with a nursing teacher from the university college when the clinical practice was completed.

The Teaching Nursing Home

The TNH included in this study has been part of a national teaching nursing home project since 1999. The TNH receives special funding for projects and measures initiated to improve the quality of care and to develop good learning environments for students (Kirkevold & Kårikstad 1999). The ideology of this TNH was based on the principles of a learning organisation. Learning organisations are described as 'organisations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free and where people are continually learning how to learn together' (Senge 1990, p.3). In the TNH, one of the aims was to: ' improve and secure quality and competence for patients in nursing homes' and 'establish an environment that stimulates professional development and research on questions attached to care and treatment of patients in nursing homes' (Kirkevold & Kårikstad 1999, p. 18).

The TNH project was characterised as a change-oriented applied research project (cf. Polit & Beck 2008) designed to help the staff explore and improve their professional knowledge. This approach was chosen because it has a bottom-up perspective (cf. Tones *et al.* 1990). In the TNH-concept, the staff could apply for funding to carry out projects in areas in need of improvements, as determined by daily experiences.

Due to the high number of patients with AD, a substantial number of projects and a large amount of the DT conducted in the TNH, both prior to and at the time of this study dealt with issues related to person-centred care for patients with AD. An acknowledgement that improvements in the quality of care for patients with AD were necessary was the foundation for this focus. Domestic teaching was offered through weekly voluntary lectures. The wards included in this study were general wards which had no special arrangements for patients with AD except from a reminiscence room in the NH. All patients required help with personal hygiene and daily living activities. About 80 % of the patients were estimated to suffer from cognitive impairment, which is in agreement with the percentage reported by the Directorate for Health and Social Affairs (2007). The patient to staff ratio was 9/3.

Data collection

Data collection was conducted in 2006. Field observations and field notes (cf. Hammersley & Atkinson 1990) were made prior to and during clinical practice. Observations prior to the clinical practice of the NSs took place in the living room, the duty room and the corridors. This period of field observations, was conducted to allow the first author to become familiar with the TNH as a site for clinical practice. Field observations in the clinical practice of the NSs were conducted over a 10-week period in which the NSs focused on elderly care and the care of patients with AD. Observations on the activities of patients and on the collaborations and communication between patients, NSs and SNs were made. The technique described by Schatzman & Strauss (1973) was used when writing field notes: specifically, the writings included observational, theoretical, methodological and personal notes. Based on the literature review and observations of the TNH, an interview guide was developed with thematic questions involving aspects of the care for patients with AD (cf. McCormack 2003, Robinson & Cubit 2007). In the interviews the first author asked the NSs an introductory question with

follow up questions regarding the experiences and perceptions related to person-centred care of patients with AD. The interviews lasted between 40-70 minutes and took place in a shielded room in the TNH toward the end of the clinical practice. The interviews were taped and transcribed verbatim.

Data analysis

Field notes were analysed according to the procedure described by Hammersley & Atkinson (1990) starting with broad descriptive categories. Then the material was sorted in relation to persons, places, activities, collaboration and communication. The field notes contributed to the interpretation of the interview materials. The interviews were analysed by qualitative content analysis (Graneheim & Lundman 2004), while the texts were read and re-read to grasp a thorough understanding of each individual interview. Interviews with the NSs were condensed to determine meaning units as constellations of words related to the same central meaning (ibid). The analysis of the interviews with the NSs served as the basis for the themes inherent in the SNs' statements as well as in the field notes.

From the interviews with the NSs, 16 sub-themes emerged and were grouped into the following broad themes relating to person-centred care of AD patients:

- Attitudes regarding approaches in caring for patients with AD
- Perceptions of knowledge regarding person-centred approaches
- Views and perspectives of learning person-centred approaches
- Perceptions of implementation of person-centred approaches

Ethical considerations

This study was approved by the Norwegian Social Science Data Service. The head of the TNH granted written permission for field observations. The participants received an explanatory letter about the study and were asked to participate. Informed written consent was obtained before data collection. Confidentiality was granted and participants were assured that participation was voluntary; the subjects had the right to withdraw from the study at any time without consequences and without having to state a reason.

RESULTS

All students reported low expectations prior to entering clinical practice in a NH. However, after being given information about the TNH ideology, the development projects and the DT programme, students had positive expectations about entering an arena characterised by updated knowledge and good care, both in general and especially for patients with AD. The NSs anticipated having rich opportunities to gain insight into person-centred approaches such as VT (Feil 1993) and RT (Butler 1963) and this was stated in their learning objectives.

Attitudes regarding approaches in caring for patients with Alzheimer's disease.

One student (5) said the following about experiences of person-centred approaches in caring for patients with AD: 'Validation…well I have not experienced it here. It is more about reprehensions and corrections'. Another student (7) said: 'Validation and reminiscence work is not spoken about and I cannot remember seeing it practiced. It is all about taking care of personal hygiene and serving meals…every day follows a routine'. Similar comments were heard by other students. One student (6) said: 'They do not talk much about how to care for those with AD ', while another student (2) felt that: 'Discussions are more about how to shield them so that they don't get agitated'. Another student (3) said: '…so what I figured was that if

the patient sat quiet and dozed, then she was regarded as calm and settled'. In one situation a student (4) experienced a professional attitude that she found objectionable: 'They made jokes about it…'is it medication or placebo…no it must be sweets, she is just as crazy'.

All SNs expressed that caring for patients with AD was an important part of their daily work that was interesting, demanding and challenging. Their attitudes regarding this care were based on a genuine concern about what they saw as the consequences of cognitive impairment. One SN (5) said: 'Patients with AD are fearful, have anxieties…are afraid'. The care of patients with AD was regarded by SNs as being as demanding and challenging as expressed by a SN who said that: 'What is needed the most in care for the elderly is knowledge about AD'.

These statements confirmed that SNs understood the complexity in caring for AD patients. The importance of issues regarding care for these patients was expressed with reference to development projects and DT in the TNH on for example, validation and reminiscence therapy. The statements of the SNs support the first author's impressions from conversations with them, as they expressed concern about the well-being of patients with AD and their low threshold for stress. However, the observations indicated a somewhat different practice, as maintaining order in the unit rather than person-centred care seemed to guide the practice. The concern of the SNs for patients with AD was observed as forthcoming and joyful, but the SNs often passed by too quickly for their concern to be perceived by the patient in question.

The experiences narrated by the NSs contradict the expressed interest and commitment in the statements given by the SNs: the expressed interest and commitment were only articulated and made known to the NSs to a limited extent. The experiences of the NSs from field

observations exhibited a discrepancy between the SNs' expressed attitudes, perceptions and concerns and the factual practice in the care of patients with AD.

Perceptions of knowledge regarding person-centred approaches.

The NSs looked forward to taking part in and learning from what they expected to be knowledge-based practice of person-centred care. One student (7) said the following about how deviant behaviour was dealt with: '…so maybe there is a lack of knowledge? It does not seem as if they know how to deal with it'. Another student (5) said: 'I think knowledge about AD and care for patients with AD is very important, but…it seems as if they don't think much about it. They are very kind and caring toward them, but that is not enough'. A third student (2) asked: 'What happened to the knowledge about reminiscence work…and deviant behaviour?'. Another student (6) said: 'I feel that I have learned little about care of patients with AD'.

One of the SNs (1) said: 'We have had meetings with faculty to make them prepare students about what they will experience here; deviant behaviour, use of committal protocol etc.'. Another SN (5) said: 'We have learned about how patients with AD experience their situation'. A third SN (3) said: 'The entirety…how to handle patients with AD; that is important for them (NSs) to learn about doing clinical practice here'.

The statements show that both NSs and the SNs recognised knowledge as necessary in meeting the complex needs of AD patients. Field observations showed few initiatives from the SNs to communicate knowledge about person-centred approaches to the students. The first author made no observations of interactions with NSs that included VT or RT. These observations support the statements from the NSs.

Views and perspectives of learning person-centred approaches.

The NSs had expectations about observing and learning specific approaches in caring for and communicating with AD patients. With regards to this one student (5) said: 'I had planned being with a patient with AD one day, but then there was lack of staff and I was asked to care for several other patients'. Another student (4) said: 'Well, from lectures at the university college I looked forward to practicing in a TNH…you know…the projects…but I haven't experienced the professionalism I had expected'. A third student (6) said: 'I had planned to spend some time with a patient in the reminiscence room when the SN wanted me to join in preparing blood samples'. Another student (7) said: '…and the reminiscence room…I have not ever seen it being used'.

The SNs' perceptions regarding how to learn to care for AD patients can be summarised from two quotes. One SN (3) said: 'Care for patients with AD…I think it can be learned from observing how we (staff) act toward them. NSs can learn from that and from caring for them'. Another SN (4) stated: 'I don't know, maybe they (NSs) haven't learned so much about reminiscence work and validation here, but they have learned about taking care of patients with AD in providing basic needs like personal hygiene and nutrition'.

The first author observed that the method of learning by doing was practiced. The additional supervision was observed to be limited. As a result, the NSs experienced limited learning from the SNs as role-models in demonstrating person-centred approaches and paying attention to the socio-emotional aspects of patients with AD. The statements from the NSs and SNs reveal discrepancies in perceptions of how to learn to care for patients with AD. The SNs underpin the importance of learning from observing what they perceived as the best practice. Field observations were contradictory in that they showed that the NSs, usually practiced

independently or with a fellow student. The NSs were also guided toward activities that were mostly task oriented, even though they wished to practice VT and RT in caring for patients with AD. Initially, the NSs spent some time communicating with patients with AD, but as the clinical practice continued, they spent more time retreating to the duty room when not occupied with physical care and other routine work. Limited field observations of the NSs and SNs engaged in shared interactions with these patients agree with the perceptions of the NSs that the clinical practice in the TNH was less profitable than expected.

Perceptions of implementation of person-centred approaches.

Referring to the expectations regarding clinical practice in a TNH, one NS (1) said: 'Actually, I am disappointed over the professional outcomes. This is a TNH and that gave me some expectations about learning from professional development work, the projects you know, but I have not noticed them'. Another student (3) said the following about an experience: 'We (NSs and doctor) have discussed an ongoing research project and the possible use of placebo for a patient with deviant behaviour because of AD; that was interesting'.

One SN (1) said: 'Our routines are good in creating quietness during meals for those with AD'. Another SN (5) said 'I think they could have been better cared for than what they are here'. A third SN (3) said: 'I have not participated in project work or domestic teaching. It has been too much'. One SN (1) said: 'It would have been nice if we had time to take part in domestic teaching regarding AD. That is important when working here'. Another SN (4) said the following about a project: 'In our project we wanted to continue reminiscence work; create activity and fellowship…but there is no time to continue doing it'.

These statements show that the SNs found it difficult to participate in development projects and DT. These difficulties were observed by the first author on the days in which DT occurred, but the work was not organised in a way that facilitated participation. The fact that there was insufficient time available for the SNs to attend DT and to practice the knowledge obtained from development projects, negatively affected the implementation of person-centred approaches.

The statements of the NSs, demonstrate that they did not experience results from professional development projects and perspectives taught in DT as an integrated part of the care of patients with AD. These statements are in agreement with observations made by the first author prior to and during clinical practice showing that the nurses were busy with daily tasks and that there was a lack of discussion regarding person-centred care for the patients with AD. In meeting with and seeing the patients with AD, the SNs addressed them, made comments or touched them physically. However, these actions were hasty and lacked the significance of genuine person-centred care that requires knowledge, time and tranquillity.

DISCUSSION

The NSs expressed a wish to learn the practice of person-centred approaches for patients with AD. They sought experiences in adapting communication skills toward these patients. Puentes (2000) found that NSs found reminiscence interaction to be positive and enjoyable and that these interactions helped them to view patients in a more positive manner. These positive interactions were not as frequent for the NSs in this study. The SNs articulated commitment, engagement and genuine concern about patients suffering from AD. However, these attitudes did not result in observed systematic person-centred approaches. The care provision was task-oriented (cf. McCormack 2003) with routines and timetables (cf. Roth 1963) structuring the

practice and the main focus was to accomplish the work. Routines are important due to the patients' need for assistance with personal hygiene and meals. The challenge is to carry out routine care activities while providing opportunities for expressive interaction rather than allowing these interactions to occur as solitary acts. This is instrumental in maintaining person-centred care.

The SNs acknowledged that the care of patients with AD requires multiple skills and special training as arranged for in the TNH through development projects and DT. From the perspective of the NSs and the observations of the first author, there is a divide between the espoused theory and the theory in practice (Argyris & Schön 1978). From the SNs' point of view this discrepancy was caused by the staff being time-starved in a situation in which the provision of physical care was so demanding that there was insufficient time for person-centred socio-emotional care. This resulted in patients with AD feeling lonely and unimportant and being treated like members of a homogenous group rather than as individuals. Institutionalisation, ward behaviour and role dispossession may result from this type of treatment (Goffman 1991).

According to the observations of the first author, the staff members did not spend much time with patients with AD. Except for assistance with basic physical needs, most of the contact between the staff and patients was limited to nice, pleasant comments from the staff when passing the patient. Conversations were often ignored when they became demanding due to the degree of the patients' cognitive impairment and thus, their ability to communicate. It has been found that a patients' experience with staff members who do not listen (Tuckett 2007) results in the patients becoming isolated with limited interpersonal relationships. This corresponds with Kitwood's (1997) description of caregivers' work as being done with

kindness and good intentions while still having a traditional view of the outlook of the care of patients with AD. This may result in infantilisation, labelling and objectification and finally de-personalisation as described by Kitwood (1997). These phenomena were observed by the first author when the staff were short and kind in their encounters with the patients and infantilised them by calling them ‘sweetheart’ while patting their heads.

The observed withdrawal of students from interaction with the patients with AD is interpreted to be a result of limited supervised experiences in practicing person-centred approaches and an experienced lack of support from their SNs in establishing person-centred communication This may be caused by the emphasis on task-oriented care (cf. Tappen *et al.* 1999) and a ward culture that emphasised ward orderliness (cf. Tuckett 2007) before person-centred socio-emotional focused encounters. A focus on routines and ward orderliness may be interpreted as a defence used to avoid experiences of anxiety (Menzies Lyth 1988) in being together with and communicating with AD patients. Ekman *et al.* (1991) found that patients with cognitive impairment received less nursing time than other patients implying that caregivers seldom address patients with AD for solely communicative purposes. The importance of the SNs as role models (cf. Davies 1993) affected the actions of the NSs as they observed brief interactions between the SNs and patients with AD.

Observations showed that the NSs usually cared for patients with AD on their own or with a fellow student. Thus, they had to rely on themselves to determine how their approaches suited the situations in which they were involved. This coincides with findings showing that NSs spend two-thirds of their time practising alone during clinical practice in NHs but spend three-quarters of their time with a nurse when practicing in a hospital ward (Havn & Vedi 1997).

Norbergh *et al.* (2006) found that in general nurses showed positive to neutral attitudes toward individuals with AD. The findings in this study corroborate this finding. A study by Brodaty *et al.* (2003) showed more negative than positive perceptions in working with demented patients and found that working with cognitively impaired patients is associated with high stress levels. The SNs in this study found that the care of AD patients was interesting but conflicted with their workload and their available time.

Norway has experienced a shortage of nurses, especially in NHs (Ministry of Health and Social Affairs 2005-2006). If the quality of care of patients with AD is to be improved, the number of nurses must be increased. Recruitment and retention of nurses in NHs can be achieved through establishing learning networks (cf. Adams & Richardson 2005), organised as group and individual sessions to improve learning of person-centred care for patients with AD. The sharing of ideas and knowledge, combined with reflection on difficult and challenging situations may provide pathways to support the quality of care for patients with AD.

The SNs stated that knowledge about care for AD patients is important. They discussed the importance of preparedness for clinical practice in the TNH where approximately 80% of the patients suffered from cognitive impairment. They recognised knowledge as the basis for the quality of care for AD patients. The experienced lack of time for attending DT and implementing projects, revealed a conflict between intentions and results. The experiences of the NSs support this. For example, they were directed away from planned person-centred encounters with patients to accomplish routine tasks. The NSs had expectations of learning to practice person-centred communication. These methods have proven to be effective for health care professionals to learn about and appreciate the lives of their patients (Shellman 2006).

The NSs found that their expectations of learning outcomes regarding person-centred care of AD patients were unmet.

In this respect the TNH did not function as a community of practice engaged in a process of collective learning (cf. Wenger 1998) which included the NSs. Whether a health organisation, as a community of practices improves its performance depends on its commitment to taking on responsibilities to implement quality measures achieved by development projects and to ensure participation in DT. The importance of SNs as role models (Tuohy 2003) was not significant for the NSs and learning-by-doing without critical reflections seemed to be the perceived method of clinical learning. The NSs stated that they saw professional discussions as a pathway for learning. According to Martinsen (1989) the NSs' knowledge in clinical practice is from advice and dialogue with an expert. The NSs' experiences in this study did not include dialogues about person-centred approaches in the day-to-day practice. This indicates that the outcomes of the learning experience were incomplete. If the attitudes and learning of NSs regarding care of patients with AD are to be changed, a dynamic process is required. This process should be one in which training, knowledge and measures for quality improvement are internalised in both the clinical organisation and in the individuals working there.

Limitations

The small sample and the qualitative approach in this study limit the application of the findings to other situations. Although the study examined one TNH in a Norwegian context and a small number of participants over one specific period of time, the findings may be relevant for preparing and supporting the learning possibilities and learning outcomes of NSs regarding person-centred care of patients with AD.

Conclusion

Several challenges regarding NSs' learning of person-centred care of patients with AD in clinical practice await solutions. Collaboration between the university-college and NHs concerning person-centred approaches as part of the NSs' learning objectives and appurtenant assessments is important. The NSs entered the TNH for clinical practice with updated knowledge about VT and RT as person-centred approaches. This knowledge was the basis for their expectations that they would learn to practice these therapies in the TNH. Their expectations may have been somewhat unrealistic as individual and organisational learning concerning the outlook of the care of patients with AD take time. Challenges in establishing a culture for learning and implementing principles of a learning organisation are addressed. The establishment of a culture in which knowledge and positive results from research and development projects are actively discussed and mandated in the practice of person-centred care is of great importance. A leadership responsibility is also addressed. The final challenge is to communicate and emphasise knowledge, expertise and professional experiences for NSs. Collaboration between competent SNs and NSs during clinical practice is vital if approaches of person-centred care are to be implemented.

Relevance to Clinical Practice

Unless the knowledge basis of person-centred approaches in the care for patients with AD is strengthened and implemented in practice, NSs will continue to experience a gap between theory and practice (Kirkevold 1996). In addition, patients with AD will continue to experience de-personalisation and institutionalisation caused by staff with the traditional outlook of patients with AD. Subsequently, NSs will continue to experience only limited learning of person-centred care of patients with AD unless changes are implemented.

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Contributions

Study design: MWS, HKN, NH.

Data collection and analysis: MWS, HKN, NH.

Manuscript preparation: MWS, HKN, NH.

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Table 1. Schedule of curriculum for the participating nursing students

	Focus	**Clinical practice**	**Duration**	**Clinical site**
1. year of study	Basic nursing	Basic nursing care and skills	6 weeks	Nursing homes
2.year of study	Acute and critical illness and nursing care	Specialized nursing care and skills	Two periods of 10 weeks	Medical and surgical wards in hospitals
3. year of study	Elderly care and mental health care	Specialized nursing care and skills	Two periods of 10 weeks	Nursing homes, psychiatric institutions and/or home care

ARTIKKEL III

To what extent does the oral shift report stimulate learning among nursing students? A qualitative study.

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Abstract

Aim and objective

The aim of this study was to describe oral shift reporting and to discuss whether it stimulates learning for nursing students in clinical rotations in nursing homes. The goal was to investigate aspects that are important for oral shift report to be instructive for nursing students.

Background

Nursing students' clinical learning experiences are important components of their professional development. Oral shift reporting serves several purposes and provides an opportunity for professional communication that supports both educational and social functions for nursing students during clinical practice.

Design

A qualitative study.

Methods

The study features both field work with field notes and qualitative research interviews was conducted in 2006. Twelve third-year nursing students and their supervising nurses (n=11) participated in the study.

Results

The nursing students described a range of experiences with oral shift reports. Some perceived little educational benefit from the oral shift reports, while others felt that both the form and content of the oral shift reports were useful. The students' experiences corroborated the statements provided by the supervising nurses in the nursing homes.

Conclusions

We conclude that oral shift reporting may be an important learning opportunity. This is especially true when nursing students engage in professional discussions with their colleagues

and superiors. Our findings suggest solutions to improve the learning value of the oral shift reporting process for nursing students.

Relevance to clinical practice

Oral shift reporting can stimulate learning if it includes consultation and discussion between nursing students and the nursing staff.

Keywords

Oral shift report, handover, nursing home, older people care, nursing student, learning.

What is known about this topic

- Oral shift report can serve educational, emotional, social and organisational purposes.
- Oral shift reporting can facilitate interpersonal communication and reflection.
- Silent report has become more prevalent in nursing practice.

What this paper adds

- Oral shift reporting, including professional discussions, can help with nursing students' learning.
- Nursing student who consider the shift report to be instructive achieved better learning outcomes.
- Effective use of oral shift reporting to support learning requires systematic management and good leadership.

Implications for practice

- The content and form of oral shift report must be adjusted to educational purposes.
- Measures for oral shift reporting to be instructive must be implemented in sites for nursing students' clinical practice.
- There is need of an awareness of the oral shift report's significance as a situation for learning.

INTRODUCTION

Clinical practice is a component of nursing education that helps students to develop independent professional expertise and also promotes role socialisation (Papp *et al.* 2003, Myrick *et al.* 2006). The purpose of this hands-on component is to refine practice skills including critical thinking, clinical judgement and the use of holistic patient care. In clinical practice, each student should receive clinical teaching, supervision, support and assessment to facilitate learning (Ministry of Education and Research 2004).

Nursing students' (NSs) clinical experiences are important to their professional development. Through clinical practice in nursing homes (NHs), students prepare themselves to enter complex practice communities (Wenger 1998). Supervising professionals function as resources for the learning process and as role models in the preparation and delivery of care and socialisation (Kilcullen 2007). Clinical practice requires that students demonstrate the ability to observe, reflect, analyse and systematise from both theoretical and clinical standpoints (Ministry of Education and Research 2004). To achieve this, NSs must be allowed to participate in relevant nursing care scenarios that integrate theory and clinical practice.

The oral shift report (OSR) is an inter-shift report, also called a report handover (Eggland & Heineman 1994) that normally takes place in the morning, afternoon and evening. The purpose of the OSR is to transfer information from the outgoing staff to the incoming staff (Hays 2002). The OSR is a complex and important part of nursing practice that serves several purposes, including the provision of updated information, continuity and quality of patient care (Sherlock 1995, Meizner *et al.* 2007), as well as assignment of responsibilities and routine tasks.

Studies of OSR have primarily addressed their type, duration, content and rituals (Taylor 2002). Some studies have emphasised the complexity of OSR and recent attempts to question its role as a potential learning and teaching situation (cf. Sherlock 1995, Thurgood 1995, Payne *et al*. 2000). During the working day in NHs, NSs regularly encounter oral shift reporting. In addition to serving as instructional tools for NSs, OSR also aids the preparation and delivery of nursing care.

OSR may assist NSs with education, social interaction, emotional support and socialisation into the professional nursing role (Kerr 2002). Gundersen (1997) and Payne *et al.* (2000) reported that OSR facilitates interpersonal communication and reflection and is an important learning situation in the sense that aspects of patient care can be articulated and discussed. In addition, it helps with the transfer and exchange of knowledge.

During OSR, students' understanding and assessment of nursing care can be expanded and related to both practical and theoretical knowledge. In OSR, attitudes can be disseminated, developed and adjusted as different elements of a patient's situation are discussed. If OSR is used to its full potential, it constitutes an essential learning situation for NSs (cf. Hamran 1991) by providing person-centred perspectives (Kitwood & Bredin 1992) regarding the provision of patient care. Incorporating teaching in the OSRs can enhance their role in the NSs' learning experience. The NSs' curriculum includes learning objectives related to caring for older people, interaction between patient and nurse, problem solving, communication, documentation, management and the general organisation of nursing care (Ministry of Education and Research 2004).

Aim of the study

The aim of the study was to describe OSR and discuss whether it provides learning opportunities for nursing students undertaking clinical placements in nursing homes as part of their training.

Material and methods

A qualitative design (cf. Polit & Beck 2008) including field observations, field notes and qualitative research interviews (cf. Hammersley & Atkinson 1990) was used in this study. Field observations helped to identify practice in both a structural and a cultural context (Hammersley & Atkinson 1990, Polit & Beck 2008). Qualitative interviews provided the means to examine the subjective experiences and perceptions of individuals (Graneheim & Lundman 2004). At the end of the clinical practice, semi-structured interviews (Kvale 2001) were conducted with each participant. Relevant literature was sourced from Cinhal, ProQuest and PubMed by combining the following keywords: oral shift report, handover, nursing home, care for older people, nursing student and learning.

The contexts of the study

We focused on three NHs in Norway that are part of the municipal health care service and were founded following The Act of Health Care Services in the Municipalities (Ministry of Health and Care Services 1982). The NHs had been used as sites for clinical placements on a regular basis for several years through a mutual agreement between the university and the local municipality. The NHs included in this study are the NHs which were used for clinical practice for the participating NSs at the time of the study. The leaders of the NHs allowed the first author to be present during OSRs and make field notes.

No workload statistics were available for these NHs. Nursing staff reported that all patients needed help completing their daily activities. They estimated that 80% of the patients suffered from cognitive impairments, although not all had been diagnosed with Alzheimer' disease (AD). This is consistent with the percentage cited in a report from the Directorate for Health and Social Affairs (2007). There were no significant differences between the three NHs with respect to the staff/patient ratio (3/9). OSRs were conducted in the duty room at the NHs . They were conducted in the morning, afternoon and evening. According to the schedule, 30 minutes were allotted for OSR in the morning and in the afternoon.

Seven students (1-7) were assigned to the first NH (A) for their clinical practice; two students were stationed on each of three wards and one student was assigned to a fourth unit. On these wards, OSRs normally lasted ten minutes. Care plans were not used as a basis for the reports and the reporting nurse mostly read from a handwritten self-adhesive note or presented memorised information about elimination, sleep, rest or unrest for a small number of patients.

Two students (8 and 9) undertook their clinical practice in the second NH (B). One student (8) was stationed on a sheltered ward for patients suffering from advanced AD. In this ward, the 30 minutes allotted for OSR were fully used and extended if necessary. Reports were based on care plans that included information about the physical and psychosocial conditions of all patients. Reports from the perspective of the individual patient were also used. Another student (9) was assigned to a general ward. On this ward, the average time spent on OSR activities was ten minutes. Care plans were not used as a basis for these brief reports. Nurses simply focused on physical parameters like elimination, sleep and rest for a limited number of patients.

Three students (10, 11 and 12) were placed in the third NH (C) which was part of a healthcare centre. The institutional portion of the centre comprised an NH unit and a general practitioner hospital (GPH) unit. Oral shift reporting nominally lasted 30 minutes, but this period was extended if necessary. Care plans were used as the basis for person-centred reports. Nurses reported on both the physical and psychosocial conditions for all patients and often included statements about the responses of the patients.

Participants

We enrolled in our study all final third year NSs (n=13) in the university who undertook ten weeks of clinical practice involving care of older people. One student dropped out, leaving 12 participants. The students had previously completed six weeks of general clinical nursing practice in NHs during their first year of study. Eleven nurses who served as supervising nurses (SNs) for the NSs in one-to-one relationships also participated in our study. One SN acted as a supervisor for two students. The SNs were experienced supervisors but held no formal supervisory qualifications. They were informed in writing and in a preparatory meeting about the NSs' learning requirements. No specific supervisory guidelines were given. The SNs were expected to practice nursing care together with the NSs and to initiate counselling according to learning objectives and practical experiences. In-service training was given on a regular basis on gerontological topics. The first author had no prior relationship with the students and did not hold any professional role in the students' clinical placements.

Data collection

Data was collected in 2006. Field observations with field notes (Hammersley & Atkinson1990) focused on oral shift reports in the duty room during the NSs' ten weeks of clinical practice. The observation period was divided between the three NHs according to the

number of students at each location. The field observations of oral shift reporting were performed in the mornings and in the afternoons when NSs were present. Observations were centred on content, focus, duration and participation. The technique described by Schatzman and Strauss (1973) was used when taking field notes in the form of observational, theoretical, methodological and personal descriptions. Field notes were transcribed on a daily basis following data collection.

At the end of the clinical period, semi-structured interviews (Kvale 2001) were conducted with each participant. These interviews included questions to explore OSR as an aid to learning. An interview guide was developed with thematic questions, including OSR-relevant prompts from other research studies (Liukkonen 1992, Gundersen 1997, Payne *et al.* 2000, Kerr 2002) and from observations of the NH reporting sessions. During the interviews, the first author posted an introductory open question (cf. Kvale 1997) to the NSs and the SNs about OSR with respect to learning: 'Could you tell me about whether you consider the OSR to be helpful for teaching and learning?' The interviews lasted between 40 and 70 minutes and took place toward the end of the clinical practice period. The interviews were audio recorded and transcribed verbatim.

Data analysis

Field notes were analysed by the first author using the procedure described by Hammersley and Atkinson (1990), starting with broad descriptive categories and sorting the material in relation to content, focus, duration and OSR participation. The interviews were analysed using qualitative content analysis. The transcriptions were read and reread to grasp a thorough understanding of each individual interview. After the NS interviews, a condensation step was performed to determine units of meaning by classifying constellations of words related to the

same central themes (cf. Graneheim & Lundman 2004). Our analysis of the NS interviews served as the basis for a selective approach (cf. Polit & Beck 2008) that involved extracting the themes that were common across the SNs' statements and the phrases in the field notes.

Ethical considerations

The study was approved by the Norwegian Social Science Data Service. The heads of the NHs gave written permission for the field observations. The participants received an explanatory letter about the study and were invited to participate. Informed written consent was obtained before data collection began. Participants were assured that involvement was voluntary and that they had the right to withdraw from the study at any time without consequence or the need to state a reason. Anonymity and confidentiality were guaranteed in any publication of the results. Participants were also informed that the audio recordings and transcriptions would be destroyed on completion of the study.

RESULTS

Several intertwined factors played a role in how students perceived the OSR as a learning environment. Seven sub-themes were constructed from the NS interviews. They were abstracted and grouped under three main themes:

- the oral shift report as a context for professional discussions
- the content of oral shift reports
- the oral shift report in the context of learning

The textual findings are presented in terms of NS experiences regarding the main themes. They are illustrated with quotations from students and SNs along with field observations as reported by the first author.

The oral shift report as a context for professional discussions

The NSs saw professional discussions with staff - especially their SNs – as very helpful in stimulating learning. However, their experiences of these discussions were variable. One student (5) said: 'I wish there were more professional discussions during reports because I would learn more.' Another student (1) said: 'The routines are very entrenched here and there are few professional discussions during reporting sessions.' This statement was supported by another student (2) who told that: 'Attempts to encourage professional discussions are mostly futile.' Another student (7) said: 'If I try to raise a professional issue during reports I feel like it is normally perceived as criticism.' The NSs seemed to try to compensate for the lack of professional discussions during OSRs by engaging in similar discussions with fellow students. One student (4) stated: 'We (students) discuss our experiences, but they (the staff) are not really interested.' Other students had different experiences. One student (12) said: 'There are many good discussions during reporting sessions', while another (10) said: 'During reporting sessions all patients are discussed and this results in good, professional dialogue that helps me learn.'

In seeing OSR as an arena for professional discussions and learning, the NSs expected to be engaged in planning and assessing patient care. They thought that they would be asked about their knowledge and they expected that their comments would receive attention during OSRs. However, one student (6) said: 'During reporting sessions, the staff never ask for my point of

view.' Others had more positive experiences; one student (12) said: 'We are always being challenged and listened to during reporting sessions.'

Differences in student experiences with respect to professional discussions during OSRs were expressed by their SNs. One nurse (5) said: 'The reporting sessions could have been better.' This was substantiated by another SN (4) who stated: 'We try to address various issues, but reporting sessions are too short.' One SN (3) said: 'We should have had more discussion.' Another SN (8) said: 'In the morning report I follow up issues and relay announcements. In the afternoon we just hand over the ward as the staff is in a rush to get home.' In NH B, SN (9) said: 'I bring up different issues during reporting sessions and discussions follow from there.' One SN (11) said: 'We place an emphasis on professional discussions and we spend as long as is necessary to ensure good report quality.'

Based on the observations and field notes made by the first author, the experiences of the students and the statements from the SNs appeared to be consistent. OSR content with respect to professional discussions varied from being almost non-existent to being a significant focus of each reporting session. On the wards where professional discussions hardly ever occurred, OSRs were very brief, lasting approximately ten minutes without the use of care plans. It was clear that incoming staff on these wards rarely took notes on what was reported. Distribution of tasks was based on routines rather than care issues and was not normally discussed, unless staff shortage required specific schedule adjustments. On these wards, the NSs were silent and uninvolved during the reporting sessions.

On certain wards, the scheduled time for OSR was fully used and was sometimes extended because of discussions that required additional time. On these wards, OSRs were based on

care plans and incoming staff took notes on a sheet of paper for use during their shifts. Students took the initiative during OSRs on these wards and they were actively asked about their opinions regarding care options for specific patients. In addition, students were given opportunities to share their knowledge regarding any issues that arose. Discussions also dealt with how the NS learning objectives could best be met. In NH C, the leader was present at all daytime OSRs. During OSRs, this leader created time-outs on a regular basis when subjects suitable for critical reflection, teaching and learning were brought up.

The content of the oral shift reports

The OSR has several purposes, such as to plan care and distribute tasks to promote quality and continuity of patient care. One NS (9) said: 'Reporting periods deal with practical issues and necessary observations.' Another student (3) said: 'During reporting periods one briefly talks about any unusual patient status information and offers practical instructions, for example that incontinence diapers are being used too regularly.' Such experiences were not noted by students on other wards as one response (10) indicates: 'During reporting sessions all patients are discussed both in terms of what has happened as well as what will happen in the near future…and during reporting periods the staff encourage and remind each other of issues that are important for high quality care.'

The SNs reported experiences and perceptions regarding the content of OSRs that mostly corroborated those cited by the students they supervised. An SN (1) said: 'In reporting sessions it is a challenge…to know what to include and what to leave out.' Another SN (10) said: 'In oral shift reporting, we are strict about distinguishing between small talk and professional issues. The time for OSR is spent on issues that are of relevance for patient care.' This statement was representative of OSRs that the NSs found instructive.

The differences in the experiences of the NSs corroborate observations made by the first author. Reports on certain wards were brief, only mentioning conditions like elimination, sleep, unrest and medications among a few patients before the staff started the working day by engaging in patient care based on non-communicated reasoning and routines. Words like 'fine', 'difficult' and 'nothing unusual' were often used. This contradicted observations from NH C and from the sheltered ward in NH B where reporting sessions were often extended as necessary. Staff would discuss all of the patients, both in retrospect and in prospective care planning and also engaged in discussions of general nursing care practices. Another significant difference was that in these sites psycho-social dimensions and patient-reported issues were emphasised. Thus, the staff took into account not only the nurses' views but also the patients' perspectives. In these sites, students were engaged as active OSR participants. They were asked about care options and were encouraged to actively participate in nursing activities.

The oral shift report in the context of learning

The NSs expected that, through the clinical placement, they would become better qualified nurses and would be able to promote high quality care through planning and assessment. Consistent with their expectations, they saw the OSR as a meaningful learning situation. Regarding OSR as instructive, the following statement (4) was representative of the experiences of several students: 'Reporting at this facility does not lead to a meaningful learning experience because the reporting sessions are too brief and superficial.' The perceptions of the SNs corroborated these opinions. One SN (6) stated: 'We don't have enough time to perform thorough reporting.' This statement is consistent with the perceptions of other SNs who considered that time was a limiting factor in ensuring high-quality OSRs.

Other students experienced the opposite. For instance one NS (11) said: 'I have learned a lot from the reporting sessions', and another (8) stated: 'At this facility reporting periods are used as an opportunity for everyone to learn, not just students.' The nurses who supervised these NSs offered insights into the use of reporting sessions for teaching and learning. One SN (9) said: 'We have thorough person-centred reporting that focuses on every patient on the ward, including both their physical and their psychosocial needs. Students can learn from these discussions.' Another SN (7) said that: 'We conduct the reports even more stringently when we have students here'. This statement was elaborated when the SN added: 'They (the students) should learn from participating in the reporting sessions.'

The experiences and perceptions of the students regarding OSR learning outcomes are consistent with observations made by the first author. In NH A and in the general ward in NH B that conducted only the briefest OSRs, there were few discussions and minimal question time or critical reflection time to investigate patients or issues concerning person-centred care. The approach was more routine - and task-orientated.

On the wards where the OSRs were patient-centred, issues regarding certain conditions and prospective patient care often resulted in communication that included theoretical knowledge, assessment and shared learning to promote quality of care. On these wards, the OSR sessions included opportunities for the students to talk about their experiences and receive emotional support to improve their reactions to clinical situations. This directly facilitated the learning process.

DISCUSSION

Several studies state that shift reporting may promote learning (Sherlock 1995, Lamond 2000, Kerr 2002). NSs' perceptions of OSR as a learning situation varied in our study. Their experiences were consistent with both the statements offered by the SNs and the observations recorded in the field notes. The main themes from the NS interviews highlight the challenges associated with establishing structures and routines for instructive OSRs with professional discussions, social interaction and emotional support.

Student expectations of OSR with respect to professional discussion opportunities relate to several phenomena in nursing practice. NSs are new, temporary members of the nursing community during their clinical placements. The OSR allows students to become integral members of the nursing community. To learn from experience, students need to participate in dialogue with experienced nurses about their approaches to patient care. This helps the students develop understanding and nursing insights. Support of NSs' learning processes requires adjustments to the OSR on some of the wards in our study. Several deliberate adjustments were made in NH C and on one ward in NH B. These adjustments positively impacted NS learning outcomes and also benefited the nursing staff in general.

Some studies have shown that NSs may see caring for older people as tedious, boring and professionally unchallenging (Lovell 2006, Kloster *et al.* 2007). In caring for older people, students experience situations that can affect them emotionally such as patients suffering from AD, deviant behaviour and dying patients. This may cause the students to experience stress and anxiety (Beck 1996). Thurgood (1995) points to OSR as one means of sharing experiences to alleviate stress and anxiety.

As part of their learning process, students must be exposed to scenarios where physical, psychosocial, emotional and practical issues in nursing care are raised and discussed. Using the OSR for professional discussions is one possible approach. Task orientation in the OSR, may have consequences for student' perceptions of nursing care values. A study by Smith (1992) shows that students need appropriate guidance and support if they are to nurse flexibly and with sensitivity. The OSR offers the possibility of supporting such NS needs.

The NSs in our study expected to be given opportunities during OSR to disseminate their knowledge and points of views regarding nursing care. In addition, they saw OSRs as particularly constructive when material they had learnt was questioned. If these events are absent from clinical placements, students may develop practice routines that are never critically evaluated. Consequently, their development as critical and reflective practitioners (cf. Schön 1983) may well be impaired. In contrast, the ideal situation is one in which students experience learning and socialisation into a professional nursing role through person-centred individualised OSRs (cf. Yurkovich & Smyer 1998).

The condition of NH patients does not usually change drastically from day to day (Liukkonen 1993) and this may be one reason why OSRs on some wards tended to be brief and included only limited communication about the patients' needs. Brief OSRs may be appropriate for the regular staff as patient needs and tasks appear obvious to them. However, such brief OSRs may limit the learning possibilities for NSs. Articulation of seemingly standard knowledge and the development of mutual understanding is important for NSs since they are novices (Benner 1984) who are still in the early stages of professional development. Unarticulated knowledge may exclude students who are new and temporary members of the nursing community.

For the NHs included in this study, reliance on mutual knowledge and understanding seemed to be standard practice on those wards that featured brief and seemingly superficial communication during OSRs. Person-centred communication was instead primarily observed during spontaneous encounters while on shift. They practiced alone, therefore, students were seldom included in such communications (cf. Fagermoen & Nygård 1989).

In NH C and on the sheltered ward in NH B, students experienced and participated in OSRs that were instructive and supported the development of professional sensitivity and appropriate attitudes regarding care for older people. Oral shift reporting was conducted in a dialogue-driven manner that delivered value premises and refined the understanding and skills that are relevant to quality nursing care. In both this NH and on the sheltered ward, it was observed that staff members took notes during OSRs as 'scraps' (cf. Hardey *et al.* 2000) for use in their care for the patients.

Meizner *et al.* (2007) found that the percentage of nurses in ten European countries who reported being dissatisfied with their OSR processes ranged from 22% in England to 61% in France. In this study, the SNs on wards that conducted brief, task-orientated OSRs, stated that they saw a potential for improvement. They commented that the lack of time and the uncertainty regarding relevant OSR-content were the major reasons for unsatisfactory OSRs.

Norberg and Asplund (1987) concluded that the length of reporting on psycho-geriatric wards for patients suffering from AD varied from 5-21 minutes with a mean duration of 10 minutes. This is consistent with some of our findings in which the NSs were dissatisfied with OSR sessions that they perceived as only offering limited learning opportunities. Norberg andAsplund (1987) found that the reports focused on problems with elimination,

communication, personal hygiene and sleep. This coincides with some of the findings in our study, except for the fact that communication with the patients was rarely dealt with on those wards that relied on brief, summary reporting**.**

The traditional OSR has been criticised for being time consuming and inefficient (Bø 2007). A change from face-to-face OSR to silent reporting has been implemented in many healthcare settings in an attempt to increase efficiency (Pollitt & Bouckhaert 2000). From the perspective of OSRs as situations for NS learning, silent reporting seems disadvantageous. NSs need to learn from dialogue and critical reflection (cf. Schön 1983) with expert nurses.

On the wards where the NSs believed that OSR offered meaningful learning experiences, field observations showed that person-centred reports placed equal emphasis on physical, social and psychological aspects such as communication and the feelings expressed by patients. The OSRs on these wards included time for in-depth elaborations of the issues at hand. Because many NH patients suffer from cognitive impairments, addressing the psychosocial aspects of care can be vital. A study by Lindgren and Murhy (2002) concluded that family and staff are often concerned about socio-emotional care for NH residents.

Trustworthiness and limitations

Trustworthiness was established through method triangulation (Polit & Beck 2008) by using multiple data collection methods to investigate whether OSR sessions were instructive. The co-authors checked the reliability of the data by comparing interpretations of the data. Morse and Field (1996) wrote about possible change in behaviour when an observer is present. The first author's experience was that most participants were not influenced by the presence of the observer during oral shift reports.

The small sample and the qualitative approach in this study limit the generalisability of our findings. One must be cautious in drawing conclusions from a study conducted across only three NHs. One site was a GPH and another site a sheltered ward for patients suffering from advanced AD. These factors must also be taken into consideration. Although the study only examined the OSR practices in Norwegian nursing homes for a small number of participants over a short time period, our findings may nonetheless be applicable and relevant to other contexts involving NSs' clinical practice and learning.

Conclusions

It is broadly accepted that OSR can be a meaningful learning opportunity in clinical practice. From the findings in our study this is especially true for OSR given appropriate content, time, sufficient professional discussions and patient-centred focus. However, some of the findings from this study seem to suggest that there exists potential for improvement. Discussions of the psychosocial dimensions of patient care and physical issues must be given the necessary time in OSRs. To provide educational opportunities, oral shift reports must emphasise both retrospective and prospective issues of relevance to patient care. The use of labelling phrases (cf. Sherlock 1995) like 'fine' and 'difficult' must be avoided as should statements such as 'nothing unusual to report'. In assigning students to clinical placements, the ward leader has a special responsibility for explicitly teaching students by using examples and by contributing to the integration of theory and practice. A designated and responsible leader is therefore essential. If the NSs are to learn from OSRs, they must be engaged throughout these sessions. Uncertainty about what to include in the OSR, requires that we investigate how it can be improved to increase the instructive value for NSs.

Relevance to clinical practice

Efforts to establish a ward culture dedicated to and supportive of the quality of NS clinical learning processes, must be acknowledged and implemented in practice. Measures for conducting instructive OSRs must be implemented as part of the responsibilities in allocating clinical placements for nursing students. The change from OSR to silent reporting in nursing practice may represent the loss of a unique learning situation for NSs. The positive experiences of some of the participants in this study underline the learning advantages of oral shift reports.

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Contributions

Study design: MWS, HKN, NH.

Data collection: MWS

Data analysis: MWS, NH, HKN

Manuscript preparation: MWS, HKN, NH.

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Table 1. Participants and nursing homes included in the study.

	Ward	Students	Supervising nurses
Nursing home A	1	1,6	1,2
	2	4,7	3
	3	5	4
	4	2,3	5,6
Nursing home B	1	8	7
	2	9	8
Nursing home C	1	10,11,12	9,10,11

Table 2. Examples of the process of qualitative content analysis.

Meaning unit	Condensation	Sub-themes	Theme	Main theme
I wish there were more professional discussions during reports because I would learn more	The NS recognize professional discussions as a potential for learning	Being dissatisfied with OSR because of absence of professional discussions	Limited learning from professional discussions during OSRs	The oral shift report as a context for professional discussions
During reporting periods one briefly talks about any unusual patient status information and offers practical instructions, for example that incontinence diapers are being used too regularly	The reports as summarily	Dissatisfied with OSRs having a retrospective and practical focus	Experiences of the content in OSRs in respect of learning	The content of the OSRs
Reporting at this facility does not lead to learning experiences because the reporting sessions are too brief and superficial	Lack of learning from reports	Dissatisfaction with OSRs as a situation for learning	Experiences regarding OSRs as instructive or not	The oral shift report in the context of learning
At this facility reporting periods are used as an opportunity for everyone to learn, not just students	Reports experienced as instructive	The aspect of learning is integrated in the OSRs	OSRs function regarding common professional learning	

Table 3. Sub-themes, themes and main-themes in the qualitative content analysis.

Sub-themes	Themes	Main-themes
Being dissatisfied with ORS because of absence of professional discussions Compensate missing professional discussions with nursing staff by discussing with fellow students. Being satisfied with OSRs as instructive because they include professional discussions	Limited learning from professional discussions during OSRs	The oral shift report as a context for professional discussions
Experiences OSRs as brief and superficial Experiences of OSRs as thorough in respect of being person-centred	Experiences of the content in OSRs in respect of learning	The content of the oral shift report
Experiencing limited learning form OSRs Being satisfied with OSRs as instructive	Experiences regarding OSRs as instructive or not	The oral shift report in the context of learning

ARTIKKEL IV

Clinical learning environment and supervision: experiences of Norwegian nursing students. A questionnaire survey.

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Abstract

Clinical learning environment and supervision: experiences of Norwegian nursing students. A questionnaire survey.

Background

Nursing students' experiences of the clinical learning environment are important with respect to their perceptions of nursing and future workplaces. A validated questionnaire was used to measure experiences with clinical learning environments in a sample of Norwegian nursing students.

Objective

The aim of this study was to measure nursing students' experiences and satisfaction with their clinical learning environments. The objective was to compare the results between students with respect to clinical practice in nursing homes and those in hospital wards.

Design

A cross sectional, descriptive, correlational design.

Settings

Nursing educations departments at five university colleges in Norway.

Participants

A total of 511 nursing students completed a Norwegian version of the questionnaire, Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) evaluation scale in 2009.

Methods

The questionnaire was applied empirically to all nursing students from five non-randomly selected university colleges in Norway. Data including descriptive statistics were analysed using the Statistical Program for the Social Sciences, release 15.0. Differences across sub-groups were tested with chi-square tests for categorical variables and t-tests for continuous variables. Multiple linear regression analysis of perceptions of the ward as a good learning environment was performed controlling for age, sex, study year, supervisory conditions and institutional context.

Results

The participating nursing students with clinical placements in nursing homes assessed their clinical learning environment significantly more negatively than those with hospital placements on nearby all sub-dimensions.

Conclusions

The evidence found in this study indicates that measures should be taken to strengthen nursing homes as learning environments for nursing students. Nursing students must be assisted in discovering good clinical learning environments in nursing homes.

Key words: Nursing education, clinical learning environment, nursing student, CLES+T.

What is already known about this topic

- The clinical learning environment is a complex social entity
- The pedagogical atmosphere determines whether the environment is conducive to learning
- The supervisory relationship is an important factor in clinical learning

What this paper adds

- The Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) evaluation scale is used in a Norwegian context for the first time
- CLES +T was used to compare Norwegian nursing students' perceptions of nursing homes and hospital wards as learning environments
- Nursing students performing clinical practice in nursing homes are generally more dissatisfied with their clinical learning environment as compared to those performing clinical practice in hospital wards
- Perceptions of wards as good learning environments are affected by a stable and good relation with the supervisor and by the occurrence of spontaneous supervision

1. Introduction

Nursing students' (NSs) clinical experiences are important for their learning, professional development and preferences for future workplaces (Edwards *et al*., 2004, Myrick *et al*. 2006). Several studies show that clinical experiences have an impact on preferences regarding nursing homes (NHs) as future workplaces (Bergland & Lærum 2002, Kloster *et al.* 2007). The number of NSs interested in working with older people has declined (Herdman 2002; Lovell 2006, Kloster *et al.* 2007). It is therefore of interest to examine how nursing students experience different clinical learning environments they are assigned to as parts of the nursing education. Before this study, the Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) evaluation scale (Saarikoski *et al*. 2008) was not yet tested in Norway.

The background of this study is based on research on clinical learning and learning environment undertaken since the 1990s (Dunn &d Hansford 1997, Nolan 1998, Papp *et al*. 2003). Several research studies show that the learning environment is a significant component with respect to clinical learning and learning outcomes (Löfmark & Wikblad 2001, Spouse 2001, Andrews *et al*. 2006).

A clinical learning environment includes everything that surrounds the NS, including the clinical settings, the staff and the patients (Papp *et al*. 2003). Bergland (2001) describes a learning environment to be constituted by psychosocial, physical and organizational factors. The learning environment is furthermore described as "[…] the conditions, forces and external stimuli that affect the individual […]. We regard the environment as providing a network of forces and factors which surround, engulf, and play on the individual" (Bloom, 1964 p. 87).

In clinical placements nursing students enter new settings for learning purposes. In order to learn the students depend upon a supportive atmosphere based on psychological and pedagogical aspects (Saarikoski *et al*., 2002, Chan 2004). This includes staff – student relationships and meaningful learning situations constituting a pedagogic atmosphere (Saarikoski *et al*. 2002).

Ward managers carry many responsibilities. The main task is to assess patients' need for care. Leadership is a catalyst for transforming potential into action and reality (Pfeiffer 2002) and includes responsibilities for allocating clinical placements for nursing students (Cowie *et al*. 2008). Leadership within nursing is based upon the ability to influence the staff toward the achievement of goals through motivation and support (Bezuidenhout *et al*. 1999). Regarding the clinical learning environment the ward manager holds a pivotal role in creating a positive ward atmosphere that is conducive to learning (ibid). In general ward managers in Norway are not directly involved in clinical teaching or in the supervision of nursing students.

Good interpersonal relations, support and feedback have an impact on the clinical learning environment, and they create and maintain a positive clinical learning environment for NSs (Levett-Jones *et al*. 2008). The concept of "supervision" is used with a unifying meaning and includes different aspects of supporting NSs in their clinical learning, e.g. teaching practical skills, assessing and facilitating learning, supporting the NSs in obtaining clinical knowledge, giving feedback, facilitating the fusion of theory and practice, role modelling and engaging in critical reflection with the student (Lyth 2000, Lambert & Glacken 2005, Kilcullen 2007). Furthermore the supervisor helps students to socialise to the nursing profession. According to Löfmark & Wikblad (2001) staff nurses' negative attitudes and behaviours have impact on nursing students' learning in clinical placements.

1.1. Norwegian nursing education

Norwegian nursing education is a three-year bachelor programme covering 180 European Credit Transfer System (ECTS) points and is approved in European Community countries. The number of places for nursing students in Norway is approximately 9000 (Ministry of Education and Research 2009) including both public and private university colleges. In 2009 about 8920 nurses were expected to graduate (Ministry of Education and Research 2009). Clinical practice and theoretical study each amounts to 90 ECTS. Clinical practice consists of general nursing during the first year of study, medical and surgical nursing during the second year and community and mental health care in the third year. Through the clinical placements in the nursing education, the nursing students experience mainly acute care and long- term residential care. Acute care is chiefly characterised by a practice focusing on curing illness and saving lives so that patients become self-reliant as a result of treatment. This is in contrast to long-term residential care, where patients cannot be expected to become self-reliant. Alvsvåg (1997) has described the overall value of acute care as being based on a utilitarian perspective, and that of long-term care as being based on unconditional nursing care where measurable progress is more difficult to achieve, e.g., in patients with dementia.

In Norway, sites for nursing students' clinical placements are established through mutual agreements between university colleges and health care institutions (Ministry of Education and Research 2008). In its general plan the Ministry of Education and Research (2008) states that each student has the right to receive expert advice, supervision and support to facilitate learning. How this is arranged may vary between the different university colleges and clinical sites. The most common structure is that during clinical practice, the students receive expert advice and individualised supervision from an appointed supervisory, registered staff nurse on a daily basis.

1.2. Objective of the study

The aim of this study was to measure nursing students' experiences and satisfaction with their clinical learning environments and supervision in a Norwegian nursing education. The specific objective was:

- To compare the experiences and satisfaction between nursing students with respect to clinical practice in nursing homes and those in hospital wards.

2. Method

2.1. Design

This cross-sectional study entailed a quantitative questionnaire analysis (CLES +T) of nursing students at five university colleges in Norway selected at a non-random basis. The study was conducted in 2009.

2.2. Participants and context of study

The original data were collected from nursing students (n= 511) at two small university colleges, two middle-range university colleges and one larger university college. The deans at the university colleges allowed the study to take place by releasing the names and addresses of the nursing students. The study population consisted of all first-, second- and third- year students. The students were asked to respond to the questions according to their most recent clinical placement in their education programme at the time of the completion of the questionnaire. The sample size was based on the recommendation by Polit & Beck (2008), advocating that the number of respondents be 10 times the number of items for performing factor analysis of items.

Of a total of 1229 nursing students 511 answered the questionnaire, giving a response rate of 41.6%. The sample consists of 4.5 % of the approximately 9000 nursing students in Norway, but cannot be considered statistically representative of the study population. Our primary interest was to compare perceptions among nursing students regarding the clinical learning environments in nursing homes and hospital wards (acute care and psychiatric hospitals). From the total sample, (n= 511) 407 respondents who had clinical practice in nursing homes and hospitals (64 % of the total sample) fulfilled the selection criteria for this study. Respondents who marked their practice area as to home-based care and "other" were excluded. In this paper we present the responses from students who had their last clinical placements in institutionalised health care; nursing homes, acute care hospitals and psychiatric hospitals. Some missing data exist; therefore, the number of answers does not reach 407 for all variables. From the sample included in this paper, 146 (35.9 %) NSs had performed clinical practice in nursing homes, while 261 (64.1 %) had their clinical placements in hospitals.

Insert table 1.

2.3. The questionnaire

The questionnaire used in this study was developed by Saarikoski & Leino-Kilpi (2002) and Saarikoski *et al*. (2005, 2008) from a literature review covering the 1980s (Fretwell 1980, 1983, Ogier 1981, Sellek 1982) and 1990s (Wilson-Barnett *et al*., 1995, Levec & Jones 1996). The use of the questionnaire was approved by Saarikoski. The questionnaire consists of background variables (10 items). Furthermore the questionnaire (CLES+T) consists of 34 statements regarding three subject areas: 1 Clinical Learning Environment: *pedagogical atmosphere* (nine items): *leadership style of the ward manager* (WM) (four items) and

nursing care on the ward (four items), 2 Supervision: *the content of supervisory relationship* (eight items) and 3 Role of the Nurse Teacher: *enabling of the integration of theory and practice by the nurse teacher* (three items), *cooperation between clinical placement and nurse teacher* (three items) and *relationship among student, mentor and nurse teacher* (three items). This last sub-dimension is not included in this paper, as it will be presented in a separate paper. The respondents answered the statements using a five-step Likert type scale with the following alternatives: (1) fully disagree; (2) disagree to some extent; (3) neither agree nor disagree; (4) agree to some extent and (5) fully agree. The questionnaire also contains background variables for the professional title of the supervisor, types of supervisors and occurrence of supervision.

The original questionnaire (CLES+T) in English was translated into Norwegian and blindly back-translated by two bi-lingual independent translators using the procedure described by Polit & Beck (2008). As there were no words with specific cultural bearing in the original questionnaire, the translation was centred with loyalty to the original scale items (CLES+T). Before finalising the Norwegian version of the questionnaire, a panel of university teachers evaluated the translated version. Finally a pilot study was conducted among 14 health care profession students at a university college in order to pre-test the questionnaire before the major study. The pre-test resulted in minor revisions and refinements. The factor analysis of items differed somewhat from the original structure found by Saarikoski *et al*. (2008) as three of the items originally contributing to "*pedagogical atmosphere*" loaded on the sub-dimension "*nursing care on the ward*". The results in the present paper are presented according to this new factor structure resulting in renaming of the sub-dimension "*nursing care on the* ward" as "*nursing care and learning situations on the ward*".

2.4. Procedure

The participants received an information sheet and the questionnaire with a stamped reply envelope. When the deadline had expired a reminder was sent to non-respondents.

2.5. Analysis

The statistical analyses were carried out using the Statistical Program for the Social Sciences (SPSS) for Windows, standard version: release 15.0. For the comparison between types of institutions statements on single items were recoded with the response categories "fully agree" and "disagree to some extent" (=1), "neither agree nor disagree" (=2) and "agree to some extent" and "fully agree" (=3), and differences were tested across sub-groups by applying chi-square tests. The average sum-scores for the sub-scales were compared between institution types using independent samples t-tests. A multiple linear regression analysis was performed for the single item "*The ward can be regarded as a good learning environment*" as the dependent variable controlling for age, sex, study year, supervisory relationship, spontaneous supervision and institutional context. The statistical significance level for all tests was 5%.

2.6. Ethical considerations

The study was approved by the Norwegian Social Science Data Services. The principals at the university colleges received a letter that described the study with a request of a list with the names and addresses of the students. They were informed that no details referring to university colleges or clinical sites would become public. The participants were informed about the purpose of the study. Their informed consent was given by completing and returning the questionnaire. Confidentiality and anonymity were guaranteed.

3. Results

Nursing students' perceptions of the clinical learning environment

The students evaluated their perceptions of their clinical learning environment according to the sub-dimension*s "pedagogical atmosphere", "leadership style of the ward manager (*WM*)*", "*nursing care on the ward*" and "*the content of supervisory relationship*". The results on the sub-dimensions are presented according to the responses "agree to some extent" or "fully agree" (Table 2). Overall students in nursing homes evaluated their learning environments more negatively than those in the hospital group on most items (Table 2).

For the sub-dimension "*pedagogical atmosphere*", differences on three out of six items proved statistically significant with more positive evaluations for NSs with placements in hospitals as compared to those with nursing home placements (Table 2). On the item concerning "*The staff learned to know the student by their personal name*", the experiences from nursing homes had a higher positive score than those from hospital placements with statistical significance.

Evaluation in favour of the hospital setting was found regarding the sub-dimension "*leadership style of the ward manager*" (Table 2). There were significantly more positive results in hospitals regarding whether the ward manager viewed the staff on the ward as a key resource and whether the ward manager was regarded as a team member. For the items concerning feedback from the ward manager as a learning situation and appreciation of employees' individual efforts, the differences between the two groups proved to be non-significant.

Regarding the new sub-dimension "*nursing care and learning situations on the ward*" all items proved statistically significant in favour of hospital placements. The strongest differences were found regarding documentation of nursing, meaningful and multidimensional learning situations and perceptions of the ward as a good learning environment.

The single item "*the ward can be regarded as a good learning environment*" proved strongly statistically significant with p-value = .000 (Table 2), with nursing homes showing a more negative score compared to hospital wards.

The sub-dimension "*the content of the supervisory relationship*" consisted of eight items related to pedagogical and psychological aspects of the supervisory relationship (Table 2). Overall the students in hospital placements were more satisfied with their supervisory relationships compared with students in nursing homes. Of the eight items, five proved statistically significant. Students referring to nursing home placements were least satisfied with the experience of receiving individual supervision, the continuity of feedback and supervision that promoted learning.

Insert table 2

Total scores favoured hospital wards in the areas of nursing care and learning situations on the wards and for supervisory relationships.

Insert table 3.

In the linear regression analysis, a good relationship with one supervisor, the occurrence of spontaneous supervision and clinical placement in hospitals as opposed to nursing homes, significantly predicted scores on the item "*the ward can be regarded as a good learning environment*".

Insert table 4

Discussion

The outcomes of this study indicate that the participating nursing students whose clinical placements were in nursing homes (n= 146) assessed their clinical learning environment more negatively than those (n= 261) with hospital placements. We have not found any Norwegian or international quantitative studies comparing the clinical learning environment in nursing homes with that in hospital settings. Several qualitative studies (Happel 1999, 2002, Herdman 2000; Kloster *et al*. 2007) indicate that nursing students hold a negative view of the clientele in nursing homes, the working environment, negative feedback, previous personal experiences in this area and the lack of professional challenges in this line of work. The experience of a negative working environment will result in nursing students finding care for older people unsatisfactory. Ageism exists in modern society (Herdman 2000, de la Rue 2002) and work in aged-care institutions is one of the lowest rated preferences for future work among nursing students (McKinlay & Cowan 2003, Kloster *et al*. 2007). This may be based on several conditions. One interpretation may be that nursing students are influenced by myths and stereotypes about ageing (Hweidi & Al Obeisat 2006). Perceptions of care for older people as having a low status and older people as economic burdens on society may also have an impact (Lovell 2006). Another interpretation may be that nursing students regard the scientific nursing tradition with observable and useful outcomes (Stevens & Crouch 1998) as being

more interesting than nursing care-based values which are not measurable to the same degree and mainly focus on psycho-social life conditions (cf. Alvsvåg 1997) and the patients' feeling of home (de Veer & Kerkstra 2001). This has been described as the cure-care dichotomy (Stevens & Crouch 1995) resulting in nursing students preferring to work in acute health care settings involving curing illness and saving lives.

A Norwegian study (Espeland & Indrehus 2003) showed that Norwegian nursing students were generally satisfied with the clinical practice as part of their nursing education as compared to nursing theory instruction. This supports the importance of investigating nursing students' perceptions of and experiences with their clinical learning environments. From such knowledge proper actions can be implemented in order to strengthen nursing homes as learning environments. This may increase the recruitment of graduated nurses to this field of work (Kirkevold & Kårikstad 1999) as clinical experiences are found to have impact on future choice of workplace (Edwards *et al*. 2004).

In the questionnaire the sub-dimension "*pedagogical atmosphere*" included items concerning psychological and learning aspects. There were differences among the two groups in favour of the nursing home group regarding "*the staff learned to know the student by their personal name*". The majority nursing home students reported that staff learned to know the students by name, with a lower result among students in hospital settings. This indicates that the students to some degree experienced a positive psychosocial atmosphere where they were known to staff by their names. One way of interpreting this can be that hospital wards normally are larger than nursing homes, with more staff, patients and higher turnover (Norwegian Directorate for Health 2008). Such conditions may make it difficult for hospital staff to remember the names of new, temporary members of the practice community. From

scores on other items though, this is not sufficient for the environment to be perceived as instructive.

Students in nursing homes found it less easy to approach the staff as compared to students in hospital placements. This may be caused by the fact that nursing homes in Norway are often lower staffed than hospitals, perhaps resulting in nursing students feeling that they were a disturbance when and if approaching nurses. In Norway there is a lack of nurses in nursing homes (Dolonen 2009) and the number of nurses as part of the total staff is lower than in hospitals.

The item dealing with the atmosphere on the ward showed statistically significant variation between the two groups of students with a lower percentage finding a positive atmosphere in nursing homes than in hospitals. Whether the atmosphere in a clinical placement is perceived as positive or not depends upon several interwoven factors. Whether the students feel welcomed will have an impact on how they experience the atmosphere in the ward. An unwelcoming environment will not support learning and will make the students focus on being accepted rather than on learning (Ranse & Grealish 2007). Clinical practice as a potentially stressful experience was noted in a study by Elliott (2002) and Chan (2004) that focused on the relationship between student learning in clinical placement and the social climate in the learning environment.

Another important factor deals with how nursing students experience that they are being supported in their learning process (Robinson *et al*. 2007). There is a global focus on shortage of nurses (Oulton 2006) and the lack of nurses who wish to work in nursing homes (Kirkevold & Kårikstad 1999, Lovell 2006). In Norway, only half of the staff at nursing homes are

registered nurses, and care provided by auxiliary nurses and unlicensed nursing assistants has increased proportionally (Dolonen 2009). These conditions raise both capacity and professional competence issues regarding the possibilities of creating a positive atmosphere for nursing students entering nursing homes for educational purposes. Capacity issues will affect the integration of the students into the professional nursing community. The lack of nurses will affect clinical teaching and learning outcomes for the nursing students.

No studies focusing on differences in interest for the supervision of nursing students in nursing homes and hospitals have been found. In this study, students reporting from hospital wards experienced a stronger interest in student supervision than the respondents from nursing homes. The difference was highly statistically significant (p-value = .002). Staff nurses' experiences of workload in nursing homes may be part of the reason why nursing home staff showed less interest for supervision than staff nurses in hospitals. This may be caused by the fact that nursing staffing is lower in nursing homes than in hospital settings (Dolonen 2009). Negative attitudes towards aged care will negatively impact nurses working within this field (cf. Happel 2002) and hence affect the efforts to provide nursing students with professionally confident supervision during clinical practice. It will also be easier for clinical settings with sufficient nursing staff to free nurses to participate in supervision training courses. Preparation for supporting and supervising nursing students will make nurses more confident with their role in facilitating learning in clinical placements (Landmark et al., 2003) and contribute to nursing students' experiences of the clinical learning environment (Clarke *et al*. 2003).

For the two items concerning meaningful learning situations and multi-dimensional learning situations there were highly significant differences in favour of the hospital group (Table 2).

This is in agreement with findings in other studies (Happel 1999, 2002, Fagerberg *et al*. 2000; Kloster *et al.* 2007) showing that nursing students experience caring for older people as unchallenging, custodial and having a heavy workload, while nursing and nursing activities in hospitals are found more interesting, to have high status and high variety (Herdman 2002) and to be more in line with what they had learned in college (Fagerberg *et al*. 2000). Students also tend to perceive care in nursing homes as being routinised (Lumley *et al*. 2000).

Students in nursing home placements evaluated the item "*the ward can be regarded as a good learning environment*" more negatively than those in hospital settings with high statistical significance. Many factors impact on how the learning environment is perceived. Supportive relationships are important, as is how the students experience the learning situations that they are exposed to in terms of meaning and content. Nursing students undergoing clinical practice in nursing homes must be helped and supported in viewing gerontological nursing as not being unchallenging, repetitious or boring (cf. Happel 2002, Brown *et al*. 2008); this may allow them to perceive nursing homes as good learning environments.

The sub-dimension "*leadership style of the ward manager (WM)*" consisted of four items. There were differences between the two samples on all items and the differences regarding "*the* WM *regarded the staff on her/his ward as a key resource*" and "*the WM was a team member*" was statistically significant. Overall this sub-dimension was not identified as being very visible in this study. This might be because in both in Norwegian nursing homes and Norwegian hospitals, the WM normally does not have supervisory responsibilities with regard to nursing students. Still, the WM was shown to have an impact on the learning environment in a study by Bezuidenhout *et al*. (1999); this role consists of welcoming the students, giving

them sufficient orientation and promoting motivation in the staff for the inclusion and involvement of the students in the ward.

The quality of nursing care was identified in the sub-dimension "*nursing care and learning situations on the ward*". All items were statistically significant showing that students performing clinical practice in hospital settings experienced a clearer defined nursing philosophy and that patients received individual patient care, an unproblematic information flow and clear documentation of nursing. The largest variation was in connection with the item about documentation. More students in nursing homes reported dissatisfaction with nursing care documentation as compared to students referring to experiences with hospital placements ($p = .000$). Shift reporting as part of nursing care documentation is one of the situations nursing students regularly encounter when undergoing clinical practice. For nursing students oral shift reporting may assist with education, social interaction, emotional support and socialisation into the professional nursing role (Kerr 2002). These factors will influence the students' perceptions of the clinical learning environment, as several studies have shown that thorough and patient-centred shift reporting may promote learning (Sherlock 1995, Lamond 2000, Kerr 2002). Normally the condition of patients in nursing homes does not change drastically from day to day, resulting in task-orientated documentation (Liukkonen 1993). This may be a reason why students in the nursing home group reported having unclear nursing documentation and a lack of nursing plans and recordings of procedures.

From the results in this study the supervisory relationship is important. This corroborates with other studies showing that the supervisory relationship is an important factor for nursing students while undergoing clinical practice (Lloyd Jones *et al.* 2001, Vallant & Neville 2006, Zilembo & Monterosso 2008). The participating students were overall supervised by staff

nurses who were appointed for individualised supervision. There existed differences between the two groups of students in all items concerning the supervisory relationship, with more negative results for students in nursing homes. The experiences concerning mutual respect and approval and a supervisory relationship characterised by a sense of trust varied between the two groups, but was without statistically significance (Table 2). On the other items, students from nursing homes showed significantly lower scores than students in hospital wards for their experience of the supervisory relationship. This implies that students who had clinical practice in nursing homes, experienced less individual supervision than those reporting from hospital settings, and that they were less satisfied with the supervision they received. Taking into consideration the importance that clinical experience has for socialisation to and perceptions of the nursing profession, it is notable that only half of the students in nursing homes "agreed to some extent" or "fully agreed" that they continuously received feedback from their supervisor and also that they were less satisfied with the promotion of learning by supervision.

The results are interpreted in light of the limitations connected to cross-sectional study design and self-reporting on variables. Generalisations cannot be made because this is a convenience sample and had a low response rate. However, we find that the study offers valuable insights into nursing students' experiences of supervision in nursing homes and hospital wards as learning environments and in a Norwegian context. The validity of the study is strengthened by comparing institutional placements in order to provide comparable contexts for the use of the instrument.

Conclusions

The results of this study reveal that there are challenges for practitioners and educators in achieving positive clinical learning environments in nursing homes. However, it is important to note that the data from this survey were statistically analysed by measuring the results according to the alternatives "*agree to some extent*" and "*fully agree*" on the Likert scale. This indicates that even if Norwegian nursing students are more dissatisfied with nursing homes than hospitals as learning environments, the overall results suggest that the majority are satisfied. The results suggest a potential for the improvement of nursing homes as learning environments.

There are few Norwegian studies giving data on Norwegian nursing students' experiences and perceptions of their clinical learning environment except those referring to preferences for future workplace (Bergland & Lærum 2002, Kloster *et al.* 2007). The findings in this study confirm the importance of a pedagogical atmosphere characterised by positive engagement and supervision in a supportive and trusting atmosphere (Chan 2004, Saarikoski *et al*. 2005). Nursing students are eager to learn and to practice theory obtained at school (Ranse & Grealish 2007). In order to recruit graduated nurses to work in nursing homes, it is necessary that nursing students experience positive clinical learning environments characterised by a pedagogic atmosphere conducive to teaching and learning with a clear nursing philosophy and systematic individual supervision in a one-to-one relationship.

Relevance to clinical practice

In order to support recruitment of nurses to nursing homes it is of importance to examine factors influencing the clinical learning environments nursing students participate in during their nursing education. The CLES+ T instrument has proven to be an adequate data

collection tool across both groups, but in order to obtain a representative selection the study must be repeated in institutional contexts more similar to those in studies conducted by Saarikoski *et al*. (2002, 2005, 2007, 2008) and to a representative sample.

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Contributions

Study design: MWS, NH, HKN.

Data collection: MWS.

Data analysis: MWS, NH, HKN.

Manuscript preparation: MWS, NH, HKN.

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Table 1 Demographic characteristics, practice sites and supervision conditions of nursing students (n=407)[7]. Per cent unless otherwise indicated.

Age (years, mean, SD)

Total	27.4 (7.9)
Female	27.1 (7.7)
Male	29.6 (9.3)

Study year

First	24.7
Second	42.4
Third	32.9

Practice site

Nursing home	35.9
Acute care hospital	44.0
Psychiatric hospital	20.1

Supervisor title

Nurse	79.8
Specialist nurse	19.4
Ward manager	0.8

Organization of supervision

No supervisor appointed	0.5
One supervisor, strained relation	10.4
Changed supervisor	4.4
Situational supervisor	10.1
Group supervision	6.5
One supervisor, good relation	68.1

Spontaneous supervision

Never	8.9
1-2 times	21.8
< Weekly	14.9
Weekly	17.8
> Weekly	36.6

[7] N may vary slightly due to differing missing rates

Table 2 Per cent reporting "agree to some extent " or "fully agree" to statements regarding aspects of learning environment quality in nursing homes and other practice sites (acute care hospitals, psychiatric institutions) for student nurses (n=407)[8].

	Nursing homes	**Other sites**	**χ2**	**p-value**
(n)	(146)	(261)		
Learning environment				
- *Pedagogical atmosphere*				
The staffs were easy to approach	77.4	86.2	9.49	.009
I felt comfortable going to the ward at the start of my shift	72.6	77.8	1.47	.480
During staff meetings (e.g. before shifts) I felt comfortable taking part in the discussions	50.7	49.2	0.12	.941
There was a positive atmosphere on the ward	66.2	78.1	7.12	.028
The staffs were generally interested in student supervision	47.9	62.5	12.94	.002
The staff learned to know the student by their personal name	78.1	65.1	8.09	.018
- *Leadership style of the ward manager (WM)*				
The WM regarded the staff on her/his ward as a key resource	64.1	76.6	8.63	.013
The WM was a team member	52.7	65.9	7.49	.024
Feedback from the WM could easily be regarded as a learning situation	38.0	45.0	2.52	.284
The effort of individual employees was appreciated	57.3	68.3	5.57	.062
- *Nursing care and learning situations on the ward*				
The wards nursing philosophy was clearly defined	45.4	58.7	9.50	.009
Patients received individual nursing care	74.3	85.4	8.82	.012
There were no problems in the information flow related to patient's care	52.1	65.5	7.08	.029
Documentation of nursing (e.g. nursing plans, recording of nursing procedures etc) was clear	57.9	74.9	19.1	.000
There were sufficient meaningful learning situations on the ward	51.4	74.9	28.6	.000
The learning situations were multi-dimensional in terms of content	42.1	69.4	29.6	.000
The ward can be regarded as a good learning environment	57.6	76.8	17.0	.000

[8] n may vary slightly due to differing missing rates for single items

- *The content of the supervisory relationship*				
My supervisor showed a positive attitude towards supervision	74.5	83.5	5.13	.077
I felt that I received individual supervision	62.3	81.2	17.4	.000
I continuously received feedback from my supervisor	50.7	66.3	11.6	.003
Overall I am satisfied with the supervision I received	64.1	76.5	8.72	.013
The supervision was based on a relationship of equality and promoted my learning	64.4	75.4	9.99	.007
There was a mutual interaction in the supervisory relationship	64.1	77.2	8.66	.013
Mutual respect and approval prevailed in the supervisory relationship	77.4	85.4	4.31	.116
The supervisory relationship was characterized by a sense of trust	75.9	83.1	3.17	.205

Table 3 Student nurses' evaluation on CLES sub-scales in nursing homes and other practice sites (acute care hospitals, psychiatric institutions)

	Nursing homes	Other sites	Total
(n)[9]	(141)	(255)	(396)
p-value	M (SD)	M (SD)	M (SD)
Pedagogical atmosphere on the ward .146	3.73 (0.92)	3.87 (0.82)	3.82 (0,86)
Leadership style of the WM .099	3.55 (0.95)	3.71 (0.97)	3,72 (0.96)
Premises of nursing and learning situations on the ward .000	3.51 (0.85)	3.94 (0.70)	3.79 (0.78)
Supervisory relationship .000	3.80 (1.14)	4.18 (0.96)	4.04 (1.04)

[9] n may vary slightly due to differing missing rates for single items

Table 4 Multiple linear regression analysis of "The ward can be regarded as a good learning environment" (1=fully disagree, 5=fully agree) among student nurses (n=368)

	B	SE B	t	p-value
One supervisor, good relation (1,2)	0.67	0.12	5.19	.000
Spontaneous supervision (1,5)	0.23	0.04	5.35	.000
Practice in hospital vs. nursing home (1,2)	-0.42	0.13	-3.01	.002

R^2 = .23

Excluded variables: Age, sex, study year

APPENDIX

Vedlegg 1.

INFORMASJON TIL SYKEPLEIERSTUDENTER

Undertegnede er prosjektleder for et forskningsprosjekt med arbeidstittelen:

Læringsmiljø i sykehjem.

Hensikten med forskningsprosjektet er å studere læringsmiljø, læringsprosess og faglig utbytte hos sykepleierstudenter som gjennomfører praksisstudier i eldreomsorg i sykehjem.

Jeg ber med dette om din medvirkning i prosjektet ved at du gir ditt skriftlige samtykke til at jeg gjennomfører observasjoner i situasjoner som inkluderer samhandlings- og veiledningssituasjoner med kontaktsykepleier i løpet av praksisperioden i eldreomsorg. I forlengelsen av observasjoner ønsker jeg å gjennomføre et kvalitativt forskningsintervju med deg. For å kunne arbeide grundig med innholdet i intervjuet, ber jeg om tillatelse til å ta samtalen opp på lydbånd. Båndet vil bli oppbevart i låst skuff, og kun jeg selv og mine veiledere har mulighet til å høre på båndet. Utskrift av intervjuet vil bli behandlet på samme måte.

Alle data som samles inn vil bli anonymisert. Dette innebærer at når jeg bearbeider det innsamlede materialet, vil jeg ikke benytte navnet ditt. Når forskningsprosjektet er fullført, vil alle dokumenter og lydbånd bli makulert. Resultatene fra forskningsprosjektet vil bli presentert på en slik måte at ingen enkeltpersoner kan bli gjenkjent.

Observasjonene vil fortrinnsvis skje på dagvakter. Jeg vil utarbeide en nærmere plan for min tilstedeværelse i løpet av den aktuelle praksisperioden. Intervju/samtale planlegges gjennomført i samarbeid med deg med hensyn til tidspunkt.

Gjennomføringen av studien er tilrådd av personvernombudet for forskning, Norsk Samfunnsvitenskapelig Datatjeneste og Institutt for klinisk medisin, Universitetet i Tromsø.

Hvis du samtykker i at observasjon og intervju/samtale kan gjennomføres med deg, ber jeg om at dette bekreftes skriftlig på vedlegg i dette brevet. Om du ikke ønsker å gi et slikt samtykke har det ingen negative konsekvenser for deg. Dersom du sier ja, kan du likevel trekke deg ut av prosjektet når du måtte ønske det frem til prosjektperiodens slutt uten at det på noen måte vil få negative konsekvenser for deg.

Deltakelse i prosjektet vil forhåpentligvis kunne gi ny og nyttig kunnskap som vil komme sykepleierstudenter og ansatte i praksisfeltet til gode.

Medarbeidere i prosjektet er førsteamanuensis Nils Henriksen og førsteamanuensis Ketil Normann, Avdeling for sykepleie og helsefag, Institutt forklinisk medisin, Universitetet i Tromsø.

Dersom du har spørsmål, kontakt da undertegnede på telefon:

Arbeid: **77 64 54 63**
Privat: **77 65 79 98**

Hvis du sier ja til å delta i prosjektet, vil jeg be deg returnere nedenforstående svarslipp.

Med hilsen

Avdeling for sykepleie og helsefag

Mari Wolff Skaalvik
Stipendiat

Klipp av svarslippene og returner den til:

Mari Wolff Skaalvik
Avdeling for sykepleie og helsefag
Institutt for klinisk medisin
Universitetet i Tromsø
N-9037 Tromsø

SVARSLIPP

Erklæring om samtykke for deltakelse i forskningsprosjekt

Undertegnede bekrefter med dette at jeg sier ja til å delta i forskningsprosjektet: Læringsmiljø i sykehjem. En studie av læringsprosess og faglig utbytte hos sykepleierstudenter som gjennomfører praksisstudier i eldreomsorg ved et sykehjem." Jeg er gjort kjent med innholdet i prosjektet samt at jeg kan trekke meg fra prosjektet på hvilket som helst tidspunkt uten at det får negative konsekvenser for meg.

…… …….

Sted/dato Tittel og signatur

Vedlegg 2

INFORMASJON TIL SYKEPLEIERE

Undertegnede er prosjektleder for et forskningsprosjekt med arbeidstittelen:

Læringsmiljø i sykehjem. En studie av læringsprosess og faglig utbytte hos sykepleierstudenter som gjennomfører praksisstudier i eldreomsorg i sykehjem.

Hensikten med forskningsprosjektet er å studere læringsmiljø, læringsprosess og faglig utbytte hos sykepleierstudenter som gjennomfører praksisstudier i eldreomsorg i sykehjem.

Jeg ber med dette om din medvirkning i prosjektet ved at du gir ditt skriftlige samtykke til at jeg gjennomfører observasjoner i situasjoner som inkluderer samhandlings- og veiledningssituasjoner med student i løpet av praksisperioden i eldreomsorg. I forlengelsen av observasjoner ønsker jeg å gjennomføre et kvalitativt forskningsintervju med deg. For å kunne arbeide grundig med innholdet i intervjuet, ber jeg om tillatelse til å ta samtalen opp på lydbånd. Båndet vil bli oppbevart i låst skuff, og kun jeg selv og mine veiledere har mulighet til å høre på båndet. Utskrift av intervjuet vil bli behandlet på samme måte.

Alle data som samles inn vil bli anonymisert. Dette innebærer at når jeg bearbeider det innsamlede materialet, vil jeg ikke benytte navnet ditt. Når forskningsprosjektet er fullført, vil alle dokumenter og lydbånd bli makulert. Resultatene fra forskningsprosjektet vil bli presentert på en slik måte at ingen enkeltpersoner kan bli gjenkjent.

Observasjonene vil fortrinnsvis skje på dagvakter. Jeg vil utarbeide en nærmere plan for min tilstedeværelse i løpet av den aktuelle praksisperioden. Intervju/samtale planlegges gjennomført i samarbeid med deg med hensyn til tidspunkt.

Gjennomføringen av studien er tilrådd av personvernombudet for forskning, Norsk Samfunnsvitenskapelig Datatjeneste og Institutt for klinisk medisin, Universitetet i Tromsø.

Hvis du samtykker i at observasjon og intervju/samtale kan gjennomføres med deg, ber jeg om at dette bekreftes skriftlig på vedlegg i dette brevet. Om du ikke ønsker å gi et slikt samtykke har det ingen negative konsekvenser for deg. Dersom du sier ja, kan du likevel trekke deg ut av prosjektet når du måtte ønske det frem til prosjektperiodens slutt uten at det på noen måte vil få negative konsekvenser for deg.

Deltakelse i prosjektet vil forhåpentligvis kunne gi ny og nyttig kunnskap som vil komme ansatte i praksisfeltet sykepleierstudenter til gode.

Medarbeidere i prosjektet er førsteamanuensis Nils Henriksen og førsteamanuensis Ketil Normann, Avdeling for sykepleie og helsefag, Institutt forklinisk medisin, Universitetet i Tromsø.

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SVARSLIPP

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Undertegnede bekrefter med dette at jeg sier ja til å delta i forskningsprosjektet: Læringsmiljø i sykehjem. En studie av læringsprosess og faglig utbytte hos sykepleierstudenter som gjennomfører praksisstudier i eldreomsorg ved et sykehjem." Jeg er gjort kjent med innholdet i prosjektet samt at jeg kan trekke meg fra prosjektet på hvilket som helst tidspunkt uten at det får negative konsekvenser for meg.

…… …….

Sted/dato Tittel og signatur

Vedlegg 3

STUDENTUNDERSØKELSE OM LÆRINGSMILJØ I PRAKSIS

Kjære sykepleierstudent.

Vedlagte spørreskjema inngår som en del av mitt doktorgradsarbeid ved Avdeling for sykepleie og helsefag, Institutt for klinisk medisin, Universitetet i Tromsø. I doktorgradsarbeidet gjennomfører jeg en studie knyttet til sykepleierstudenters erfaringer og oppfatninger om klinisk læringsmiljø.

Jeg har fått opplysninger om ditt navn og din adresse fra høgskolen du studerer ved.

Deltakelse i spørreskjemaundersøkelsen er frivillig.

Det opplyses for hvert tema i spørreskjemaet hvordan du skal angi ditt svar.

Besvar spørsmålene med utgangspunkt i din sist gjennomførte praksisperiode. Det er viktig at du besvarer alle spørsmålene så ærlig som mulig. Hvis du er i tvil om hva du skal svare på et eller flere spørsmål ber jeg deg likevel svare. Velg da det svaralternativet du opplever som mest riktig for deg. Resultatene av spørreskjemaundersøkelsen vil bli bruk til forskning og inngå i min doktorgradsavhandling.

Spørreskjemaet er merket med en koplingsnøkkel. Denne vil bli slettet etter at det er gjennomført purring for ubesvarte spørreskjema. Opplysningene som samles inn vil bli behandlet konfidensielt.

Dersom du på det tidspunkt du mottar spørreskjemaet ikke har gjennomført praksisstudier som en del av sykepleierutdanningen, ber jeg om at du fyller ut svarslippen du finner nederst på arket og returnerer den i vedlagte frankerte svarkonvolutt. **Svarfrist 15 mai 2009.**

Det tar ca 15 minutter å svare på spørreskjemaet som returneres til undertegnede i vedlagte ferdig frankerte svarkonvolutt.

Prosjektet er meldt til personvernombudet for forskning; Norsk samfunnsvitenskapelig datatjeneste AS Personvernombud for forskning.

Takk for at du bidrar til gjennomføringen av studien.

Med vennlig hilsen

Mari Wolff Skaalvik
Stipendiat

Avdeling for sykepleie og helsefag
Institutt for klinisk medisin
Universitetet i Tromsø
N-9037 Tromsø

Telefon: 77 64 48 82

Svarslipp:

Spørreskjemanummer:
Jeg har ikke gjennomført praksisstudier på det nåværende tidspunkt: Sett kryss

Vedlegg 4

Intervjuguide sykepleierstudenter

- Innledende ord om prosjektet og intensjon med intervjuet
- Bakgrunnsdata: navn, alder, praksiserfaring (før og under utdanning, fra sykehjem, omfang)
- Tanker om eldreomsorg som fagfelt
- Motivasjon for praksis i sykehjem
- Forventninger til praksisperioden
- Opplevelse av mottakelse og forberedthet i sykehjemmet ved praksisperiodens begynnelse
- Opplevelse av læringsmiljøet i sykehjemmet/avdelingen
- Om bruk av målsetting for praksisperioden
- Om veiledning ut fra behov/ønsker
- Om forholdet mellom hjelp, støtte og veiledning i utøvelse av sykepleie
- Om relasjonen til kontaktsykepleier
- Om refleksjon sammen med kontaktsykepleier
- Om faglige diskusjoner
- Om integrering av teori og praksis
- Om tilbakemelding underveis
- Eksempler på konkrete læringssituasjoner som oppleves som gode
- Andre forhold knyttet til læringsmiljøet

Vedlegg 5

Intervjuguide kontaktsykepleiere

- Innledende ord om prosjektet og hensikten med intervjuet
- Bakgrunnsdata: navn, alder, erfaring som sykepleier, erfaring fra sykehjem(et), erfaring med veiledning av sykepleierstudenter, eventuelle etter/videreutdanning, eventuelle deltakelse i fagutviklingsprosjekter.
- Synspunkter/erfaringer med læringsmiljøet i sykehjemmet/avdelingen
- Eventuelle opplæring/kurs i veiledning
- Tanker om innholdet i veilederrollen
- Opplevelse av å være kontaktsykepleier
- Eventuelle forberedelser til å være kontaktsykepleier
- Erfaringer med studentenes motivasjon for praksis i sykehjem
- Tanker om hva det er viktig at studentene lærer i denne praksisperioden
- Om bruk av studentenes målsetting i tilrettelegging og veiledning
- Opplevelse av forholdet pasientomsorg og studentveiledning
- Tanker om spesielle situasjoner for læring
- Oppfatninger om studentenes faglige utbytte av praksisperioden
- Andre forhold knyttet til læringsmiljøet i sykehjemmet/avdelingen

Vedlegg 6

KLINISK LÆREMILJØ,VEILEDNING OG SYKEPLEIELÆRER

1651

(CLES+T) evalueringsskala

BAKGRUNNSDATA

Kjønn: ☐ Kvinne ☐ Mann

Alder ☐☐

Nåværende utdanningsår..... 1 2 3

Nåværende utdanningssemester..... 1 2 3 4 5 6

Sett ring rundt ditt svar

I hvilken helseinstitusjon gjennomførte du din siste kliniske praksis: *Sett kryss ved ditt svar*

☐ Sykehjem

☐ Somatisk sykehus

☐ Psykiatrisk institusjon

☐ Hjemmetjeneste

☐ Annet: *(skriv inn ditt svar)*.....

Praksisperiodens varighet: ☐☐ uker

De følgende utsagnene angående læringsmiljøet, veiledningen og sykepleielærerens rolle i praksis er delt inn i hovedområder, hvert med sin egen overskrift.

LÆRINGSMILJØ

For hvert utsagn, vennligst velg det alternativet som best beskriver din egen oppfatning ved å sette ring rundt ditt svar.

Evalueringsskala:
1= helt uenig
2= delvis uenig
3= verken enig eller uenig
4= delvis enig
5= helt enig

Pedagogisk atmosfære:

Det var lett å ta kontakt med personalet	1	2	3	4	5
Jeg følte meg vel med å gå til avdelingen ved begynnelsen av vaktene	1	2	3	4	5
Jeg følte meg vel med å delta i diskusjoner på møter (f.eks før vaktskifte)	1	2	3	4	5
Det var en positiv atmosfære på avdelingen	1	2	3	4	5
Personalet var generelt interessert i studentveiledning	1	2	3	4	5
Personalet lærte seg navnet på studentene	1	2	3	4	5
Det var tilstrekkelig med meningsfylte læringssituasjoner på avdelingen	1	2	3	4	5
Læringssituasjonene var sammensatte m.h.t. innhold	1	2	3	4	5
Avdelingen kan betraktes som et godt læringsmiljø	1	2	3	4	5

Avdelingsleders lederstil:

Avdelingsleder så på personalet ved sin avdeling som en nøkkelressurs	1	2	3	4	5
Avdelingsleder var et medlem av teamet	1	2	3	4	5
Tilbakemeldinger fra avdelingsleder kunne lett ses på som en læringssituasjon	1	2	3	4	5
Den enkelte ansattes innsats ble verdsatt	1	2	3	4	5

Sykepleie på avdelingen:

Avdelingens sykepleiefilosofi/grunnlagstenkning var klart definert	1	2	3	4	5
Pasientene mottok individuell pleie og omsorg	1	2	3	4	5
Det var ingen problemer med informasjonsflyten i forbindelse med pleie og omsorg til pasientene	1	2	3	4	5
Dokumentasjon av sykepleie (f.eks. pleieplaner, daglig loggføring av sykepleieprosedyrer etc.) var klar	1	2	3	4	5

VEILEDNINGSRELASJONEN

I dette skjemaet refererer veiledning til rådgivning, støtte og vurdering av sykepleierstudenten, foretatt av kliniske sykepleiere. Veiledning kan foregå som individuell veiledning eller som gruppeveiledning. Begrepet veileder betyr en navngitt personlig veileder.

Veilederes yrkestittel:
Sett ring rundt ditt svar

Sykepleier 1

Spesialsykepleier 2

Assisterende avdelingsleder 3

Avdelingsleder 4

Annet, i så fall hva?.....

Forekomst av veiledning:
Sett sirkel rundt kun ett alternativ

Jeg hadde ikke veileder i det hele tatt	1
En personlig veileder ble oppnevnt, men forholdet til denne personen fungerte ikke i løpet av praksisperioden	2
Veileder ble byttet underveis, selv om dette ikke var planlagt	3
Veileder varierte ut fra vakt eller arbeidsoppgaver	4
Samme veileder hadde flere studenter og var mer en gruppeveileder enn en individuell veileder	5
En personlig veileder ble oppnevnt og forholdet vårt fungerte i løpet av praksisperioden	6

Andre former for veiledning, vennligst spesifiser:

.....

Hvor ofte hadde du spontan, individuell veiledning med veileder (uten sykepleielærer)
Sett sirkel rundt kun ett alternativ

Ikke i det hele tatt	1
En eller to ganger i løpet av praksisperioden	2
Mindre enn én gang i uka	3
Ca. én gang i uka	4
Oftere	5

Innholdet i veiledningsrelasjonen:

Følgende utsagn omhandler forholdet til veileder.

For hvert utsagn, vennligst velg alternativet som best beskriver din egen oppfatning ved å sette ring rundt ditt svar.

Evalueringsskala:
1= helt uenig
2= delvis uenig
3= verken enig eller uenig
4= delvis enig
5= helt enig

Min veileder viste en positiv holdning til veiledning	1	2	3	4	5
Jeg følte at jeg fikk individuell veiledning	1	2	3	4	5
Jeg fikk kontinuerlig tilbakemelding fra min veileder	1	2	3	4	5
I det store og hele er jeg fornøyd med veiledningen jeg mottok	1	2	3	4	5
Veiledningen var basert på et likeverdig forhold som fremmet min læring	1	2	3	4	5
Det var gjensidig interaksjon i veiledningsforholdet	1	2	3	4	5
Gjensidig respekt og anerkjennelse preget veiledningsforholdet	1	2	3	4	5
Veiledningsforholdet var preget av tillit	1	2	3	4	5

SYKEPLEIELÆRERS ROLLE I PRAKSIS

En sykepleielærer er en lærer (ansatt ved universitet eller høgskole) som er ansvarlig for den kliniske praksisperoden. Følgende utsagn om sykepleielærer er delt inn i hovedområder, hvert med sin egen overskrift.

For hvert utsagn, vennligst velg alternativet som best beskriver din egen oppfatning ved å sette ring rundt ditt svar

Evalueringsskala:
1= helt uenig
2= delvis uenig
3= verken enig eller uenig
4= delvis enig
5= helt enig

Sykepleielærers evne til å integrere teori og praksis:

Etter min mening var sykepleielærer i stand til å integrere teoretisk kunnskap i daglig utøvelse av sykepleie	1	2	3	4	5
Sykepleielæreren var i stand til å tydeliggjøre læringsmålene for den kliniske praksisperioden	1	2	3	4	5
Sykepleielæreren hjalp meg til å redusere gapet mellom teori og praksis	1	2	3	4	5

Samarbeid mellom praksisstedet og sykepleielærer:

Sykepleielærer var som et medlem av sykepleieteamet	1	2	3	4	5
Sykepleielærer var i stand til å overføre sin pedagogiske spesialkunnskap til det kliniske teamet	1	2	3	4	5
Sykepleielærer og det kliniske teamet jobbet sammen for å støtte min læring	1	2	3	4	5

Forholdet mellom student, veileder og sykepleielærer

De vanlige møtene mellom meg selv, veileder og sykepleielærer var behagelige opplevelser	1	2	3	4	5
I våre felles møter følte jeg at vi var kollegaer	1	2	3	4	5
Fokus for møtene var mine læringsbehov	1	2	3	4	5

Takk for ditt bidrag!

LUNDBLAD MEDIA AS, TROMSØ. TLF: 77 75 32 50

Vedlegg 7

Oversikt over godkjenninger

Dokumentene offentliggjøres ikke da de angir institusjonene. Disse opplysningene ville kunne føre til antagelser om informantenes og respondentenes høgskoletilhørighet. Kommisjonen vil få tilsendt dokumentene ved forespørsel.

1. Tillatelse til gjennomføring av prosjektet i institusjonene.
2. Svar fra regional komité for medisinsk forskningsetikk (REK V) om at prosjektet ikke ble vurdert til å høre innunder REK.
3. Godkjenning fra Norsk samfunnsvitenskapelig datatjeneste.
4. Tillatelse til bruk av spørreskjemaet CLES+T.

OVERSIKT OVER TIDLIGERE DOKTORGRADSAVHANDLINGER VED PHD-GRADEN I HELSEVITENSKAP DER HOVEDVEILEDER OG/ELLER BIVEILEDER HAR VÆRT ELLER ER ANSATT VED INSTITUTT FOR KLINISK MEDISIN/INSTITUTT FOR HELSE OG OMSORGSFAG, DET HELSEVITENSKAPELIGE FAKULTET, UNIVERSITETET I TROMSØ.

Sissel Lisa Storli – (2007) Living with experiences and memories from being in intensive care. A lifeworld perspective.
Hovedveileder: Professor Kenneth Asplund
Biveileder: Professor Anders Lindseth

Åshild Fause – (2007) Forpleiningen tilfredsstillende. Prisen ligesaa.
Hovedveileder: Førsteamanuensis Ingunn Elstad

Gunn Kristin Øberg – (2008) Fysioterapi til for tidlig fødte barn. Om sensitivitet, samhandling og bevegelse.
Hovedveileder: Professor Eline Thornquist

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