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Identification of Essential Factor in a Nursing Education Programme

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Abstract

A nursing programme in southern Sweden was revised to meet future demands. The aim of this study was to explore important conceptual areas to be included in a nursing programme in order to meet long-term societal and health care requirements. Group concept mapping (GCM), a mixed-methods approach, was used. Thirty-four experienced teachers participated. Data was collected during brainstorming sessions in focus groups. Following editing and removal of duplicates, 101 statements remained to be sorted into piles that had similar conceptual representation in nursing education. The final step was then to rate each statement from 1 to 5 (higher values = more important/more feasible). Quantitative analysis using non-metric multidimensional scaling and hierarchical cluster analysis resulted in 11 clusters. Assessment and treatment and Person-centred care were rated as the most important and scientific theories and methods, Basic caregiving in nursing and Person-centred care had the highest feasibility ratings. Further analyses suggested that the content of nursing education can be seen from a systems theory perspective, represented by the macro, meso, and micro levels. These levels may increase the understanding of the complexity of nursing care. Furthermore, the cluster analysis can facilitate the development of a concept-based curriculum for nursing education.

Keywords: Concept-based curriculum; Curriculum development; Group concept mapping; Mixed-methods; Nursing education; Person-centred

Introduction

The curriculum and core courses of nursing education have been discussed for decades. Care providers claim that students are not ready to work as nurses after graduation. One criticism is that the programmes have become increasingly theoretical and academic and do not prepare students with the knowledge they need in clinical care, leaving a gap between theory and practice. In addition, each teacher tends to defend his or her subject as the most important. This makes it difficult to reach consensus on the content of the nursing education. Therefore, it was proposed that the gap between theory and practice could be bridged by applying a more holistic view in order to reach a more appropriate balance. To meet future demands in health care there is a need for nursing programmes to transit from a content-based to concept-based curriculum, which requires a major shift in thinking and application among educators. The concept-based curriculum empowers students to develop critical thinking and a broader base of interconnected principles and concepts, i.e. a more holistic perspective, that will further a broader understanding of nursing care compared to a content-based curriculum [1]. Health care is facing major challenges with an increasing ageing population, reduced resources and increased costs. The healthcare sector is also constantly evolving with the development of new knowledge and methods, which make it increasingly, specialized and fragmented. Thereby, healthcare becomes complex and simple causality may not be assumed. This intricate situation also places demands on nursing education to accommodate to the constant changes in healthcare [2]. According to students were not prepared to work as nurses when they graduated, due to the separation of the practical dimension of nursing from that of theoretical knowledge during nursing education. Studies have shown that newly graduated nurses lacked the confidence needed to handle the increased responsibility as an autonomous nurse. They therefore required more practice-based learning before graduation. Students can experience a distinction between what they learn in the classroom compared to what they encounter in their professional nursing practice. To cope with this difference, suggest that it is necessary to develop a curriculum in interactive collaboration between the nurses and the faculty [3]. A recent study used the Person-Centred Framework to deductively investigate person-centred care based on CCNs experiences during the first phase of the COVID-19 pandemic. CCNs described how organisational structures such as visiting restrictions required preventing the spread of the virus, affected person-centred outcomes, and patients were objectified because of less contact with patients' relatives [4]. It is tempting to say if CCNs in the present study had have sufficient moral courage they might had spoken up and challenged unacceptable practices. However, according to the relationship between moral courage and moral distress is not straightforward. Organizations are not always supportive and may act defensively to concerns about standards of care even the most morally courageous staff might feel uncomfortable to speak up [5]. The ethical nature of nursing care is associated with wishing well for others, which is a form of giving and taking that relies on the recognition of the other as a unique person. Ricœur's philosophy and his dialectical approach to mutuality contrast with idea of care that places the onus of responsibility on caregivers. Asserted that if people do not answer the needs of others, they may experience persistent feelings of guilt; he further stated that people are bound to one another by love, sympathy, and solidarity. As such, doing well for someone who is ill benefits both the ill person and the CCN, and being prevented from doing this could cause harm to the ill person and a sense of moral distress to the CCN [6]. According to, the ethical climate of a given workplace is an essential contributor to feelings of moral distress, and they proposed tools and skills that would better address ethical challenges related to morally distressing clinical situations. Additional research about the cause of and ways to prevent moral distress is needed [7]. CCNs described Deceptive communication as when relative's interpreted changes as

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being more significant than changes were and became hopeful of an unlikely recovery. This is consistent with the study, which found that poor communication between physicians and families was a cause of distress. In this study, CCNs experienced that the physicians' discomfort informing patients and their families about hopeless situations, had the effect of prolonging relatives' hope for patients' recovery [8]. The CCNs also asserted that not confirming a dying patient's request to discuss death resulted in very high levels of moral distress, which is in line the finding. A review concluded that communication issues between CCNs, physicians, patients and the patients' relatives were frequently described as sources of moral distress, which further confirms the CCNs' experiences related to communication difficulties. Lake found that most moral distressing situations for nurses during the first phase of the COVID-19 pandemic were the risk of transmission the virus to the nurses' families, caring for patients whose family members were unable to be present and caring for patients who were dying without any relatives present [9]. The nurses experienced anxiety and reported sleeping difficulties, and their feelings of moral distress decreased with effective communication suggested that health care professionals' moral sensitivity could be enhanced through team discussions. The possibility of discussing situations within a group, with a structured and guided debriefing format, would provide each CCN with the opportunity to reflect on their feelings and coping strategies with others. CCNs described feeling moral distress related to Poor teamwork and/or misunderstandings within the team. Previous research have identified that a common source of moral distress among CCNs during COVID-19 pandemic was working with nurses who were not as competent as the nursing care of the patient required [10]. This created an uncertainty about general nurses' competence and influenced the patient care interaction. International Council of Nurses, nurses actively promote patient safety, ethical conduct in the event of errors or near-misses, speaking up when patient safety is threatened, advocating for transparency and working with others to reduce the potential of errors. Physicians in emergency department and ICU describe that good ability to communicate and inter professional team training is required to achieve good teamwork. During the pandemic, CCNs constantly worked with new colleagues which have been associated with higher moral distress among CCNs during the pandemic compared to before the pandemic. This finding highlights the importance of good communication among team members which has been substantiated. Successful ICU teams exchange information and work together or deal with emotions from relatives whose loved ones are critically ill. Based on this, improvements in communication and teamwork are needed to reduce moral distress among ICU staff [11]. Thirty-nine percent of the CCNs in this study were considering leaving their current position because of moral distress and this is higher than reported in their studies. According to leaving the field of nursing may be a last resort for some nursing professionals and a way to avoid the negative consequences of moral distress and the subsequent ill health, but this solution does not benefit the common good of healthcare. Considering the growing concern over CCN shortages, moral distress, and health of CCNs must be considered [12].

Conclusion

This study has several limitations. The selection of study participants was a non-probability sample from three nursing groups on social media platform and it was impossible to calculate a response rate. Despite our intention, we only reached a small sample from our designated target group [13]. However, those who answered wanted their voices to be heard. Participants who had been working during the second year but who had left their positions due to moral distress also may have had the possibility to answer, since the questionnaire had no connection to the CCNs' employment. Because inactivity, suspended notifications and/or posts that rapidly drop down in the information flow, it is unlikely that all the nursing group followers saw the posts about the questionnaire [14]. During the COVID-19 pandemic, CCNs, due to their education and experience of intensive care nursing, assume tremendous responsibility for critically ill patients. Throughout, communication within the intensive care team seems to have a bearing on the degree of moral distress and improvements in communication and teamwork are needed to reduce moral distress among CCNs [15].

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