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DOMAINS OF NURSING PRACTICE: APPLICATION OF BENNER'S MODEL

by

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A DISSERTATION

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ABSTRACT OF DISSERTATION
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The purpose of this study was to use hermeneutical phenomenology to describe the clinical knowledge embedded within the everyday practice of senior nursing students and registered nurses. This study employs Benner's (1984) research on the nature of clinical expertise as a framework. An examination of the relationship of the research subject's practice to Benner's seven domains of nursing practice was undertaken.

The subjects of the study consisted of two groups: one 5-member group of senior nursing students in their last semester before graduation from an NLN-accredited baccalaureate program, and one 6-member group of general duty registered nurses 22 to 24 months after graduation from the same NLN-accredited baccalaureate program. Subjects attended four nonmixed small group sessions and provided a paradigm case at each session. Paradigm cases are clinical experiences that stand out in one's mind, an episode that alters one's understanding of future similar clinical experiences. The unit of analysis was the 44 paradigm cases. The interviews were audiotaped and transcribed, and the cases were systematically analyzed using an interpretive approach. The interpretations were later validated with the participants.

Based on the analysis of 20 student paradigm cases, the domain most often represented was the Helping Role with cases also representing four other domains. The analysis of the 24 RN paradigm cases indicated that the predominant domain was also the Helping Role. Cases representing five other domains were also found.

This study contributes to knowledge development in nursing in the following ways: (a) the validity of the domains of nursing practice is supported for nurses in the advanced beginner and competent level of practice, (b) understanding of the aspects of practical knowledge is enhanced by description of examples and themes from the clinical practice of senior nursing students and registered nurses, and (c) support is provided for the use of an interpretative approach called hermeneutical analysis as a valid method for exploring the clinical practice of nurses.

Abstract Approved by: Committee Chairman Ann F. Edgil

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CHAPTER I

Introduction

Nursing is an applied science in the sense that it is the application of knowledge from the basic sciences such as chemistry, anthropology, and sociology. However, nursing is more than just application. It is the sorting, selecting, adapting, and inferring of the basic sciences to nursing (Ellis, 1969).

Presently, nursing is striving for recognition as a scientific discipline in its own right. Matwig (1969) defined nursing science as "that system of knoweldge based on scientific principles, concerned with the observation and classification of facts and establishing verifiable theories, concepts, and general laws comprising the theoretical core of nursing knowledge" (p. 11). Colaizzi (1975) wrote that the "beginning of a science should be a philosophical inquiry into an appropriate realm of being, the identifying or the describing of the proper object of that science" (p. 197). She further stated that nurses have not yet identified the proper object of nursing science. It also was proposed by Colaizzi that nursing would attain the status of a science after it clearly identified its domain with a verifiable body of knowledge which can be controlled and corroborated.

Abdellah (1969) stated that "the term 'nursing science' was rarely used in the literature until the late fifties" (p. 195). Since that time, there has been an increasing emphasis on the development of an unique body of knowledge for nursing (Carper, 1978). It is generally

agreed among nurse scientists that there is a need for knowledge in the field of nursing that is systematically organized into models and theories for the purpose of describing, explaining, and predicting phenomena of special concern to the discipline of nursing (Abdellah, 1969; Bush, 1979; Carper, 1978; Notter, 1968). Colaizzi (1975) has declared that nursing practice provides the knowledge base for the development of the science of nursing, and ultimately will define nursing's uniqueness.

A knowledge base is developed through theories that provide a general frame of reference. For the discipline of nursing these theories guide nursing's practice and inquiry (Kim, 1983). Theory development in nursing will evolve through building and using knowledge about the phenomena of concern to clinical nursing practice.

Nursing practice has been studied primarily from sociological and anthropological perspectives. Nurse researchers have studied role relationships, socialization, leadership, and acculturation. Benner (1985) wrote that nurses have "learned less about the knowledge embedded in actual nursing practice - i.e., that knowledge that accrues over time in the practice of an applied discipline" (p. 1). The systematic observations of what nurse clinicians have learned from their clinical practice is missing (Benner, 1983). Ellis (1968) wrote "the domain of nursing practice should delimit the domain approrpiate to theory development for nursing. What is significant for nursing, what theory, what knowledge the professional nurse should spend time pursuing, is that which pertains to practice" (p. 222).

Single case studies have been published, but only a few clinical observations using patient populations are recorded in the literature. Nurses have not kept records of their clinical learning and practice.

Since nurses have not sysematically studied their clinical practices, nursing theory development is missing the unique knowledge that is an integral part of clinical practice. Unless nurses develop an organized plan to record what they learn from their own experiences, the untapped knowledge incorporated into clinical practice will never be fully explored and developed (Benner, 1984).

Statement of Problem

Research in the clinical setting is essential to identify the knowledge base for the domain of nursing practice. Research into nursing practice provides for identification of nursing practice domains, evaluation of practice, greater understanding of what is optimal nursing practice and for learning how best to teach and to provide optimal nursing care. This researcher's phenomenological study closely examines and analyzes domains of nursing practice as described by senior nursing students and practicing registered nurses.

Nursing practice requires strong educational preparation in the psychosocial sciences, biological sciences, and nursing. The combination and adaptation of these sciences are the basis for knowledge building in nursing which will lead to further theory development. Faculties of schools of nursing must attempt to expand students' educational experiences, both in scope and complexity. Students need to be prepared to deal with the increasing challenges of clinical practice, as greater responsibility, advanced technology, and sicker patients become the norm. Knowledge obtained during the educational process will limit or enhance the nurse's practice in the clinical situation (Benner, 1984). Research into clinical practice can result in additional information to be used for the development of nursing theories that may be incorporated into educational programs.

To date, data embedded in actual clinical performance have not been systematically used as a basis for theory development or curriculum planning and evaluation by nursing programs. The identification of the domains of nursing practice that contribute to success of a nursing program's graduates, as well as identification of those areas where gaps exist, has only recently been explored by nurse educators (Benner, 1984; Fenton, 1984; Steele, 1986). The present phenomenological study continues the exploration of this focus.

Statement of Purpose

Analysis of paradigm cases can provide valuable information that describes the actual experience of clinical practice. Paradigm cases are clinical episodes that stand out in the clinician's mind. They alter the nurse's way of understanding and perceiving future clinical situations. They become reference points for practice and are used in similar future situations as a basis to project and predict a clinical episode (Benner, 1984). Paradigm cases can be analyzed with Heideggerian hermeneutics for common meanings. The meaning of these lived experiences can contribute to the understanding of clinical nursing practice and add to the nursing knowledge base.

The purpose of this hermeneutical, phenomenological study was to describe the domain of nursing practice of senior baccalaureate nursing students in their last semester prior to graduation and of baccalaureate graduates (RNs) 22 to 24 months after graduation. Both groups attended the same NLN-accredited baccalaureate school of nursing program in a Southeastern state. These descriptions of domains of nursing practice will contribute to knowledge building in nursing. This research extends the knowledge of nursing in the practice setting as well as extending the research of Benner (1984), Fenton, (1984), and Steele (1986).

Research Questions

1. What are the domains of nursing practice of senior nursing students enrolled in their last semester in a baccalaureate program in a school of nursing in a Southeastern state?

2. What are the domains of nursing practice of registered nurses (RNs) 22 to 24 months after graduation from the same baccalaureate program in a school of nursing in a Southeastern state?

3. What domains of nursing practice are similar between these senior nursing students and registered nurses identified above?

4. What domains of nursing practice are different between these senior nursing students and registered nurses identified above?

Conceptual Framework

The conceptual framework used in this research study was Benner's (1984) seven domains of nursing practice. This framework includes 5 skill levels and 31 clinical competencies within 7 domains of nursing practice. Benner's original seven domains of nursing practice are as follows: (a) the Helping Role, (b) the Teaching-Coaching Function, (c) the Diagnostic and Patient-Monitoring Function, (d) Effective Management of Rapidly Changing Situations, (e) Administering and Monitoring Therapeutic Interventions and Regimens, (f) Monitoring and Ensuring the Quality of Health Care Practices, and (g) Organizational and Work-Role Competencies.

Paradigm cases were analyzed and identified by Benner (1984) as representative of a particular competency. Benner described competency as an interpretively defined area of skilled nursing performance that has been identified and described by a clinician from her own experience in an actual practice situation. Thirty-one separate competencies were

identified. These competencies were grouped into the seven domains but in no way were intended to be finite.

Five skill levels were adapted for nursing by Benner (1984) from the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1980). The Dreyfus model is a situational model based on a study of chess players and airline pilots conducted by Stuart Dreyfus, a mathematician and system analysis, and Hubert Dreyfus, a philosopher. Benner wrote that the Dreyfus Model "takes into account increments in skilled performance based upon experience as well as education" (p. 13). Dreyfus and Dreyfus proposed "that in the acquisition and development of a skill, an individual passes through five levels of proficiency: novice (Level I), advanced beginner (Level II), competent (Level III), proficient (Level IV), and expert (Level V)" (Benner, p. 13). [See Appendix A for more detailed definitions of levels].

The five levels of proficiency reflect changes in three aspects of skilled performance. The first is a change by the individual from reliance on abstract principles to the use of past concrete experiences. For example, a student has to rely on what was learned from a textbook the first time she cares for a child with pyloric stenosis. The second time the student cares for the same type of child, she will be able to use her actual past concrete experience (Benner, 1984).

The second aspect of skilled performance is a change in the learner's perception of a clinical sitaution. Clinical situations, over time and with experience, are viewed more as a whole in which only certain parts are relevant to determine the necessary nursing action, instead of a compilation of equally relevant parts (Benner, 1984). The novice (Level I) nurse is frequently unable to quickly prioritize necessary nursing actions in a clinical situation. As the novice

(Level I) gains more experience and advances through the skill levels to advanced beginner (Level II), the nurse is able to decide more quickly which nursing action has priority.

The third aspect of skilled performance is a passage from detached observer to involved performer. The individual is involved in the situation instead of outside the situation (Benner, 1984). The novice (Level I) and advanced beginner (Level II) in many clinical situations, especially emergencies, frequently become observers due to inexperience. Later, as they gain experience and move through the skill levels, they are the nurses who actually handle the situations that arise with patients.

The five levels of proficiency are not mutually exclusive. An individual may function the majority of the time at a single level, but a totally new situation may force the same individual to function at a lower level. For example, an RN functioning at the proficient level (Level IV) on a medical-surgical unit might function as a novice (Level I) or advanced beginner (Level II) if suddenly forced to work in a newborn nursery.

These five skill levels of proficiency function as a defining characeristic of the sample. The sample, by definition, were functioning at a level no higher than the competent level (Level III) of performance as defined by the Dreyfus Model of Skill Acquisition. The sample was comprised of senior baccalaureate nursing students in their last semester prior to graduation and registered nurses with 22 to 24 months experience.

Senior students were defined as advanced beginners (Level II). An advanced beginner (Level II) has dealt with real situations and has a small pool of "prior experience" for use in future situations (Benner,

1984). The registered nurses were defined as operating predominantly at the competent level (Level III) as they had approximately 2 years of experience. This level is reached by the individual who has been on the job approximately 2 years. Nurses at this level have been involved in a wide variety of experiences and have dealt with many situations. The competent individual lacks the speed and flexibility of the proficient level, but does have a feeling of mastery and the ability to cope with many aspects of clinical nursing (Benner).

Benner's (1984) Domains of Nursing Practice have been used as a main focus for this research. (See Appendix B for detailed listing of the seven domains with their competencies). These domains are briefly described below.

The Helping Role Domain

Nurses are expected to provide a different kind of help to patients than are other health care professionals. The expert nurse takes special care to limit the patient's sense of obligation during his dependency. Benner (1984) suggested that nurses "tried to establish a context of attentiveness that was central to being a 'nurse' and not dependent upon a social contract or exchange on the patient's part" (p. 49). This domain sometimes encompasses simply the courage to be with the patient, offering whatever comfort the situation allows. An example of a competency in this domain is maximizing the patient's participation and control in his or her own recovery. An exemplar of this competency with a summary statement follows.

> An experienced nurse described several episodes with an elderly patient who was recovering from a mild stroke. The patient, a concert pianist, was depressed over the weakness in her right hand. The first incident described was in response to the patient's refusal to go to physical therapy (Benner, 1984, p. 59).

> Expert nurse: I just sat down and listened and talked to her. I did not say that I wanted her to go to physical therapy, but that was my intention. I said to her that she was showing some progress. "Think about two days ago; today you can move your fingers a little bit more. You have made progress because of the exercise. If you keep doing these exercises, I expect that you will be able to have more use of your hands." I encouraged her--pointing out the positive things because she was only zeroing in on the negative things and looking at how much she didn't have. I reminded her that when she first came in that her arm was weak and that she needed a lot of help to eat. Now she is able to hold a cup by herself. Now she is able to move her fingers and raise her arm; she could even raise it over her head. I said, "Look, you couldn't do that yesterday and you are able to do that today." I just went through all the things that I could see that I hadn't seen the day before. After our talk she went to physical therapy (Benner, 1984, pp. 59-60).
>
> In this exemplar, the nurse helps the patient regain a sense of control and active participation in recovery. Many patients feel alienated from their recovery and treatment; frequently it is the nurse who assists the patient in regaining a sense of participation and control (Benner, 1984, p. 61).

The Teaching-Coaching Domain

Nurses coach their patients through an illness and teach them about their illness. Nurses help the patient to know what to expect during the course of an illness. When possible, the nurse forewarns the patient about what to expect, corrects misinterpretations, and offers explanations whenever necessary. What is foreign and fearful to the patient is made familiar and less frightening by the nurse. In this role, the nurse must learn to communciate and to teach in less than optimal situations. The nurse offers not only information, but also ways of being, ways of coping, and new possibilities for the patient by providing new perspectives on the patient's situation. An example of a competency in this domain is assisting patients to integrate the implications of illness and recovery into their lifestyles. An exemplar of this competency with a summary statement follows. "An expert nurse described the role she played, early in her career, in helping a severely handicapped woman re-establish a meaningful life" (Benner, 1984, p. 81).

> When I was very young, I worked for the Visiting Nurses Association. One woman I went to see on consultation hadn't been out of her bedroom for five years and was just dying of depression. She'd had a stroke and had not had much physical therapy. She had one completely frozen arm and very little mobility with her right leg. At the time, I knew very little about her chances for recovery. There were no orders for physical therapy. "Her heart is bad, the exercises might kill her," I was told. (Now you have to remember, that this was many years ago). And I said, "She's dying anyway, she is dying because her whole world is just the four walls." And I wanted the opportunity to help, and I asked the doctor to give the opportunity, by giving an order for physical therapy. And I promised to talk to the husband and to her about the fact that it is taking a big chance and that she may die. The doctor reluctantly gave me an order, and I exercised that woman, and got her out of bed. I got a book out of the library and read up on CVA physical therapy because I knew very little about physical therapy. She never regained the use of her hand and arm, of course, but she did get to the point that she could walk with help. And the first day she walked out of her bedroom, she just burst into tears. She died five and a half years later while cooking dinner. She had learned to peel potatoes with her one hand, wedging them against her paralyzed arm. She was a marvelous lady who was dying because she was being treated like an invalid, and she felt useless and hopeless (Benner, 1984, p. 81).

In this exemplar, the nurse "assessed the importance of trying to continue with normal activity versus the cost of inactivity and isolation" (Benner, 1984, p. 84).

The Diagnostic and Patient Monitoring Domain

The Diagnostic and Patient Monitoring Domain is an important domain because if a patient does not require this function of the nurse, the patient is not usually hospitalized. This domain has expanded dramatically as technology has increased. Included is everything from multiple drug therapies with their possible incompatibilities, contraindications, and adverse reactions, to detecting early signs of rejection in heart transplant patients. Many diagnostic tests and therapeutic interventions require careful monitoring. It is often the nurse's early detection while performing this function that saves the patient. "We have much to learn from the wisdom embedded in the diagnostic and monitoring skills of expert nurses" (Benner, 1984, p. 96). An example of a competency in this domain

is providing an early warning signal: anticipating breakdown and deterioration prior to explicit confirming diagnostic signs (Benner, 1984).

An exemplar described by Benner (1984) for this domain follows:

> We have gathered a number of stories of the nurse anticipating deterioration before the evidence was convincing in terms of change in vital signs or other measurable evidence. When the stories are examined carefully, it is clear that the nurse is not using blind intuition, but rather is picking up on subtle changes in the patient's behavior or appearance (p. 100).

> Expert Nurse: We had a patient who had an esophageal dilatation in X-ray. She was a very uncomplaining woman of about 60 years of age. When she came back her vital signs were OK, and she was up in the bathroom. Later she started getting nauseated and she had streaks of very light pink drainage which I could account for by dilatation procedures, but I just had this feeling that something else was going on. She became worse; she became very nauseated. I called the house officer. Her vital signs were still stable, but I indicated that I wanted the house officer to check her. The house officer examined her but was not ordering any tests. I wanted to order blood work. I pointed out that the patient's nail beds were cyanotic. The house officer was unimpressed. It was almost time for me to go off duty when the patient started having chills with a temperature, so I called the house officer again and said there was something going on with this patient, and that I wanted to see something done for her before I went off duty. Later I found that the patient had a rupture in her esophagus; she also had aspiration pneumonia. Her pulse had gone up to 150. The house officer credited my persistence in getting early treatment in making a difference in the patient's outcome (Benner, 1984, pp. 100-101).

"This advanced recognitional ability frequently makes a critical difference in patient recovery. The effectiveness of this competency, however, gets linked with the nurse's skill in getting an appropriate and timely response from the physician" (Benner, 1984, p. 102).

The new graduate must gain expertise in this competency. She must "master the recognitional component, the documentation, and finally the convincing presentation of the case" (Benner, 1984, p. 98). The following exemplar illustrates this process.

> Nurse: When I first began, I found myself in a situation where the patient I was taking care of was behaving very strangely. Granted, it was a confounding situation. But I kept on running

> out of the room saying, "This is too weird." I really didn't make an assessment. In the beginning I would say, "Something is wrong in here," and go to somebody else, and they would say, "What are the patient's vital signs? What does the wound look like? What does the patient look like?" And I wouldn't have checked any of that. I would just say, "I think" or "I feel" that something's wrong. Whereas now I do a thorough assessment and contact the the physician immediately, if warranted (Benner, 1984, p. 98).

The Domain of Effective Management of Rapidly Changing Situations

The nurse is the caregiver who most often detects the first signs of change in a patient's condition and must manage the situation until the physician arrives. "One way to interpret this domain is simply to call it a 'break in the system' and hope that future 'breaks' can be avoided; this is an 'incident report' approach" (Benner, 1984, p. 109). This domain needs further documentation so that it can be recognized as a legitimate function and therefore better prepare nurses to deal with these situations. An example of a competency in this domain is skilled performance in extreme life-threatening emergencies: rapid grasp of a problem (Benner).

The following exemplar and summary statement related to this domain are offered by Benner (1984). "This area of skilled practice includes the ability to grasp the problem quickly, to intervene appropriately, and to assess and mobilize the help available" (Benner, p. 110).

> Expert Nurse: At approximately 7:30 PM on a Friday afternoon, the Emergency Room was busy. Many of our staff were tied up in the major trauma room with an automobile accident. At this point the paramedics arrived with a 50-year-old woman who was complaining of chest pressure which and begun while she was gardening. Premature ventricular contractions were treated at the scene with a Lidocaine bolus, and an I.V. was running. I met the patient and the paramedics at the door and began talking to the patient. As we entered Room 2 the patient said, "I'm going to faint." The monitor showed ventricular fibrillation. I instructed the paramedic to begin chest compression as I rushed to plug in the defibrillator and called for the physician. The physician arrived just as I was ready to defibrillate her and offered to intubate her. I indicated that I thought that wouldn't be necessary and went ahead with the fibrillation, since I knew the time of onset and wanted to interrupt

> the arrhythmia as soon as possible. I then defibrillated the patient who responded immediately. She, in fact, requested to go home for a shower. Her monitor showed a regular sinus rhythm, and her vital signs were within normal limits. This incident was satisfying because the patient made a full recovery. It turns out that her problem was the life-threatening arrhythmia and not a myocardial infarction. She was able to go home in three days (Benner, 1984, pp. 110-111).

In this exemplar, the nurse "grasps the importance of immediate intervention since she saw the transition into ventricualr fibrillation" (Benner, p. 113).

The Domain of Administering and Monitoring Therapeutic Interventions and Regimens

Administering and monitoring therapeutic interventions and regimens is the "procedure book" domain, but it is more than just doing the procedures. "Nurses often fail to give themselves credit for their skill in administering the often complex and intricate current therapeutic interventions and regimens" (Benner, 1984, p. 121). Many of these complex regimens are passed on to the nurse in an ad hoc fashion, and the newly demanded skills are developed. An example of a competency in this domain is starting and maintaining intravenous therapy (I.V.s) with minimal risks and complications (Benner).

Intravenous therapy and/or blood products are received by most hospitalized patients. The nurse becomes very proficient in administering I.V.s, while at the same time taking into account variables such as length of therapy, age of the patient, and condition and size of veins. Benner (1984) stated that:

> The applied technology of intravenous therapy has grown considerably. It is no small accomplishment today to learn how to pace I.V. therapy accurately, to administer a variety of medications and fluid products that may or may not be compatible, and to assess when an I.V. should be discontinued due to infiltration of phlebitis (pp. 123-124).

An examplar from a new graduate nurse and summary statement follows.

> New Graduate Nurse: There are a lot of tricks of the trade when it comes to I.V.s. When I was team leading on days, we were responsible for all the I.V.s and all the meds on one side and I would go to my preceptor and say, "Why won't this I.V. go?" And she would come and raise the I.V. up a little and play with the tubing--things that I didn't know how to do--and I would turn around and find that it was going. Otherwise, I would just be wondering, "Why won't it go?" She really knew the tricks and that helped a lot. That was very helpful, because a lot of times it just won't go, and sometimes it's just positional, things like that. And I would say to her, "There's something wrong with this I.V., and she would say, "Have you tried this and have you tried that? Have you done this?" She was really helpful about that (Benner, 1984, p. 124).

This exemplar demonstrated the "nuances involved in mastering the technology of intravenous therapy" (Benner, p. 125).

The Domain of Monitoring and Ensuring the Quality of Health Care Practices

This domain involves the nurse in the detection and prevention of errors. The nurse is . . . "especially alert during the initial learning stages of new residents. It is as if the system should be better and that potentially dangerous errors should never happen" (Benner, 1984, p. 135). This domain is similar to the "Rapidly Changing Situations" domain, but in this case the nurse is dealing not with emergencies, but with day-to-day situations. An example of a competency in this domain is assessing what can be safely omitted from or added to medical orders (Benner). An exemplar and summary statement follows. Nurses must learn to use discretion when carrying out medical orders for their patients. "They are expected to assess what they should do to provide the best possible care for the patient rather than simply carry out by rote medical orders, even though this may involve risks for them (Benner, 1984, p. 140).

> Expert Nurse: In the beginning, I was writing down all the times that blood pressures were to be taken, and then I thought, "Hey, wait a minute, let me think about this and decide whether I need

> to take them or not. After all it's not just something I'm supposed to do to make me feel better." So I stop and think, what if I know what someone's blood pressure is? What does that tell me? Do I really need to know it? Especially with some of the postoperative eye patients who have been postop for a couple of days. We are expected to use our judgment as to when to discontinue the vital signs at night. So we carefully study the trends and the patient. Sometimes I substitute close observations, so the patient can sleep (Benner, 1984, p. 141).

In this exemplar:

> "The nurse makes a judgment about the relative merits of rest and comfort over the prescribed therapy at a particular time in the patient's illness. There can never be precise scientific guidelines for these decisions, because there could never be enough research done to capture the particulars of all situations (Benner, 1984, p. 141).

The Domain of Organizational and Work-Role Competencies

The development of the organizational and work role competency is based on training received on the job. Nursing schools are increasing their content of managerial and leadership components. According to Benner (1984), the complexity of the organizational demands placed on the new nurse who must learn the ". . . local, the particular, the contingent, and the historical in mastering management and leadership on a particular unit . . ." (p. 145) cannot be taught. An example of a competency in this domain is building and maintaining a therapeutic team to provide optimum therapy (Benner). An exemplar and summary statement follow. "Every health team member with responsibility for a patient will assess that patient's potential for wellness. And for the therapy to be optimally effective, each person involved must present his or her perspective to the other team members" (Benner, pp. 149-150).

> A nurse describes the aftermath of a major confrontation between herself and a doctor over giving a patient EST (shock therapy): We'd missed a really valuable step, and that was in getting the doctors involved in writing policy with us. Even though it's not as strong, some people would say rigid, as I would like, at least

> it's generally followed because it was passed by the psychiatric staff . . . what I think is that it's real important saying, "We're in this together, even if we're disagreeing" (Benner, 1984, p. 150).

It is evident from this exemplar that "expert nurses recognize the team as an integral part of their own effectiveness as they are in the business world" (Benner, p. 151).

The domains, competencies, and exemplars presented above are just a few examples of the knowledge that can be found in the actual practice of nursing. This knowledge is a limitless data source for nursing. There are implications for research, education, and clinical practice (Benner, 1984).

Organization of the Study

The first chapter has presented the introduction to the study, the statement of the problem, statement of the purpose, research questions, and conceptual framework. Chapter II contains a review of relevant literature in the areas of hermeneutical phenomenology and descriptive research on the domains of nursing practice. The third chapter is a description of the methodology of the study including the subject selection, data collection process, and the procedure for analysis. In Chapter IV, the findings are reported. Chapter V includes a report of the conclusions, discussion, implications, and recommendations for future research.

CHAPTER II

Review of Literature

In this review of the literature, Heideggerian hermeneutical phenomenology, as the research methodology used, is discussed. The study of Dreyfus and Dreyfus (1980) is discussed in light of their impact on the work of Benner (1984) in clinical nursing. Benner's descriptive research that led to the identification of the domains of nursing practice is also discussed. The research of others who have used Benner's domains of nursing practice as a framework completes this chapter.

Heideggerian hermeneutics is a particular view within the methodology called phenomenological research. It is an interpretive method that was developed by Martin Heidegger (1962). He proposed that hermeneutics is an appropriate approach for the study of human action.

Hermeneutics is an ancient discipline (Palmer, 1969), originally developed as a method for finding the hidden meanings in biblical texts. Ancient students of these texts sought to discover and reconstruct the messages from God that they believed have become hidden. The term hermeneutics refers to the wing-footed messenger-god, Hermes, whose function is that of transmuting what is beyond human understanding into a form that human intelligence can grasp. Later hermeneutics was expanded to other textual interpretations, and eventually applied to human behavior as well (Palmer, 1969).

Heidegger (1962) believed that hermeneutic phenomenology is a method of investigation that is most appropriate to research and to

understanding human behavior. Hermeneutics allows for the study of the individual within the context of everyday activities. Its goal is the discovery and understanding of the meanings embedded within everyday activities.

According to Allen, Benner, and Diekelmann (1986), the Heideggerian view is:

> To be human is to be-in-the-world, to participate in cultural, social, and historical contexts. This is a relational view of the person, and "human nature" is not considered fixed. The person is self-interpreting through and through, and these self-interpretations are not individually generated, but are handed down in the language and cultural practices. Social practices and perceptions are already laden with interpretations. Underlying all interpretation-laden practices and self-understanding handed down through language and culture is the notion of "The Background." This full-blown notion of the background preunderstanding is one of the major distinctions between Heideggerian phenomenology and critical theory . . .. This background cannot be made fully explicit; nor can we get completely clear about it or clear of it (p. 28).

Consequently, it is impossible in all interpretation-laden practices to be totally objective or an entirely neutral observer. This "background" distinguishes human beings from computers, as human beings come to every experience with a history and a story (Packer, 1985).

Hermeneutic phenomenology seeks to understand the transaction which occurs between the individual and his culture (Benner, 1985). Further, the hermeneutic method seeks to preserve the context of human behavior. It "is holistic in that it seeks to study the person in the situation, rather than isolating person variables and situation variables and then trying to put them back together again" (Benner, p. 6).

Hermeneutic inquiry is grounded in pragmatic, everyday activity. The knowledge, generated by this type of inquiry, exists prior to the development of theory in any discipline. Using specific, contextual situations, everyday activity within a discipline becomes the place to discover and refine theory (Allen et al., 1986). The hermeneutic

interpretation of everyday activity is conveyed through three modes of engagement as proposed by Heidegger (1962). The three interrelated modes of engagement or involvement that people have with their environment and labeled by Heidegger are ready-to-hand, unready-to-hand, and the present-at-hand.

The ready-to-hand is the most basic of the three modes. When individuals are in this mode, they are actively involved in practical projects that they view as a whole. For example, when a person rides a bicycle, awareness is holistic in that one does not think about all of the actions and movements made simultaneously while riding as maintaining balance, pedaling, turning, and stopping. These activities are so familiar that they are taken for granted. Only when a problem is encountered within the activity does the individual become aware of the parts. At this point, the unready-to-hand mode is entered (Packer, 1985).

An example of the unready-to-hand mode would be if the bicycle chain broke. The experience changes because the individual recognizes that there is a problem. The source of the breakdown (i.e., the chain) becomes conspicuous in a way that it was not in the ready-to-hand mode. It is recognized as an aspect of a situation, but only stands out against a background provided by the activity involved, in this case bicycling (Packer, 1985).

The third mode is the present-at-hand and is entered when the individual steps back from the situation and reflects on it, usually because a problem has been encountered. The problem is usually resistant to direct solution and necessitates reflection for a more general or abstract solution (Packer, 1985). At this point, the individual becomes aware of the chain's characteristics as length, greasiness, and

individual links. These properties are distinct from the aspect that characterize the unready-to-hand level. The distinction between the chain, the wheels, and pedals are apparent, and an alternate solution through theorizing and generalizations can be attempted (i.e., not near home, no repair tools available to fix chain; therefore, seek alternate solution).

Heideggerian hermeneutics attempts to decipher meaning from the semantic or textual structure of everyday practical activity. The ready-to-hand mode of engagement gives the most direct access to human phenomena. Packer (1985) writes "because this is the mode of direct practical engagement in which we actually do much of our everyday living, this task [ready-to-hand] amounts, for him [Heidegger], to the same as describing human beings; . . ." (p. 1084). Furthermore, the ready-to-hand mode of involvement is the starting point for hermeneutic inquiry in two respects (Packer).

> First, the ready-to-hand mode of engagement is the proper object of inquiry for each investigation, [as explication of meaning from the lived experience is the desired focus and] secondly, it is the primary source of a researcher's understanding of what he or she is studying (Packer, p. 1089).

Thus, the interpretation made of an episode is grounded in the ready-to-hand mode of understanding. However, it is very difficult, if not impossible, to capture this mode of engagement as it occurs.

So much of what is observed can be considered ordinary or taken for granted, that "we fail to appreciate the complexity of what we understand" (Packer, 1985, p. 1089). Thus, the task of hermeneutic inquiry becomes to reveal the unready-to-hand mode, thereby making it accessible to description. This approach brings to light those aspects of an interaction that are understood. This approach is essential in order

to elicit the meaning and nature of an experience or situation that is to be researched. Nurse researchers have used this interpretive strategy in studying the phenomenon of health and illness. Benner's (1984) study is considered an "original" in using this method in clinical nursing.

The philosophical background of Benner's research is the Dreyfus Model of Skill Acquisition as described by Dreyfus and Dreyfus (1980), and applied to Heideggerian hermeneutics. Dreyfus and Dreyfus studied the phenomenon of intuition in an attempt to understand human behavior. The authors described intuition as a learned response based on past experience, the kind of experience that comes from being an expert in a given situation.

In 1979, Dreyfus conducted a study under a grant of the United States Air Force. The author interviewed fighter pilots and also studied chess players. Through analysis of the skilled performances of the two groups, Dreyfus concluded that only novices proceeded according to formal rules. The author noted that as individuals become more proficient at a skill, they rely increasingly on context and experience. The Dreyfus study found that what guided the expert was not analytic thought but intuition. For example, chess masters do not analyze each possible board position, but rather they are able to sense the right move as it simply springs to mind (Dreyfus). A five-stage model for the process of skill acquisition was identified.

Dreyfus proposed with the five-stage model that with the acquisition and development of a skill, an individual proceeds through five levels of proficiency: (a) novice, (b) advanced beginner, (c) competent, (d) proficient, and (e) expert. Skill acquisition is a progression from use of abstract, detached, analytical reasoning to concrete,

involved, holistic reliance upon experience. The beginner wrestles with seemingly innumerable, equally important facts which somehow have to be related to memorized rules and principles. The more experienced individual is more deeply involved in the real situation and able to almost instantaneously "see" essential facets and crucial situation-dependent features without any apparent effort (Dreyfus & Dreyfus, 1980).

Benner (1984) adapted the Dreyfus model to nursing in an effort to clarify the characteristics of nurse performance at different stages of skill acquisition. Simply stated, Benner's adaptation of this model to clinical nursing practice is based on a dialogue with nurses about nursing. A 12-year federally funded research project entitled "Achieving Methods of Intra-Professional Consensus, Assessment, and Evaluation (AMICAE)" was conducted (Benner, Colavecchio, Gordon, & Fiekl, 1981).

The aim of the AMICAE project was to develop methods for evaluation of clinical performance for seven participating schools of nursing and five hospitals in the San Francisco Bay area. Benner (1984) found significant differences between both ideal and real performance expectations of new graduates, nurse educators, and nurse clinicians. To understand these discrepancies in performance appraisal and, in addition, to examine experiential learning in nurse clinicians, a systematic comparison was made of differences between expert and novice clinicians' perceptions and descriptions of the same clinical situation (Benner et al., 1981).

Twenty-one paired interviews were conducted with beginning and expert nurses selected from three hospitals where preceptors were used to orient new nurse graduates. Each member of the pair was interviewed separately about patient care situations she had experienced in common

and that had stood out for them. Additionally, interview and/or participant observations were conducted with 51 additional experienced nurse clinicians, 11 newly graduated nurses, and 5 senior nursing students in six different hospitals--two private community hospitals, two community teaching hospitals, one university medical center, and one inner-city general teaching hospital. "No attempt was made to classify the nurses themselves according to the proficiency levels; rather, each clinical situation was judged independently as reflecting a particular level of practice" (Benner, 1984, p. 15). This evaluation was in keeping with the nature of the Dreyfus model.

Four small group interviews, approximately 2 hours in length, were held with four to eight experienced nurses from different patient care units within the same hospital. The interviews varied in schedule from daily to bi-weekly. Individual interviews were also conducted with 51 experienced nurses, and participant observations were obtained on 26 of the nurses. The interviews were tape recorded, and verbatim transcripts were made for textual analysis (Benner, 1984). Each of the nurses described a paradigm case which was then analyzed and interpreted regarding content and common meanings. Based on analysis, considerable confirming and no disconfirming evidence was found for use of the Dreyfus Model of Skill Acquisition in clinical nursing practice.

The results of this research provided supportive evidence that the problem approach, type of problem perceived, and access to intervention differed markedly for the beginning, competent, proficient, and expert nurse. It became evident that a progression occurs in nursing, as with chess players and pilots, as a nurse moves from novice to expert clinical performance. Nurses moved from reliance on rules and guidelines as described in the Dreyfus novice proficiency level to the expert

clinician, where they used past concrete clinical situations as paradigms for current clinical situations. This pattern of clinical performance conformed to the pattern identified by Dreyfus and Dreyfus (1980). Based on this study of skilled nursing practice, Benner (1984) characterized nursing performance according to the five levels of competency described by Dreyfus and Dreyfus.

After completion of this portion of the project, re-analysis was performed on the clinical episodes collected from the original sample of the 1,200 nurses involved in the AMICAE project. Benner (1984) was able to develop a taxonomy of nursing experience as a result of the re-analysis on the clinical episodes derived from the interviews and participant observations which described patient care in detailed narrative form. They included nurses' intentions, their interpretations of the events, and the chronology of the action and the outcome. The interpretive approach utilized by Benner to analyze these data was dedicated to synthesis rather than analysis. This approach yielded a "manageable, yet rich" description of actual nursing practice (Benner).

From this data, 31 competencies or areas of skilled performance emerged. These competencies were then grouped into seven domains (clusters or categories) based on similarity of function and intent. The following seven domains were derived inductively from the competencies: (a) the Helping Role, (b) the Teaching-Coaching Role, (c) the Diagnostic and Patient Monitoring Function, (d) Effective Management of Rapidly Changing Situations, (e) Administering and Monitoring Therapeutic Interventions and Regimens, (f) Monitoring and Ensuring the Quality of Health Care Practices, and (g) Organization and Work-Role Competencies.

Benner (1984) stated that 31 competencies are in no way intended as a complete or exhaustive list of nursing performance. New domains or

competencies may be added and others deleted at any time. The intent of Benner's work was to encourage nurses to inquire into their own clinical practices and deal with research questions raised within their own spheres of clinical knowledge.

Benner has offered her work as a new way of viewing clinical nursing practice, a way that is not limited by a linear, problem-solving process. The meaning ascribed to everyday experiences are viewed as arising from participation in a shared history and culture (Benner, 1985). Meanings constitute, and are constituted by, a particular history and culture.

The practical knowledge that is embedded in clinical nursing practice has remained virtually undisclosed, keeping hidden its potential significance and value for practice and education. This knowledge need not be unattainable. Benner (1984), through her research, has demonstrated the need for and a way to uncover such knowledge. She has issued a call for nurses to begin to document carefully and systematically their own clinical learning in order to meet that end.

Fenton (1985) was one of the first to "test" Benner's framework for nursing. Fenton evaluated the performance of clinical nurse specialists (CNSs) to determine the areas of skilled performance used to meet the demands of the role of master's prepared nurses. Interviews and participant observations were conducted with 30 master's prepared nurses over a 6-month period. The subjects were employed in a large health science center in the Southwest and represented all clinical areas within the hospital. Experience as a clinical specialist ranged from 1.5 to 6.0 years, with a mean of 3.4 years. Fenton reported data from the interviews and observations of the clinical specialists in the sample. Small group audiotaped interviews of four to five participants

were held five to six times, as well as individual interviews of those unable to attend the group sessions. Participants were asked to describe incidents in their nursing practice that were significant, as well as everyday types of occurrences. Each participant was also observed one to three times in the clinical area. A total of 105 interviews and 50 participant observations were conducted. Data were analyzed in accordance with the Dreyfus model and Benner's adaptation. No attempt was made to classify the nurses according to their level of expertise. Instead, each situation was judged independently on whether it reflected an expert level of practice.

Transcripts of the taped interviews were analyzed. An interpretive approach as described by Benner (1984) was used to identify the areas of skilled performance. There were three components of the analysis: verification that the areas of skilled performance of experienced nurses described by Benner were present in this sample, identification of new areas of skilled performance, and the emergence of categories that have distinct relevance for successful performance of the advanced nursing role.

The clinical nurse specialists demonstrated activities in all of Benner's areas of skilled performance, plus a new domain, the Consulting Role, which was added to Benner's domains of nursing practice. A composite picture of common competencies and areas of skilled performance of the clinical specialist emerged from the data (Fenton, 1985).

Olsen's (1985) study examined the relationship of the nursing practice of expert oncology nurses to Benner's seven domains of nursing practice. Using quantitative and qualitative methods, Olsen sent a questionnaire to 111 randomly selected expert oncology nurses throughout the United States. The questionnaire was designed to elicit the .

nurses' perceptions of the importance of Benner's seven domains of nursing practice in oncology nursing. The questionnaire was also intended to determine to what extent the 111 nurses used the seven domains in their own practice. Concurrently, nine of the 111 nurses were interviewed to obtain three paradigm cases from each nurse.

The 27 paradigm cases were analyzed using hermeneutics and categorized according to Benner's seven domains. The Helping Role and the Teaching-Coaching Function were the two domains most often represented in the interviews and with the questionnaire. A new competency titled "preserving and protecting diversity in a world that seeks to heal through domination and control" was also identified. This competency was included in the domain, the Helping Role. The nurses interviewed also presented paradigm cases that were representative of the new domain documented by Fenton (1984), the Consulting Role of the Nurse. The works of Benner (1984) and Fenton (1985) were supported by this study.

Brykczynski (1985) used hermeneutical analysis to explore the clinical practice of nurse practitioners. Twenty-two experienced nurse practitioners comprised the sample group. Data consisted of small group interviews, participant observations of patient visits, and individual interviews with subjects to obtain specific clinical episodes. A total of 199 episodes were obtained and analyzed. The results supported Benner's (1984) seven domains of nursing practice. Paradigm cases were also presented that supported the domain, the Consulting Role of the Nurse, identified by Fenton (1984).

A study by Jorgenson and Crabtree (1986) explored the clinical nursing practice of expert critical care nurses in relation to Benner's seven domains of nursing practice. They used quantitative and qualitative methods on two groups of expert critical care nurses. Group I

consisted of nurses randomly selected from the American Association of Critical Care Nurses (AACCN) membership list. Group II consisted of nine expert critical care nurses from a local medical center. Both groups completed a questionnaire designed to elicit the nurse's perception of the importance of Benner's seven domains of nursing practice in critical care nursing and to determine to what extent the domains were used by the subjects in their own practices. The nine nurses in Group II were interviewed to obtain three paradigm cases from each nurse.

Results from a total of 86 questionnaires indicated that the expert critical care nurses perceived the Diagnostic and Patient-Monitoring Function, Effective Management of Rapidly Changing Situations, and Administering and Monitoring Therapeutic Interventions and Regimens as the most important domains in their practices. The 27 paradigm cases were hermeneutically analyzed and categorized according to Benner's seven domains. The Helping Role and the Teaching-Coaching Function were the two domains most often represented in the interviews. The interview results supported Benner's seven domains of nursing practice. It also supported the work of Olsen (1985) and Fenton (1985).

Steele (1986) reported on four master's prepared child health nurses who were a part of the sample in the study reported by Fenton (1985). Steele identified areas of graduate study that needed to be strengthened based on the data. They were as follows:

1. Development of collegial relationships with physicians and other health care providers.
2. Development of successful strategies for influencing bureaucracies to respond to the needs of patients and families.
3. Articulation and validation of the value of the role of the advanced nursing practitioner in the health care system.
4. Development of the formal and informal consulting role of the advanced nurse practitioner (Steele, p. 115).

Summary

A selected review of research, which provided the background for this study, has been presented in this chapter. Heideggerian hermeneutical analysis was discussed concerning its role in the research methodology used in this study. Benner's (1984) research that led to the identification of the domains of nursing practice was presented in some detail. Reports of research conducted by others who used Benner's domains of nursing practice as a framework concluded the chapter.

CHAPTER III

Research Methodology

The purpose of this study was to describe the domains of nursing practice exhibited by senior nursing students in their last semester before graduation, and registered nurses with 22 to 24 months experience. Both groups of nurses received their education at the same baccalaureate school of nursing in a Southeastern state. Benner's (1984) seven domains of nursing practice were used as a conceptual framework.

Design

The phenomenological approach was selected as the overall design for this research. In particular, an interpretive strategy known as hermeneutics was used to analyze the paradigm cases. The strength of qualitative methodology, in this instance phenomenology, is that this process is a process of discovery--"to know about" rather than to "know." To know about requires first-hand knowledge and a "commitment to represent the participants 'in their own terms'" (Lofland, 1971, p. 4). There is a commitment to describe what is going on as factually and as descriptively as possible. Phenomenology offers a qualitative approach that is a fitting method for investigating questions arising from clinical practice.

The project consisted of four phases: Phase I - Pre-Data Collection, Phase II - Data Collection, Phase III - Data Analysis and Interpretation, and Phase IV - Preparation of the Report.

Phase I - Pre-Data Gathering Process

Setting. The setting from which the sample was drawn was a university-based NLN accredited baccalaureate nursing program and a 600-bed community hospital located in a city in a southeastern state.

Population. The sample for this study was drawn from two separate populations. The first population consisted of senior baccalaureate nursing students enrolled in their last semester prior to graduation from an NLN accredited school of nursing during the academic year 1987-1988.

Registered nurses with 22 to 24 months' experience and graduates of the same program as the seniors comprised the second population from which the sample was drawn.

Sample. The sample consisted of two groups drawn randomly from the above populations that met the following criteria:

Group I - Senior generic students enrolled in their last semester of a BSN program at a school of nursing at the time the data was collected.

Group II - Generic graduates (RNs) with 22 to 24 months experience after graduation from the same BSN program as the students at the time data were collected.

Procedure. Following approval of an expedited application to the Institutional Review Board (Appendix C), the dean of the school of nursing and the director of nursing at the hospital were contacted for permission to ask for participation of the appropriate individuals for sample selection. The researcher requested the names of all individuals who met the criteria from the two institutions.

Names from each population were randomly drawn from the identified individuals. Those nurses and students whose names were drawn .

were personally contacted and invited to participate. During initial contact, the purpose of the study was explained to the individuals and written consent to participate obtained (Appendix D). If a potential subject declined to participate, another name was drawn and that individual contacted. This method of random drawing was continued until the two groups were completed. The two sample groups consisted of five subjects in the student group and six subjects in the registered nurse group. All subjects were female.

Both anonymity and confidentiality were maintained. The written consent forms were secured in a locked file to assure confidentiality. Subjects were assured that any typed reference to the names of physicians, other nurses, patients, and/or institutions would be designated by letter or falsified name in the interest of confidentiality. No reports from the study included data by which a specific individual could be identified.

Phase II - Data Gathering Process

Each of the groups met separately with the researcher until four audiotaped interviews were obtained from each subject. There were five student subjects and six RN subjects, yielding a total of 44 interviews. The sessions were held at a mutually agreed non-work/clinical time. A session was held if three subjects could meet at that time. Six student sessions and eight registered nurse sessions were held.

Interview Instruments. Two instruments were used in this study. The first was the "Guidelines for Recounting Case Studies" (Appendix E). The guidelines assisted the subjects in preparing for what they would be expected to recall during the small group sessions. These guidelines were adapted with the authors' permission (Appendix F).

The guidelines were used by Benner (1984) to guide recall of paradigm cases by her study subjects. According to Benner, a paradigm case is:

> A clinical episode that alters one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current clinical practice. Paradigm cases form the basis for predictions and projections. They can easily be communicated if the lesson is simple (describing how an error might occur or be prevented), but if the knowledge is more complex and dependent upon many other paradigm cases or personal knowledge, it cannot be translated to another clinician, unless the other clinician has a similar fund of personal knowledge and paradigm cases. Paradigm cases are exemplars that become a part of the clinician's perceptual lens (p. 296).

The guidelines were given to the subjects after they consented to participate in the study and prior to the first interview session. Following Benner's model, interviewer asked participants to describe paradigm cases in their clinical practice and to provide as much detail about the clinical episodes as possible.

The second instrument was an unstructured interview tool which consisted of probes (Appendix G). It guided subjects in their recall of paradigm cases and was used by the investigator to prompt them during their account of each paradigm case. The probes were only used to assist the subject's elaboration of the paradigm cases without providing undue structure to the interview.

Small Group Sessions. Audiotaped interview sessions of approximately 2 hours were held with each group over a 10-week period. The researcher was the facilitator in the interview sessions for each group. The interview sessions were focused but unstructured. The subjects were asked to describe their clinical paradigm cases in a narrative format including as much detail as possible. Probes were interjected only as necessary to elicit more information on how and why decisions

were made, what the subject was thinking about or was concerned about, and what the greatest sources of satisfaction and frustrations were.

Each nurse related one paradigm case per session. The individual paradigm cases provided the data for analysis. The analysis did not take place until all sessions were completed. A total of 44 paradigm cases were obtained for analysis.

Phase III - Data Analysis and Interpretation

Benner (1984) suggests five cirteria of internal validity which were outlined by Cherniss (1980). The criteria are as follows:

> First, they should help us to understand the lives of the subjects; we should better comprehend the complex pattern of human experience as a result of these. Second, the themes should maintain the integrity of the original "data." Third, the interpretations should be internally consistent. Fourth, data that support the findings should be presented. Usually, these data will take the form of excerpts from interviews. Finally, the reported conclusions should be consistent with the reader's own experience. In qualitative research, the readers must critically scrutinize the results of the analysis, playing a more active role in the process of "validation" than they normally would (Cherniss, pp. 278-279).

Cherniss' third point on internal consistency means that interpretations are considered internally consistent if the episodes cited match those interpretations given.

Analysis of Interviews. Verbatim transcripts of all recordings were made for analysis. The transcripts were verified by the researcher for accuracy by comparing the tapes to the transcripts. The clinical episodes were then isolated from extraneous materials on the tapes by the researcher. The transcripts were than re-typed for the paradigm cases alone and to make any necessary corrections.

Data analysis began as soon as all transcriptions were completed. The data analysis team consisted of the principle researcher and a master's prepared registered nurse who was familiar with the

interpretative method being used in this study. The 44 paradigm cases were analyzed in multiple stages of interpretation as outlined by Benner (1984) and adapted for this study. The interpretative method used was the Heideggerian hermeneutical paradigm case analysis.

The purpose of the first stage of interpretation was to examine the entire set of 44 paradigm cases as a whole. The investigator and her assistant read approximately 190 pages of text. There was no attempt at this stage to interpret any of the episodes.

In the second stage, the verbatim text of each paradigm case was analyzed separately by the investigator and her assistant for the purpose of identifying competencies in Benner's model. Sessions were held on a regular basis by the investigator and her assistant to discuss individual interpretations, with excerpts from the interviews as supporting data. A dialogue took place between the two readers regarding individual interpretations. Consensus of the two readers regarding the identification of the individual competencies and placement in one of Benner's seven domains of nursing practice was the ultimate goal. Each interpretation was accepted only if there was agreement in labeling and interpreting the major competency demonstrated. The incident was then accepted into a domain.

The third stage involved preparing a synopsis of the text of the clinical episode based on the interpretations of both readers. Benner's (1984) model, including the seven domains of nursing practice was used as a framework to provide a basis for data analysis. Excerpts from the interviews were described to support domains of nursing practice that were identified.

During the fourth stage, the subjects were given the opportunity to review the analysis for further consentual validation. A copy of

each individual subject's four paradigm cases, with interpretation, competency identification, and placement within a domain, was mailed to the individual participants. They were requested to read the researcher's interpretation of their four individual cases and to indicate whether they agreed or disagreed with the interpretation. Comments were welcomed from the participants. All of the participants responded with complete agreement to the researcher's interpretation.

The final stage of data analysis encompassed the preparation of the final report. Sufficient excerpts and paradigm cases were used so that the reader can again validate the findings. This final stage is presented in Chapter IV.

In summary, analysis was undertaken to verify that the domains of skilled performance, as described by Benner (1984), were present in the sample. Identification of any potential new domains of skilled performance and the identification of deficit areas were also a part of analysis. The data were also compared to the findings of Benner and the other researchers as reported in Chapter II. The interpretations were compared by the researcher and her assistant and consentually validated. Each interpretation was accepted only if there was agreement in labeling and interpreting the major competency demonstrated.

CHAPTER IV

Results

The results of the study are presented in four sections which correspond to and answer the research questions. The first section describes the results of the interpretive analysis of the paradigm cases of the senior nursing students and their application to Benner's (1984) domains. The second section describes the results of the interpretive analysis of the paradigm cases of the registered nurses and their application to Benner's domains. The third section discusses the similarities in the domains of nursing practice between the two groups and the fourth section discusses the differences between the two groups. For anonymity, all names in the study have been changed.

Interview Results - Seniors

This aspect of the study entailed the hermeneutical analysis of the 20 paradigm cases provided by the senior nursing students; followed by interpretation and comparison of the text with the domains of nursing practice previously identified by Benner (1984). The research question to be answered in this section was, "What are the domains of nursing practice of senior nursing students enrolled in their last semester in a baccalaureate program in a school of nursing in a southeastern state?"

Five of Benner's seven domains of nursing practice are represented in the 20 paradigm cases in the student group. The five domains are the Helping Role, the Teaching-Coaching Function, the Diagnostic and

Patient-Monitoring Function, Effective Management of Rapidly Changing Situations, and Administering and Monitoring Therapeutic Interventions and Regimens. The data are presented in the format of the five domains. Exemplars consistent with identified competencies in each domain are presented in excerpts abstracted from the paradigm cases.

Domain #1: The Helping Role

Nursing care as "helping" goes beyond the more narrowly defined therapeutic role traditionally ascribed to nurses. Helping, as described by Benner (1984), encompasses transformative changes in meanings. The exemplars in this section demonstrated that the nurse is operating beyond the point where cure, that it measurable changes for the better are sought. The helping described here demonstrates that even the beginning nurse has the courage to be with the patient and offer whatever comfort is possible

The Helping Role and the eight competencies included in this domain are shown in Table 1. The competencies addressed in this study are listed in the table.

Eleven (55%) of the 20 paradigm cases for the student group have been placed in The Helping Role domain. They represent four of the eight competencies in the domain and therefore represent 13% of the total 31 competencies. Of the 11 paradigm cases placed in this domain, 4 represent the competency, providing comfort measures and preserving personhood in the face of pain and extreme breakdown; 4 represent the competency, presencing: being with a patient; 2 represent the competency, providing comfort and communication through touch; and 1 represents the competency, providing emotional and informational support to patients' families.

Table 1

Domain #1: The Helping Role (Senior Students)

Competencies	# of Paradigm Cases	# of Total Cases
The healing relationship: creating a climate for and establishing a commitment to healing.		
*Providing comfort measures and preserving personhood in the face of pain and extreme breakdown.	4	36
*Presencing: being with a patient.	4	36
Maximizing the patient's participation and control in his or her own recovery.		
Interpreting kinds of pain and selecting appropriate strategies for pain management and control.		
*Providing comfort and communication through touch.	2	18
*Providing emotional and informational support to patients' families.	1	9
Guiding a patient through emotional and developmental change: Providing new options, closing off old ones: channeling, teaching, mediating.		
Acting as a psychological and cultural mediator.		
Using goals therapeutically.		
Working to build and maintain a therapeutic community.		
Total	11	99**

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 50.

*Indicates addressed in this study

**Does not equal 100 due to rounding

Providing Comfort Measures and Preserving Personhood in the Face of Pain and Extreme Breakdown

Four of the seniors' paradigm cases are representative of this competency. Three exemplars are presented.

Exemplar I. The senior, in this situation, had been "set up" by the floor staff that the patient was always "messy," would not look at the nurse, or talk. To the senior it made no difference, she still saw him as a person. (Names have been changed).

> Wanda: He was about 83 years old and he was up on the orthopedics floor because he had a right total hip replacement because he had broken his hip and the nursing home didn't know how, cause he wasn't walking and when they got him up he kinda fell to one side. So one time I came in on days and they [nurses] said, well, Wanda, how do you feel about working with John and I said I don't mind. I always wanted to work with him so I got my chance. They [nurses] said, "I'm going to tell you about him. You go in there, he's not going to talk to you and every time you turn him there is going to be a bunch of mess behind him because he couldn't control his feces or whatever and he had a GT tube in and we had to do his tube feeding and all that." And, I said that's fine, I can handle that. And sure enough, every time you turned him it was something there and sometimes when you wiped him, there was something coming out. He never said anything. So that morning I gave him his bath and they [nurses] said he's kind of hard to bathe because he doesn't want you to bathe him so a lot of time we just sponge him off and let him go. I noticed that his skin was like real dry, his legs and his feet and I mean his mouth was terrible, like he hadn't had oral care in about a month. So, I pulled all that dead skin off and stuff like that and cleaned his mouth out real good and then I bathed him. And he kept looking at me because usually he doesn't even look at you. He kept looking at me. I gave him his bath and powdered him down, I lotioned his legs and things real good because it was so dry and then he started, I felt him doing like this [slapping side] to his side. I said, what is it John, do you want to say something?
>
> John: Thank you.
>
> Wanda: It just really touched me because he never said anything. I said, Oh, you're welcome, you're welcome. And he said, you're so sweet.
>
> Interviewer: You must have talked to him?
>
> Wanda: Yes, I talked the whole time. I would say, "These guys just let you get all messed up, didn't they Johnny? And he would

> just look at me. I said, "Well I'm going to lotion your legs down, and get you all oiled up so you won't be so dry. I powdered him down and I would hold his hand and rub his hand and stuff and when I finished, that's when he said, "Thank you."

This client began to talk with others also. The staff and the head nurse commended the senior on the job she had done with John. However, she later had a conversation with one of the staff nurses concerning the physical condition John had been in that first day.

> Wanda: I was talking to a nurse about the way he was that first day. I couldn't believe it. She said, "Well, he's been here a while and everybody gets tired and after a while you'll know and you'll understand and you'll be the same way, and I said, God knows I hope I will never be that way.

Wanda was upset at the nurse's remarks; however, this situation strengthened her own resolve to continue to treat clients as people. She demonstrated the meaning of preserving personhood in the face of extreme breakdown.

Exemplar II. In this case, Sloan was working with a woman in her early 40s who had been in a diabetic coma for about 2 months. There had been no response during that time. She cared for her and talked with her as though she were not comatose. She even talked with the woman's two daughters about the things that their mother liked.

> Sloan: I had been talking to her too. But they [two daughters] gave me some insight into some of the things that she liked and some of the things she used to do. So, I started talking to her more about that. She used to garden and they would tell her it's summer time. It's when your flowers are really looking pretty. They named some flowers, I can't remember now and that she had a cat that she really loved. His name was Oscar. They would say that Oscar is getting fatter and fatter and missing you and we want you to come back home. So, I started bringing that in when I would go in. Later that week, I went in and turned her and I was talking to her, you know, holding her hands and everything and I said, "Mrs C. I wish you could tell me how you're doing" and I felt her hand move and she said, "fine." It was real spooky. So, I went running down the hall and I got one of the other nurses and said come back to see if she will do it again. She did. We said, "Mrs. C. are you okay?" and she said, "uh-huh." It was real faint, but you could hear it.

Exemplar III. One final brief exemplar is presented here as one which nurses will face with increasing frequency. In this exemplar, Sloan encounters an AIDS patient and a staff nurse who was 2 years away from retirement. The young man with AIDS was 27 years old, had TB and a positive strep culture. He and the staff nurse had an altercation which resulted in his leaving against medical advice. The senior tried to find out what was wrong.

> Sloan: I said I'll go in and talk to him. I just grabbed a mask to put on and went in. He was up in a corner, he'd pulled his IV and blood was everywhere. I said, "What's wrong, what happened in here?" He said, "Well everybody comes in here, they have a mask, gown, and gloves and treat me like I'm some plague or something. You're the only one who's been in here for 3 days that has treated me like I'm a person! I'm a human!" Well, she [staff nurse] comes in here and tells me she is going to put this bolus up and starts yakking off at the mouth. I'm not putting up with it any more. She's been my nurse for 3 days. He then left.

Sloan, in this situation, received direct feedback that she had preserved this young man's personhood. Even in the midst of his anger, he was able to acknowledge that Sloan had treated him as a person.

Presencing: Being With a Patient

Traditionally, nurses were trained to believe that they are always supposed to be doing for the patient. Today, nurses know the importance of just being with the patient. Several of the seniors appear to know already that presencing is important.

Four of the seniors' paradigm cases represent this competency. Two exemplars are presented.

Exemplar I. The senior was dealing with the situation of just being there for a patient. The exemplar is presented below.

> Sherry: Her name was Mrs. A. She had multiple myeloma and she was real far into it. She was a no code. She was in major pain, you could touch her like that. She never complained, I mean never. She was sitting there and all she wanted me to do was just sit in there with her all day long and just hold her hand. So, I did. I sat there all day and I just talked to her.

Interviewer: Was she your only patient?

Sherry: She wasn't, but I dropped the other one. My instructor said go ahead because this woman was real close to death and she didn't want to be by herself. I was just sitting there all day and she talked to me. They [Mrs. A. and her family] lived across the street from the hospital. When they were little, the hospital wasn't there. And, she was telling me, she talked real, real quiet and it would take her a long time to say anything, but she was telling me how they used to go and collect nuts and firewood on the land that was now where the hospital was and how she liked the mountains. When her sisters came in and they joined in the conversation and they were talking about things that they used to all do together. How her son lived in the mountains and they would all go up there. They had her room all decorated, it was Easter time, and they had decorated every inch, bunnies everywhere, or there were jelly beans everywhere because that was her favorite candy and she couldn't eat them now. So they were real good to her and they were giving her support. She just talked all day and I just sat there and listened to her. While I was in there, Dr. K. came and he was explaining to her that there's really not a whole heck of a lot more that can be done and he was making her laugh. So she knew that it was getting real close to the end and she was just sitting there. I was reading and she pulled me down and she gave me a kiss on the cheek and I was like - Oh, God that killed me. I just about started crying. She died the next morning, it was real sad. But all day I thought she was going to die any second. But she just sat there and squeezed my hand tight all day and talked. It was a real neat feeling, but like I said there wasn't any nursing care in terms of the physical, but I think I was doing patient care. It was a real neat day.

This senior could see the value of just being with the patient. She knew the woman's time was very short and that talking was important to her.

Exemplar II. The senior had to deal with an emotional situation regarding the death of an infant. The exemplar is presented below.

Kathy: There was this one lady that I took care of on the Ob/Gyn unit. She was about 30 or 32 years old and pregnant with her first child. She had PIH and delivered very prematurely, like at 30 weeks or something. She was really sweet, but she was worried about her baby and by the first time I had her, she had already had the baby. The third time I had her, I had just come on and I was working second shift and we were in report and I was going to have this lady again and they had said that her baby had died. I didn't know what I would say to her or anything and she wasn't even back from the NICU yet. She had gone over there when they found out that the baby was rapidly deteriorating. They called her over there and she was there when I came on. So, when she came back, I saw her and her husband coming back. Her husband was kind of helping her and they went into the room. I knew I had to go in there and I did not want to go in there. I didn't

> want to have anything to do with her because I didn't know what to say to her. My head nurse was standing at her desk and I said, "I don't want to go in there, I don't know what I am going to say to her." She was only somewhat helpful, she said like well I'm not sure if there is a right thing to say, you just have to be supportive in any way you can. So I kind of saw all of my other patients first, trying to think of what I would say. So finally I knocked on the door and I walked in there. Her husband was sitting in the chair and she was sitting on the bed. She had tears running down her face and then I burst out in tears, because I didn't know what to say to her. I just walked up to her and I said that I was really sorry to hear about her baby. Then she was helping me. She put her arm around me and I gave her a hug. She goes, "Well we did the best or whatever." I just kind of stayed in there. I'm sure I remembered it [paradigm case] most just because it was so emotional and I had never ever really had to deal with a really difficult situation. I didn't feel comfortable with it, yet I knew it had to be done.

In this exemplar, the senior could verbalize her fear of dealing with this situation. She recognized that it is an important part of care to just be with patients. She knows the importance of person-to-person contact between the nurse and patient. She was uncomfortable in the situation, but did not avoid it.

Providing Comfort and Communication Through Touch

Touch has long been recognized as a message of support and encouragement. Two seniors reported paradigm cases in which touch was all they had to offer in the situation. These two exemplars are presented.

Exemplar I. The senior dealt with this situation by letting the patient know she was there. The exemplar is presented below.

> Stacy: This guy was 21 years old and he had been stabbed by his brother. It was an accident. You know, they had been drinking and he stabbed him in the chest. Well he had been in ICU, and he had chest tubes and everything and they had pulled the chest tubes, and thought he was doing OK, so they sent him to us. Well, the early part of the shift they were like, okay Stacy, take him down to x-ray. After I got him back up, about 15 to 20 minutes later, the nurse I was working with, she was like, "Stacy we need to get all this stuff together, they're going to put a chest tube in on this guy here on the unit." I was very nervous, because they don't usually put chest tubes in on the floor. I say okay, we'll handle it and we'll be fine. The doctor comes in. He was real upset because this guy's lungs had, it was really, really infected and it was just spreading all over his chest cavity.

Interviewer: What kind of shape was the guy in for all this.

Stacy: He thought he was doing fine, he felt okay. He was just having a little trouble breathing and he thought it was just because he had just had chest tubes pulled out earlier that morning. So they start giving him Vercet. It doesn't really kill the pain, it just causes temporary amnesia so you don't remember the pain. The doctor kept calling for more and more and the nurse just finally said, I refuse to give him that much. So, the doctor reaches over and gives his guy all this Vercet. The doctor started and all I could do was just stand there and hold the guy's hand - he is more or less awake and he can feel it at that time. I was holding the guy's hand, the nurse had to leave and the doctor was saying things and I was like I'm sorry, I'm not allowed to do these things. So all I could do was hold the guy's hand, he was in so much pain. This guy, I've never seen anybody in that much pain before and the only thing I could do was hold his hand because the medicine wasn't taking away the pain. The doctor wasn't helping any by sticking his finger in there [chest] and cutting him. What made me remember that [this case] most, was just holding that guy's hand seemed to help him cope a little better.

Exemplar II. The lady in this exemplar was 50 to 55 years old. She had an abdominal hysterectomy and her wound became infected and filled with pus. The physician was going to open and pack the wound in her room. She was given Valium and Morphine, but it was not sufficient to relieve the pain of the procedure. The physician began to cut and opened her wound to clean and pack it.

Kathy: She was sitting there just crying and he [doctor] was just ripping up the thing [wound]. So I thought I've got to do something. I went and I got her a washcloth and I started wetting the washcloth. The doctor said, "What are you doing?" I said, "I'm just getting a washcloth for her forehead." So I gave her the washcloth and she was like grabbing my hand and hold on to it so tight. She would say over and over, "I'm glad you're here, I'm glad you're here, I'm glad you understand." I had wrung out the washcloth a couple of times by now and she still had my hand and you could just tell that there was a different relationship between me and this lady. I really felt like I could understand where she was coming from. I mean, I really felt for her and how the doctor was treating her.

Both exemplars involved painful procedures being performed in the client's room. Medication was provided in both cases, but was insufficient to control the pain. Touching, in both cases, was the only way the seniors could demonstrate support and caring for their clients.

Providing Emotional and Informational Support To Patients' Families

The one paradigm case representing this competency dealt with the young parents of an infant who was scheduled to receive his first immunization. One exemplar is presented.

Exemplar I. The senior was dealing with a situation of presenting information to parents regarding risk factors. The exemplar follows.

> Stacy: Well they get through the physical okay and they go back out to the waiting room. I give them that little sheet of paper that has all the side effects and risks, that the parents are supposed to read and sign. So, I take it out there to them and let them read it. I came back a little later and they were sitting there crying. The mom is hysterical and the dad is like - "No! We are not going to let our son have this shot!"

The senior tried to provide the parents with the information necessary for them to understand that the risk from the DPT is really minimal when compared to the risk of getting the disease(s). All of her efforts appeared to be unsuccessful. The doctor persuaded the parents to agree to the immunization, but they left the clinic still crying and upset. The senior was inexperienced in handling frightened parents. However, with these parents, even a more experienced RN might not have been successful. The senior tried to provide emotional and informational support to these parents, but her efforts appear to have been unsuccessful.

Domain #2: The Teaching-Coaching Function

Nurses, as a part of their role, coach patients through an illness and teach them about their illnesses. The nurse frequently tries to anticipate for the patient and then tells him what to expect, corrects misinterpretations, and helps him understand what is happening to him. The coaching role in this domain deals with the culturally unacceptable (such as death) and adolescent pregnancy and makes it less foreign and more acceptable.

The Teaching-Coaching Function and the five competencies included in this domain are shown in Table 2. The competencies addressed in this study are listed in the table.

Table 2

Domain #2: The Teaching-Coaching Function (Senior Students)

Competencies	# of Paradigm Cases	# of Total Cases
Timing: Capturing a patient's readiness to learn.		
Assisting patients to integrate the implications of illness and recovery into their lifestyles.		
*Eliciting and understanding the patient's interpretation of his or her illness.	2	50
Providing an interpretation of the patient's condition and giving a rationale for procedures.		
*The coaching function: Making culturally avoided aspects of an illness approachable and understandable.	2	50
Total	4	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 79.
*Indicates addressed in this study

Four (20%) of the 20 paradigm cases for the student group have been placed in this domain. They represent two of the five competencies in the domain and therefore, 6% of the total 31 competencies. Of the four paradigm cases placed in this domain, two represent the competency, eliciting and understanding the patient's interpretation of his or her

illness; and two represented the competency, the teaching-coaching function: making culturally avoided aspects of an illness approachable and understandable.

Eliciting and Understanding the Patient's Interpretation of His or Her Illness

Two paradigm cases have been placed into this competency. Two exemplars are presented.

Exemplar I. The senior in this exemplar dealing with a 7-year-old girl recently diagnosed with Acute Myelocytic Leukemia (AML). This family used humor as a method of coping with this illness. They even joked about the child losing her hair. The senior respected their way of coping and learned from them.

> Sherry: The way they handled everything was real neat because like immediately they got into a support group which I thought was sort of interesting. They had all these books about AML and they really wanted to know everything they could about it and they would joke about it. They knew it was serious. Dede had real long hair and didn't want to brush it one day. Her mom's like - that's okay because in a couple of months you can just throw it to me and I'll just brush it out. She didn't have a wig on but she said that. And, she would talk about it, the little girl would talk about it, the parents would talk about it, it was just a real open thing and it was just really neat I thought.

The senior suggested that this family made a significant impression on her. "This is why I knew that I wanted to go into nursing, was this one client, and I know I can never forget her for some reason, but the way they handled the whole thing about being diagnosed is real neat." In this situation, the senior learned from the patient and family and can use the experience in future situations.

Exemplar II. The senior in this second exemplar was dealing with a young pregnant patient who was near term, attending the Ob/Gyn clinic. This young woman was diagnosed with her third variety of a sexually

transmitted disease during this visit. The patient did not understand why she kept getting infections as she had been faithful to her boyfriend and felt that he had been faithful to her.

The senior in this situation allowed the patient to express her feelings about her condition without being judgmental. Due to the young woman's repeated infections, it was obvious that she or her boyfriend was engaging in intercourse with other individuals.

> Wanda: I was sitting with her and was asking her did somebody plan to be with her when she gave birth and she said her boyfriend did. I said that's good. You've been going through class and everything. She said no, he just wants to be in there with me when I have the baby. I said, do you plan to get married? She said, well, maybe, we don't really know yet, but I hope we do. She said he really loves me and all this but it's just kind of hard because some things have been turning up since I got pregnant. I said, some things like what? She said, well I keep getting these infections. I said are you getting yeast infections because yeast infections are pretty common with pregnancy? She said no. When I first came they told me I had chlamydia. She said I never had chlamydia before but I tested positive for chlamydia. I said really? She said yes, they've been trying to treat me for that and that was like my third month. A couple of months back I came and I tested positive for gonorrhea. So I said really, and she said yeah. I know my boyfriend isn't messing around on me. So I said, are you messing around on your boyfriend? She said no, I haven't been with anybody but him. I'm just wondering why I'm getting all these infections. I said you know all of these are sexually transmitted infections. She said, well I just don't understand. He promised me he hadn't been with anybody and you know I love him and he loves me and we've been faithful to each other. So I said what brings you back this time? Well, I have a regular visit, but then too I have been real sore down there. Sometimes it's hard for me to sit down, I have to sit on a pillow and I kind of have like some bumps on my thighs.

It turned out that the "bumps" were condyloma, venereal warts. The patient had a very severe case that was going to require surgery after the baby was born. The condyloma would also necessitate that the baby be born via a C-section.

The senior stayed with the young woman and allowed her to start the process of working through the possibility that her boyfriend was having intercourse with others and then transmitting the diseases to

her. The senior did not argue with the young woman about her statements concerning her boyfriends. She let her share information with her without trying, at that time, to convince her that she was wrong. The senior was truthful but understood this young woman's need to believe that the boyfriend was faithful. She accepted the patient's interpretation and helped her work through from that perspective.

The Coaching Function: Making Culturally Avoided Aspects of an Illness Approachable and Understandable

In the coaching function, the nurse makes culturally avoided situations as adolescent pregnancy and other unique situations more understandable and acceptable. It can also be a time of learning for the nurse. Two paradigm cases were representative of this competency. The first exemplar deals with adolescent pregnancy, while the second deals with a more unique situation of a woman with a beard extensive enough to require shaving.

Exemplar I. The senior in this paradigm case dealt with a 15-year-old adolescent on the morning after delivery. In this instance, the senior appears to be the only one accepting of this young adolescent mother.

> Sherry: I went in and I was just talking to her and another nurse came in and was real short with her. No matter what she said she cut her off, she was turning her real rough and stuff and I was like, "What's the deal?" So the nurse walked out and the girl said, "She does like that to me." She got real upset. She was already upset because she had just had a baby. So I figured I would give the nurse the benefit of the doubt, maybe she was having a rough day or whatever. Well, she wasn't. I went and talked to her and she had a thing about adolescent moms. She just doesn't like them. I thought, first of all you're in the wrong job. She said, "You are more than welcome to take care of her." I went and got the baby and I brought him in and put him down near her and she didn't touch him or talk to him and she kept calling him "it." I picked him up and I put him back down and she picked him up in this real weird way. It was like this isn't good. So then I showed her the proper way to pick up a

> baby. I told her the first time I had picked up a baby I was scared. She had never baby sat or had any interactions at all with infants. I thought, "great." So I let her hold him and she was being a little bit more relaxed and I showed her how to feed the baby and to burp him. She was loosening up just a little bit and she started to talk to him. Then her [grand] mother walks in and immediately she [mother] puts the baby down like this. Then the grandmother said, "Well let me have him, I know how to do it right." So I was like we're going to get a lot of support from the [grand] mother (said with sarcasm). The grandmother started feeding him, you know, no big deal. During our conversation, I referred to the mother of the baby as "mom" a couple of times. You could see terror in her eyes. So I started asking her some questions, just in a nonchalant way to find out how much she knew. Well, she knew absolutely nothing about the baby. From not ever having diapered a baby or seeing a baby diapered to never feeding a baby. So I started telling her, okay the biggest thing was that I felt the most pressure on was that she was going to get no encouragement from her mother because she [grandmother] thought she did everything better. Remember when I said she came in and took the baby away from her, well, this happened three or four times until I finally took her [grandmother] out in the hall and told her she was going to have to let her [mother] do it. The girl had dropped out of school and was going to be the primary caretaker during the day while the [grand] mother worked. So not only was she going to be home by herself all day long, not knowing how to take care of the baby, but she would get no support from her mother and the nurse was being a total idiot. She was being discharged the next morning which meant any teaching she got, I had to do within the next couple of hours. I stayed for 1 to 1½ hours after clinical just trying to teach her basic childcare. I gave her some of the teaching materials and said, "Please read some of it." When I left that day I thought I had done the best I could, but like had I done enough. This girl was scared to death and had this helpless little baby. She showed a lot of interest once I would tell her something, if I asked her a few minutes later, bring that topic back, she would know, she would repeat back what I had told her or by the end of the time when I left she was talking to the baby, you know, looking at his hands and feet, which you know they say the mom is supposed to do in the bonding real early. Even to this day, I wonder what happened to her because she showed so much interest. She wanted to take care of the baby, but she knew nothing about it and was going to get no help.

The senior recognized that the RN did not like adolescent mothers and was not supportive of this patient. The grandmother was telling the young woman, "I know how to do it [infant care] right." This young mother however, was going to be responsible for the infant's care at home as the grandmother would be working. The senior determined that the young mother knew nothing about child care and was very scared. She

was very accepting of this young mother and used teaching to provide her with some skills to cope with this infant at home. Adolescent pregnancy is a culturally avoided event in many families. This senior opened ways of coping for this adolescent by increasing her knowledge of childcare.

Exemplar II. This second case was a cultural rarity. In this situation, the senior was dealing with a bearded female patient who needed to be shaved.

> Sloan: I was nervous. She had a trach, was very obese, and she had a lot of hair on her face. She'd been on hormones. I had given her a bath. Then she started doing her face and I said, "We had washed your face" and she said, "No." She motioned to me to help her get up, so I helped her up and she got out a razor. I had never shaved anyone, much less a woman. So I said okay. She had shaving cream so that helped and I did the shaving. I was worried, she had growth on her neck too and I was real worried about the trach. So I did all of her face up here [cheek area] and she motioned to her neck and I said, well, what about your trach? She held her hand where she could still breathe and I shaved. It was so nice because she helped me. Afterwards, she plugged off the trach long enough to say "Thank you. We worked together, did it together." So it helped me a lot with her giving me the support. I think she knew that it was my first time shaving anybody. But with - she perceived it, but she was able to help me through it.

This situation was one of critical learning for the senior. Her understanding expanded through working with this woman. She later learned that the woman was able to shave herself, but had chosen to have the student participate. The senior learned to shave a patient, an experience she can use again and again. Sloan stated, "We worked together. I think she knew that it was my first time shaving anybody. I feel like she taught me more than anything."

Domain #3: Diagnostic and Patient-Monitoring Function

The diagnostic and patient-monitoring role of nursing has expanded over recent years. New technologies, sicker patients, and increased specialization have all contributed to the expansion of this domain.

In fact, it is the need for the nursing care in this domain that frequently results in hospitalization of the patient. If the patient does not need monitoring, he usually does not need to be hospitalized. Three senior paradigm cases represent this domain. Even though they lack experience, these seniors are still functioning within this domain at an advanced beginner level.

The Diagnostic and Patient-Monitoring Function and the five competencies included in this domain are shown in Table 3. The competencies addressed in this study are indicated in the table.

Table 3

Domain #3: Diagnostic and Patient-Monitoring Function (Senior Students)

Competencies	# of Paradigm Cases	# of Total Cases
Detection and documentation of significant changes in a patient's condition.		
Providing an early warning signal: anticipating breakdown and deterioration prior to explicit confirming diagnostic signs.		
*Anticipating problems: future thinking.	1	33
*Understanding the particular demands and experiences of an illness: Anticipating patient care needs.	1	33
*Assessing the patient's potential for wellness and for responding to various treatment strategies.	1	33
Total	3	99**

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 97.
*Indicates addressed in this study
**Does not equal 100 due to rounding

Three (15%) of the 20 paradigm cases for the student group have been placed in this domain. They represent three of the five competencies in this domain and therefore 10% of the total 31 competencies. Of the three paradigm cases placed in this domain, one represents the competency, anticipating problems: future thinking; one represents the competency, understanding the particular demands and experiences of an illness: anticipating patient care needs; and one represents the competency, assessing the patient's potential for wellness and for responding to various treatment strategies.

Anticipating Problems: Future Thinking

One paradigm case has been placed in this competency. The one exemplar is presented below.

Exemplar I. The senior in this situation was dealing with a man in his early 60's who was extremely malnourished. He was given a medication that resulted in wildness and confusion.

> Stacy: We put a posey on him because we didn't want him to get out of bed and we knew he would. Well, we put a posey on him to see if that would remind him to call us. I explained what it was for and everything, and he seemed to take it okay. Well, this man was a smoker too. Later, when I went back to his room and he had taken a cigarette lighter and burned right through the posey - melted that thing clean into two little pieces. So I ordered a posey vest this time and I thought surely he can't do anything to this one. I had got rid of what I thought was all the cigarette lighters. So I go in later after I thought he had gone to sleep and he had found another cigarette lighter and burned through the posey vest. He met me at the door. Well, I got him back in bed and somehow or another he got back out of another restraint. We caught him walking down the hall. This time I got to him just as he was getting ready to fall. The man just fell right to the floor and I just eased him on down and here we both were sitting in the middle of the hall.

The man had been restrained in anticipation that he might get out of bed and hurt himself because of his confusion from the medication. He was carefully watched, again in anticipation that he might accidentally hurt himself. This was a valid concern since he kept getting lighters

and burning his way out of the poseys. He was even caught as he began to fall in the hall. As a result of Stacy's anticipation of problems, this man did not experience any injuries as a result of his confusion.

Understanding the Particular Demands and Experiences of an Illness: Anticipating Patient Care Needs

One paradigm case has been placed in this competency. The exemplar is presented below.

Exemplar I. The patient in this case was a 32-year-old man who had had extensive surgery. He had been a patient for 5 months and had become very ritualistic about his care. He had to have certain items, in certain positions, during certain procedures. This was his way of having control and coping with his illness. This situation was an example of understanding this man's particular illness and his patient care needs.

> Sloan: You would bring him his tray and you'd ask him to sit up and he'd want to be on the bedpan. He wouldn't get out of the bed, he wanted to sit in the bed on the bedpan. You had to have chux beside it, two towels, three washcloths that were wet, and two washcloths that were dry. It was just his general attitude. Everything just had to be so so, never wanted to get out of the bed to eat. He would get his ice pitcher. He would ask for it full of ice and no water and you'd go in there later and he would have the milk sitting down in there.

The senior did not actually recognize this as the patient's coping style. However, even without understanding, she allowed him to maintain his rituals. She was able to work very effectively with this man during her time as his nurse. With more experience, she perhaps would be able to identify similar coping styles of patients with a variety of illnesses.

Assessing the Patient's Potential for Wellness and for Responding to Various Treatment Strategies

One paradigm case has been placed in this competency. The exemplar is presented below.

Exemplar I. The senior was working with an elderly man who spent all of his days sitting in his room. He was not watching TV or listening to the radio. He just sat. The senior assessed that he was capable of more activity. She stated, "My big goal for him was to get him out of his room." Several techniques were attempted to get him out of his room. They worked, but only temporarily.

> Kathy: Mr. G. was a little old black man. I went to visit him and his apartment door was kept open. Most people treat it like apartments and keep their door closed, but he had his door wide open. He was sitting on his couch. We started talking to him a little bit. I asked him what he did during the day.
>
> Mr. G.: Oh, I just sit here up until 6:00.
>
> Kathy: What do you do at 6:00?
>
> Mr. G.: Watch TV news.
>
> Kathy: That's all he did all day long, just sit on the couch and do nothing. He didn't talk to anybody, he jsut sat there. It didn't seem like depression. Anyway, my big goal for him was to get him out of his room. So every week, [I asked] you want to go walk out?
>
> Mr. G.: No.
>
> Kathy: And so, I went up there one time and I took his blood pressure and it was fine, but I told him it was really high. Your blood pressure is really high, you need to go downstairs to the clinic and have it checked.
>
> Mr. G.: My blood pressure, I never had high blood pressure before.
>
> Kathy: I said lots of time you know, it kinda gets like that and you go and get it checked and it'll be okay. So next week he came down to the blood pressure clinic. He just walked in and said "Told me I had to get my blood pressure checked." Well, Mr. G., it's good to see you. I took his blood pressure and it was fine and I told him, "It's doing okay, but you better come back next week. [He didn't like that]. So next week it had gotten

near the end of the afternoon and he hadn't come down. So I went up there to his room. You didn't come down and get your blood pressure taken.

Mr. G.: There ain't nothing happened to me yet.

Kathy: We were doing aerobics that we did sitting in a chair. Well, I go get Mr. G. to come to aerobics, right. So I went in and told him we were having some exercises out in the lobby. Do you want to come.

Mr. G.: No.

Kathy: It will be lots of fun, music, and nothing really strenuous, just kind of sitting in a chair. So finally I think I bugged him enough that he said, well, I'll come. So he comes down, it took him about half an hour to walk down the hall and he sits down. We had this pretty contemporary music and I had it up kind of loud. It was so funny because he started getting into it. I'd say raise your hands over your head and he was just getting into it.

Kathy left information for the senior who came next through the rotation behind her. This information concerned what she had done. She reported that Mr. G. needed encouragement and stimulation to participate in activities. When she left, there were no further attempts to get him out of his room. Kathy's assessment for his potential to be more active was correct, her strategies to get him out of his room worked. However, follow-up was unsuccessful.

Domain #4: Effective Management of Rapidly Changing Situations

This domain encompasses nursing care that is required when there is a sudden change in a patient's condition. It may be managing a patient situation until a physician arrives or actually handling a situation and mobilizing appropriate resources. The domain of Effective Management of Rapidly Changing Situations and the three competencies included in this domain are shown in Table 4. The competencies addressed in this study are listed in the table.

Table 4

Domain #4: Effective Management of Rapidly Changing Situations (Senior Students)

Competencies	# of Paradigm Cases	# of Total Cases
*Skilled performance in extreme life-threatening emergencies: rapid grasp of a problem.	1	100
Contingency management: rapid matching of demands and resources in emergency situations.		
Identifying and managing a patient crisis until physician assistance is available.		
Total	1	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 111.
*Indicates addressed in this study

One (5%) of the 20 paradigm cases for the student group has been placed in this domain. It represents one of the three competencies in this domain and, therefore, 3% of the total 31 competencies. The one paradigm case placed in this domain represents the competency, skilled performance in extreme life-threatening emergencies: rapid grasp of a problem.

Skilled Performance in Extreme Life-Threatening Emergencies: Rapid Grasp of a Problem

One senior student presented a paradigm case that fits into this competency, and the exemplar is presented. She was in the Intensive Care Unit at the time and was working with a new RN. When the emergency occurred, both performed appropriately, but neither was experienced enough to handle the total situation.

Exemplar I. The senior in this situation was dealing with a woman in the Intensive Care Unit. The exemplar is presented below.

> The client was a young woman of about 35 years of age. She had a little girl. Everyone was talking about her little girl that she had brought up on the unit. She was showing her around, which was real unusual because our patients just don't walk. She would sit up in her bed and she was reading the comics. She would wave to you as you walked by and say, "Come on in and talk to me." It was just real unusual to have her in there [ICU]. She was in there just reading the Sunday comics and something made me ask myself, "What is she here for?" There's nothing wrong with her, she was not hooked up to anything except the cardiac monitor and everything was fine. She had this rare thing wrong with her lungs that apparently the physicians working with her had never seen. They were like honeycombs. They would hold everything in them and she had a really bad time with coughing up blood. So then we were sitting at the desk and were charting and the RN who had her said, "Kim, come in here, she's coughing up blood." I said okay. I started walking and she [RN] said "MOVE IT!" So I went running in there. The lady is sitting up over the bed table, with a garbage can and blood is gushing, like when you pour a can of paint out. So I, who don't know anything and a brand new RN are in there and the RN, who was experienced in working with her, was on the phone trying to get in touch with the doctor. The only thing between the two of us that we could think to do as we were watching this lady, I mean it was just 10 minutes of gushing blood, and the only thing that we could think to do was keep her sitting up and get the Tonsil suction so she wouldn't aspirate. Anyway she eventually aspirated and coded and for some reason the head nurse, the assistant head nurse, and the clinical director were all there. So they all come running because they know that there is chaos going on over in this corner. Well, the lady had coded and she was out. But before she coded, while I was standing there with the Tonsil suction in her mouth, we thought she bit her tongue off. Well, she didn't bit her tongue off, her lungs were coming out of her mouth into the garbage can. I know that there were at least 50 or 60 people in that room trying to revive the lady. They coded her I know for an hour and a half or so. They couldn't do anything for her and she died.

Sherry and the RN handled the situation approrpiately. There was very little that they could do for this woman except to attempt to keep her airway clear and call for assistance. They were both inexperienced in this type of emergency, but they recognized the situation immediately and performed appropriately. The senior and RN did what they could in this situation, but they were not experienced enough to handle the total situation [code] and other more experienced personnel took over.

Domain #5: Administering and Monitoring Therapeutic Interventions and Regimens

Nurses are responsbile for administering therapeutic interventions. These interventions are often complex because the nature of health care has become more complex. Intravenous therapy, medications, rehabilitation, and wound management have all become more sophisticated and complex. Monitoring is an essential aspect of all of these complex interventions.

The domain Administering and Monitoring Therapeutic Interventions and Regimens and the four competencies included in this domain are shown in Table 5. The competencies addressed in this study are listed in the table.

Table 5

Domain #5: Administering and Monitoring Therapeutic Interventions and Regimens (Senior Students)

Competencies	# of Paradigm Cases	# of Total Cases
Starting and maintaining IV therapy with minimal risks and complications.		
Administering medications accurately and safely: monitoring untoward effects, reactions, therapeutic responses, toxicity, and incompatibilities.		
*Combating the hazards of immobility: preventing and intervening with skin breakdown, ambulating and exercising patients to maximize mobility and rehabilitation, preventing respiratory complications.	1	100
Creating a wound management strategy that fosters healing, comfort, and appropriate drainage.		
Total	1	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA; Addison-Wesley, p. 123.

*Indicates addressed in this study

One (5%) of the 20 paradigm cases for the student group has been placed in this domain. It represents one of the four competencies in this domain and, therefore, 3% of the total 31 competencies. The one paradigm case placed in this domain represents the competency, combating the hazards of immobility: preventing and intervening with skin breakdown, ambulating and exercising patients to maximize mobility, and rehabilitation, preventing respiratory complications.

Combating the Hazards of Immobility

Exemplar I. The senior in this paradigm case was dealing with her patient's physical condition. Many of her interventions were related to the hazards of immobility. The patient was 94 years old and a new admission to the unit. She had pneumonia and required total care.

Sloan: I went in there and said, "Gina."

Gina: Hey, mama, how yaw doing?

Sloan: I said, "I'm just fine, how are you?"

Gina: Well, I'm just fine.

Sloan: I said you have to turn over Gina.

Gina: I like this side better.

Sloan: I said okay - Gina, you skin's gonna break down and you're gonna have sores if we don't turn you over.

Gina: But, baby, I don't want to turn over.

Sloan: I said, well, I'll make a deal with you. If you turn over on this other side for at least an hour, I'll bring you some ice cream. You can eat some ice cream on this side and then I'll turn you back over.

Gina: Alright, we'll do that.

Sloan: So, I went and got the ice cream because they had told me that she liked it. I went and got the ice cream and fed it to her. She agreed with that and I told her, I said, let's stay on this side for a little longer. She said okay. She said, "turn on that TV." I said okay. There was music on and she wanted it on that channel. She said, "let's dance." I thought OK. I said,

> you dance for me first Gina. She just wiggled. But she hated to be turned. She got those arms - "No! I like this side better!" So you had to bribe her to get her to turn over.

Sloan's interventions were aimed at keeping her client turned from side to side on a frequent basis. She used ice cream and the lady's love of dancing to coax her into turning side to side. The lady's pneumonia was resolved and she went back to the nursing home without any other complications.

In this situation, Sloan assessed what interventions were needed and planned appropriate management strategies to handle the potential hazards of immobility. The senior maximized her client's mobility using individualized planning.

Interview Results - Registered Nurses (RNs)

The second section describes the results of the interpretative analysis of the paradigm cases of the registered nurse group and their application to Benner's (1984) domains. The research question to be answered in this section is: "What are the domains of nursing practice of registered nurses with approximately 2 years' experience after graduation from a baccalaureate program in a school of nursing in a southeastern state?

Six of Benner's seven domains of nursing practice are represented and provide the format by which the data are classified. The six domains represented are the Helping Role, the Teaching-Coaching Function, the Diagnostic and Patient-Monitoring Function, Effective Management of Rapidly Changing Situations, Administering and Monitoring Therapeutic Interventions and Regimens, and Monitoring and Ensuring the Quality of Health Care Practices. Exemplars consistent with competencies described by Benner are presented in excerpts abstracted from the paradigm cases.

Domain #1: The Helping Role

The RNs involved in this section went beyond the narrowly defined traditional role of "helping" that is attributed to nurses. The cases presented demonstrate that nurses operate beyond just rrying to cure the patient.

The Helping Role and the eight competencies included in this domain are shown in Table 6. The competencies addressed in this study are listed in the table.

Nine (38%) of the 24 paradigm cases for the RN group have been placed in this domain and represent three of the eight competencies in the domain and 10% of the total 31 competencies. Of the nine paradigm cases placed in this domain, two cases represent the competency, the health relationship: creating a climate for and establishing a commitment to healing; four cases represent the competency, providing comfort measures and preserving personhood in the face of pain and extreme breakdown; and three cases represent the competency, presencing: being with a patient.

The Healing Relationship: Creating a Climate for and Establishin a Commitment to Healing

This competency includes mobilizing hope for the patient and nurse that healing is possible. It involves finding a way to understand the illness and stress and assisting the patient to find and use any necessary support. Two of the RN paradigm cases are representative of this competency, and these two exemplars are presented.

Exemplar I. This case is an example of the nurse's interventions making a difference in the outcome for this patient. She reported that

Table 6

Domain #1: The Helping Role (RNs)

Competencies	# of Paradigm Cases	# of Total Cases
*The healing relationship: Creating a climate for and establishing a commitment to healing.	2	22
*Providing comfort measures and preserving personhood in the face of pain and extreme breakdown.	4	44
*Presencing: Being with a patient.	3	33
Maximizing the patient's participation and control in his or her own recovery.		
Interpreting kinds of pain and selecting appropriate strategies for pain management and control.		
Providing emotional and informational support to patients' families.		
Guiding a patient through emotional and developmental change: Providing new options, closing off old ones: Channeling, teaching, mediating		
Acting as a psychological and cultural mediator.		
Using goals therapeutically.		
Working to build and maintain a therapeutic community.		
Total	9	99**

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 50.
*Indicates addressed in this study
**Does not equal 100 due to rounding

this young 25-year-old man had given up on living. His pain was intense, he was young, he had had to get married, and he had never seen his newly born son.

> Sue: He had been on a tractor and the tractor overturned on him. He originally came to the unit [ICU] basically with a broken pelvis without too many other problems. As he progressed, he began to have other problems. His bowel sounds were not present, something was going on. By the time they operated on him, he had a severe abscess and so we add one more thing to it. He then had a respiratory problem and ended up being opened from the sternum to back bone with three chest tubes in place. So now, we've got a really sick young man with a 17-year-old wife who is due to deliver any time. They're from the country, not highly educated, and the nursing staff is trying their best to be supportive and reassuring. He did not tolerate pain at all. We had to use a lot of pain medicine on him. It took three or five nurses on duty on the unit to do dressing changes on him because it took two to hold and one to change his chest tube dressings. We also ended up having to put him on a ventilator. Now we've got three chest tubes, six IVs, a drain from his belly, a ventilator, a wife due to deliver at any time, and a man who had already told us he chose to die. He was pulling everything [tubes, etc.] he could pull, anytime he could pull it.
>
> Interviewer: He didn't want to fight to see his baby?
>
> Sue: He was hurting, he said he had had to get married anyway and didn't really want the kid. So we got to a point, his wife delivers and she brings him some pictures of the baby. He's really excited because now he's seen this little person and it's a son and he's into sons. So I get a call one day from the nurse on the maternity unit saying "I'll bring the wife and the infant down to see him" I say, "Fine, sounds great to me, he really needs to see his baby." Well, I did not realize she did not have it approved by her head nurse. I didn't have it approved by my head nurse because, in my opinion, the baby was a newborn protected by the mother's antibodies. I arranged for the infant to be brought when there would be no visitors and would go directly to the father's room. The baby would not really be exposed in a dangerous way. My head nurse went bananas and decided that the infant would not come under any circumstances. I basically said that the infant was coming. In the meantime, the patient's doctor comes and says, "No, the infant will not be brought." I say, "The infant will be brought. He's on his way." The doctor finally agreed that the baby could be brought to the doorway, but could not enter the room. The mother brought the baby down and held her son up for her husband to see. He absolutely melted. They had all of 5 minutes together to talk and see his son. After seeing his son, we had a complete turn around in attitude by the patient. He never attempted in any way to interfere with his treatments again. He never pulled another IV, he never made any

> attempt to extubate himself, and he was finally on his way to recovery. I have since seen this patient six or seven times. He walked out of the hospital, he's fully employed, his son is now about a year old, and very healthy and happy. They are a family unit.

Sue said that she felt that seeing his son would start the bonding process and mobilize some hope within this man to get well. She went against her head nurse and the physician because her belief was so strong. She could not be sure that seeing his son would be successful, but she had to try. It was only after he had seen his son that she would know if her intervention worked. She said:

> I really feel that the turnaround for this entire family was in the bonding, the chance to be with the infant. If I had not stood up for the patient and said this was a necessity, and I really was fighting a battle because the head nurse and attending physician both said no, it would not have happened. The reason I chose to take a chance and go against my head nurse and the doctor and insist that in fact the infant would come, was because he [client] had nothing to live for. He had no chance to bond. His wife was frightened. She needed him to see the child. Even if he did die, she would have the knowledge of knowing that he had seen the baby and that he cared.

The nurse was a key person in understanding the situation, mobilizing hope, and bringing in the support systems that resulted in this man choosing to live.

Exemplar II. The nurse in this paradigm case assessed that this patient had given up on living. He had pancreatic cancer and decided that he preferred to die. Nancy used her judgment that it was a realistic expectation for this patient to recover enough to go home. She felt that the patient could regain hope and want to live. She knew that hope was important to his morale and even to his recovery. She could not be sure that her efforts would be successful, but she had to try.

> Nancy: This gentleman was an elderly man, 72 years old admitted to the hospital with cancer of the pancreas. He weighed around 75 pounds and stood about 6 feet tall - was real anorexic and didn't want to eat. He just could not eat anything no matter what we talked to him about. I called in a dietitian to see if that would help, thinking maybe he just didn't get what he was wanting to eat. He was a person who lived in the country and he wasn't used to the hospital food. That didn't work. So I said, "How about bringing in your family so we can talk?" So we called a family conference and we had everybody sit down together and he just said he just wasn't happy. He was sick and he felt that he was going to die. He'd rather go ahead and get it over with and die instead of being a burden on her [wife] and the family. He was just going downhill all the way no matter what the medical diagnosis was or what changes they made in his medicine - it just wasn't the right thing at all, it was just getting worse. I think back, I thought, I called in Hospice, I called in the chaplain, I called in the doctors to do medical consults telling them something was going on. I couldn't pick it out, but he was real depressed. The family conference didn't work, social services/patient family services, social worker, and I even called in for like a marriage counselor. When he died, it was like, I hadn't done everything.

Nancy called in support people to try to mobilize hope for this man. Her hope was that the patient would again want to live and would be able to recover enough to go home for a while. Her efforts were unsuccessful.

Providing Comfort Measures and Preserving Personhood in the Face of Pain and Extreme Breakdown

Four of the RNs' paradigm cases are representative of this competency. Four exemplars are presented.

Exemplar I. Nancy knew that this patient's "prognosis was very grim." He was 35 years old, admitted for a second craniotomy, and was in a coma.

> Nancy: The first time was 8 years ago. He had a gunshot wound to the head. He had been in a coma. They [doctors and nurses] worked on him for several months and he went home functioning just as good as he had been prior to the accident. He was taking Dilantin and Phenobarbital on a daily basis. He supposedly went to a witch doctor who told him to stop taking the Phenobarbital and Dilantin. He went off the medication and suffered a seizure while playing basketball-- he was very active in sports. He was in good physical condition and otherwise had been healthy except for after being in ICU. They [doctors] said he would probably be in a coma for the rest of his life. The doctors said for us just to give care to keep him going. They didn't have any hope for him because of the

> previous injury to the head. He had blown a ventricle and they didn't think it was going to be a very good prognosis. We worked with him for a very long time, just family members, to get them aggressive with his care, to talk to him when they came into the room. We played television, we played music. I would come in in the morning and would tell him - it's Friday morning and 8:00 AM, the weather is such and such. This program is on television. We found out what he did normally during the day and tried to keep his schedule as much like what he had done at home. He liked to watch basketball games. His 13-year-old son would come in the afternoons and say, "Dad, I need help with my homework," and knowing that his dad would not be able to tell him the answer, he went ahead and said, "Dad, my homework is this, my math problem is this, help me figure this out." The most support he got was from his mother. She would come in and do different things to him like a back rub, and work on his feet. We taught her how to do range of motion. Every time someone would walk into the room, they would address him as though he were alert and could speak back to us. He may not be able to respond back to us, but his pupils, his eyes, whenever you touched him would move. I said [to the family] do like you would if you were coming in if he was just sick and could talk back to you. I got accustomed to going in the room and saying my name is Nancy. I would call Mr. so and so. They said it would probably be better if I called him by his first name, so after I started calling him by his first name, I got on a one-to-one basis with him. He was not a patient and I the nurse. I was his friend coming in to see him and I would say, "How are you doing and call him by name. We are going to do physical therapy to all extremities. At 6:00, we are going to have dinner. I can sit him up even though he wasn't eating by mouth, he had tube feedings. I'd tell him, we are going to have this and your mom is having such and such. We got him so he could talk to us, feed himself, and could move from the bed to a chair by himself. He went to the rehab unit and supposedly walked out of the hospital. The doctors seemed to think that it was a miracle. They called him our miracle person because they had thought that he would never progress that far. When he first come in, it was like there was nothing and after you keep working with him to see him progress.

Nancy knew that the possibility for this patient to awaken from his coma was minimal and that he was not expected to recover. Knowing this, she still did not abandon this patient. She preserved his personhood by involving the family in a routine that treated him as a valued participant. She found out what he normally did during the day and tried to maintain his schedule. His 13-year-old son was encouraged to come and interact over his homework, just as he had with his father prior

to this hospitalization. Nancy told the family to "just go ahead and do like you would a normal person."

Even though he was in a coma, she worked to keep him in the mainstream of his family, so that they would continue to see him as a person and still a member of the family. Her efforts resulted in him being able to eventually return home to this family. They had never given up on him either.

Exemplar II. Sharon works in an ICU setting. Many of her patients are in a coma and will not recover. She preserves their personhood by directing her efforts toward maintaining their dignity and worth as people.

> Sharon: What I was going to tell you was something that makes me feel good about what I do. And, that's when it usually happens when I'm on night time and there's not all the commotion and everything going on [like] during the day. I have more time to concentrate on the patient care stuff, like the nursing. I like doing the patients' baths and sometimes I just can't do it during the day, the aides do it. But people, a lot of them have N/Gs and the tape stays there forever. Nobody ever changes it and all the goo gets all over their nose. And, I like to do that, you know, change the tape and make sure everything looks nice. Really brush their teeth good and really give them a good bath and get everything looking nice. Either do this for a patient that's not responsive or something like that and needs it. It's real important for the family members what they look like.

Sharon paid attention to "human" things such as brushing their teeth, giving a good bath, and just making them look better overall. She did not continue to try to cure, but focused on the quality of time remaining for them and their families. She continued to see them as people, who have value. She stated, "I feel good when I do just those little things and I think, for that 8 hours no one else was doing those things for that patient and I made a difference for him."

Exemplar III. The patient in this case was 55 years old and had injured his leg very badly. The same leg had been injured a year

earlier and he had lost toes at that time. During this admission, he was facing the possibility of losing the leg.

> Shannon: Mr. K. was a patient of ours about a year ago. He was in a bobcat, one of those bulldozer type things just a real small machine. He messed up his toes on his right foot and they did the revascularization surgery on him and it didn't take. They ended up going back and taking his toes off. He got real depressed when he was here before and I think we helped him a lot then. I think this time it [depression] is a little bit more so because this time he had, was in the same bulldozer and he fractured his leg and the bone came through. He's demanding, but he's a very easy person to joke around with and if you don't like something he says, you can be sassy and joke with him and he'll kinda laugh with you. We do little things for him, like washing his hair and running down and getting creams and stuff. He hates the hospital. I think when the hospital or pharmacy or dietary messes up, it falls back on the nurse to take care of whatever is wrong. He says it's the worst place he's ever been. He's always complaining about the hospital and he's said a few things about different nurses, but I have a good rapport with him. He said to me one time, well, right when he came that when they were in the ambulance, he told them to take him to [another hospita] because he hated this hospital. He said it's not you all, it's the hospital and all. I like the nurses.

Shannon knew that this patient was very depressed. She allowed him to express his dislike of the hospital without being defensive of judgmental. She considered him a person who had a right to voice his beelings.

Exemplar IV. Nancy's patient, in this situation, was 86 years old and had a diagnosis of renal failure, ascites, liver failure, and congestive heart failure (CHF). He looked, in her opinion, "like he was on his last leg."

> Nancy: He was still alert and fairly oriented. He would respond to questions spontaneously. He could carry on a conversation. He had been in and out of the hospital several times and kept coming back in for the same problems. He was on teaching service and everyday he'd get a new doctor and they had this miracle treatment they wanted to do on this man. It was really frustrating to have him confused and to have the posey and wrist restraints and him to be talking to you and saying, "I don't need this, please take the ropes off, I'm not confused." I left the wrist restraints off.

Interviewer: So you did take the wrist restraints off?

Nancy: Yes, because he seemed alert. I'd go in and say, "Mr. so and so are you okay?" He'd say, "I'm doing fine." He would recognize my voice when I'd come into the room and I'd say, "How are you today?" and he's say, "Oh, Nancy, I'm doing fine." Other nurses would say, "He's out of it" and tie him to the bed. You'd go in and his legs and arms would be restrained and he would be just lying there with a posey on. It wasn't what I intended for him. That didn't seem to be right. He came from the unit [MICU] to our floor. They said he had been a no code which to us means you do everything possible but as far as extra treatment you can't go overboard with it. It seemed like the doctors were trying to go overboard.

The man was transferred back to the MICU for some specialized treatment. This treatment would help the clotting of the blood so he would be able to stop bleeding.

Nancy: He came back to us in worse shape than he had been before he left. Thoroughly confused this time and I was having to keep the restraints on him because he did not know what was going on. Another doctor came in and said, "We're going to send him back to the unit." And I said, "No, we're not going to send him back to the unit. If he needs something, we can give it to him here. You transferred him to the unit for treatment and it didn't work. He got in worse shape than he had been." I needed to know why he needs to be transferred. The doctor said we are going to transfer him back to the unit because the nurses here on this floor aren't giving him the kind of care we think he should be getting. I said, "you know, I've been working with this gentleman for days on end" and I said, "what is it that we're not doing for this man? I'm following the orders. I'm doing everything possible." The doctor said, "I feel that you, with eight patients, aren't able to give him the type of care that he needs whereas in ICU they would only have two to three patients at a time and they could monitor him a little bit more frequently.

Interviewer: Was he getting more oriented now that he was back with you?

Nancy: Yes, I would come into the room and he would recognize me even if I hadn't been working with him for days. He would say, "Help me, please help me." Talking about the other nurses and doctors and what they had done. He said, "I don't want them to put any more tubes in, no more medicines." The doctor would say, he's not getting the care on this unit, maybe we should transfer him back to the other unit [MICU] which made me feel bad because here I was spending extra time with this patient because I knew he was getting the runaround and he didn't want help. I asked [the doctor], "Is there a certain treatment that you are going to do in the unit that needs to be monitored. Does he need telemetry

> or some sort of other thing that necessitates that he be transferred to another unit? Otherwise, if you're not going to make any new orders in his care, we can do what he's got here on this unit. We feel confident with that." The other nurses were saying you're going to lose your job, you're putting yourself on the line. At that point, I was frustrated and I thought - well, maybe it's not nursing. I was stepping out of bounds there by refusing to send him to the unit.

The man was not transferred to the unit as a result of Nancy's actions.

Later in the session, Nancy said:

> When I think about it, I was right in the way the patient, as far as being a patient advocate, he didn't need to be taken through all of that again. He had been through it going to the unit several times. They didn't do anything for him, but he came back in worse shape [mentally] than what he had gone in. Then we had to fix him up again - just enough to send him back. The gentleman eventually did die several weeks later, but he would have died anyhow I think just based on his condition. So, I felt like I had done the right thing by refusing to send him back to the unit because there were times when he looked at me and said, "Please don't let them hurt me anymore. Don't let them do this to me." The client had even told his family, "This is what I want. I've lived life and I'm satisfied." They [his daughters] understood and they were real supportive of us.

Nancy listened to this man as a person who had a right to be a part of the decision process. He had told her, "I don't want them to put any more tubes in, no more medicines." She acted as a patient advocate by challenging the physician's order for transfer. Her actions were aimed at enhancing the quality of this man's life, short though it would be.

Presencing: Being with a Patient

There are three paradigm cases representing this competency. The three exemplars follow.

Exemplar I. The patient in this situation was a 26-year-old man who had shot himself in the head. He had a trach, a G-tube, his mouth was wired, and he had had a craniotomy.

> Jayna: He was alert, he would nod his head yes or no to things you were saying to him. He was getting better and knew he was, getting more alert and oriented. And, then he got the trach out, you know they corked the trach for a while and then eventually pulled it out. I enjoyed myself working with him, seeing him get better, it was nice. I got to where I would spend a lot of time with him when I could to let him just talk to me, if nothing else, because he had been there for so long. Another time, I went in and he was still awake which usually he was asleep. We talked for like 2 hours, off and on, he was in a talkative mood.

The young man eventually recovered fully and went home. He was able to walk and talk, was alert, and was oriented with no neurological deficits.

> Jayna: It made me feel good to know that I helped him even if it wasn't doing anything but just talking because, you know I got a close relationship with him [client]. He would tell me that I was the only one that spent time with him, just talking. And it made me feel good to know that he was appreciative.

Jayna recognized that it is an essential part of care to just be with the patient. Person-to-person contact between the nurse and patient is important.

Exemplar II. Jayna again presented a situation that is an example of the nurse being with the patient. The patient was a man who shot himself in the head and had a craniotomy. He also had a history of psychological problems.

> Jayna: They did the craniotomy and he came out of the unit and he was just terrible. I mean he was just real frustrating to take care of him because he just wanted someone with him all the time. It was real frustrating. He would yell, he would cuss. He was down at the end of the hall and he would disturb the other ones [patients]. There wasn't that much you could do for him [physically]. When I was working nights, I would go and sit with him and talk to him until he would fall asleep. He would sing to us. He was a country singer, but he never really made it big. He had a very nice voice and he could sing Amazing Grace the best of anybody.
>
> Shannon: You'd say, John, sing us a song and he would say what do you want to hear?
>
> Jayna: That would be one of the things that would keep him quiet. Even if you were talking through the intercom, he would be quiet as long as he knew that there was somebody there.

In this situation, Jayna made use of the intercom to be with this patient. She used this technique whenever she could not physically be in the room with the patient.

Exemplar III. In this brief exemplar, Jayna was working with a young man who had been in an automobile accident. His vehicle had rolled over seven or eight times and he had broken his neck. After a cervical fusion, he was admitted to the unit.

> Jayna: I had him one night and sat in there; most of my patients were sleeping, they were pretty stable. I sat in there and fed him pitchers of ice and just talked to him.

Domain #2: The Teaching-Coaching Function

Nurses coach patients through an illness and teach them about their illness. The nurse frequently tries to anticipate for the patient and then tells him what to expect, corrects misinterpretations, and helps the patient understand what is happening to him.

The Teaching-Coaching Function and the five competencies included in this domain are shown in Table 7. The competencies addressed in this study are listed in the table.

Three (13%) of the 24 paradigm cases for the RN group have been placed in this domain. They represent two of the five competencies in the domain and, therefore, 6% of the total 31 competencies. Of the three paradigm cases placed in this domain, one represents the competency, providing an interpretation of the patient's condition and giving a rationale for procedures; two represent the competency, the coaching function: making culturally avoided aspects of an illness approachable and understandable.

Table 7

Domain #2: The Teaching-Coaching Function (RNs)

Competencies	# of Paradigm Cases	# of Total Cases
Timing: capturing a patient's readiness to learn.		
Assisting patients to integrate the implications of illness and recovery into their lifestyles.		
Eliciting and understanding the patient's interpretation of his or her illness.		
*Providing an interpretation of the patient's condition and giving a rationale for procedures.	1	33
*The coaching function: making culturally avoided aspects of an illness approachable and understandable.	2	67
Total	3	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 79.
*Indicates addressed in this study

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

In this situation, the nurse must assess how much information a patient really wants and needs. The information that she provides must be related in a level of language that the patient can understand. One paradigm case has been placed into this competency, and one exemplar is presented.

Exemplar I. Glenda's patient was a 13-year-old boy who had been shot in the head. He had been on Pavulon and Morphine for about a week. She recognized that the boy would wake up from the drugs and not know where he was or what had happened to him. She also knew that it

would be several hours before he was drug-free enough to be extubated. She assessed that he would need to know what was being done to him and why if he was going to be able to tolerate the ET tube until removal.

> Glenda: They get real wild after they come off it. All of a sudden they wake up and have this tube down their throat. And so, I was afraid he was going to be real wild too. I hadn't had that much experience with kids and I was scared. I didn't know how to handle it and I was trying to explain it to him. What happened and why he had the tube down his throat. I said now you be still so we can get this tube out, because if they keep fighting, the pO2 goes down and you can't get them weaned off the vent. I came on at 3:00 PM and by 7:00 PM, we were still weaning him down and still hadn't gotten him off [the ventilator]. His blood pressure was going up and he was perspiring. He was really wanting to get that tube out. So, I kept explaining to him the things we were doing. I told him, "We just drew blood and your blood levels look good. If you just keep doing what you're doing, we'll get that tube out." So by 9:00 PM, we had the tube out. I've never had an adult do as well as this 13-year-old. It was really a satisfying experience.

By anticipating his need for information before he could physically ask for it, Glenda provided an interpretation of his condition and gave a rationale for procedures. She offered constant encouragement to him. She told him the things that he could do to relax and keep his PCo2 down to an acceptable level. This was crucial for coming off the ventilator and removing the ET tube. She took a foreign and fearful situation to the boy and made it more familiar and less frightening.

The Coaching Function: Making Culturally Avoided Aspects of an Illness Approachable and Understandable

In the coaching function, nurses make culturally avoided situations such as death more understandable and acceptable. Two of the RN paradigm cases have been placed into this competency. Two exemplars are presented.

Exemplar I. Sue relates an experience "of a patient giving back to me more than maybe I gave the patient. This was a lady of rare

courage and I have ended up maintaining a relationship with her family. She gave an awful lot to all of our staff. Through tears of pain, she would smile at us and reassure us that it was okay that we were hurting her because she knew that we had to do the things we had to do.

Sue has come to grips with death, which for many laypersons is an unknown and frightening situation. The client in this situation was 75 years old and had an infarction of her spine after cervical surgery. She was a quadraplegic and was going to be ventilator-dependent for the rest of her life. The woman made the decision that she wanted to go home. So arrangements were made and she went home on a ventilator.

> Sue: That was her one desire, her only request. She was always alert and oriented and she made the decision to go home on a ventilator and she made the decision to go home knowing that she probably would not have a very long period of time. We did, in fact, get her home. And I had promised to visit because like I said, I guess I broke the rule. This is my one family to do all the things that you shouldn't do, getting emotionally involved. I sought them out to give them information. She gave so much to me that I thought I needed to return that by giving to her family. Six weeks after she went home I knew I had to get there, I had to go. So I called and made arrangements to go to her home and at that point in time, she was in fact eating again, had been extremely alert and had had a really good time at home. The 2 days it took from the time I called until the time I got there, she was comatose. When I arrived at the home, I went back and talked to her [client] for a little bit and then I went out and spent the next 3½ hours talking with the daughter. I allowed her to go through all of what had happened and her emotions, how she felt and by this time, that grieving was in process. I gave her some feedback, some more information, explained that the emotions that she was going through - she wasn't going crazy, that these were normal. These are the things you're going to have to deal with, these are the battles you are going to fight, these are the choices you have. I just allowed her to talk. That was on a Tuesday. On Friday, her mother was taken to the ER and diagnosed with pneumonia and a couple of other problems. The next Monday, they made the decision to disconnect the vent, for her to finally be at peace. The daughter then called me and I went over and basically what she said, "On Tuesday, I had not known to let her [client] go. I had made the decision to not let them do this [disconnect vent]. But you allowed me to talk Tuesday and work through all these things I was feeling then. I knew that as long as her mind was 'Mom' and she had the judgment to make the choices, because she had directed her own care until the last week of her life. That it was okay to

> to let her fight the battle and have the pain to do the things that she chose to do. But now that we know she is just worn out, that she is gonna be septic, that the chances of these things ever correcting again is slim. That it was okay to finally release her and say good-bye." So, basically I feel like that if I had not made a visit that she [client] would have ended up being re-admitted to the hospital and dying in the hospital in impersonal surroundings and not the way she had chosen. But I found it to be very rewarding because it allowed someone [client] to really have their choices and it allowed the daughter to work through the things that she needed to work through to accept it [death].

Sue was able to help the daughter understand and accept the mother's impending death. She opened ways of coping for the daughter.

Exemplar II. The patient in this situation was a young man of 26 years who had muscular dystrophy and a stroke. Jayna recognized that death was probably near for this man.

> Jayna: There really wasn't much that I could really do for him, but just keep him comfortable and turned and things like that. I found out that it was important for the family, any little change and they would call you in there. I stayed in that room half the day. And I found out that I was going to have to do for the family, not him, just try and keep them comfortable and try and do some talking to them and let them ventilate their feelings because they were having a hard time dealing with it.

The physician thanked Jayna after the young man died. He told her, "the family was real pleased with what you did and they said that you helped them out a lot." It made me feel good that I helped the family, since I couldn't do that much for him, but keep him comfortable.

Domain #3: Diagnostic and Patient-Monitoring Function

New technologies, sicker patients, and increased specialization have all contributed to the expansion of the diagnostic and patient-monitoring role of nursing. It is the patient's need for this nursing role that frequently results in hospitalization.

The Diagnostic and Patient-Monitoring Function and the five competencies included in this domain are shown in Table 8. The competencies addressed in this study are listed in the table.

Table 8

Domain #3: Diagnostic and Patient Monitoring Function (RNs)

Competencies	# of Paradigm Cases	# of Total Cases
*Detection and documentation of significant changes in a patient's condition.	3	60
Providing an early warning signal: anticipating breakdown and deterioration prior to explicit confirming diagnostic signs.		
*Anticipating problems: future thinking.	1	20
Understanding the particular demands and experiences of an illness: anticipating patient care needs.		
*Assessing the patient's potential for wellness and for responding to various treatment strategies.	1	20
Total	5	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 97.
*Indicates addressed in this study

Five (21%) of the 24 paradigm cases for the RN group have been placed in this domain and represent three of the five competencies in this domain and, therefore, 10% of the total 31 competencies. Of the five paradigm cases placed in this domain, three represent the competency, detection and documentation of a significant change in a patient's condition; one represents the competency, anticipating problems: future thinking; and one represents the competency, assessing the patient's potential for wellness and for responding to various treatment strategies.

Detection and Documentation of Significant Changes in a Patient's Condition

Nurses are the health care providers who work most closely with the patient. Because of this close association, they are frequently the first to become aware of changes in a patient's condition. Once a significant change has been detected, it is the responsibility of the nurse to document the change thoroughly. These changes are frequently documented by means of measurable data such as blood pressure, vital signs, and monitor readings. The nurse must be able to recognize that a change is occurring, be able to document the change, and present a convincing case to the physician in order to obtain action. Three of the RN paradigm case represent this competency and are presented below.

Exemplar I. Glenda spent most of the time, during the following clinical situation, observing her patient's neck wound and measuring her blood pressure. She ascertained that there was difficulty in maintaining the patient's blood pressure at the desired level. She used available resources for assistance and reported her findings to the physician.

> Glenda: I had this lady in ICU who had a carotid endarterectomy. She was about 55 years old. Usually nine times out of ten, if they come back to us they were on a ventilator. We'd wean them off the ventilator that night and they are okay. This lady developed a hematoma on her neck that was real hard and large. The next morning they [doctors] came in and wrote extubation orders and everything was going fine. Vital signs were fine and just as soon as they extubated her, her blood pressure shot up to 180 [systolic]--I mean just like that. I thought, she's excited. She was just fine the rest of the time. I gave her a little bit of morphine and I tried not to get her excited. Her blood pressure didn't come down. It was 190 to 200. And, then I asked another nurse, because I was still fairly new, what I should do. I had closed her curtain, didn't want her to get hyped up because of the other noises. I made her as comfortable as possible.

The physician was called and the changes in this patient's condition were reported to him. He ordered a Nitpride drip to be started.

> Glenda: We started the Nitpride, but couldn't get her blood pressure down. She was okay except that she didn't know why we were so excited. Her neck got real hard, I mean it was hard as a brick. We rushed her back to surgery. She had an artery that had come undone from the graft. The doctor wanted her pressure under 140, but she was so sensitive that her pressure went down to 50, then we got it back up. I couldn't keep it below 140. It was 142, but she was okay, and tolerating the pressure. The next morning, her potassium was real low and several of her other labs were messed up. Later in the afternoon her blood pressure went up to 170. We were going real slow on the Nitpride and it was like she was getting resistant to it. She stayed on the Nitpride for 2 days and it didn't do anything. He [doctor] took the Nitpride off and started Apresoline which I had asked for before and he wouldn't do it. And, then he stopped the Apresoline and started her on PO. She was tolerating her high blood pressure, but he didn't want it that high.

Glenda was able to document changes in the status of her client's neck wound and also her blood pressure. She even requested a change in the blood pressure medication, but initially to no avail. She continued to document and report her information until the patient was returned to surgery the next day. Her inexperience in the setting made it more difficult for her to present her case convincingly to the physician.

Glenda acted to report early warning signals of the changes in this patient. Even though the physician was not receptive to her (in her opinion), she continued to document and report her findings. Eventually, actions were taken which benefitted the patient.

Exemplar II. Glenda again had a case that dealt with a blood pressure problem. The patient was in his late 60's or early 70's. He had had a triple A [Abdominal Aortic Aneurism) surgical procedure and ended up on dialysis.

> Glenda: He was totally unresponsive except for the first couple of days, then he got real restless and we had to sedate him. We didn't want to sedate him because we wanted him to wake up, but when we didn't sedate him he was trying to get out of bed. We would orient him and you know, but he still would twist and turn. We were afraid that he was going to pull out his A-line and bleed or several other things. He ended up having to be on dialysis. I had my first experience with dialysis, where their blood pressure

> goes down to 70 [systolic]. I panicked, but found out it's not that big a deal if it's down in the 80's. The dialysis nurse says if it goes down in the 80's, it was not that big of a deal. But if it went below 80, they would call the doctor. I called the doctor anyway. And, I really bugged the dialysis nurse to death during the 6 hours that he was on dialysis, because I had never experienced that before. My patient, it's tough to see your patient's BP go down that low, especially when it's been 120 or whatever.

The patient recovered and was transferred out of the ICU. Glenda's inexperience in the situation made it difficult for her to be comfortable with the low blood pressure during dialysis even with the reassurance of the dialysis nurse. She did, however, use the dialysis nurse as a resource. She documented her findings regarding the situation.

Exemplar III. In this situation, Sharon spent her time observing and documenting her patient's condition. She was present at the time when the 60-year-old client "popped a hole in his ventricle." She used her avaialble resources for assistance and reported her findings to the physician.

> Sharon: His heart surgery went alright. He got infarcted in his sternum and he had to come back to ICU. They did a mediastiostomy where they go in and take out all the infection in his mediastinum. He was very unstable. He was on the ventilator and they left him on the ventilator because they were going to go back in 2 days and clean out some more. We were suctioning him because he had a lot of junk in his lungs. We suctioned all the time he was on the ventilator. He was coughing, which happens when you suction because it hits the gag reflex. And, he was coughing and he popped a hole in his ventricle. We were like doing major surgery in the room. We got him kind of fixed for the night, but the first thing in the morning they took him back to surgery and did some more work on him.

The patient continued to have problems. He got a huge decubitus on his bottom; they removed his sternum and did muscle grafts over the heart to protect it. He finally got better. The time that Sharon spent with this patient required constant assessment and problem-solving. She stated, ". . . he had one problem after another and was just totally weak."

Anticipating Problems: Future Thinking

This competency requries that the nurse think about the future course of the patient's road to recovery. She must try to anticipate problems that could arise and be prepared to deal with them. One RN paradigm case represents this competency and is presented below.

Exemplar I. In this situation, Sue anticipated that the patient, a 5-year-old girl, might have difficulty tolerating four immunizations given at the same time. The exemplar is presented below.

> Sue: They [doctors] decided they were going to give her four vaccines at once. I talked until I was blue in the face and said I don't want to do this. She has a history of reacting to these. We're not going to know what she is reacting to, but if we give her four, the chances of her having a reaction are real, real strong. The pharmacist said no, do it' the pediatrician said no, do it; everybody said do it. So I had to follow the orders. But, I drew up the antidote before I went into the room and had it ready because it was a pediatric dose and I was used to working with adults. I didn't want to make any errors when I felt somewhat panicked, so I had the antidote drawn. So I went in, gave her the injections and within 5 minutes her tongue was swollen out of her mouth. She was all the way puffed up. She was turning blue, even on the vent. It was closing off even with her having a trach in. So I gave her the antidote and she was fine within about 15 to 20 minutes. I was on duty and had taken precautions because I had felt like this was a strong possibility. I acted very quickly and she didn't have any more problems with it after that.

Sue finally followed through on giving the immunizations after much consultation with the physician and pharmacist. She was not comfortable about doing so, and anticipated the care needed if a reaction occurred. She recognized her own discomfort with pediatric dosages and did not want to have to prepare a pediatric antidote in an emergency situation. The child did have a reaction. Sue's anticipation of the problem resulted in a quickly given antidote and a child who had no further difficulties.

Assessing the Paient's Potential for Wellness and for Responding to Various Treatment Strategies

A patient's potential for wellness, whether back to a previous state or to an adjusted state, must be assessed by nurses. Once

assessed, treatment strategies must be devised to accomplish the desired goals for the patient. There is one RN paradigm case for this competency, and one exemplar is presented.

Exemplar I. The patient in this case had been hospitalized for 16 months. He had had a massive GI bleed, resulting in multiple major surgeries. He would not eat and was confused and combative when he first arrived on the unit.

Shannon assessed the patient's potential for wellness and planned treatment strategies accordingly. Wound management was devised to care for his neck fistula, a jejunostomy, gastrostomy, and a stomach wound.

> Shannon: He had a jejunostomy, a gastrostomy, and at one time, he had a big stomach wound that you had to clean. We had to have a private duty nursing assistant with him all the time just to make sure that he didn't pull anything out because they say if he pulled anything out they would have to take him back to surgery. It would be emergency surgery because of the way everything was connected. We worked with him, like getting a calendar in the room, and constantly re-orienting him. I worked with him a lot. The last time he had surgery and they reconnected everything like the permit read. He came back to us and it was this time that he started getting more oriented and being able to remember you and everything. We would go down there and say "hi" to him. The last thing he had done, he had a colostomy, he's got a colostomy bag now over where that deep wound was in the stomach area. It's all healed up basically and there is just a stoma with a colostomy bag over it. He basically had to learn how to eat again and his nurse would have to stay with him and make sure he doesn't choke or anything. He went to a nursing home here in town. He was alert and oriented and he was eating and could walk a little bit. He could basically do everything for himself as far as feeding and bathing. He left after being with us for about 16 or 17 months. The doctors didn't think he was going to live just after the surgery.

This patient's wellness potential was appropriately assessed, and a plan was devised and carried out. Shannon had the belief that this man's life had possibilities, even if the surgeons were not optimistic. The client did not return to a state of total wellness, but returned to a functional state, basically doing everything for himself.

Domain #4: Effective Management of Rapidly Changing Situations

The nurse is the health care provider who spends the most time with the patient. She is usually the provider that is first to identify signs of deterioration in a patient's condition. She is the provider who is usually the first on the scene whenever a client emergency presents itself. She must be prepared to deal with whatever situation arises, whether it is to provide IV lines or CPR until a physician arrives.

The domain, Effective Management of Rapidly Changing Situations, and the three competencies included in this domain are shown in Table 9. The competencies addressed in this study are listed in the table.

Table 9

Domain #4: Effective Management of Rapidly Changing Situations (RNs)

Competencies	# of Paradigm Cases	# of Total Cases
Skilled performance in extreme life-threatening emergencies: rapid grasp of a problem.		
Contingency management: rapid matching of demands and resources in emergency situations.		
*Identifying and managing a patient crisis until physician assistance is available.	1	100
Total	1	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA; Addison-Wesley, p. 111.
*Indicates addressed in this study

One (4%) of the 24 paradigm cases for the RN group has been placed in this domain and represents one of the three competencies in this domain and, therefore, 3% of the total 31 competencies. The one paradigm case placed in this domain represents the competency, identifying and managing a patient crisis until physician assistance is available.

Identifying and Managing a Patient Crisis Until Physician Assistance is Available

One paradigm case represents this competency. The exemplar is presented.

Exemplar I. Nancy was confronted with an emergency that required immediate intervention until the physicain could arrive. The exemplar is presented below.

> Nancy: I'm going to talk about a 16-year-old that was in a motor vehicle accident. He had some damage to his lower extremities. They took a graph from the right leg and put it as a vein graft back to the left leg. A fractured ankle, I guess it was, and had fixed him up in traction, and wrapped his leg up. So, the only thing, when you went in to assess him, that you could do was take the pedal pulses and check traction to see if everything was okay. As far as the bandage itself, we assumed it was healing as normal as possible, because the right leg had healed up and cleared up. So no one ever took the bandage off to check underneath down to the skin. Only the doctor would come in during the day and change it. Working second we never saw it. He was feeling much better in a couple of days and we said everything was looking okay. His parents were saying, we are leaving now that everything is okay. I said fine, was at the nurse's desk and a few minutes later he called and said "I need some help, I'm bleeding." I went in and he had blood everywhere, on the sheets, the whole bed was soaking. He had the traction hooked up to his left leg, but he was taking the right leg off the bed. He was on this side of the bed coming off with his leg hanging in the air. It was just a panic situation.
>
> Interviewer: Now the leg that was hanging off is the one that was bleeding?
>
> Nancy: No, the one still in traction. It's bleeding, blood is going everywhere and he's got the right leg off the bed, almost all his body is off the other side of the bed. So he had traction going on the left hand side of the bed and his body going to the right hand side of the bed. The first thing was like, I've got to do something. I've got to get him calm, but first, I've got to

> calm myself. I said calm down and in the midst of telling him to calm down, I'm doing it psychologically to myself. You've just got to calm down, you've got to find out where the bleeding is coming from and just take it step-by-step. I thought after we had finally got him calmed back down and got him into the bed, someone came in to help me. I pulled the button like for a code and said I need some assistance. They asked me where was the blood coming from. I didn't know. We finally got him back in the bed and got him straightened up and applied pressure to the area and got the bleeding stopped.

The nurses started an IV and began to monitor his vital signs. They continued to apply pressure until the physicians arrived.

> After we got everything under control, the doctors came in and we took the bandage off. Actually after I saw the wound, I realized the reason it had blown. Had I seen the wound before and he said "I was bleeding," I would have understood. They hadn't sewn the left leg back up like they did on the right leg. They left it open, the fracture and everything was open all the way down to the bone. You could see the veins where they went in and grafted everything together. It had been a muscle tissue that had split and the vein had gotten caught and just moved away. It was coming out. They needed to go back in to do like two sutures and then put some bandages back over it. He [doctor] still did not close the skin. He said it would close by itself.

Nancy identified the need for rapid intervention in this sitaution. She stayed with the patient, initiated emergency measures [applied pressure, monitored vital signs], and continued until a physician arrived to insert stitches.

Domain #5: Administering and Monitoring Therapeutic Interventions and Regimens

Nurses have the primary responsiblity for administering the therapeutic plan of care for most patients. They are also responsible for monitoring the patient once the plan is being carried out. Due to new and more complicated technology, the nurse's role has become more complex. The nurse has more responsibility regarding intravenous therapy, administering medications, dealing with wounds, and combating immobility. This domain is descriptive of the necessary skilled practice required of nurses to provide appropriate care to the patient.

The domain, Administering and Monitoring Therapeutic Interventions and Regimens, and the four competencies included in this domain are shown in Table 10. The competencies addressed in this study are listed in the table.

Table 10

Domain #5: Administering and Monitoring Therapeutic Interventions and Regimens (RNs)

Competencies	# of Paradigm Cases	# of Total Cases
Starting and maintaining IV therapy with minimal risks and complications.		
*Administering medications accurately and safely: monitoring untoward effects, reactions, therapeutic responses, toxicity, and incompatibilities.	1	50
*Combating the hazards of immobility: preventing and intervening with skin breakdown, ambulating and exercising patients to maximize mobility and rehabilitation, preventing respiratory complications.	1	50
Creating a wound management strategy that fosters healing, comfort, and appropriate drainage.		
Total	2	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 123.
*Indicates addressed in this study

Two (8%) of the 24 paradigm cases for the RN group have been placed in this domain and represent two of the four competencies in this domain, and therefore, 6% of the total 31 competencies. Of the two paradigm cases placed in this domain, one represents the competency, administering medications accurately and safely: monitoring untoward effects,

reactions, therapeutic responses, toxicity, and incompatibilities; and one represents the competency, combating the hazards of immobility: preventing and intervening with skin breakdown, ambulating and exercising patients to maximize mobility and rehabilitation, preventing respiratory complications.

Administering Medications Accurately and Safely: Monitoring Untoward Effects, Reactions, Therapeutic Responses, Toxicity, and Incompatibilities

The nurse's responsibility for administering and monitoring medications has increased with the development of an increasing number of new and potent drugs. Frequently, nurses also may be involved when a drug is being given on an experimental basis. They have to rely on their own skills to identify any side effects or sign of problems since there is usually little documentation concerning what to expect in the human client in the experimental situation. One paradigm case represents this competency, and one exemplar is presented.

Exemplar I. Shannon determined early in her reporting of this clinical situation that this patient had "setbacks when he was on Dilantin and Phenobarbital." She ascertained that the 37-year-old man was acting "possessed" and "totally bizarre," but could not initially get the physician to order any labs to determine blood levels.

> Shannon: He came to us in August or September after the evacuation of a subdural hematoma. He was in ICU for a while and came to us alert, but confused. He couldn't do much for himself, he couldn't really walk very well, you know, you might could pivot him out of the chair but that was about all that you could get from him. He was just really confused. He had a cranioplasty in November and I then became his primary nurse. We worked with him. He had his setbacks when he was on Dilantin and Phenobarbital. We would have trouble with his levels. His Dilantin level, we found out after about a week and a half of him acting possessed, - you expected his head to turn around. He had been doing great before that and he - it was like a week and a half of us telling the doctor that he was just totally bizarre, that he was not just confused, that he was bizarre. We told the doctor that he was acting possessed and the

> doctor was like that's a crock of s___. He still didn't order any labs or anything. So after about a week and a half of his acting this way, the doctor came in and said, "He's really confused isn't he?" He's been like that for a week and a half and we called you and you've been in here and you've seen this. He ordered Dilantin levels. The normal is 10 to 20 and his was 54. The doctor ordered that the Dilantin be held.

This same patient's Dilantin was held at one point previously, and he started having seizures after he was off the drug for about 2 days. It was the nurse who monitored the client while he was off the Dilantin.

> Shannon: We held it for about a day. We were the ones again that had to mention - "Are there any labs you need to check?" and then after we held it for another day, we were the ones that had to mention "Don't you think he needs to be checked again or started on it [Dilantin] again because of his history of seizures and what happened last time?" We finally got it straightened out where he didn't act possessed and he wasn't acting bizarre. He was more alert, more oriented. He could remember your name. He started talking about when his brother would be coming in - "Didn't you just get off third shift?" which his brother works rotating shifts and he knew what shift his brother was supposed to be on.

Shannon's continued observations and her persistence with the physician finally resulted in the patient's Dilantin level being checked. His medication was adjusted to proper amounts and he began to make steady improvement in his mental status.

Combating the Hazards of Immobility

One paradigm case represents this competency. The exemplar is presented below.

Exemplar I. In this situation, Sue was dealing with her patient's physical condition. Many of her interventions were related to the hazards of immobility. She was working on the rehabilitation unit at the time of this situation and was the primary nurse for this patient.

> Sue: This was an elderly gentleman that came to us from another hospital in the area. They were very understaffed and it showed when he got to our unit. He had been in a motor vehicle accident and after the accident had stroked. He was 76 years old. He came to us directly from an ICU unit. When he came to us, he had 16 decubiti, had contractions to the point that his legs were in this

position. Really, he had like 45 degrees at the knees, and the hips were about the same. He had aspiration pneumonia. They [other hospital] had been feeding this man and he was aspirating when he ate. He had no ability to talk and he had tremors in both hands. He did not have use of his hands when he came to us. Immediately, we made him NPO and put in a G-tube. As time progressed, it became obvious that he was not going to progress to a level where he could go home because he was going to require around-the-clock care. We cleared all decubiti but one before he left us. Fifteen had been healed, he had all the way to stage four's. Most were stage two and three when he came. We cleared the ones on his sacrum, all down his legs, and on his arms. There was one on his heel that when he came to us, actually there were two when he came to us that had eschar. We started lobbying from the beginning to have the eschar surgically removed because he was diabetic in addition to being elderly and because the whole diameter was covered in eschar. We started lobbying and lobbying and lobbying. "Let's get it removed and let's get the healing process started so we can get to it [heel]. So we can work with it [heel]. And, finally 2½ months into his stay with us they finally agreed to debride the heel and when they did it, at that point, it finally went all the way to the bone on the heel. He finally had a graft in surgery which failed. We tried the hyperbaric oxygen route hoping that we could get some results with that. I think if it had been done earlier, it would have, but there was nothing left. The doctor that was finally called in to do the surgery said you can't grow something on stone and basically that's what it feels like. There was no circulation in his feet. The feet were always severely purple with dependent and independent edema. There was no circulation really to speak of in his feet. But, we were really successful in all other decubiti. Because he was so bad when he first came into the unit, we were concentrating on saving his life. They did not do the positioning and such that the contractures were very bad. Got some improvement in that, got so that his legs would go about like this approximately 90 degrees . Unfortunately, because his legs had not been set, and there had been a lot of bone changes so that it became apparent later that surgical release of contractures would not take care of the problem because he had a lot of bone changes in the joints and had some arthritis before so that was aggravating the situation.

Interviewer: How long had he been in the ICU before he came to you? I mean, are we talking weeks or months?

Sue: We are talking months. He would tolerate anything. In therapy, they would put him on his belly and put weights on his feet and everything contract and pull and stretch the muscle. He would lie down there and you could tell by the look on his face that it was really extremely painful therapy for him. But, when he got to a point where he could communicate, the first thing was "What's my schedule today? I don't want to be late." But the successes we really had with him were clearing, basically, up his skin, and getting rid of his pneumonia. He was never going to be able to feed himself, he was a total feed because of the tremors

> in his hands a result of the stroke . His dressing changes were still every shift on his heel. We did manage to keep it clean and it looked good when he left for the nursing home . Again, that was something that was always a constant uphill battle. There was always the use of elase or travise or this or that when it started looking the least bit grungy in the whirlpool. I don't think they would have ever gotten any healing and I'm not sure that they could have kept it clean because it took a lot of work to keep him from developing more necrotic tissue. I really think, I really believe that if they had listened to nursing and we'd debrided when he first came in that there would have been enough tissue, because it really was very necrotic when he [doctor] debrided on that day. They kept thinking well it's firm, it's probably granulating. We're saying this man is elderly. He's diabetic. He doesn't have any blood circulation. He's not granulating. He achieved for us the ability to assist with his transfers. When he came to us he was a plus 4 max. That is it took four of us using all our strength to move him. It took four of us to move him from the bed to the wheelchair. It took two using max effort to move him in the bed when he first came to us. So, I feel like we made a lot of gains with him. We took him from very bad to somewhat functional. When he first came to us, he couldn't so much as help roll. He could not turn. When he left, it took just one person to work with him in the bed. He could assist you. We got him from basically, for all intents and purposes, a vegetable.

Sue determined what was needed and planned appropriate management strategies to correct the hazards of immobility that were already occurring when the client arrived on the unit. She intervened with measures to heal previous skin breakdown, maximized his mobility, and dealt with his respiratory status.

Domain #6: Monitoring and Ensuring the Quality of Health Care Practices

Of all health care providers, nurses spend the most time in direct contact with the client. They are, therefore, in a position to detect problems, identify changes in conditions, and protect the client from errors made by new medical students, interns, and residents. The domain, Monitoring and Ensuring the Quality of Health Care Practices, and the three competencies included in this domain are shown in Table 11. The competencies addressed in this study are listed in the table.

Table 11

Domain #6: Monitoring and Ensuring the Quality of Health Care Practices (RNs)

Competencies	# of Paradigm Cases	# of Total Cases
*Providing a backup system to ensure safe medical and nursing care.	1	25
Assessing what can be safely omitted from or added to medical orders.		
*Getting appropriate and timely responses from physicians.	3	75
Total	4	100

Note. Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley, p. 137.
*Indicates addressed in this study.

Four (16%) of the 24 paradigm cases for the RN group have been placed in this domain and represent two of the three competencies in this domain, and therefore, 6% of the total 31 competencies. Of the four paradigm cases placed in this domain, one represents the competency, providing a backup system to ensure safe medical and nursing care; and three represent the competency, getting appropriate and timely responses from physicians.

Providing a Backup System to Ensure Safe Medical and Nursing Care

Nursing is sometimes ordered to use an intervention that may have an impact upon the safety of the patient. The nurse must decide whether or not it is appropriate to follow the order. One paradigm case representing this competency and one exemplar are presented.

Exemplar I. In this situation, Sharon dealt with the problem of a physician ordering that a patient's hands be left unrestrained. The nurse did not feel that this was appropriate, but did follow the physician's order.

> Sharon: He [client] was so paranoid that we were out to kill him. And, when they are like that you can't reason with them at all. I feel sorry for them because that is their reality - that people are going to hurt them. Well, we had to do something, he was trying to get out of bed and his heart rate would hit way high. We needed to give some medication for his heart rate, only he wouldn't let us get near him to push anything IV because we were going to kill him with it. It was really awful. We finally got him out of bed because people who try to get out of bed, it's easier for us to keep him in a chair, because we always tie them to a chair anyway. And, Dr. B. came by and he said, at some point, if you restrain hands it's worse than if you don't. It just makes them worse. Well, Dr. B. said to unrestrain his hands. We had restrained them. When we did [unrestrained him] he turned around and socked a nurse right in the eye. It was awful. We had to get the [nursing] consultant to call Dr. B. in on that because that was not an appropriate judgment. She [nurse] was like I really don't think he needs to be unrestrained and he [Dr. B.] unrestrained him.

With additional experience, the nurse might have been able to provide a stronger case for keeping the patient restrained and would not just follow the physician's orders. Nurses can act on their own judgment whether it would be safe to allow a patient to be unrestrained.

Getting Appropriate and Timely Responses From Physicians

This competency is used most frequently when something has gone wrong with a patient and the physician is needed. The nurse must learn how to get a physician to respond when he is called. The situation must be presented in such a way that the physician will respond quickly. Three cases represent this competency. Three exemplars are presented.

Exemplar I. Sharon had difficulty in this situation in getting the physician to respond. The patient was 21 years old, in the ICU, and very unstable (i.e., heart rate, blood pressure, and temperature).

> Sharon: And, I was just real frustrated with him all day, I think I had one other patient that I hardly saw all day because I was with him and I think he had blocked down, his heart rate had dropped down and in the early morning, they had started an epinephrine drip and a lidocaine drip and a dopamine drip for his blood pressure. So, when I got there he was on all those. After a couple of hours, his heart rate was 160, his blood pressure was in the 70's, and his temperature went up to 106 degrees. I tried to figure out what was going on and his general surgeon was his main doctor. They're just not there in the hospital on the weekends like some of our other doctors. So, I was having to call him every 15 or 20 minutes about something and I said gosh I wish he was here. And, I had to try to help, talking with some other nurses; trying to figure what was happening inside his body to give the doctor some idea of what to do. Put him on hypothermia and get his temperature down, get blood cultures and all that stuff. I said, well this epinephrine is just too much for his heart. He's a young guy and we had put a Swan catheter in and his indexes were real good and his heart was in good shape, he did not need the epinephrine. I said, let's wean down off of that [epi] and the doctor said okay, but his blood pressure was still so low. And, he didn't want to put him on L & T [Levophed and Tegitine] because he didn't think it did any good. I was at my wits end and I was really frustrated with him, but I was frustrated most with the doctor not being there. So we suggested to the doctor that we use neosynpherine to increase his blood pressure because sometimes they'll really clamp down well with neo, and that really seemed to do the trick. So we got him off some of that and his pressure started coming up, his heart rate came down and by the time my 8 hours was up; his temperature was down, heart rate was 120, and pressure was up in the 100's. So, I really felt good that day.

Sharon collected data that would allow her to present a convincing case to the physician in order to get an appropriate response from him even via the phone. She made many suggestions to the physician, who remained at home, concerning the care of this patient. Her competency was apparent in her discussions with the physician. Through persistence, she was able to get the necessary responses from him and provide appropriate care to the patient.

Exemplar II. The client in this case was in his mid 60's. He had had a craniotomy for some type of benign tumor and had been admitted to the ICU immediately after surgery. He was confused, disoriented, and combative. The history from this man's wife was that he had been drinking

beer, several beers a day, for years. With this information, Glenda approached the physician about starting this man on librium.

> Glenda: I mentioned [what the wife had told her] to the doctor that night and asked him if he wanted to start him on some librium or whatever and he said he didn't want to do that.

As the shift progressed, the man became progressively more combative, appeared scared, and very confused.

> Glenda: So anyway, the doctor came in and he still refused to give him librium. That morning he came, he did not want us to give him any librium or anything. So, I did give him some pain medicine because I thought that might help calm him down. So anyway, we got him back to bed, he was really fighting then; we couldn't keep him in bed, couldn't keep him in the chair, he was wanting to squirm in bed and stuff. He had gotten to where his breathing was hard. One of the nurses, L., who had been there [ICU] for years; I kept going to her and asking her advice because he was obviously going into withdrawal or we thought he was. We'd call the doctor and let him know what was going on. Finally, he ordered librium 50 mgm IM every 4 hours, so we gave him that. It didn't touch the guy. So, I called the doctor and told him it didn't touch him and he said well give him, I forgot what it was and that didn't touch him either. Finally, we had to give Ativan. We were trying to get him calmed enough to take him down to CT scan to get another scan to see if maybe he had done something that they weren't aware of. And by the afternoon, it was like 2:00 PM and I had been calling the doctor, or either he was in and he knew what was going on. I charted each time because the guy was really out in left field - his color was very cyanotic, he was sweaty. We had to hold him down to get a chest x-ray exposed. The guy was really bad and then when you gave him Ativan, it knocked him completely out and then you worried if he was going to die. The doctor came in and he ordered beer or he had ordered it that night. So he doctor came in and said do you have the beer, so I went and got it and he said here man, take it, I drink with you. He said, it smells good. The guy, he drank some of it and he wet his lip. He drank about half of it and later on that afternoon, I gave it to him and he just slurped it down likt it was nothing.
>
> Interviewer: Did he get better?
>
> Glenda: Yes, he did. They gave him beer everyday.

This nurse collected data continuously, trying to present a convincing case to the physician in order to get an appropriate response from him.

Dealing with a "drinker" was a new experience for this RN. Finally, after several days, the physician ordered beer for this man and the situation was controlled.

Exemplar III. In this third exemplar, Shannon dealt with the problem of getting a physician to order pain medicine for her client before he manipulated the client's halo traction.

> Shannon: This is relating to Jamie. He hasn't been taking that much pain medicine, but when they readjusted his halo brace. Like I said earlier, it was right above his eyebrows. They [doctors] come in and push it up and take the pins out and put new ones in; retightened them and you know that hurts. Dr. L. came in to tighten the halo brace up and he wouldn't give him anything [for pain]. I called, but he wouldn't give him anything and then he finally came back when we were getting ready to walk out the door and readjusted it again. You can see him just moving those pins and the holes are bigger now and they were like that big. He spoke to the mother for a few minutes after he finished with Jamie. He told her that he believed it was psychological, that it was emotional, and that he wasn't in that much pain. Then they could have given him some Valium or something. They do that just going down for an endoscopy or something. Why don't they [doctors] give something for someone with pins in his head?

Shannon continued to request pain medication for this client until the physician finally came in and reluctantly ordered pain medication for the night.

Interview Results: Similarities Between the Two Groups

This third section of data analysis discusses the results of the third research question. The research question answered in this section is: "What domains of nursing practice are similar between the senior nursing students and the registered nurses?"

For both groups of nurses, the majority of paradigm cases represent Domain #1: The Helping Role domain. The students have 11/20 or 55% of their total paradigm cases in this domain. The RNs have 9/24 or 38% of their total cases in this domain (see Table 12). Two competencies in the Helping Role domain comprise the majority of representation from .

Table 12

Paradigm Cases by Domain With Percentages of Total Cases in the Two Groups

	Students		RNs	
Domain	# Cases	% Total	# Cases	% Total
1	11	55	9	38
2	4	20	2	13
3	3	15	5	21
4	1	5	1	4
5	1	5	2	8
6	0	0	4	16
7	0	0	0	0
Total	20	100	24	100

both groups. They are "providing comfort measures and preserving personhood in the face of pain and extreme breakdown and "presencing: being with a patient."

Four student cases and four RN cases represent the competency of "providing comfort measures and preserving personhood in the face of pain and extreme breakdown." Four student cases and three RN cases represent the competency of "presencing: being with a patient." These two competencies represent 8/11 or 73% of the students' cases in this domain, and 7/9 or 78% of the RNs' cases in this domain.

Two other domains are also highly represented in both groups. They are Domain #2: The Teaching-Coaching Function and Domain #3: The Diagnostic and Patient-Monitoring Function. The Teaching-Coaching domain

has 4/20 or 20% of the students' cases and 3/24 or 13% of the RNs' cases (see Table 12). There is one competency in this domain reported by both groups. The competency of "the coaching function: making culturally avoided aspects of an illness approachable and understandable" is reported in 2/4 or 50% of the students' cases in this domain and by 2/3 or 67% of the RNs' cases

The Diagnostic and Patient-Monitoring Function domain has 3/20 or 15% of the students' cases and 5/24 or 21% of the ENs' cases (see Table 12). There are two competencies in this domain that are represented in both groups. They are "anticipating problems: future thinking" and "assessing the patient's potential for wellness and for responding to various treatment strategies."

One student and one RN have represented the competency of "anticipating problems: future thinking" with a paradigm case. One student and one RN also have one case each representing the competency of "assessing the patient's potential for wellness and for responding to various treatment strategies." These two competencies represent 2/3 or 67% of the students' cases in this domain and 2/5 or 40% of the RNs' cases in this domain.

The three domains listed above represent 18/20 or 90% of paradigm cases for the student group and 17/24 or 71% of paradigm cases for the RN group. Of the four remaining domains, each group of nurses has representation in two other domains. These two domains are Effective Management of Rapidly Changing Situations, and Administering and Monitoring Therapeutic Interventions and Regimens. Neither of the two groups of nurses have representation in the Organizational and Work-Role domain. Only the RNs have representation in the domain of Monitoring and Ensuring the Quality of Health Care Practices.

Table 12 presented the number of paradigm cases in each domain for the student group and the RN group. The percentage of the total number of cases represented in each domain by each group is included. The similarities and differences between groups can be observed in this table

Interview Results: Differences Between the Two Groups

The research question that is answered in this fourth data analysis section is: "What domains of nursing practice are different between the senior nursing students and the registered nurses?" The greatest difference between groups is seen in Domain #6: The RN group has 4/24 or 16% of their total paradigm cases representing Domain #6: Monitoring and Ensuring the Quality of Health Care Practices. Three of the four cases (75%) are representative of the competency "getting appropriate and timely responses from physicians." The one remaining case represents the competency, "providing a backup system to ensure safe medical and nursing care." There is no student representation in this domain.

Also, some differences exist between the two groups in the competencies representing each of the other five domains. For example, in Domain #1: The Helping Role, the competency "the healing relationship: creating a climate for and establishing a commitment to healing" is unique to the RN group. There are two RN cases representing this competency. There are two other competencies unique to the student group in this domain. There are two student cases in the competency "providing comfort and communication through touch," and one case in the competency "providing emotional and informational support to patients' families."

In Domain #2: The Teaching-Coaching Function, the competency "providing an interpretation of the patient's condition and giving a

rationale for procedures" is unique to the RN group. There is one RN case in this competency. There is one competency unique to the student group in this domain. Two student cases represent the competency "eliciting and understanding the patient's interpretation of his or her illness."

In Domain #3: The Diagnostic and Patient-Monitoring Function, the competency "detection and documentation of significant changes in a patient's condition" is unique to the RN group. There are three RN cases in this competency. There is one competency unique to the student group in this domain. One student case represents the competency "understanding the particular demands and experience of an illness" anticipating patient care needs."

In Domain #4: Effective Management of Rapidly Changing Situations, the competency "identifying and managing a patient crisis until physician assistance is available" is unique to the RN group. There is one case in the RN group representing this competency. There is one competency unique to the student group in this domain. One student case represents the competency "skilled performance in extreme life-threatening emergencies: rapid grasp of a problem."

In Domain #5: Administering and Monitoring Therapeutic Interventions and Regimens, the competency "administering medications accurately and safely: monitoring untoward effects, reactions, therapeutic responses, toxicity, and incompatibilities" is unique to the RN group. There are no unique competencies for the student group in this domain.

The total number of competencies is 31. The RN group has representation in 13/31, or 42% of all competencies. The student group has

representation in 11/31, or 35% of all competencies. The combination of both groups is 18/31, or 58% of all competencies that are represented in this study.

In the majority of the paradigm cases reported by the RNs, the individual RN has had prior experience with the particular type of situation. The students' cases are usually first-time exposure to the particular type of situation. This difference tends to substantiate the placement of the students in the novice and advanced beginner levels of practice (Levels I and II) (Benner, 1984), whereas the RNs with 22 to 24 months of experience are approaching the competent level (Level III) of practice.

CHAPTER V

Discussion, Conclusions, Limitations, and Implications

The purpose of this study has been to explore the lived experiences of senior nursing students and registered nurses through their paradigm cases. The following discussion includes implications with consideration to limitations and recommendations for future study in the area.

Discussion and Conclusions

In their research, nurses have ignored the rich complexities of practice. Through research, Benner (1984) sought to provide a description of nursing practice rich with the meaning and context of everyday nursing practice. This study has sought to uncover the meaning and context of senior student practice and RNs with 22 to 24 months of clinical experience. Benner's domains of nursing practice are shown to have application for the subject's clinical nursing practice.

The Helping Role is the domain of major importance in the senior group and the RN group. Most of the paradigm cases from both groups fall within this domain as follows: 11 of the 20 paradigm cases for the student group, representing 4 of the 31 competencies, and 9 of the 24 paradigm cases for the RN group, representing 3 of the 31.

These results support the findings of Olsen (1985) and Jorgenson and Crabtree (1986). Each of their studies involved the analysis of 27 paradigm cases of expert nurses. Their results are that the Helping Role domain is represented in the majority of their cases. The Teaching-

Coaching domain was second in representation in both studies. This domain also had high representation in this study.

The Teaching-Coaching domain and the Diagnostic and Patient Monitoring Function domain are second and third in importance for the student group. The Teaching-Coaching domain contains four cases representing 2 of the 31 competencies, and the Diagnostic and Patient Monitoring Function domain contains three cases, representing 3 of the 31 competencies. Eighteen (90%) of 20 paradigm cases and 9 (29%) of the possible 31 total competencies for the seniors represent the three domains listed above. The two remaining cases represent two separate domains and competencies. One represented the Effective Management of Rapidly Changing Situations domain and the second represented the Administering and Monitoring Therapeutic Interventions and Regimens domain.

The Diagnostic and Patient Monitoring Function domain, the Monitoring and Ensuring the Quality of Health Care Practices domain, and the Teaching-Coaching domain are second, third, and fourth for the RN group. There are five cases representing 3 of 31 competencies in the Diagnostic and Patient Monitoring Function domain, four representing two competencies in the Monitoring and Ensuring the Quality of Health Care Practices domain, and three representing two competencies in the Teaching-Coaching domain. Twenty-one (88%) of 24 paradigm cases and 10 (32%) of the possible 31 total competencies for the RN group are representative of the four domains listed above. The three remaining cases represent two other domains. One case represents the Effective Management of Rapidly Changing Situations domain and two cases represent two competencies within the Administering and Monitoring Therapeutic Interventions and Regimens domain.

One conclusion that can be drawn is that Benner's (1984) seven domains of nursing practice and 31 competencies provided a valid framework for identifying knowledge embedded in clinical practice. Some domains and competencies are common to both groups of nurses in this study. The competencies, "providing comfort measures and preserving personhood in the face of pain and extreme breakdown" and "presencing: being with the patient" have high representation in both groups. All of the paradigm cases presented by the two subject groups represent Benner's identified competencies. No new competencies or domains were identified as a result of this study. Benner's domains of nursing practice are applicable to novice, advanced beginner, and competent level nurses in this study, just as they were applicable in the studies by Brykczynski (1985), Fenton (1984), Jorgenson and Crabtree (1986), Olsen (1985), and Steele (1986).

The domain, Monitoring and Ensuring the Quality of Health Care Practices, is unique to the RN group. The student group has no paradigm cases representing this domain. The competencies in this domain are based on the fact that nurses are ever present in the patient situation and therefore, are able to quickly detect errors and identify changes in a patient's condition. Students, as learners, spend limited time on units and are not a constant factor in the patient situation. Therefore, a conclusion is that RNs had more opportunities in practice and greater responsibility for Monitoring and Ensuring the Quality of Health Care Practices than nursing students.

Neither group of nurses has presented paradigm cases that are representative of the domain, Organizational and Work-Role Competencies. This domain is dependent upon learning on the job, therefore, it is not surprising that the students do not have representation in this domain.

The RNs, who work on units where their roles are either as a primary nurse or one-to-one in the Intensive Care Unit, also do not, on a regular basis, have to deal with the competencies listed in their domain.

Another conclusion is that both students and RNs functioned frequently as a patient advocate. They both report paradigm cases of "fighting the system" and "standing up to physicians" if they thought it would benefit the patient. It was concluded, however, that RNs are more skilled at functioning as patient advocates because of their nursing practice experience. Additionally, both groups present paradigm cases that pay attention to the "human thing" such as brushing teeth and combing hair even for the comatose patient. Both students and RNs report paradigm cases that signify they believe that they have learned from the patient.

The clinical experiences related by the students are usually first time exposures to the particualr type of situation and involve having to deal with their own fears and inexperience. They often become observers in the situation once a patient's condition changed. The clinical experiences related by the RNs represent situations in which, in most instances, the individual RN has had prior experience with the particular type of situation, and these situations provide documentation of what they have been able to accomplish or not accomplish for the patient. The RNs usually handled whatever situation presented itself with the patient.

A note of interest is the group process which occurred among the participants. Both groups were initially polite and pleasant with each other during the sessions. As the sessions progressed, the participants became very supportive of each other. They frequently validated the actions related by an individual in her paradigm case. Assistance with

problem-solving and suggestions for alternative actions in future similar situations were frequently discussed.

The groups became self-starters, eager to share their paradigm cases as soon as the session began. Both groups indicated that the sessions provided a release of frustrations. They verbalized their pleasure with the sessions, saying that it was "wonderful to talk with people who understood." Husbands didn't understand and didn't want to hear about what happened at work. "It was too gory!" Both groups expressed regret when the sessions were finished.

Limitations of the Study

A limitation is the lack of a participant observation component. Participant observation would have provided more data about the day-to-day patterns of nursing practice. This methodology would have enhanced this study by identifying clinical episodes that the subjects might not report as a paradigm case. The episodes could constitute competencies and might describe more about Benner's (1984) domains of nursing practice. Additionally, it would have provided insight into the presence of confirming or refuting evidence for the study's interpretation. Another limitation of the study is that the generalizability of the paradigm cases must await comparison and critique for similarity with the results of other studies with the same type subjects.

Implications

Benner (1984) maintained that nursing has not systematically observed or recorded its clinical practice. Subsequently, the discipline has little or no record of what is nursing practice. A beginning account of the practice of the senior nursing student just prior to graduation and entrance into the work world is provided by this study. An account of the competent practice of registered nurses, with 22 to 24 months

experience, who had graduated from the same baccalaureate program as the seniors is also begun. Such information could be a valuable addition to the content of baccalaureate nursing courses.

The Helping Role domain contains most of the paradigm cases from both groups of subjects. Consideration should be given to the evolution of curricular content around this domain. The content of paradigm cases could also be a valuable asset in educational offerings directed at the advanced beginner and competent levels of practice. Paradigm case discussions allow nurses to share their practical information. The provision of reinforcing materials, didactic content and/or clinical experience to promote the learning or adoption of practice in these areas could be promoted.

Additionally, curricular content could be expanded to include attention to the other three domains that received high priority from these nurses: Teaching-Coaching, Diagnostic and Patient Monitoring, and Monitoring and Ensuring the Quality of Health Care Practices. Eventually, content could be included that covers all the domains.

There is need for increased attention to career development and retention of nurses in direct patient care positions. Roles and responsibilities for nurses have increased. Nursing has become increasingly complex, and a major rationale for hospitalization of a patient today is the need for nursing care. Based on the comments of both groups, the opportunity to "share with someone who understands" had a beneficial effect on the individuals involved. An ongoing program that promotes this type of sharing may aid in decreasing frustrations and increasing the retention of nurses in direct patient care.

As similar studies with student and registered nurse populations at all levels of practice add to the list of exemplars of nursing practice, a model of nursing may begin to be formulated. This text can serve as a data bank for secondary analysis and consensual validation of the nurses' practical knowledge exemplified in the clinical situations presented here. The paradigms themselves can provide insight into needed areas of clinical research.

Future Research

Future studies, of nurses in other settings, are needed to contribute to increased recognition and understanding of the information embedded in clinical practice. Research across the five levels of practice, from novice to expert, is also needed. Future research is needed that will further reveal the similarities and dissimilarities of clinical practice across nursing practice areas.

In conclusion, information on the nature and significance of clinical nursing practice has been provided. It is hoped that this study will stimulate nurses to record their paradigm cases and participate in the additional uncovering of clinical nursing information.

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Appendix A

Five Levels of Competency from the Dreyfus Model of Skill Acquisition and Adapted for Nursing by Benner

Appendix B

Domains of Nursing Practice

Appendix C

Institutional Review Board Approval

The University of Alabama in Birmingham
Institutional Review Board for Human Use
205/934-3789

FORM 4: IDENTIFICATION AND CERTIFICATION OF RESEARCH PROJECTS INVOLVING HUMAN SUBJECTS

The Institutional Review Board (IRB) must complete this form for all applications for research and training grants, program project and center grants, demonstration grants, fellowships, traineeships, awards, and other proposals which might involve the use of human research subjects independent of source of funding.

This form does not apply to applications for grants limited to the support of construction, alterations and renovations, or research resources.

PRINCIPAL INVESTIGATOR Rebecca J. Patterson

PROJECT TITLE Domains of Nursing Practice: Application of Benner's Model

_____ 1. This is a training grant. Each research project involving human subjects proposed by trainees must be reviewed separately by the Institutional Review Board (IRB).

_X_ 2. This application includes research involving human subjects. The IRB has reviewed and approved this application on 2-15-88, in accordance with UAB's assurance approved by the United States Public Health Service. The project will be subject to annual continuing review as provided in that assurance.

_X_ This project received expedited review.

_____ This project received full board review.

_____ 3. This application may include research involving human subjects. Review is pending by the IRB as provided by UAB's assurance. Completion of review will be certified by issuance of another FORM 4 as soon as possible.

_____ 4. Exemption is approved based on number(s) _____.

2-15-88
Date

Russell Cunningham, M.D.
Interim Chairman of the
Institutional Review Board

University Station Birmingham, Alabama 35294
An Affirmative Action Equal Opportunity Employer

Appendix D

Interview Subject Consent Form

Interview Subject Consent Form

Purpose:

Rebecca J. Patterson, a doctoral candidate in nursing at the University of Alabama at Birmingham, is conducting a descriptive study of generic baccalaureate senior nursing students and generic graduates of the same baccalaureate program two years after graduation. The purpose of this study is to describe the clinical practice of these two groups.

Procedures:

If I agree to be a subject in this study, my participation will include: a) four small group discussions of clinical practice situations with three to four of my peers that will taped recorded and will last about one and one-half hours; b) complete a short demographic form; c) review of selected transcribed narrative accounts, for accuracy, clarification of content, and validation of interpretation. I will be given guidelines for relating clinical situations that will assist me in preparing for the discussion group.

Risks/Disadvantages:

I may experience some loss of privacy through my participation in this study. However, the investigator will keep my name separate from the transcribed text. My name will be coded by number and kept in a locked file so my confidentiality will be protected as much as possible under the law. The tapes will be used for research purposes only and will be erased following completion of the study.

During the small group discussion, I am at liberty to refuse to answer any specific question and to request termination of the discussion at any time.

My inconvenience in terms of time invested in this study will be minimized as much as possible by scheduling activities at times of convenience to me.

Benefits:

Although there is no direct benefit to me from participating, I may welcome the opportunity to share thoughts and ideas about clinical experiences with other nurse practitioners.

Questions:

The study has been explained to me. However, if I have any questions about this study or my participation, I may call Rebecca Patterson at 375-3744 (h) or 334-5010 (w).

Rights:

I have received a copy of this consent form. My participation in this study is completely voluntary. I have the right to refuse to participate and the right to withdraw from this study without any jeopardy to my school or work situation. I just have to say so.

I AM MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS STUDY. MY SIGNATURE INDICATES THAT I HAVE DECIDED TO PARTICIPATE AFTER READING THE INFORMATION PROVIDED ABOVE.

_____

Signature of participant, Date

_____

Signature of investigator, Date

Appendix E

Guidelines for Recounting Case Studies

Appendix F

Permission to Use Instruments

University of California San Francisco A Health Sciences Campus

January 12, 1988

Rebecca J. Patterson, R.N., M.S.N.
804-F East Cone Blvd.
Greensboro, NC 27405

Dear Rebecca:

Congratulations on your progress. You have my permission to use the instrument entitled "Guidelines for Recording Critical Incidents," developed by Deborah Gordon and myself. Please let me know about the outcomes of your research.

Sincerely,

Patricia Benner, R.N., Ph.D., F.A.A.N.
Associate Professor

PB:ja

Appendix G

Interview Tool

Interview Tool

During this session _____, I'd like for you to describe an episode from your clinical nursing practice in which you feel your nursing care made the difference in your patient's outcome.

Since you have had an opportunity to review the handout, has any particular incident come to mind?

I'd like for you to describe the situation and individuals you have in mind in a story form with as much detail as possible.

In this session, it will be helpful if you describe how you were thinking and feeling before, during, and after the incident.

During the progress of the session, I may be asking you questions to clarify or elaborate on information about the clinical episode you are going to describe.

Do you have any questions before we get started?

Why don't you begin with the beginning of the incident that you will be describing.

Probes

Why was this incident important to you?
What were your concerns at the time?
What were you feeling during and after the incident?
What, if anything did you find most demanding about the situation?
What did you find most satisfying about the situation?

What were your priorities during the situation?
Did your priorities change during this clinical episode? If so, how?
Did your focus on major concerns change over the course of this clinical situation? How?

Can you think of any generalizations you were making from your prior work with patients that you used with this clinical problem?
What were your major expectations in this clinical situation?
What were you watching out for in this clinical situation (the unlikely or dangerous situation)?

Would you have done _____ (specific action) with any patient with this particular problem?

Can you identify any rules, guidelines, or principles that were guiding your behavior in this clinical situation?

What guidelines would you give another nurse for handling this situation?

What were the do's and don'ts that you were concerned about in this case?

Have you worked with patients with similar problems before?

Did any particular prior cases come to mind when working with this patient?

In looking at what you did in this situation, would you say that you were guided more by readings, or lectures, or past experiences with some other patients?

Did you reason out what to do in this case?

Did you have any hunches about your patient or what was wrong?
What do you think your hunch was based on?
What actions did you take on the basis of your hunches?
Did you have any physical or emotional sensations based on these hunches?
How certain did you feel about this hunch?

Interview Tool (Excerpted with permission from: From Novice to Expert: Excellence and Power in Clinical Nursing Practice by Patricia Benner. Copyright, 1984 by Addison-Wesley Publishing Company, Inc.).

GRADUATE SCHOOL
UNIVERSITY OF ALABAMA AT BIRMINGHAM
DISSERTATION APPROVAL FORM

Name of Candidate Rebecca Jean Patterson

Major Subject Maternal Child Health Nursing

Title of Dissertation Domains of Nursing Practice: Application of Benner's Model

Dissertation Committee:

_____, Chairman

_____

_____

_____

_____

_____

_____

Director of Graduate Program _____

Dean, UAB Graduate School _____

Date _____

PS-1428