IDENTIFICATION OF LEARNING NEEDS DURING PRACTICE IN A DAY CARE CENTER

HILDA MERTZ
Assistant Professor
Faculty of Nursing, University of Toronto

I have long had a strong reaction to the notion, sometimes rather cynically expressed, "If you can't do it, teach it". In order to teach a subject, one must be thoroughly knowledgeable about it. Yet there is the problem for teachers of maintaining the level of their knowledge and skills. Essential reading about current developments in a subject can certainly keep one informed. But lacking the opportunity to test and apply this knowledge may cause a deficit in understanding. As a teacher of nursing, the teacher's remoteness from the actual giving of patient care except as incidental to the students' learning is a matter of concern to me.

The clinical teacher, according to Smith, "must be both practitioner and teacher — a duality of roles which requires a disciplined command of theory, facility in its application, and ability to help others develop knowledge and skills(1). Can a teacher retain her expertise as a practitioner when her opportunities for testing and applying theory are limited? And, if these skills are consequently diminished will it also limit her in assisting the student to develop nursing skills? Such patient contact as the teacher has is usually related to helping the student assess possible solutions to the patient's problem. Rarely is the teacher involved in helping the patient with his experience of illness and treatment. If the clinical instructor does not have the opportunity to use her own nursing skills does she retain these skills? And, is there any possibility that she will value them less highly and thus lose some of her ability to help students gain these same skills and values? Smith also states:

> One difficult aspect of clinical teaching involves helping students deal with situations which may run counter to natural human inclinations . . . such as, those who are despondent, helpless, anxious, disfigured or malodorous. Compassion is the bridge which can carry the nurse's skill and concern to those who need her most(2).

I wonder if the clinical instructor loses some of these qualities of compassion because of her infrequent exposure to patients and then is unable to help students provide care for patients with repugnant symptoms. Compassion is an essential component of high quality

ADAPTED CRITICAL EVENT RECORD CARD

Date:

Diagnosis:

Phase of Patient Care:

Nature of Decision-Making Situation:

Category of Learning Need:

Cognitive .....New Learning .....Re-Learning .....
Cognitive Affective.....New Learning .....Re-Learning .....
Psychomotor .....New Learning .....Re-Learning .....

Identify Content Needed:

How was situation disposed of?
(a) Were the needed skills acquired at the time?
(b) If acquired at the time — how? (e.g. teaching from doctor)
(c) Was other help sought? (e.g. literature)

My Interpretation:

Figure 1.

care. The teacher is held accountable for the quality of care given by her students. It seems conceivable that she may not be able to promote this quality of care when she has not been responsible for patient care over an extended period. Indeed, her potential for creativity in considering high quality care may suffer. Consideration of this was another reason for wanting more nursing practice.

Consequent to this thinking, I felt the need for continuing education in the area of practice. As a teacher, I had not had direct responsibility for patient care for thirteen years. Nor had I ever practiced in a day care centre either with individual patients or as a leader in therapeutic groups. Development of knowledge and skills needed to give care to out-patients in order to guide students in developing an understanding of this concept seemed essential, especially in view of the present trend to keep patients functioning in the community. My long-term goal was to improve my teaching.

METHOD

The setting in which the experience took place was a psychiatric day care centre of a large university hospital. Arrangements to work as a staff nurse, for four days a week, for a period of four weeks, were made with the agency. In addition to nursing intervention in the case of individual patients who were having difficulty with groups, activities included participation in interdisciplinary planning, acting as co-leader in therapeutic groups which included sensitivity groups, problem-solving groups, and insight-gaining groups.

TABLE 1

MAJOR CATEGORIES OF LEARNING

Category	No.	%
New Learning	33	66
Re-Learning	17	34
Total	50	100

My first concern was how to keep an accurate record of what I learned so that there might be some objective way of assessing whether the experience had been useful and also to have a file of new learnings and incidents which could bring new vitality to my teaching. It appeared that the Critical Event Record Card used in a study by Jones and Parker(3) would, with some revisions, serve this purpose. The major revisions were two:

1. Adding a Re-Learning category to New Learning.
2. Adding the affective category to cognitive learning.

The card as revised and used is reproduced in Figure 1.

Events were recorded on the Critical Event Record Card as soon as possible after the learning situation had occurred. Use of the Critical Event Record Card as a tool was based on assumptions similar to those that were used with students in the Jones and Parker study. These assumptions were:

(1) I had sufficient practice in self evaluation to perceive gaps in my own knowledge.
(2) Reporting would be accurate.

Two differences in my use of the cards were:

(1) I was the subject as well as the experimenter.
(2) I could make an immediate judgment as to whether the situation had required learning or re-learning and thus how it should be recorded.

ANALYSIS OF RESULTS

Cards were sorted in terms of whether the experience was new learning or re-learning and the results were tabulated (see Table 1). These situations might have occurred in any phase of patient care (assessing, planning, giving or evaluating) and in any of the learning sub-categories of cognitive, cognitive affective or psychomotor.

TABLE 2

PATIENT CARE LEARNING

Phase of Patient Care	New Learning		Re-Learning		Total	
	No	%	No	%	No	%
APGE	1	2			1	2
APE			2	4	2	4
AP			1	2	1	2
PG	2	4			2	4
P	4	8	1	2	5	10
GE	8	16	6	12	14	28
G	11	22	7	14	18	36
E	7	14			7	14
Total	33	66	17	34	50	100

A—Assessing Patient Care
P—Planning Patient Care
G—Giving Patient Care
E—Evaluating Patient Care

Although the majority of learning events were new learning, one-third of the needs were things previously learned which had to be re-learned. This indicates to me that a teacher not only has to continue learning but may have to re-learn skills which she has not been using.

Of the 50 events, 33 new learning and 17 re-learning, the highest percentage occurred in the Giving, Evaluating categories. Only a minor percentage fell into the Assessing, Planning categories (Table 2).

In looking at the first 5 categories in this table all of which involve the assessing and planning of care, one sees that they add up to only 22%, while the final 3 in which the events related to either giving or evaluating care are 78%. It should also be noted that, of the categories which make up 22% of the total 3 also include giving and evaluating care.

Further categorization of the events in terms of the domain of learning is shown in Table 3. In relation to the sub-categories, the largest number of events occurred in the cognitive area. The cognitive learning needs were in relation to philosophy of day care, new drugs and new patient approaches, individual and group behavior patterns and team functioning in a psychiatric day care centre. Cognitive affective learning needs which were concerned with dealing with reactions that were inhibiting functioning, constituted 14%, all in the re-learning area.

TABLE 3

SUB-CATEGORIES OF LEARNING

Sub-Category	New Learning		Re-Learning		Total	
	No	%	No	%	No	%
Cognitive	32	64	10	20	42	84
Cognitive Affective			7	14	7	14
Psychomotor	1	2			1	2
Total	33	66	17	34	50	100

Data were also examined with a view to determining whether recent developments in psychiatric care constituted the bulk of new learning. Four major content categories were identified through examination of the cards. These and the percentages of learning in each appear in Table 4. The category of Treatment Mode included such things as behavioral therapy, primal therapy, drug therapies, community resources and sensitivity groups; Group Functioning was concerned with patients and staff helping patients cope with self-defeating behavior. Sharing of knowledge, information, reactions and decisions were the essential components in the category of Team Functioning. Reactions to patient behavior and/or team decisions constituted the fourth category.

What happened with respect to the learning needs which had been identified? Did learning take place at the time or were the needed skills acquired later or not at all? All of the identified learning needs were taken care of in the situation, with the health team being the learning resource used most frequently. Table 5 presents the data with relation to six sources of learning.

TABLE 4

CONTENT OF NEW LEARNING NEEDS

	No	%
Team Functioning	32	64
Treatment Mode	13	26
Group Functioning	3	6
Own Reactions	2	4
Total	50	100

TABLE 5

SOURCE OF LEARNING

Source of Learning	No	%
Health Team	19	38
Nursing Team	15	30
Doctor	7	14
Individual Nurse	5	10
Patient Group	2	4
Self	2	4
Total	50	100

DISCUSSION OF RESULTS

My work in the day care centre was a re-vitalizing experience. Having patient care as the major purpose of my activities was satisfying. Also, although one is learning constantly, use of the Critical Event Record Cards gave a means of pinpointing learning experiences for analysis and provided a means for retention of the learning.

As we saw in Table 2, very little learning occurred in the categories of Assessing and Planning care. The reason might be that these skills are constantly used as a component of teaching. Although Giving and Evaluating care are also a part of teaching, the teacher does not use them directly with patients. Rather, the teacher's area of concentration is on helping the student gain needed knowledge and skills. The teacher's relationship to the patient is indirect; it is the nurse who must help the patient understand and change his self-defeating behavior.

In addition, with the new knowledge and skills that have been developed in giving patient care, it seems understandable that learning needs in the Giving and Evaluating category would be predominant. After many years of not being directly responsible for patient care I was out of touch with the recent developments in the actual giving of care. An example of this was the use of video tapes to help a patient assess his own improvement. One of the patients had had a back injury; although he was improving he denied this. By means of video-taping him walking, showing the tapes to him and discussing them with him, he was enabled to accept improvement and indeed to walk better. In another situation, I learned that schizophrenic patients could benefit by sensitivity groups. This is contrary to the literature, which states that these patients cannot tolerate closeness or confrontation. These and other incidents supported the idea

expressed by Smith that relevant teaching requires involvement with patient care(4). Some of the learning in the cognitive category consisted of basic knowledge which I had not previously acquired, or if acquired, had not had occasion to use. An example of this was in not providing a secondary gain for a patient with hysterical behavior. The patient was treated calmly and matter-of-factly and assured that she could help herself. She was able to do so.

There was no new learning in the Cognitive Affective category; possibly this can be attributed to previous comprehensive supervised practice in dealing with reactions. In one incident I had to deal with my reaction of finding it more difficult to accept illness in a male patient because of my personal values. By becoming aware of this I was able to control my personal feelings in my care of the patient. I was able to help him. I also had to deal with my reactions of non-acceptance that a patient could make no further progress toward better functioning. Once I accepted this I was able to support the patient at his level of functioning.

CONCLUSIONS, IMPLICATIONS FOR TEACHING

Use of the Critical Event Record Cards made this a very meaningful experience, most of which would have been lost without this means of recording. They continue to provide a source of recall and review. I anticipated that the first week would be mainly orientation and provide minimal learning. This did not happen. Learning started immediately and the greatest number of incidents were recorded during the first two weeks. I attribute this to having the framework to study the experience by use of the Critical Event Record Card. This could imply that in my teaching I must make every effort that students understand the frame of reference within which any learning experience is planned, in order that they have concrete categories for analyzing its meaning. In addition, the cards provide a ready reference source; any of the events can be used as illustrative material in teaching. Much of the material is information about new developments in patient care. Other incidents provide illustrations of how to deal with particular situations. The overall effect has been a revitalization of teaching.

I learned much about dealing with my own anxieties in relation to patients who are living in the community and are not under in-patient supervision. Much of the nursing is done on the telephone to help depressed patients come to the day care center. Team functioning is vitally important here, not only in providing consistency of care, but also in giving team members mutual support. Other anxieties developed due to being in a new setting and in a change of role from teacher to practitioner. Students' discomforts and anxieties during

clinical laboratory experience were seen in a new light. Since then, through sharing my own thoughts and anxieties with students, I am able to help them identify and cope with their own fears.

I have often questioned whether I could be a nurse and a teacher simultaneously. I now do not think this is an either-or proposition. Certainly, my nursing skills improved during this experience since I was responsible only for my nursing function in relation to patients. However, I have since learned that, for example, in groups students not only learn through observation of the teacher but gain confidence from observing the teacher making a contribution. Although there are many problems in clinical instruction it also has many challenges. Among these are the instructors' own learning needs. I hope that by sharing my experience some colleagues will be stimulated to consider their own further learning needs and derive benefit as I did.

REFERENCES

1. Dorothy W. Smith, *Perspectives on Clinical Teaching* (New York: Springer Publishing Co., 1968).
2. *Ibid.*
3. Phyllis E. Jones and Nora I. Parker, "The Identification of Learning Needs By Means of Critical Events," *Nursing Papers* 5 (Sept. 1973): 18-27.
4. Smith, *op. cit.*

The writer wishes to gratefully acknowledge the encouragement and support given by Dr. Nora I. Parker during the practice experience and the writing of the paper.

Proposed 1975 National Conference on Nursing Research

OCTOBER 27-29, 1975

The four Prairie university schools of nursing have applied for funding and are soliciting papers for a National Conference on Nursing Research to be held in Edmonton, on "The Development and Use of Indicators in Nursing Research." Active nurse researchers are invited to submit related papers to Margaret E. Steed, Program Coordinator, 3rd Floor, Clinical Sciences Building, University of Alberta, Edmonton, Alberta T6G 2G3.