ENGLISH-AS-A-SECOND LANGUAGE NURSING STUDENTS' PERCEPTIONS OF STANDARDIZED PATIENTS AS A TEACHING-LEARNING TOOL

by

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Abstract

To help offset an unprecedented nursing shortage and reduce healthcare disparities among visible minorities, it is imperative that Canadian nursing schools increase their enrollment and retention of English-as-a-Second Language (ESL) nursing students. However, ESL nursing students struggle academically. Thus, the aim of this study was to explore the perceived effectiveness of standardized patients as a means to achieve academic success among ESL nursing students. Using focus group methodology, 35 ESL nursing students shared their perceptions of standardized patients as a teaching-learning tool. Analysis generated seven core ideas: (1) psychological safety; (2) comfort communication; (3) psychomotor skill development; (4) second-language acquisition; (5) change in attitudes; (6) debrief, debrief, debrief; and (7) learning takes time. Based on focus group findings, standardized patient simulation creates a supportive community of practice that enables ESL nursing students to experience a sense of psychological safety as they acquired new learning in cognitive, psychomotor, and affective domains. Additionally, ESL nursing students were also able to enhance their English proficiency as they communicated complex medical information to patients and/or families. ESL nursing students professed that the opportunity to engage in both debriefing sessions and repeat practice sessions were instrumental to their learning. A strategic transformation in the delivery of education to ESL nursing students is needed. ESL nursing students will attain positive learning outcomes if they are immersed in a supportive and contextually-rich learning environment fostered by standardized patient simulation that encourages them to strive for mastery.

K***eywords:*** *simulation, standardized patients, ESL nursing students, visible minorities, debriefing, psychological safety, learning environment and attitudinal change*

Dedication

I would like to dedicate this thesis to the beloved memory of my mother. When I was a child there were many nights that I would watch my mother sit at the kitchen table and complete her own graduate work. It is through watching my mother strive to acquire a higher level of education that I developed a passion for lifelong learning.

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There are many individuals that I would like to thank for their guidance and encouragement as I wrote this thesis. It is through their support that I was able to complete this research project.

First and foremost, I would like to thank my husband Kevin. Since the passing of my mother, Kevin has provided me with unwavering support. He stood by me during the most difficult time in my life as I struggled to cope with the passing of my mother. Kevin has always believed in me. He encouraged me to pursue my dream of becoming a Registered Nurse and to complete the Master of Nursing program. I would like Kevin to know that he is the love of my life. I hope to one day be able to provide him with a fraction of the unconditional love and support that he has shown to me.

Secondly, I would like to thank my son, Karter, who is now six years old. There were many times when I thought about giving up as I wrote this thesis. However, it was the sound of his laughter as he played with his toys and the goodnight kisses that motivated me to continue. I knew that I wanted to be a source of inspiration to him, as my mother was to me. Karter is a smart and caring little boy. With hard work and dedication he will be able to accomplish anything that his heart truly desires.

Thirdly, I would like to extend my sincere gratitude to my Co-supervisors Dr. Alice Gaudine & Dr. Caroline Porr. Without their wealth of expertise, I would not have been able to accomplish such a tremendous project. They provided encouragement and support throughout this entire journey. There were many occasions when they went above and beyond to help me accomplish this goal. Their dedication to student learning is admirable.

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country at the time this study was completed, it was very difficult to find someone who spoke fluent English to help me with this project. Without a moment's hesitation, Christine offered to help me. She always offered words of motivation as we drove to the focus group sessions after a long day of teaching nursing students in the clinical setting.

And lastly, I would like to thank all the ESL nursing students who took part in this research study. I greatly appreciate the honesty with which they shared their personal struggle for academic success in the undergraduate nursing program. It is through their meaningful disclosure that it has become possible to have a more thorough understanding of possible strategies which may enhance the effectiveness of standardized patient simulation so that future ESL nursing students can more easily attain their dream of becoming a Registered Nurse.

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Chapter 1: Introduction

Admission into a Canadian undergraduate nursing program does not guarantee academic success; this is especially true for English-as-a-Second Language (ESL) nursing students. Nursing students who speak English as a second language are experiencing a tremendous struggle to succeed in undergraduate nursing programs (Hansen & Beaver, 2012). Some of the most common challenges experienced by ESL nursing students include low English proficiency, inexperience with multiple-choice format examinations, unfamiliar learning models, and trouble adjusting to new cultural norms (Hansen & Beaver, 2012; Olson, 2012; Suliman & Tadros, 2011). While ESL nursing students encounter many obstacles during their program of study, the main source of academic failure for these students is low English proficiency (Sanner, Wilson & Samson, 2002).

ESL nursing students are reporting a greater struggle for success than their native English speaking peers (Guhde, 2003; Jalili-Grenier & Chase, 1997). In the United States, ESL nursing students are experiencing a higher rate of failure on the National Council Licensure Examination for Registered Nurses (NCLEX-RN) than native English speaking nursing students. Between 1967 and 1995, the pass rate on the NCLEX-RN was 21% lower for Mexican-American nursing students who spoke English as a second language than native English speaking nursing students (Bosher & Bowels, 2008). Students who are unsuccessful on the NCLEX are unable to practice as Registered Nurses. NCLEX-RN failure can be distressing for nursing students.

Attrition and/or failure rates among ESL nursing students in the United States are readily available. However, it is problematic to obtain attrition and/or failure information pertaining to ESL nursing students in Canada. The only failure and/or attrition information that could be located for ESL nursing students in Canada was 22 years old. In 1992, the Social Planning and Research Council of British Columbia (SPARC BC) investigated the success and failure rates of

ESL nursing students who were studying in the University of British Columbia (UBC)/Vancouver Hospital (VH) program. The study revealed that 29% of all unsuccessful students in the UBC/VH nursing program were ESL nursing students. This finding is comparable to the failure rates which are being reported in the United States. In an attempt to locate recent Canadian statistics pertaining to ESL nursing students, I contacted both the Canadian Association of Schools of Nursing (CASN) and the Canadian Nursing Students' Association (CNSA) via e-mail to determine if they had any failure and/or attrition rates pertaining to ESL nursing students in Canada. Both institutions indicated that they were unable to provide any data regarding my inquiry.

ESL nursing students are struggling to succeed in both the classroom and the clinical setting. To gain an enhanced understanding of the difficulties experienced by ESL nursing students in a clinical setting, Miguel and Rogan (2011) conducted a descriptive-interpretive qualitative research study to examine course instructors' expectations of ESL nursing students while in the clinical setting. Miguel and Rogan found that the course instructors had clustered their comments pertaining to student performance into either the *good* or *improvements required* category. Those students who were placed in the improvements required category needed to improve their ability to communicate with patients and staff, be proactive, and take responsibility for their learning (Miguel & Rogan, 2011). The majority of comments surrounding student performance in the improvements required category suggested that the ESL nursing students needed to improve their ability to communicate in English. The course instructors' believed that these students were speaking too fast, demonstrated poor pronunciation, and displayed little use of attending behaviors such as eye contact (Miguel & Rogan, 2011).

Although ESL nursing students experience a greater struggle to achieve academic success than their native English speaking peers, they are not doomed to fail. Nurse educators can devise teaching-learning strategies that provide ESL nursing students with the educational support they require to achieve entry-level competencies for Registered Nurses and pass nursing licensure examinations (Abriam-Yago, Yoder, & Kataoka-Yahiro, 1999). However, there appears to be a lack of research conducted on the learning needs of ESL nursing students (Philips & Hartley, 1990). Nurse educators are left pondering which teaching-learning strategies facilitate positive learning outcomes, while ESL nursing students are left struggling to achieve academic success (Yoder, 1997).

Teaching cognitively demanding concepts in a contextually-reduced environment makes it difficult for ESL students to comprehend and retain complex nursing concepts (Abriam-Yago et al., 1999). Nurse educators can enhance the learning of ESL nursing students by teaching cognitively demanding concepts in a contextually-embedded environment (Abrian-Yago et al.). The overly utilized passive teaching-learning strategies often employed by many nurse educators throughout Canada, such as PowerPoint Presentations, are not as effective as active teaching-learning strategies. Experiential teaching-learning strategies such as standardized patients (SPs) may potentially increase the likelihood of academic success among ESL nursing students.

In this study, ESL nursing students' perceptions of standardized patients (SPs) as a teaching-learning tool were explored. "SPs are individuals who are trained to portray a patient with a specific condition in a realistic, standardized and repeatable way" (Association of Standardized Patient Educators, 2011, para 1). SPs are being used in the undergraduate nursing curriculum to teach therapeutic communication skills and psychomotor nursing skills. SPs immerse students in a contextually supportive learning environment so that students are not

simply recipients of information but active participants in the teaching-learning process (Onda, 2012). The implementation of SPs into the ESL nursing curricula ensures that students have the opportunity to integrate abstract theoretical knowledge into practice before engaging in actual patient care (Yoo & Yoo, 2003).

Since SPs have been primarily used in medical education, little is known about the teaching effectiveness of SPs among undergraduate nursing students and even less is known about the impact of SPs on the learning of ESL nursing students (Becker, Rose, Berg, Park, & Shatzer, 2006; Kurz, Mahoney, Martin-Plank & Lidicker, 2009; Wales & Skillen, 1997). This study was undertaken so that nurse educators may have enhanced understanding of ESL nursing students' perceptions of SPs as a teaching-learning tool and gain insight into possible strategies that will enhance the use of SPs in the ESL nursing curricula. Without the implementation of innovative and advantageous teaching-learning strategies, ESL nursing students will continue to struggle to achieve academic success, and some will continue to be unsuccessful in their program of study. Incorporating SPs into the undergraduate nursing program may potentially create the authentic and supportive environment that ESL nursing students require in order to achieve academic success.

Significance to Canadian Healthcare

Many Canadians take great pride in their identity as a multicultural nation. As the first nation to adopt an official policy of multiculturalism, Canada is recognized worldwide as a nation that values the preservation of native heritage among its citizens (Citizenship and Immigration Canada, 2012). Immigrants who decide to move to Canada tend to feel assured that they will not be required to assimilate and forego their native cultural beliefs and practices (Citizenship and Immigration Canada, 2012).

With an immigration rate of nearly 250,000 people per year, Canada has inherently become a culturally diverse nation (Citizenship and Immigration Canada, 2012). By 2031, it is anticipated thatnearly one-third of Canada's population or 14.4 million people could belong to a visible minority group (Statistics Canada, 2011l). Statistics Canada (2009) defines visible minorities as a group of "peoples, other than Aboriginal Peoples, who are non-Caucasian in race or non-white in color" (para. 2). Some of the common visible minority groups in Canada are Arab, Chinese, Korean, South Asian, Filipino, and Japanese (Statistics Canada, 2009).

The number of people speaking a foreign language in Canada is astounding. Roughly 6.6 million Canadians have reported speaking a language other than English or French in their home (Statistics Canada, 2011). Canada is experiencing a rapid proliferation in the number of foreign languages spoken throughout the nation; the linguistic portrait of Canada has become very diverse. In fact, as of 2011, more than 200 languages were being spoken in homes throughout the country. The foreign language that experienced the greatest growth between 2006 and 2011 was Tagalog, a Philippine-based language (Statistics Canada, 2011).

Despite the existence of progressive legislation in Canada which recognizes social equity and social justice, immigrants to Canada are encountering many healthcare disparities. For example, minority groups in Canada are reporting worse health and significantly lower utilization of certain healthcare services including PAP test screening, mammography screening, or prostate cancer screening, than those who have a native language of either French or English (Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008; Quan et al., 2006). One of the main reasons healthcare disparities exist for minority groups within the Canadian healthcare system is because healthcare providers lack the ability to meet the cultural and linguistic needs of these patients (Premji & Etowa, 2014).

At the same time as the rapid proliferation of nationalities, Canada is in the midst of experiencing a severe and unprecedented nursing shortage. The critical shortage of Registered Nurses in Canada is not a new phenomenon. In 2009, the Canadian Nurses Association (CNA) predicted that without intervention, Canada will experience a shortage of 60,000 full-time Registered Nurses by 2022. To offset the growing nursing shortage, the CAN (2009) explicitly recommends that direct-entry-to-practice education programs devise creative strategies that aim to increase the enrollment and retention of nursing students. The CAN (2009) does not specifically mandate how this goal is to be accomplished but rather implores key stakeholders, such as educational institutions and governments, to work together to find a way to accomplish this objective.

Unfortunately, many of the recruitment and retention efforts employed by nursing education programs throughout Canada have been hampered by inflexible admission requirements and a lack of teaching innovation. In order to increase the enrollment and retention of nursing students, nursing education programs throughout Canada may need to reconsider their admission criteria and the teaching-learning strategies they employ in the classroom. As many nursing education programs search for applicants who are "most likely to succeed" they are overlooking other potential candidates, including ESL nursing students, because they do not meet traditional enrollment criteria. These students may be denied entrance due to a low grade point average (GPA) or a low level of English proficiency.

Increasing the enrollment and retention of nursing students from diverse cultural and linguistic backgrounds must become a priority for nursing education programs throughout Canada. Increasing the diversity of nursing students in Canada will not only help alleviate the

impending nursing shortage but also provide a multicultural nation with the opportunity to receive culturally competent nursing care (Crawford & Candlin, 2012).

Research Purpose and Question

The purpose of this research study was to describe ESL nursing students' perceptions of SPs as a teaching-learning tool. The guiding research question was what are ESL nursing students' perceptions of SPs as a teaching-learning tool? It was anticipated that during the process of developing a meaningful understanding of ESL nursing students' perceptions of SPs as a teaching-learning tool, there would also be an opportunity to glean insight into possible strategies that would enhance the integration of simulated SP learning experiences into the ESL nursing curricula.

Chapter 2: Literature Review

A literature review was conducted to explore the knowledge that exists surrounding the use of SPs in undergraduate nursing education. Unfortunately, there is a dearth of literature pertaining to SP usage among ESL nursing students. I begin with a discussion of the need for change in the delivery of undergraduate nursing education. I then provide an overview of the utilization of simulation education in healthcare education, followed by a discussion of how situated cognition, a learning framework, can support the integration of SPs into undergraduate nursing education. Lastly, I conclude the chapter by discussing the learning outcomes and teaching effectiveness associated with SP utilization in undergraduate nursing education.

The Need for Change in the Delivery of Undergraduate Nursing Education

Many patients go to the hospital believing that healthcare professionals will *do no harm*. However, many patients experience preventable complications while under the care of a healthcare professional. It is not uncommon to learn that patients have received the incorrect dose of a medication or even the wrong medical treatment. Not all patients leave the hospital singing songs of praise about their healthcare experience; unfortunately, many are even discharged with harrowing tales of misfortune.

The Institute of Medicine (IOM) report *To Err is Human: Building a Safer Healthcare System* (1999), revealed that as many as 98,000 people in the United States die each year due to preventable medical errors. A comparable incidence of preventable medical errors can be found in Canada. The seminal report, *The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada* (2004), shed light into the fact that during the year 2000, 7.5 % of Canadian patients admitted to acute care hospitals experienced at least one Adverse Event (AE) and 36.9% of these AEs were deemed preventable (Baker et al., 2004).

While it is impossible to create a healthcare system that is entirely error-free, it is feasible to create a proactive healthcare system which takes the necessary measures to mitigate preventable errors from occurring. *To Err is Human: Building a Safer Healthcare System* (1999) recognized the need for immediate change in the delivery of healthcare education and recommended the following two key changes to the delivery of healthcare education: (1) abolishment of the traditional trial and error method of instruction and (2) incorporation of simulation into healthcare education.

Simulation in Healthcare Education

Simulation education is a unique experiential teaching-learning strategy "that replicates aspects of the real world in an interactive fashion" (Gaba, 2004, p. i2). Simulation education provides students with a learner-centered and interactive environment wherein they can begin to understand cognitively demanding concepts through "doing" (Zulkosky, 2012). Students who actively engage in simulation education are able to construct knowledge, explore assumptions, and develop psychomotor skills (Gaba, 2004). When students are immersed in a simulated learning environment they are able to practice delivering real-world healthcare such as vital sign measurement and therapeutic relationship development in a realistic setting, without causing harm to real patients. Students who engage in simulation education participate in a debriefing session after the simulated learning experience has ended. A debriefing session is defined as an "activity that follows a simulation experience led by a facilitator wherein feedback is provided on the simulation participants' performance while positive aspects of the completed simulation are discussed and reflective thinking is encouraged" (National League of Nursing, 2008, para 1). Debriefing is the component of simulation where learning actually takes place (Cantrell & Deloney, 2007; Dreifuerst, 2009; Galloway, 2009; Peters & Vissers, 2004; Rothgeb, 2008). Debriefing is, without a doubt, an essential component of simulation education (Neil & Wotton,

2011). After students have participated in a debriefing session they are provided with the opportunity to engage in repetitive practice until they are able to demonstrate consistent success.

Simulation Modalities. There are many modalities of simulation; the most common modalities available to healthcare educators are role-play, case studies, virtual reality, part-task trainers, human patient simulators, and standardized patients (Nehring & Lashley, 2010). As each particular modality of simulation has its own advantages and disadvantages, it is important to have a sound understanding of the objectives of a particular simulated learning experience before selecting a modality of simulation.

The level of fidelity or realism can vary between different modalities of simulation. Simulators which provide learners with a heightened sense of realism are considered to be of a higher fidelity than those that offer a minimal sense of realism (Nehring & Lashley, 2010). The degree of fidelity a simulation demonstrates can be classified as low, moderate, or high. Low-fidelity simulators are often used during the instruction of psychomotor skills (Nehring & Lashley, 2010). They are static: there is no interaction between the simulator and the learner. An example of a low-fidelity simulator could be a prosthetic arm that may be used by learners to practice intramuscular injections. Moderate-fidelity simulators provide participants with a higher degree of realism than low-fidelity simulators (Nehring & Lashley, 2010). Moderate-fidelity simulators could be mannequins that have the capability of producing normal and abnormal heart and lung sounds upon auscultation with a stethoscope. High-fidelity simulators create a learning environment that is the most representative of the "real world" (Paige & Daley, 2009). Traditionally, high-fidelity simulators have been referred to as 'human patient simulators'. Common human patient simulators are SimMan ® and PediSim®. Human patient simulators are computerized mannequins which are able to provide real-time physiological

responses to healthcare-initiated interventions such as tachycardia, hypotension, and diuresis (Nehring & Lashley, 2010). SPs also provide learners with a high-fidelity simulation experience (Robinson-Smith, Bradley, & Meakim, 2009). SPs, as defined in Chapter 1, provide learners with a sense of realism that cannot be achieved with a human patient simulator (Dearmon et al., 2013). When learners interact with an SP they are able to touch a real person and not the plastic surface of a mannequin; they are also able to observe non-verbal behavior and obtain verbal feedback of their performance. According to a review by Colliver and Williams (1993), SPs are so realistic that even experienced clinicians have been unable to differentiate between an unannounced SP and a real patient in the clinical setting.

History of Simulation. Simulation-based education has been primarily used to train groups of people when real world training is deemed too costly or too dangerous (Garrett, MacPhee, & Jackson, 2011). The first documented use of simulation education was by the American military in World War II. The military utilized simulation for tactical training. Another frequent user of simulation is the aviation industry. The aviation industry first employed the use of simulation to train pilots after a number of crashes had been reported due to limited visibility. Police academies have also utilized simulation to train cadets on how to properly respond to bomb threats (Chung & Huda, 1999).

Simulation education is no longer limited to the training of military personnel, pilots, or police. Healthcare educators have begun to incorporate simulation into clinical education. Dr. Barrows, a neurologist from the University of Southern California, was the first educator to incorporate SPs into medical education; he used SPs to depict a patient who was paralyzed due to multiple sclerosis (Wilson & Rockstraw, 2012). Dr. Barrows received much condemnation from

his colleagues for using SPs in medical education. However, the criticism of SPs as a teaching modality did prevent the implementation of SPs into the curricula of medical education.

Despite the routine use of SPs in medical education, nursing educators have been reluctant to incorporate SPs as a teaching-learning strategy in undergraduate nursing education. Rather nurse educators have primarily used SPs to educate advanced practice nurses such as nurse practitioners (Becker et al., 2006; Kurz et al., 2009; Wales & Skillen, 1997). The rationale for the lack of integration of SPs in undergraduate nursing education remains unclear. Perhaps nurse educators have not been convinced of the teaching effectiveness of SPs, or it may be viewed as too costly. Whatever the reason, SPs are not being widely integrated into undergraduate nursing curricula.

In 2007, CASN conducted a web-based survey of simulation education in healthcare programs across Canada. The survey was sent to all schools of nursing, medical schools, and allied health professional schools (i.e., physiotherapists, occupational therapists, paramedics, respiratory therapists, dentists) to identify the high fidelity, intermediate fidelity, and/or low fidelity simulation usage in their respective program (CASN, 2007). Results from 64 of the 71 schools that completed the survey (a response rate of 36%) revealed that medicine, paramedicine, and care aide professionals reported the highest proportion of high-fidelity simulation use. On the other hand, nursing programs reported the use of all three types of simulation in their programs, but the most frequently employed type of simulation was low-fidelity simulation (Garrett et al., 2011).

In addition to surveying the type of simulation utilized in each healthcare program, CASN also asked educational institutions to identify if simulation education hours replaced actual clinical hours in their respective program. Only seven respondents (11%) indicated that

they utilized simulation as an alternative to clinical practice experience. Most of the institutions that replaced clinical hours with simulation reported replacing less than two days of actual clinical practice. No respondents indicated that they completely replaced all clinical practical experiences with simulation.

Standardized Patients in Undergraduate Nursing Education

SPs are being utilized in undergraduate nursing education as an evidence-based teaching and evaluation method (Walker, Armstrong, & Jarriel, 2011). They have been primarily used in the healthcare education of medical, nursing, nurse practitioner, and pharmacy students. SPs have been a valuable addition to healthcare education; those students who participate in SP learning experiences are able to practice therapeutic communication skills and various psychomotor skills. A major advantage of SPs is that they are able to provide valuable feedback regarding student performance. Students are able to receive immediate feedback regarding their strengths and weaknesses (Robinson-Smith et al., 2009).

Situated Cognition: A Learning Framework for Standardized Patients in Undergraduate Nursing Education

Situated cognition, also known as *situated learning* was introduced as a model of instruction by Brown, Collins, and Duguid in 1989. Brown et al. (1989) posited that meaningful learning is more apt to occur in an environment of reciprocal interaction between (a) people (community, students, instructors, family, nurses, physicians, and auxiliary personnel); (b) ingredients or tools (prior knowledge, resources, language); and (c) activity (participation in authentic real-life events). A visual depiction of these components is found in Figure 1. Brown et al. (1989) also believed that to enhance knowledge acquisition, learners must participate in "cognitive apprenticeships" within a community of practice. Cognitive apprenticeships are

teaching methods designed to, "enculturate students into authentic practices through activity and social interaction" (Brown et al., p. 37).

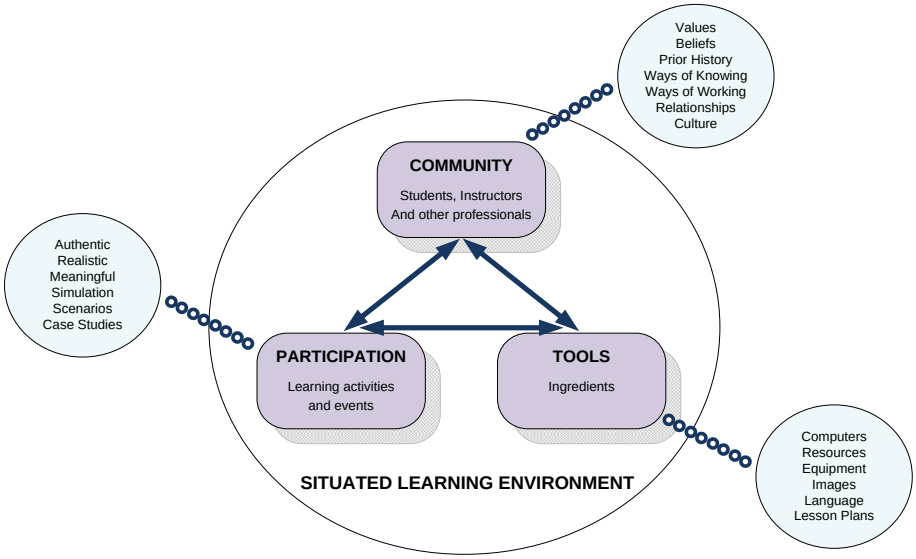

Figure 1. Ecological analysis of the situated learning environment. Adapted from "Situated cognitions and situated learning: What does it mean and where does it come from?" by K. Ryba, 2012. Adapted with permission.

To augment the work completed by Brown et al. (1989), Lave and Wenger (1991) proposed that apprentices should initially observe the community of practice from the periphery; then, as they engage, apprentices should ultimately transition from the role of observer to a fully functioning member. In essence, the theory of situated cognition asserts that learning is optimized when it takes place in an authentic or realistic environment with learners performing real-world activities (Onda, 2012).

Authentic Context. The theory of situated cognition states that the "learning environment should reflect the way the knowledge will ultimately be used, and [that] it should preserve the complexities of the real life setting" (Onda, 2012, p. e276). A well designed SP scenario has the ability to provide a realistic environment for learners. For instance, a SP

learning experience enables students to provide care in a realistic hospital room complete with hospital bed, oxygen flow meters, suction outlets, and so forth. The students are able to utilize authentic supplies that would be found in a hospital setting, such as stethoscopes and intravenous pumps. Interdisciplinary learning experiences could further enhance the authenticity of the simulated SP learning environment. Students would be able to work in a team with other health disciplines and be challenged to navigate the unique team dynamics often found within the healthcare setting.

Authentic Activities. Authentic tasks are real-world activities that would naturally occur in the practice of a particular culture (Onda, 2012, p. e276). Implementation of SPs into undergraduate nursing curricula affords nursing students the opportunity to engage in real-world nursing care in a simulated, safe learning environment. Undergraduate nursing students who participate in simulated SP learning experiences during their program of study are able to practice developing therapeutic nurse-client relationships and psychomotor skills such as medication administration, wound care, vital sign measurement, and so forth.

Learning Outcomes of SP Utilization in Undergraduate Nursing Education

Incorporating SPs into undergraduate nursing curricula is not an effortless or low-cost endeavor. A considerable amount of time must be devoted in order to implement an effective SP learning experience for students. Much time is required to develop SP scenarios and to then train SPs to properly portray the scenario. In addition to the time required to run an SP learning experience, it can also be quite costly to hire SPs for a simulated learning experience. In order to justify the tangible and nontangible resources needed to conduct SP learning experiences, there must be evidentiary support that this teaching-learning strategy enhances student learning.

A literature search was conducted to examine the effectiveness of SPs as a teaching-learning strategy in undergraduate nursing education. Both CINAHL and PubMed (MEDLINE) databases were searched using the following key words: *undergraduate nursing students, baccalaureate nursing students, and standardized patients*. Limits included journal articles that were printed in English and published between the year 2000 and 2014. A total of 15 articles resulted from this literature search. The articles revealed that SPs had an impact on undergraduate nursing student learning in the following areas: 1) satisfaction with the SP learning modality; 2) psychomotor skill development; 3) self-confidence; 4) interprofessional teamwork; 5) therapeutic communication skills; 6) knowledge acquisition; and, 7) clinical anxiety, as explicated below.

Satisfaction with SP Learning Modality

Nurse educators strive to incorporate teaching-learning strategies in the classroom that are enjoyable for students; educators do not want students to be bored or dislike learning experiences. Students who enjoy their learning experiences will become actively involved in the teaching-learning process.

Student satisfaction with the SP learning experience was addressed in three studies (Doolen, Giddins, Johnson, Guizado de Nathan, & O'Badia, 2014; Luctkar-Flude, Wilson-Keates, & Larocque, 2012; Robinson-Smith et al., 2009). In those studies conducted by Doolen et al. (2009) and the Robinson-Smith et al. (2009), participants were asked an open-ended question to evaluate their satisfaction with the learning experience. The responses from participants in both studies were overwhelmingly positive. Responses included: "I enjoyed learning through the use of the standardized patient care scenario," and "The standardized patient care scenario provided me with activity to promote my learning."

Despite the support for the use of SPs in the undergraduate nursing classroom in these two studies, the participants in the Luctkar-Flude et al. (2012) study did not share the same level of enthusiasm for the SP teaching-learning modality. Luctkar-Flude et al. evaluated the similarities and differences between undergraduate nursing students' modality satisfaction and respiratory assessment performance while using high-fidelity simulators (HFSs), standardized patients (SPs), and community volunteers (CVs). A total of 44 second-year undergraduate nursing health assessment students participated. Each participant was required to perform a respiratory assessment on either a HFS, SP, or CV.

Following the respiratory assessment session, students were asked to complete the Health Assessment Educational Modality Evaluation (HAEME). This tool measured student satisfaction with the three learning modalities. While participants were satisfied with all three teaching-learning modalities, the participants were more satisfied utilizing the CVs than the SPs or the HFSs. A significant difference in satisfaction was not found between the SP group and the HFS group.

Psychomotor Skill Development

Despite the fact that nursing is a practice-based discipline, only two research studies evaluated the impact of SP learning experiences on psychomotor skill development (Bornais, Raiger, Krahn, & El-Masri, 2012; Luctkar-Flude et al., 2012). Luctkar-Flude et al. measured modality satisfaction among second year undergraduate nursing students and also compared the ability of HFSs, SPs, and CVs to impact the respiratory assessment performance of participants. All 44 students who took part in the study were videotaped performing a respiratory assessment. To determine if their respiratory assessment performance had improved following interaction with the three experiential learning modalities, two faculty members independently reviewed

each videotape and evaluated the participants' performance using the Respiratory Assessment Checklist. Discrepancies in evaluation were resolved by viewing the video a third time and by discussing student performance. The Respiratory Assessment Checklist was an instructor-developed instrument consisting of 47 critical behaviors, divided into four groups: interpersonal communication skills (16 items), health history interview (7 items), physical examination techniques (20 items), and health teaching/concluding remarks (4 items). Those participants who performed a respiratory assessment on a HFS received the highest overall respiratory assessment performance score. HFS participants also scored significantly higher on health teaching than CV participants. There were no significant differences found in performance scores between SP and CV participants.

In this study, researchers only measured the post-intervention respiratory assessment performance. There was no measure of baseline respiratory assessment performance. Therefore, it is impossible to determine the magnitude of change in performance from baseline to post-interventions. How the educational interventions impacted performance scores is unkown. This study only confirms that HFS participants had the highest post-intervention score. Perhaps a better indicator of intervention impact on respiratory assessment performance would have been a change in respiratory assessment performance from baseline to post-intervention.

Unlike the Luctkar-Flude et al. (2012) study, researchers Bornais et al. (2012) undertook a comparative study which examined the effectiveness of SPs in improving the health assessment skills of 108 first-year nursing students. All participants who took part in this study were recruited from a university and collaborative college in Ontario, Canada. The control group received traditional health assessment education, that is, a weekly two-hour practice lab with peers, and the intervention group practiced health assessment skills using SPs.

The health assessment performance of participants was measured during two objective structured clinical examinations (OSCEs): one at baseline and one at post-intervention. SPs were chosen instead of peers because they are trained to portray a patient with a specific health condition. Performance in the OSCE was measured using a checklist of 48 competencies. The OSCEs measured health history-taking skills, infection control measures, and physical examination techniques. Possible OSCE scores ranged from 0 (*extremely poor*) to 48 (*perfect*). To avoid any perceived bias, examiners did not know which students were in the control group or educational interventional group. The results of this study indicate that participants who practiced on SPs had overall higher health assessment performance scores than those who practiced in the traditional manner with their peers.

There is not enough evidence in the empirical literature to conclude that SPs improve psychomotor skill development. While the results of Bornais et al. (2012) may unequivocally support the use of SPs to enhance psychomotor skills development, the results of the study by Luctkar-Flude et al. (2012) cast doubt. It can be concluded that there is potential for SPs to improve psychomotor skill development, but further exploration in is warranted.

Self-Confidence

It is extremely important that undergraduate nursing students increase their level of self-confidence as they progress through their program of study. Self-confidence enables undergraduate nursing students to independently plan, implement, and evaluate nursing care (Stroup, 2014). Two of the studies reviewed for this literature review included examination of the role of SPs in enhancing self-confidence among undergraduate nursing students (Dearmon et al., 2013; Robinson-Smith et al., 2009).

In both studies, statistically significant increases in self-confidence levels resulted from participation in various SP learning experiences. Participants reported increased confidence in their ability to understand course content, administer medication safely, correctly perform a physical assessment on an assigned patient, and obtain an accurate health history (Dearmon et al., 2013; Robinson-Smith et al., 2009). However, participants did not feel more confident that they could retrieve pertinent information in medical records (Dearmon et al., 2013) or that they were more prepared for tests and examinations (Robinson-Smith et al., 2009).

Interprofessional Teamwork

The World Health Organization (2010) report *Framework for Action on Interprofessional Education and Collaborative Practice* encourages the integration of interprofessional education (IPE) into healthcare programs.

The WHO defines IPE as

> the process by which a group of students (or workers) from the health-related occupations with different educational backgrounds learn together during certain periods of their education, with interaction as an important goal, to collaborate in providing promotive, preventive, curative, rehabilitative and other health-related services (WHO,1988, p. 6.)

IPE effectively prepares students for collaborative practice when they enter the workforce which in turn strengthens health systems and improves health outcomes (WHO, 2010). For example, collaborative practice improves health outcomes for patients with chronic illnesses, reduces mortality rates, and improves patient satisfaction and overall health ratings (WHO, 2010).

However, despite the impetus to incorporate IPE into health professional education programs, many prelicensure health programs continue to educate students only in their chosen profession (Gordon, Lasater, Brunett, & Dieckmann, 2015). Many educational institutions have yet to implement an IPE curricula. Future healthcare professionals are spending very little time learning together. Future healthcare professionals are spending the majority of their time

learning together; the majority of their time is spent learning in isolation rather than with their future colleagues (Gordon et al, 2015). The lack of interdisciplinary healthcare education is reflected in the paucity of interprofessional simulation research. Only one of the reviewed articles evaluated the effects of an interprofessional SP learning experience (Curran, Mugford, Law, & MacDonald, 2005). In this particular study, researchers from medicine, nursing, and pharmacy developed an HIV/AIDS interprofessional education module to improve students' ability and confidence to work together in an interprofessional team (Curran et al., 2015).

A total of 133 health sciences students agreed to participate in the module: 62 second-year medical students, 45 third-year nursing students, and 26 fourth-year pharmacy students. The students met in small groups on three separate occasions for one hour. During the first two sessions the students completed a paper-based case study about a patient with HIV/AIDS. During the third session, the students had the opportunity to interview an SP with HIV/AIDS and develop an interprofessional care plan.

Throughout the course of the group sessions, study participants completed four different evaluation instruments: role perception checklist, weekly team inventory, participant evaluation survey, and team dynamics observation checklist. The greatest role perception changes among participants of the nursing profession occurred in the areas of researcher, coach, diagnostician, and assess psychosocial. On the participant evaluation survey, participants commented that they had increased both their knowledge of the roles of other health professionals and their ability to collaborate with these professionals in the delivery of care to patients with HIV/AIDS and their families. The students also completed a weekly inventory scale that was a 15-item self-reported teamwork skills scale. A t-test analysis of the mean differences between the scores indicated a significant increase in weekly inventory scales over the three sessions for students from each

profession (nursing, medicine, and pharmacy). During the last group session, the tutors completed a team dynamics observation checklist. This session involved group interaction with an SP to develop an interprofessional HIV/AIDS plan. The major outcomes of this survey were reported to be information sharing, design of an interprofessional care plan, respect for other team members, and clarification of roles in patient care.

Therapeutic Communication Skills

Effective therapeutic communication is the cornerstone of quality nursing care. Therapeutic communication skills enable the building of meaningful helping relationships between nurses and patients. Unfortunately, with limited clinical time and the need to practice a host of clinical skills, therapeutic communication skills are often viewed by clinical nursing educators as skills that can be acquired at another time. This is not the case, however. Therapeutic communication skills must be practiced deliberately and repetitively, or else the opportunity to advance therapeutic communication may be lost.

Two studies evaluated the impact of SP learning experiences on the development of therapeutic communication skills (Doolen et al., 2014; Webster, 2013). In Webster's (2013) study, 15 undergraduate nursing students voluntarily agreed to participate in an SP learning experience. The SPs were recruited from a local community acting group to portray individuals with the following mental health illnesses: schizophrenia, bipolar mania, and bipolar depression. Each student participated in a 15-20 minute interview of the SP which was video-recorded. Immediately following the interview the students and the SPs participated in a faculty-led debriefing session.

During the debriefing session all the students provided feedback that the SP learning experience helped improve their therapeutic communication skills. One student stated, "Even

though some of what I said was awkward, this gave me a real chance to practice and get better for future interactions with real patients." Participants felt that by interviewing the SPs they were able to improve their therapeutic communication in several areas. In particular, the students discussed the impact that nonverbal behavior can have on a nurse-patient relationship. One student stated, "I was not aware that my body language caused the patient to shut down until the actor said that I appeared distant." Other students also discussed the importance of actively listening to clients when providing nursing care. For example, one student stated, "Take time to listen…and not just keep asking question after question as if you are checking something off your list of things to do."

These qualitative findings were supported by quantitative results in a follow-up study by Webster (2014). In a quasi-experimental, one-group, pre-post study, 89 senior baccalaureate nursing students who were enrolled in a psychiatric nursing course voluntarily agreed to participate in a SP experience. The purpose of the SP experience was to "determine the effectiveness of SP [experiences] as a teaching modality to improve nursing students' use of therapeutic communication skills with individuals with mental health illnesses" (Webster, 2014, p. e83). In this study, the SPs portrayed individuals with the following mental health illnesses: paranoid schizophrenia, bipolar mania, depression with suicidal ideation, obsessive compulsive disorder, borderline personality disorder, dementia, or posttraumatic stress disorder. After the first learning experience, students received formative feedback from faculty regarding their performances. The objective of this feedback was to help students improve their performances for the last SP experience. Upon completion of the last SP experience, the students received summative feedback or a grade of their ability to use therapeutic communication skills with SPs experiencing a mental health illness.

To evaluate the students' ability to develop therapeutic relationships, nursing instructors used a 14-point checklist. Each criterion was rated on a 5-point Likert scale. Some of the criteria being evaluated included *approaches client using a nonthreatening body stance, maintains appropriate therapeutic boundaries, responds appropriately (verbally and nonverbally) to patient's verbal statements*, *uses therapeutic communication techniques, demonstrates anxious behaviors, summarizes content of interaction,* and *terminates interaction appropriately*.

Significant differences were found in 12 of the 14 evaluation criteria. The two evaluation criteria that did not have a significant difference were *approaches client using a nonthreatening body stance* and *introduces self*. Although a significance difference was not noted, participants demonstrated significant improvement in the following areas *establishes eye contact, engages in efforts to put the patient at ease,* and *sets limits on inappropriate behavior*.

Knowledge Acquisition

Knowledge acquisition was evaluated in two studies (Becker et al., 2006; Dearmon et al., 2013). After reviewing both studies, it could not be determined that SP learning experiences improved the knowledge level of participants more than other teaching-learning strategies. In fact, there were mixed results regarding the ability of SP learning experiences to increase the knowledge level of participants.

Becker et al. (2006) conducted a pretest-posttest, randomized, control group pilot study on 147 senior undergraduate nursing students. Of the 147 students, 58 were assigned to the treatment group and 89 were assigned to the control group. The students in the treatment group were required to conduct a videotaped clinical interview of an SP exhibiting depression for 30 minutes, participate in a 30 minute debriefing session following the interview, and write a self-analysis of the interview. In contrast, the students in the control group participated in a

traditional clinical conference with their clinical instructor. The control group of students focused on the same SP scenario as those in the treatment group. The control group was asked what they would do for the patient exhibiting depression, whereas the treatment group conducted an interview of an SP who was portraying a mental health illness.

Both groups of participants were asked to complete the Communication Knowledge Test (CKT) at the start and finish of their respective learning experiences. The CKT is a 20-item multiple-choice test of competencies regarding therapeutic communication and the nursing care of clients with depression. The CKT was designed by six clinical, advanced-practice nurse experts in psychiatric nursing. The CKT was never tested for reliability and validity.

At the end of the study, the mean CKT scores of the treatment and control groups revealed that the knowledge level of both groups regarding depression increased after the learning experiences, there was no statistical difference.

Dearmon et al. (2013) also evaluated the impact of SP learning experiences on knowledge level. In this study, 50 undergraduate nursing students at the beginning of their program were required to provide basic nursing care to SPs. At the end of the learning experience, the participants were required to complete the Knowledge Assessment (KA) tool. This instrument, like the CKT, was not tested for reliability or validity. The results of this study indicate that the knowledge level of participants increased after the SP learning experience by an average of 0.64 points. Twenty-seven students improved their scores by one to two points. However, not all students experienced an increase in knowledge level; the knowledge level of 12 students remained the same and decreased by one or two points for 11 students.

There is no clear evidence to suggest that SP learning experiences are more effective than other teaching-learning strategies in improving knowledge acquisition. Perhaps the lack of

clarity in the literature regarding SPs and knowledge acquisition can be attributed to the fact that the measurement tools used in both reviewed studies were not tested for reliability and validity. Future investigation of the impact of SP learning experiences on knowledge acquisition should involve instruments that have been tested for reliability and validity.

Clinical Anxiety

High levels of anxiety can adversely affect performance in the clinical setting (Dearmon et al., 2013). However, despite awareness among nurse educators regarding the adverse effects of clinical anxiety, little has been done to reduce the anxiety experienced by nursing students. No concerted effort has been made to minimize clinical anxiety. A search of the literature pertaining to SPs in undergraduate nursing education produced only two articles that evaluated the impact of SP learning experiences on clinical anxiety (Dearmon et al., 2013; Doolen et al., 2014).

It is not uncommon for beginning nursing students to experience high levels of pre-clinical anxiety; the clinical setting is an unfamiliar environment for many beginning nursing students. As students enter the nursing program with little to no healthcare experience, they tend to fear the clinical setting (Dearmon et al., 2013). After all, they have never been asked to care for a complete stranger in a new environment. Beginning nursing students are often as uncertain about the clinical environment as they are in their ability to provide even the most basic nursing care. Some students experience such intense anxiety that they may begin to wonder if they are even capable of becoming a nurse.

Dearmon et al. (2013) conducted a mixed-methods, quasi-experimental study to determine the effect of a two-day simulation-based orientation activity on anxiety levels. Fifty students volunteered to take part in this study. On the first day of orientation, students were able to review the medical record of a patient for whom they would be providing care. On the second

day of orientation, students had the opportunity to provide nursing care to an SP. The results of the study indicated a significantly lower level of stress among those students with work experience in the healthcare environment compared to those without work experience in the healthcare environment. All participants showed a decrease in their level of anxiety (exacerbated by a current situation) following completion of the simulation-based orientation activity. However, the decrease in anxiety levels was not significant among male participants.

Unfortunately, it is not only beginning nursing students that can experience anxiety related to the clinical setting. Undergraduate nursing students can experience clinical anxiety as they progress through their program of study. The 94 senior undergraduate nursing students who participated in the study by Doolen et al. (2014) experienced anxiety related to the mental health clinical setting. Each of the participants completed a 20-minute mental health interview on an SP, where the SPs were trained to portray patients with bipolar disorder, schizophrenia, and anxiety. Upon completion of the interview, the nursing students, mental health instructors, and the SPs debriefed for 20 minutes. During the debriefing session the students reflected on what they did well and what they could improve upon.

At the end of the simulated learning experience, the students completed an 11-item questionnaire about the SP learning experience. It was found that 95.75% of the students believed that the SP mental health learning experience helped reduce their fear of interviewing real patients in the mental health clinical setting and effectively prepared them for this specific mental health clinical course.

Simulation Education: An Effective Pedagogy

Many nurse educators appear to support the use of simulation education as an effective pedagogy but are hesitant to replace traditional clinical hours with simulation hours (CASN, 2007). Perhaps some nurse educators are wondering if simulation education can actually

produce the competent healthcare practitioners that are needed in an increasingly demanding healthcare environment.

Until recently, the lack of certainty among nurse educators regarding the effectiveness of simulation education has been understandable. There has been a lack of longitudinal and generalizable data gathered on the impact of replacing traditional clinical hours with simulation hours on the educational preparation of undergraduate nursing students. To address this research gap, the National Council of State Boards of Nursing (NCSBN) conducted a longitudinal, randomized controlled study to examine the effect of replacing up to half the clinical hours with simulation hours on the educational preparation of undergraduate nursing students (NCSBN, 2012).

A total of 633 students from 10 pre-licensure nursing programs across the United States participated in this groundbreaking study by the NCSBN. All students were followed from their first clinical course to the first six months after graduation. The participants were randomized into one of three study groups: a control group who received traditional clinical experiences, an experimental group where 25% of clinical hours replaced with simulation hours, or an experimental group where 50% of clinical hours were replaced with simulation hours. The results of the study indicated that up to 50% of clinical time could be effectively replaced with simulation time. At the time of graduation, there were no statistically significant differences among the three groups at graduation in the areas of comprehensive nursing knowledge assessments and NCLEX-RN pass rates. In addition, there were no statistical differences in manager approval ratings of critical thinking, overall competency, and readiness for practice between groups six months after graduation. These results provide substantive evidence to

support the finding that replacing actual clinical hours with simulation hours does not hinder student learning.

Summary

There is overwhelming evidence to support the integration of SPs into undergraduate nursing education. Nursing students who engage in simulated SP learning experiences are not only satisfied with the teaching-learning tool, but they also experience an increase in self-confidence, improvement in therapeutic communication performance, and an enhanced understanding of the roles and responsibilities of various healthcare professionals. It is noteworthy that simulated SP learning experiences have also led to a significant reduction in clinical anxiety among undergraduate nursing students.

Nevertheless, there is ambiguity in the literature surrounding the ability of SP encounters to enhance knowledge acquisition and psychomotor skill performance better than other experiential teaching-learning strategies. This does not mean that improvement in knowledge acquisition and skill performance do not occur following an SP learning encounter; rather, other experiential teaching-learning modalities are more appropriate for enhancing learning in these areas. The lack of evidence may be attributed to the fact that researchers in the reviewed studies used assessment tools that had not been tested for reliability and validity. Thus, further research into the ability of SPs to enhance knowledge acquisition and psychomotor skill performance is warranted.

There was a lack of research specifically examining the effectiveness of SPs as a teaching-learning strategy among undergraduate ESL nursing students. In fact, the majority of studies that were reviewed did not describe the sample. Researchers simply indicated that the samples were comprised of undergraduate nursing students who were enrolled in a specific nursing course or in a particular year of their study. It would be helpful if simulation education

researchers included sample demographics, especially cultural and ethnic characteristics. The demographical profile of participants may offer intriguing insights regarding the group of learners who benefit the most from simulation education.

SP learning experiences have a positive impact on the delivery of undergraduate nursing education. The integration of SP learning experiences into undergraduate nursing education will not impede the delivery of a quality nursing education. In fact, up to 50% of traditional clinical hours may be replaced with simulation hours without negatively impacting student learning (NCSBN, 2012). Reliable evidence now exists to support the integration of SPs into undergraduate nursing education.

Chapter 3: Methodology

This qualitative, exploratory study utilized focus group methodology guided by Morgan (1995, 1997) and Krueger and Casey (2009) to ascertain ESL nursing students' perceptions of SPs as a teaching-learning tool. This chapter begins with an overview of focus group methodology and then describes the study design, including a description of participant recruitment, data collection, setting, data analysis, rigor, and ethical considerations.

Focus Group Methodology

A focus group study is a form of qualitative research which involves conducting a series of discussions on a particular topic of interest (Krueger & Casey, 2009). Researchers must carefully plan how they will conduct focus group studies. For example, when deciding to conduct a focus group study, researchers must have a thorough understanding of the study's purpose. Understanding the purpose will ensure that researchers are able to formulate appropriate discussion questions and select participants who are able to shed light on the topic of interest (Krueger & Casey, 2009). Focus group researchers should also carefully choose a moderator to lead the focus group sessions. They should select a moderator who is able to demonstrate empathy toward participants (Krueger & Casey, 2009). It is extremely important that researchers choose a skilled moderator who ensures participants feel respected and comfortable enough to share a wealth of in-depth information about the topic of interest (Krueger & Casey, 2009).

The first focus group sessions were conducted during World War II by Robert Merton, a social scientistwho explored the morale of the US military for the war department (Krueger & Casey, 2009). Until this time, qualitative researchers had been reluctant to use focus groups for data collection. Rather, they had been conducting individual interviews with a predetermined questionnaire and a set number of closed-ended response choices. Social scientists, including

Merton, began to question the accuracy of this data collection strategy (Krueger & Casey, 2009). They were uncertain if this research method was yielded accurate findings, since study participants were limited to predetermined responses.

Despite the compelling nature of Merton's study, focus group methodology did not become immediately accepted. It was not until the end of World War II that interest surrounding focus group methodology began to mount (Krueger & Casey, 2009). As the business industry began to boom, companies became interested in learning how to make their products more appealing to consumers. To do this, market researchers began conducting focus groups, a cost-effective research technique. Focus group discussions provided valuable insight to businesses regarding product design, packaging, and advertising (Krueger & Casey, 2009). The incorporation of suggestions from focus group discussions led to increased business revenue (Krueger & Casey, 2009).

Traditionally, focus group methodology has been viewed as a preliminary method of data collection that is later supported by other research methods such as quantitative research (Morgan, 1997). However, this frame of thought has begun to change. Researchers have begun to understand that focus group data not only provides a rudimentary appreciation but a meaningful understanding of a research topic. For example, Holmgren and Ivanoff (2004), utilized focus group sessions to gain a meaningful understanding of the challenges facing Swedish women on sick leave (due to work related injuries) when they return to work. They hoped to use this information to develop a rehabilitation program that helped women with work-related injuries return to work. A total of 20 women who were absent from work for less than six months participated in this study. Holmgren and Ivanoff felt strongly that the data they had collected from the study was credible and that it was not necessary to conduct additional

research studies to expand upon the knowledge gained from the focus group sessions. They believed they had acquired meaningful data to help them develop a rehabilitation program that would enable women on sick leave due to work-related injuries to return to work. Researchers have since gained a more thorough understanding of focus group methodology allowing its acceptance as a sole method of data collection.

In this study, focus group discussions were used as the sole method of data collection. I felt that because the participants, ESL nursing students, often struggle to communicate complex concepts in English that a group setting could potentially facilitate a more in-depth discussion about SPs. In a group setting, participants with limited English proficiency would be able to speak to other members of the group in their native language and obtain assistance translating their thoughts into English. It became evident during the focus group discussions that participants did indeed rely on each other to communicate their thoughts about SPs in English. As Krueger and Casey (2009) claim, focus group discussion generated synergy and enhanced the ability of participants to produce meaningful data such as suggestions for improvement to the SP learning experiences.

Participants and Recruitment

All of the nursing students who took part in this study were enrolled in a Canadian nursing university in a foreign country where Arabic is the official language. This nursing university delivers a CASN accredited nursing program. This particular university offers two pathways toward achieving a Bachelor of Nursing (BN): the regular-track nursing program (BNRT) and the post-diploma nursing program (PDBN). The BNRT program is composed of students who have completed high school and are seeking a nursing profession; whereas, the PDBN program is designed for students with a previous nursing diploma who wish to obtain a

BN. Students enrolled in this university have come from around the world in search of a BN. This particular nursing university has altered the way nurses in this country are educated. Nursing students are no longer educated at the diploma level but are now being educated at the baccalaureate level; they are encouraged to think critically and are supported in their endeavors to incorporate nursing theory into practice.

This academic institution was chosen as the site for participant recruitment mainly because it contained a multitude of nursing students in one location who spoke English as a second language. At the time of this study, there were 291 students enrolled from 33 different nations, such as India, South Africa, Turkmenistan, Sri Lanka, and so forth. Since the completion of this study, the enrollment of non-native, English speaking students has increased. While more detailed information regarding the student population would help other researchers better understand the context of this study, this pertinent information has been withheld to protect the identity of the participants, academic institution, and the country where the study took place. This academic institution was chosen for convenience purposes. At the time of this study, I, the primary researcher, was also a nursing instructor at this academic institution. I had ready access to potential participants.

Purposeful sampling was used to recruit study participants. Purposeful sampling is the most common qualitative sampling technique; it ensures that study participants possess the desired qualities or traits which best help answer the research question (Marshall, 1996). The participants of this study had many similarities. For instance, all participants were enrolled in the same undergraduate nursing program, experienced a simulated education experience using SPs during the winter and spring semesters of the 2012–2013 academic year, and spoke a native language other than English.

It was estimated that during the winter or spring semester of the 2012–2013 academic year, 105 undergraduate nursing students had utilized SPs during their program of study. However, this number could not be verified by supporting documentation. The exact number of undergraduate nursing students who had actually utilized SPs during this period of time is unknown. The students who participated in this study were either enrolled in the BNRT program or the PDBN program. A total of 35 students took part in the study; 20 students were completing the BNRT program and 15 students were completing the PDBN program. Participants spoke a variety of languages such as Arabic, Tagalog, Malayalam, Bengali, and Afrikaans. Student participation was less than what I had anticipated. This may be attributed to two reasons: (1) nursing students using SPs in courses taught by the primary researcher were ineligible for participation; and (2) the majority of SP users were PDBN students who had little time to participate in the study due to competing work, school, and family obligations. No participant withdrew from this study.

To ensure that all students at the university were knowledgeable about the study, a recruitment poster (Appendix B) was displayed around the university, and the study was discussed in some nursing courses that used SPs as a teaching-learning tool. Course instructors were not present for the discussion of the project and were not informed of the identities of students who chose to participate, or chose not to participate, in the study. All participants who demonstrated interest in the study were informed of the study purpose, potential risks and benefits, and that their decision to participate or not participate in the study would not affect their course grade.

Approximately two weeks before the start of data collection, a reminder was sent by electronic message (Appendix C) to those participants who had agreed to take part in a focus

group discussion. This reminder electronic message provided further information about the study, such as the topic and the various incentives that would be provided to those who took part in the study. It was emphasized to students that if they did participate in the study, they would receive a certificate of participation and be entered into a draw to potentially win a gift. Incentives were given to participants as a measure of gratitude for participation in the project. The day before holding the focus group, a follow-up electronic text message (Appendix D) was sent to all participants who had voluntarily agreed to participate in this study. This message conveyed that attendance at the focus group session was greatly valued.

Data Collection

During the winter and spring semester of the 2012–2013 academic year, all undergraduate nursing students who had utilized an SP during a nursing course and had a native language other than English were invited to take part in a focus group session to discuss their perceptions of SPs as a teaching-learning tool. Prior to the commencement of the focus group sessions, each participant was asked to complete a demographical questionnaire (Appendix E). On the demographical questionnaire, the participants were asked to identify their native language and the length of time they had been speaking English.

Each of the six focus group sessions lasted approximately 75 minutes. The majority of the focus group sessions were dedicated to learning about the participants' perceptions of SPs as a teaching-learning tool. At the beginning of the session, the moderator provided participants with a brief introduction to the focus group. During the introduction, participants were informed of the purpose of the study and encouraged to share their thoughts, even if they differed from those of other participants. Participants were also encouraged to keep all information shared during the discussion confidential. Each focus group session concluded by asking participants if

they had any further information to share, followed by an expression of gratitude from the moderator.

During the focus group sessions, I was both the primary researcher and the moderator. As moderator, I was responsible for facilitating the discussion and ensuring that group members remainded on task. Each focus group session accommodated between 5-10 students. Focus group size was designed in accordance with guidelines set forth by Krueger and Casey (2009). Focus group sessions of 5-10 people are small enough to allow for thorough group discussion but also large enough to provide researchers with a diversity of data (Krueger & Casey, 2009).

However, due to circumstances beyond my control, one focus group session had only two of the invited ten participants in attendance. The reasons for not attending the session were varied. Some participants were sick; others had family obligations and some could not be released from work on time to attend the focus group session. Initially, I was concerned that such a small number of participants would yield insufficient data. However, it became quickly evident that the two participants who did attend the session were very passionate about the topic and that a meaningful discussion was possible. Those eight students who missed the first focus group session were able to take part in subsequent focus group sessions.

During the focus group sessions, I ensured that all of the data collected during the discussion was recorded by a digital audio recorder. In addition, a transcriptionist recorded the focus group sessions as they were occurring. The transcriptionist was asked to take quality notes and identify who was speaking during the focus group sessions. Speaker identification by the transcriptionist proved to be very helpful during the data analysis phase, as it was important to know the identity of the speaker. This information assisted in identifying whether key ideas were of the entire group or select members of the group (Morgan, 1997).

Setting

All focus group sessions were conducted in a meeting room at the academic institution attended by the participants. A meeting room at the academic institution was thought to be more convenient for participants and thus increase student participation. The meeting room reserved for all of the focus group sessions was directly attached to the SP suites, allowing the participants to visualize the SP suites during the focus group discussions. The close proximity of the meeting room to the SP suites was purposefully chosen. Direct visualization of the SP suites by study participants would help the participants recall their simulated SP learning experience with greater clarity. The meeting room was configured to facilitate meaningful discussion. During all focus group sessions, the participants sat in a circle around a low-level coffee table. The circular room configuration allowed participants to view each other during the discussion. Interruptions during the focus group sessions were minimal. The meeting room was located far enough away from the main classroom area that there were few disruptions.

Data Analysis

One of the most crucial phases in the research process is data analysis. It is well documented that focus group data analysis should be systematic, verifiable, sequential, and continuous (Krueger & Casey, 2009). When performing analysis of the collected data during a research study, the process should be planned and deliberate; it should not be random or illogical (Krueger & Casey, 2009). Employing a systematic and sequential data analysis approach ensure that researchers do not overlook important ideas when performing data analysis (Krueger & Casey, 2009). To answer the proposed research question, my thesis supervisors and I conducted a thorough, transcript-based analysis using the analytical framework of key concepts (Krueger & Casey, 2009). The identification of important ideas, experiences, and preferences assisted in the

illumination of the research study (Krueger & Casey, 2009). Accordingly, the key concepts framework facilitated the identification of core ideas pertaining to ESL nursing students' perceptions of standardized patients as a teaching-learning tool and possible strategies which may improve implementation of SPs into the ESL nursing curricula.

Throughout this research study, data analysis was continuous. Data analysis began during the first focus group session and continued until the study was completed; in other words, data collection and data analysis occurred simultaneously. Continuously analyzing the data helped improve the quality of the collected data (Kruger & Casey, 2009). For example, as data analysis was continuously being performed throughout the study, it became evident, as moderator, that I needed to move more quickly through the introductory phase of the focus group session to allow more time for actual data collection.

All emerging core ideas should be verifiable or replicable by another researcher when using the same data (Krueger & Casey, 2009). Verifiable data represents an accurate portrayal of what the participants actually expressed during the focus group sessions (Krueger & Casey, 2009). In order for another researcher to determine if the results are verifiable, there must be a sufficient trail of evidence (Krueger & Casey, 2009). As my thesis Co-supervisors were located in a different country at the time of data collection, they were unable to attend the focus group sessions. They needed to be provided with evidence so that the core ideas could be verified. In this study, the trail of evidence consisted of transcriptions of each focus group session.

It is important for all focus group researchers to know that not all data is worthy of analysis (Krueger & Casey, 2009). A novice researcher may hold the misconception that only data frequently expressed in a focus group session should be analyzed. Krueger and Casey (2009) suggest that the frequency of an expressed idea should not be the determining factor used

by focus group researchers to determine if data is worthy of analysis. They claim that an idea expressed only once may be even more valuable than an idea which was expressed on numerous occasions. Krueger and Casey identify four criteria which may be utilized to decipher what constitutes key data: frequency, specificity, emotion and extensiveness. Consideration of the above four criteria will assist researchers in their quest for the identification of significant key concepts or data.

Rigor

There has been much debate about the rigor of focus group methodology and the legitimacy of focus group findings. To ensure that the findings of this study accurately portrayed the experiences of study participants, Guba's Model of Trustworthiness was applied. Guba (1981) asserts that the criteria of credibility, transferability, dependability, and confirmabiity should be adhered to if the qualitative researcher is in pursuit of trustworthy data.

Credibility. Credibility is the believability of study findings (Krefting, 1991). Since this study examined the ESL nursing students' perceptions of SPs as a teaching-learning tool, only the participants can judge the believability of the study findings. Credibility can be ascertained by having an in-depth discussion with the participants (Streubert-Speziale & Carpenter, 2003). During each focus group session, I, as moderator, repeatedly posed clarification questions to the participants to ensure that I possessed an accurate understanding of the content of the message they had conveyed. The use of clarification questions throughout the focus group session enhanced the credibility of the derived data. All participants had an opportunity to freely discuss their perceptions of the SP program. They were also able to openly discuss their recommendations for improving the SP program.

Dependability. Dependability refers to whether the study findings would be replicable if using the same context, methods and participants (Shenton, 2004). In order for other researchers to replicate this qualitative research study, a precise description of the research design, data gathering process, and analysis must be provided (Shenton, 2004). Without a comprehensive description of the processes that took place during the study, the study would not be auditable (Krefting, 1991). To further ensure the dependability of this study, I built a stepwise replication technique into the study design. For example, my supervisory committee and I conducted our own separate analysis of the transcripts and then met to discuss identified key ideas. This helped to ensure that generated findings were replicable.

Transferability. Transferability or fittingness is the degree to which the study findings can be transferred to other similar situations (Shenton, 2004). To ensure the transferability of the collected data, it is imperative that adequate information pertaining to the study context be discussed. The provision of sufficient contextual information will enable other researchers to determine if the findings in this study are able to be transferred to their situation of interest (Shenton, 2004). For example, in this study, an in-depth description of the study participants (native language, length of time studying in English) and the research setting were provided.

Confirmability. Confirmability is a measure of how well the study findings are supported by the data collected (Lincoln & Guba, 1985). It is important that the study findings represent the ideas of the participants and are free from researcher bias (Krefting, 1991). One method often used to ensure confirmability of qualitative research studies is to develop and maintain an audit trail. An audit trail is a form of ongoing documentation about the researcher's decisions regarding data collection and analysis. Ideally, after an audit was completed, the auditor would be able to arrive at similar conclusions as the researcher given the same data,

context, and participants. During the course of this study, an audit trail was maintained so that an external auditor could conduct an audit of decisions made throughout the study.

Ethical Considerations

Prior to the commencement of this study, approval from two research ethics boards was obtained. As this study is being completed in partial fulfillment of the requirements of the Master of Nursing program at Memorial University of Newfoundland (MUN), and it involved interviewing human subjects at another university, I obtained approval from both the MUN Research Ethics Board (HREA) and the University of Calgary Conjoint Research Ethics Board (CHREB). Ethical concerns including informed consent, balance of power, and confidentiality were thoroughly addressed.

Informed consent. Once approval from both the HREA and CHREB were obtained, I began the process of recruiting participants for this study. In order to ensure that potential participants were able to make an informed and voluntary decision about their involvement they were informed of the study's purpose, the foreseeable risks and benefits that may arise from participation in the study, and the option to withdraw at any time, for any reason. The consent form was reviewed with each participant (Appendix F) and any concerns or questions regarding the study were clarified with the participants before signing the consent form. As primary researcher, I was witness to the signing of informed consent by all of the participants. Each participant was provided with a copy of the consent form and were informed that they could contact the primary researcher, the HREA, or the Dean of Research at their academic institution if they had questions or concerns regarding the study. Contact information for these individuals was provided on the consent form. To my knowledge, no such queries were made before, during, or after the study.

Balance of power. As I was a nursing instructor at this particular university, I wanted to ensure that students did not feel coerced to participate in this study. It was emphatically emphasized to students that their decision to participate or not participate in the study would not impact their current course grade or future course grades. In addition, as I often used simulation education as a teaching modality in the classroom, any student who was using SPs in one of my current courses was ineligible for participation in this study.

Confidentiality. All study participants were assured that their personal information would be kept in strictly confidential. All data collected during the focus group sessions, such as audio recordings and transcription notes, were kept in a locked filling cabinet in my locked office. In addition, any electronic data was stored on a password-protected external hard drive and placed in a locked filling cabinet in my locked office. There was no identifying information included on the transcripts and participants were assigned participation numbers. Participants were informed that only three groups of individuals were to have access to the collected data: my supervisory committee, the transcriptionist, and myself. All individuals who had access to collected data were required to sign an oath of confidentiality prior to listening or viewing the collected data.

Chapter 4: Research Findings

In this chapter, I present the findings of this study. The purpose of this study was to explore ESL nursing students' perceptions of SPs as a teaching-learning tool. This chapter is divided into two sections. The first section entails a fulsome description of the participants who took part in this study. The second section captures the seven core concepts that resulted from this study: (1) psychological safety, (2) comfort communication, (3) psychomotor skill development, (4) second-language acquisition, (5) change in attitudes, (6) debrief, debrief, debrief, and (7) learning takes time.

Description of Participants

A total of 35 participants took part in this focus group study. All participants were undergraduate ESL nursing students enrolled in either the BNRT or PDBN program at a Canadian-operated nursing school in a country where Arabic is the official language. Twenty participants were in the process of completing the BNRT program and the remaining fifteen participants were studying in the PDBN program. There were 30 female students and 5 male students who volunteered to take part in this study. The age of participants is unknown. Participants were not asked to supply information regarding their age as this information was not relevant to the study. However, participants were asked to provide information about their native language and the length of time they had been speaking English. Participants spoke a variety of native languages including Arabic, Tagalog, Malayalam, Bengali, Afrikaans, and so forth. The majority of the participants (60%) spoke Arabic as their native language.

All participants were asked to identify the length of time they had been speaking English (see Figure 1). The majority of participants (80%) had been speaking English for more than 10

years; whereas, 20% of participants had been speaking English for a duration of 2 to 5 years. There were no participants who had been speaking English for less than 2 years.

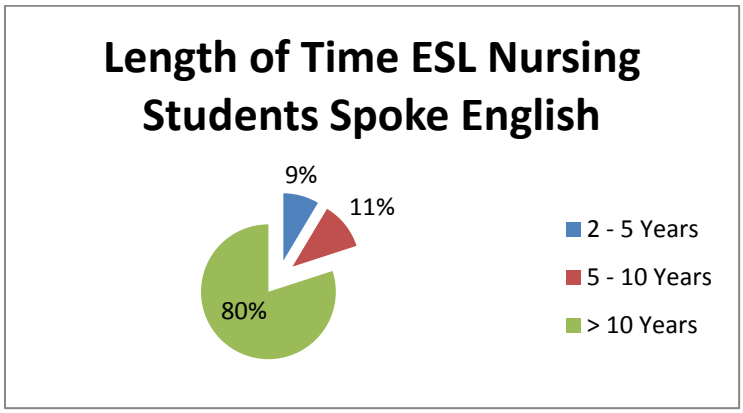

Figure 2. Length of time ESL nursing students spoke English

At the time of the study, all participants had recently taken part in an undergraduate nursing course which had integrated SPs as a teaching-learning tool. Participants were enrolled in either a foundational nursing course, a family nursing course, a health assessment nursing course, and/or a mental health nursing course. The exact length of time or the frequency each participant utilized SPs is not known.

Concepts

Seven concepts emerged from the focus group sessions. They are: (1) psychological safety; (2) comfort communication; (3) psychomotor skill development; (4) second-language acquisition; (5) change in attitudes; (6) debrief, debrief, debrief; and (7) learning takes time. As previously mentioned, concepts refer to core ideas, experiences and preferences that assist in the illumination of a research study (Krueger & Casey, 2009). The identification of core ideas was especially helpful for understanding the effectiveness of SPs as a means to academic success and

possible strategies that may improve the implementation of SPs into the ESL nursing curricula. Each of the seven concepts identified in this research study will be substantiated with data provided by the ESL nursing students during the focus group sessions.

Psychological Safety

At the commencement of this study, I had erroneously assumed that participants would experience the same heightened level of anxiety and/or fear while learning with SPs that I have personally witnessed many other undergraduate nursing students experience in the hospital setting while learning with real patients. However, upon listening to the participants and upon analyzing the data, it was clear the participants did not experience fear while learning with the SPs; rather, they felt comfortable engaging in SP learning experiences. One participant stated, "Like, I was very comfortable and open with them and they were [the] same way to me." The participants described the simulated SP learning environment much differently than how nursing students commonly describe learning in the hospital setting. The participants' perceived that the SPs created a learning environment that was not inundated with fear but one that was "fun" and "relaxing."

Simply viewing the language used by participants to describe the learning environment may lead one to think that the participants simply had a preference for this particular teaching-learning modality. However, delving deeper into the participants' perceptions of SPs as a teaching learning tool allows one to understand that the participants had more than a mere preference for learning in a simulated SP environment; the SPs enabled them to feel "safe" while they were learning. Throughout the focus group sessions, the participants indicated that the SPs made them feel safe to learn by preparing them for the unknown, accepting them as learners, and creating a risk-free learning environment.

Preparation for the unknown. In this study, the PDBN program participants seemed to be capable of making smooth transitions from one learning experience to another during their program of study. Perhaps this ease of transition could be attributed to the vast amount of work experience that they had acquired prior to furthering their nursing education. However, the BNRT program participants struggled to adapt to the unknown realities that were presented to them during their program of study. In particular, the BNRT program participants indicated that prior to engaging in the SP learning experiences they were fearful of going to the hospital setting for their first clinical learning experience. The BNRT program participants had very little experience, if any, in the hospital setting during their nursing program at the time they participated in this study. After engaging in the SP learning experiences, the BNRT participants felt the SPs had adequately prepared them to go to the hospital setting. They now knew what to expect when they went to the hospital for their first clinical learning experience. For example, one participant stated, "When you have dealt with the standardized patients you know what's gonna be expected from you, like the way you introduce yourself…it like trains [you] to go into the hospital setting."

Additionally, the participants' believed that SPs were more effective at preparing students for the unknown than part-task trainers or mannequins. They felt that the part-task trainers or mannequins were unrealistic and therefore, had little impact on preparing nursing students to transition from one learning experience to another. One participant said, "When we use a dummy for an assessment or something, there is no response." However, the participants' believed that the SPs were more effective at preparing them for the unknown realities in the hospital setting because they portrayed a more "realistic" representation of actual patients.

Sense of Acceptance. Participants' perceived that the accepting demeanor of the SPs reduced the level of anxiety they experienced when participating in simulated SP learning experiences. The participants felt as though the SPs were invested in their learning. One participant stated, "The [SPs] accept us…. they accept us, they accept us a student nurse… to practice…many times on them."

In comparison, the participants' believed that real patients in the hospital were less enthusiastic than SPs to have nursing students directly involved in their nursing care. For example, one participant stated, "But in [the] hospital, you have to be quick… because they are real patients and they are sick and so they cannot be patient with us." The participants indicated that the real patients' believed the role of nursing students should be observational and that they should not be involved in actual healthcare delivery. The inability of patients to engage in long practice sessions was interpreted as a lack of desire by patients to help the participants learn. One participant shared, "A real patient would kind of get annoyed… I think they have somewhere inside their head that she's a student nurse and she's working on me and [she is] not as good as the real nurse."

Both the openness and receptiveness of the SPs towards the participants enabled them to feel as though they were accepted as learners. The participants' believed that the SPs enjoyed helping them learn and that the nursing care they provided to the SPs was valued.

Risk-free learning. In the simulated SP learning environment, participants are able to be immersed in a learning environment that is perceived to be risk-free. During the focus group sessions, the participants frequently referred to the simulated SP learning environment as a place that was "safe to [make] mistakes." Learning in an environment that is perceived to be risk-free can be beneficial to student learning. In a risk-free learning environment, nursing students do

not fear that they may harm a patient. Rather, they are able to focus their efforts on improving areas of clinical weakness so that they may become "better nurses." Simulation education fosters the growth and development of nursing students; students feel that they are safe-to-learn. One participant said, "It … was um easier for me because you know that it's a learning tool. You're not afraid to do something wrong. You can always learn from your mistakes."

In the hospital setting, medical errors or mistakes can result in tragic patient outcomes. However, in the simulated SP learning environment, mistakes do not have real-life consequences and can be made without harming the health and wellness of patients and families. The simulated SP learning environment enables participants to learn in a risk-free environment. One participant stated, "If I did something wrong or whatever, I will not hurt her, I will not miss information or, you know, I will not interfere with her treatment or something."

Comfort Communication

The participants' believed that engaging in simulated SP learning experiences improved their ability to develop "comfort" communication with patients and families in the hospital setting. In the nursing literature "comfort" communication is more commonly referred to as therapeutic communication or relational practice. Participants who were required to develop therapeutic nurse-patient relationships during their simulated SP learning experiences believed they would be more comfortable engaging in therapeutic relationships in the actual clinical setting. One participant stated, "Therapeutic relationships [are] very difficult to apply in the real world… It's not easy to do comfort conversation… the SPs [make] you feel like it's easier for you…[when] you reach the clinical setting."

Due to limited time in the clinical setting, undergraduate nursing students cannot thoroughly practice everything they need to know before they graduate. With such a substantial

emphasis placed on skill acquisition during clinical courses, nurse educators are left with little time to devote to therapeutic communication practice. Unfortunately, this may lead to the erroneous assumption among nursing students that therapeutic communication practice is not as important as psychomotor skill practice. Engaging in therapeutic relationships with SPs validated the importance of developing therapeutic relationships with patients and families. One participant stated, "If you touch [their] hands, if you know just put your hand on their shoulder, it means something to them. A lot of time, really we are forgetting those things."

The participants also believed that it was easier to develop therapeutic relationships with SPs than with classmates. Participants indicated that the ability to engage in comfort communication was greatly influenced by the nature of the learning environment. Participants thought the "casual" learning environment created when working with classmates hampered their ability to establish and maintain therapeutic relationships, while the "serious" SP learning environment facilitated the development of therapeutic relationships.

One participant explained this difference in interaction:

> Without the standardized patients we might not have been able to perfect those skills because when you're practicing with your friends it is a very friendly casual manner and you giggle a lot. But [with] a standardized patient you are very serious and you're very professional, the same exact way you would be in real life nursing situation, in a hospital. (Participant)

Psychomotor Skill Development

Participants from both the PDBN and BNRT programs indicated that their ability to perform psychomotor nursing skills had improved as a result of participation in simulated SP learning experiences. The participants who took part in simulated SP learning experiences as part of the foundational nursing course indicated that they had improved their ability to perform vital sign measurement, whereas participants who took part in SP learning experiences for the

health assessment nursing course improved their ability to perform system-specific health assessments.

The participants associated with the foundational nursing course were expected to correctly measure the vital signs of an SP. They reported difficulty completing this task during their first simulated SP learning experience. The participants shared that they struggled to correctly locate the radial pulse of the SP.

One participant expressed difficulty locating the radial pulse of an SP:

> [I had to go to] the patient and do everything, the vital signs, pulse and blood pressure. I did blood pressure in twenty minutes (laughter). I didn't have time to do the pulse… [I] couldn't feel the pulse. She was old, so her pulse was so slow … yeah, weak, so weak, I guess. Everything went wrong. (Participant)

After completing the first simulated learning experience, the participants engaged in a debriefing session. They were provided with constructive feedback regarding their performance during the simulated SP learning experience. After the debriefing session and with their feedback in mind, the participants participated in the scenario, a second time. Participants reported an improvement in their performance during the second simulated SP learning experience. One participant stated, "My second experience … was so much different. [The SPs] pulse was … so easy to find…So, now I guess [that] I have an idea where to look [and I know] how to put my fingers."

The PDBN participants who took part in the simulated SP learning experiences that were associated with the health assessment course verbalized improvement in their ability to perform a thorough health assessment. The participants spoke candidly about their inability to competently perform a head-to-toe assessment prior to engaging in the simulated SP learning experiences. Even though they were experienced nurses who cared for real patients on a daily basis, they did not try to conceal the fact that prior to their simulated SP learning experiences they could not

accurately perform a health assessment. The honesty with which these participants spoke was admirable.

> Before [I didn't] know how to do it… I'll read the theory but when I want to do it like [in] practical, I don't know [how]. That's why some … nurses they copy [the health assessment]… In the hospital, [the nurses] copy, paste; copy paste; copy, paste; copy, paste. (Participant)

Following completion of the simulated SP learning experiences, the participants had acquired the ability to competently perform a thorough head-to-toe assessment. They no longer felt the need to "copy, paste" the documentation of another nurse or healthcare professional, but that they could independently perform a head-to-toe health assessment.

> I am different…[After working with the SPs], I am doing, I am taking my stethoscope, I am assessing the, the lungs sound[s], I'm assessing the heart sound[s] [and] I am assessing the abdomen … I am not copying anymore. (Participant)

During the simulated SP learning experiences, participants had primarily received a formative rather than a summative assessment of their performance. Therefore, it is not possible to determine with certainty if their skill level actually improved or just their level of self-efficacy for performing the required skill(s).

Second Language Acquisition

During the focus group sessions, the participants asserted that interacting with the SPs improved their ability to communicate in English more so than practicing with a part-task trainer or low-fidelity mannequin. When learning with the SPs, the participants were able to practice communicating in English. However, when interacting with low-fidelity mannequins, practicing verbal communication was not possible.

> The SPs… help you to put the right words in the right sentence. [When] they say something to you … and you have no idea how to reply to it you can just ask them for clarification, you can ask them to repeat what they are saying and they can help you. If you are working with a mannequin they can't say anything to you. (Participant)

The participants also indicated that as a result of their interaction with the SPs, they were able to communicate complex medical information to patients and families in a simplified manner. One participant stated, "The standardized patients improve our communication… in [theory], we learn a lot but when we go to the actual patients we… have to change our words… you have to tell them in a simple way."

In addition, the participants' believed that the simulated SP learning experiences enhanced their familiarity with cultural idioms. Idioms are phrases, words, or expressions that have a meaning that cannot be taken literally. Despite their extensive English training prior to entering the nursing program, participants revealed that, before the SP learning experiences they were unfamiliar with many cultural idioms commonly used by patients and families in the healthcare setting.

> Even though they do use uncommon language or something that I'm not familiar to, I would like to educate myself and be familiar with those phrases or those words like 'feeling blue'. I should know that 'blue' means 'sad.' (Participant)

Change in Attitudes

As a result their engagement in simulated SP learning experiences, participants experienced significant changes in some of their longstanding attitudes and beliefs. During the focus group sessions, the participants indicated that they were able to develop new practice framework convictions, overcome stereotypical views about patients with mental health illnesses, acquire positive attitudes about older adults, and adapt to new cultural norms regarding gender segregation.

Develop new practice framework convictions. Prior to the simulated SP learning experiences, participants felt as though providing family-centered nursing care was not a priority.

The focus of their nursing practice was centered on the patient and the timely completion of tasks.

One participant expressed this previously held view:

> For me, honestly, what they taught me is [that] the patient is like a task, you know… like you have to finish the work within 8 hours and certain procedures should be done within a specific time and medication and all of that stuff. So, then I said ok, I just started focusing on my time management. (Participant)

Following the completion of the simulated SP learning experiences, the PDBN students described how they adopted new practice framework convictions. The participants indicated that because of their participation in the simulated SP learning experiences, they realized that it was extremely important to provide family-centered nursing care. One participant stated, "It helped us to see how important the family is." Furthermore, the participants were able to integrate these new beliefs into practice once they returned to the hospital setting.

> [I now] treat the patient equal to their family. Both of them they need my attention; both of them, they need my care. I [am] always reminding myself that I have to talk to the family or the primary caregiver. (Participant)

The participants' perceived that the incorporation of family-centered nursing care improved the quality of the relationship between nurses and families; they believed that a more meaningful connection between families and nurses began to emerge. Evidence of the revitalized nurse-patient relationship can be seen in the statement "The family started to remember my name and wherever they are seeing me, there is a big smile on their face." The PDBN students who took part in this study began to adopt a new philosophy of care. Instead of continuing to provide only patient-centered nursing care, they began incorporating family-centered nursing care into their nursing practice.

Overcome stereotypical views about patients with mental health illnesses. In the fourth focus group session, all participants were BNRT program students who had recently taken part in simulated learning experiences with SPs who had portrayed various mental health illnesses such as schizophrenia, bipolar disorder, dementia, obsessive compulsive disorder, and depression. While some of the participants had cared for clients with mental health diagnoses during previous clinical courses, none had ever cared for patients with a mental health illness in a psychiatric hospital.

Throughout the focus group session, the participants were concerned about caring for patients with mental health illnesses. Many were unsure "what to expect" and some even conveyed fear of being harmed when they went to the psychiatric hospital for their clinical course. The high level of anxiety experienced by the participants may be attributed to existing societal stigmas in this particular country surrounding patients with mental health illnesses.

> When you hear other, other students talk about the different cases and the diagnosis out there in the psychiatric hospital, you get really frightened because you haven't got any experience at all so you really don't know what to expect. (Participant)

Some participants indicated that they came to the simulated SP learning experiences with a preconceived notion that all patients experiencing a mental health illness are dangerous. A lack of understanding regarding mental health illnesses made participants fear for their personal safety during the mental health clinical course. For example, one participant described her fear of caring for patients with mental health illnesses as follows: "I was afraid in a way that I didn't want to turn my back to someone without noticing what they're doing because, you know, something bad could happen."

The SPs who had been trained to portray patients with various mental health illnesses created a "realistic" and "safe" learning environment that allowed students to be immersed in a

simulated psychiatric setting. As a result of participating in the simulated SP learning experiences, the participants were able to overcome the stereotypical views they held about patients with mental health illnesses. One participant stated "It helped me a lot in knowing what people with mental health issues really act like….SPs help me a lot in knowing what to expect when I went to clinical practice." Upon completion of the simulated SP learning experiences, the participants were no longer concerned about going to the psychiatric hospital for their mental health nursing course and no longer feared for their personal safety.

Acquire positive attitudes about older adults. Many of the participants who took part in this study indicated that prior to engaging in simulated SP learning experiences they possessed negative attitudes towards older adults. The participants' believed that older adults were unproductive and that declining health and quality of life was a natural consequence of aging. This notion is evident in the following quote:

> I thought like most elderly people ah they cannot like, they cannot [live] normal life….Because in our country elder people like, most likely, they have a cane, a chair outside by the street and they just sit and look at people going here and going there. [They have] nothing to do….[They are] not healthy to walk. (Participant)

Another participant stated "I thought like every single old [person] just sits and, I don't know, they're sad and not healthy." After engaging in the simulated SP learning experiences, the participants acquired positive attitudes about older adults. They began to realize that it is possible for older adults to be productive and healthy. Some participants were surprised to realize that older adults could perform volunteer work in the community or have a job. Several other participants were astounded to learn that older adults were choosing to adopt a healthy lifestyle. One participant stated, "I [was] shocked…. when he talked to me about his life….he

eat[s] vegetables, he watch[es] his diet….And he told me he like ah walks four to five kilometers."

Adapt to new cultural norms about gender segregation. The participants of this study reside within a Muslim country. Due to deep-rooted cultural beliefs and practices, very little interaction takes place between the male and female residents who live there. While male and female socialization is not strictly prohibited in this country, gender segregation is commonly practiced in the community. In fact, many independent schools in the nation provide gender-segregated schools for students.

In this country, there seems to be an emerging discrepancy between the cultural norms in the community and the cultural norms in the hospital regarding gender segregation. Even though male and female interaction is not encouraged in the community, female nurses are expected to deliver nursing care to male patients in the hospital. This lack of congruency is causing a significant amount of distress to undergraduate nursing students.

The SPs helped participants adjust to caring for male patients in the hospital. The participants' believed that interacting with male SPs prior to commencing their clinical course enabled them to feel at ease when caring for male patients. The participants were beginning to adjust to the new cultural norm of caring for male patients in the hospital.

> I was shy the first time … He came in for [a] respiratory assessment and you have to do hands on like percussion and auscultation so … I was kinda like shy in the beginning. Then I just went with the flow, like you get used to it. That's why now, I'm doing [a specific clinical nursing course] [in a] a male trauma unit [and] I don't have any problem doing [a]health assessment. [Now] I feel good. (Participant)

Debrief, Debrief, Debrief

The post-simulation debrief was viewed by participants as an essential component of the simulated SP learning experience. The participants felt that it was during the post-simulation

debrief that learning actually took place. During the debrief, participants were able to reflect on the quality of their nursing care during the simulated SP learning experience and receive meaningful feedback from the SPs, the other learners, and the facilitators about the quality of their nursing care.

> It is actually very helpful for us to hear … a patient tell us how they think, how they felt, about our intervention. Was it good, was it bad, did we need to change something to make it better for a real patient. (Participant)

During the debriefing sessions, participants were able to glean insight into their nursing practice. They were able to identify areas of their practice that were skillful and others that were in need of improvement. Several participants were willing to share the meaningful feedback they received during the debriefing session with other participants who took part in their focus group session.

> So, I learned something from her feedback … during … communication with the family, [it] is not always necessary to only communicate in conversation and talk with them. There is [other] ways which we [can] connect with the family like emotional support or [a] hug… the mom was really really sad … I just hug[ged] her and she really trust[ed] me after that. (Participant)

Another participant also received valuable feedback about her ability to develop therapeutic relationships with patients and families. The SP informed the participant that it is important to consider both verbal and nonverbal behavior when attempting to develop therapeutic relationships with patients and families.

> The questions were just flying, I didn't leave the time for the patient to think … [I was] always in a hurry to ask the next [question] because I [didn't] want to forget. … Once we finished the interview, our instructor and the patient said, "it would have been more helpful if you had given us more silence." (Participant)

After a thorough analysis of all the focus group data, it was determined that the participants preferred to debrief immediately after engaging in simulated SP learning

experiences. One participant said, "I enjoyed having the opportunity to have feedback immediately from the, the standardized patients themselves."

While most of the debriefing sessions took place at the end of the simulated SP learning experiences, there were a few occasions when the participants felt as though they did not receive timely feedback due to a lack of availability of simulation educators. For example, one participant expressed, "With [the] standardized patients, [there] is [no one that] is watching you, what you're doing. Like the teacher has to be in all the places at once."

Those participants who felt as though their debriefing session did not occur in a timely manner experienced a high level of uncertainty regarding the quality of their performance during the simulation. Their lack of confidence halted their ability to continue participating in the simulated SP learning experience.

> It gets hard for the instructor to give attention to all of us equally… sometimes we just stand there not like, not knowing what to do when the instructor's viewing someone else… [with] the standardized patient you have to wait until the teacher comes, you have to wait for your turn … like you just get stuck. (Participant)

Timely feedback was highly valued among study participants. Those who were unable to receive timely feedback during their simulated SP learning experience strongly conveyed their preference for using alternative modalities of simulation education that would provide immediate feedback.

> For me, [human patient simulators were] much better than standardized patient because you were being watched and you were being, like, you know, and we were getting feedbacks just right then… when you come back, right after you come back, you get feedback. (Participant)

Learning Takes Time

The participants who took part in the simulated SP learning experiences felt as though the time allocated to complete the simulated SP learning experience was too short. In fact, many

participants longed to have "more time" interacting with the SPs so that they could perform to the best of their ability.

> If it's a new topic [we need] more time. [For] the different system[s], especially the respiratory and the cardiovascular [system], we had only like one, like one, day to practice all of it on our SP… It's like it takes time to really get the sound[s]. (Participant)

Insufficient scenario completion time caused many participants from meeting the objectives of the simulation; they were unable to deliver the nursing care that was expected of them during the simulated SP learning experience.

> We ran out of time … we were on a tight timeframe. One patient [had] so many things going on … [we] lost track of time and then the [instructors] come in and [told us], "ok, your time is up." It [was] time to debrief and… [we] were not even half way through all the questions that [we had] to ask. (Participant)

In addition, due to insufficient time, many participants were not able to incorporate the constructive feedback they had received during their debriefing session into practice. Instead of being encouraged to engage in repeat practice after the debriefing session, many participants were informed that the simulated SP learning experiences had come to an end. The concept of repeat practice did not seem to be prevalent in this study. While some participants were able to engage in repeat practice after the debriefing session, others only had one opportunity to participate in a simulated SP learning experience. Participants' believed they should be provided with the opportunity to apply the feedback obtained during the debriefing session until they were able to demonstrate significant improvement in their nursing care. One participant emphatically stated that a single simulated SP learning experience "is not enough."

The participants emphasized that repeat practice would be beneficial to their learning because it would enable them to recall how to competently perform the skill(s) embedded within a simulation when caring for patients and families. The participants' believed that if they could

practice a nursing skill until they "got it right" they would be able to more easily remember how to perform the skill in the hospital setting when providing care to real patients and families. One participant stated, "Like, [when] you do it a lot, it's gonna be in your memory. You won't forget it when you go [to] the hospital."

Summary

The participants of this study spoke passionately in their perceptions of SPs as a teaching-learning tool. All the participants' believed SPs to be a remarkable teaching-learning tool which ultimately helped them to "become better nurses." It is through the open and honest disclosure of the participants that I was able to gain a thorough understanding of their perceptions regarding the effectiveness of SPs as a means to academic success.

The SPs created a safe learning environment for the participants. The participants described the simulated SP learning environment as "fun" and "relaxing," rather than one that invoked fear. The simulated SP learning experiences enabled them to feel safe to learn by preparing them for the unknown, by accepting them as learners, and by creating a risk-free learning environment.

The simulated SP learning experiences also improved the participants' ability to competently perform psychomotor nursing skills. The participants' believed that simulated SP learning experiences enhanced their ability to correctly measure vital signs and perform thorough head-to-toe assessments. The participants no longer believed that they needed to "copy, paste" the documentation of other healthcare providers. After completion of the simulated SP learning experiences, the participants felt confident in their ability to competently perform their own health assessments in the hospital setting.

The participants also believed that the SPs helped improve their ability to develop therapeutic relationships with patients and families and recognize the importance of these

relationships. More specifically, the participants indicated that the SP learning experiences enhanced their ability to convey empathy through nonverbal communication.

It was readily apparent that the ESL nursing students who took part in this study struggled to communicate effectively in English. In particular, the participants expressed difficulty communicating complex medical information to patients and families. However, the participants' believed that as a result of their interaction with the SPs, their ability to covey complex medical information in a more simplified manner had improved and that they had become more familiar with cultural idioms. For example, one participant learned that "feeling blue" actually meant "feeling sad."

Simulated SP learning experiences also significantly affected attitudinal change among the participants. After engaging in simulated SP learning experiences, the participants verbalized a significant change in some of their longstanding beliefs and attitudes. The PDBN program participants experienced a dramatic shift in their practice beliefs; they believed that their practice framework convictions had changed from being patient-focused to family-centered. The BNRT program participants also experienced a transformation in some of their attitudes and beliefs. The BNRT program participants' believed they were able to overcome some of the prevalent stereotypical views they had harbored about patients with mental health illness and they were able to adjust to new cultural norms in the hospital regarding gender segregation.

While the participants voiced numerous positive learning outcomes associated with the integration of SPs into the undergraduate nursing curricula, they indicated that its inclusion into the nursing curricula is in need of improvement. The participants thought the learning experience could be enhanced by conducting debriefing sessions immediately after the

completion of a simulation and by requiring ESL nursing students to engage in repeat practice sessions until they are able to demonstrate, repeated, and consistent success.

All the participants strongly felt that debriefing was an essential component of the simulated SP learning experience. They asserted that debriefing enabled them to gain insight into their nursing practice. During debriefing sessions, participants were able to identify areas of their practice that were skillful and other areas that were in need of improvement. The participants' believed that it would be more beneficial to their learning if they were able to participate in debriefing sessions as soon as a simulated SP learning experience was completed.

The participants also voiced concern regarding the lack of opportunity to incorporate the feedback they had received during the debriefing session into practice. The participants preferred to engage in repeat practice after a debriefing session until they are able to demonstrate, repeated, and consistent success. Engaging in repeat practice was perceived to play an instrumental role in helping the ESL nursing students improve their nursing care and transfer their learning from the educational setting into the clinical setting.

Chapter 5: Discussion

The focus group sessions provided valuable insight into ESL nursing students' perceptions of SPs as a teaching-learning tool. Through the meaningful disclosure of participants it was possible to gain a profound understanding of how SPs were influencing the learning of ESL nursing students. It should be reemphasized that despite the recent growth of simulation research, I was unable to find research studies which specifically examined the impact of SP learning experiences on ESL nursing students. This is not to say that ESL nursing students did not take part in some of the reviewed studies but that they were not the focus of the studies. Therefore, it is necessary to exercise caution when drawing parallels between the findings of this study and those of other research studies that utilized SPs as the educational intervention.

The seven concepts identified in this research study enrich the existing concepts pertaining to standardized patients in the simulation education literature and support the use of SPs as an effective teaching-learning tool among ESL nursing students. In this chapter, the findings of this research study will be discussed in relation to relevant literature under the following headings: Supportive Community of Practice, Rich Opportunity for Learning, Bridging Language Barriers, Debriefing: An Essential Component of Simulation Education, and Mastery in Nursing Education.

Supportive Community of Practice

The clinical setting has served as the primary learning environment for experiential learning in undergraduate nursing education. The clinical learning environment (CLE) has played an integral role in linking the "knowing what" with the "knowing how." The CLE is considered by many to be the gold standard for undergraduate clinical nursing education because it enables students to engage in real-world practice, in an authentic context, and to join a *community of practice* (CoP). The phrase CoP was coined in 1991 by anthropologists Lave and

Wenger in their book titled *Situated Learning: Legitimate Peripheral Participation*. A CoP is, "a group of people who share a concern or passion for something they do and learn how to do it better as they interact regularly" (para.3). In the CLE, the CoP is often thought of as a mixture between the culture and the pattern of relationships that exist within the healthcare environment.

As nursing is a practice-based discipline, it is essential that nursing students engage in real-world nursing care in an authentic environment such as a simulated learning environment (SLE) or the CLE. However, it is equally important that nursing students have the opportunity to join a supportive CoP. "Becoming a nurse is about joining the community of practice represented by qualified nurses as much as it is about learning the technicalities of nursing" (Cope, Cuthbertson, & Stoddart, 2000, p. 854). Nursing students who have the opportunity to join a supportive community of practice will be able to master their clinical skills and also acquire a professional identity and a sense of belonging to the work environment (Portoghese, Galletta, Sardu, Contu, & Campagna, 2014).

At first glance, it may seem as though the CLE and the SLE are very similar. In both learning environments, learners are afforded the opportunity to perform real-world nursing care in an authentic environment and join a CoP. However, despite the extensive similarities between the two learning environments, there is a stark difference between the CoP in the CLE and the CoP in the SLE. The culture of nursing within the CLE is not as supportive of nursing students as it needs to be. In fact, nursing students have reported feeling unwelcome in the clinical setting and that the clinical setting is a hostile learning environment for quite some time (Bradbury-Jones, Sambrook, & Irvine, 2007; Castledine, 2002). The nursing students who took part in this particular study also described the CoP within the CLE in a similar fashion. Some participants indicated that they did not feel as though they were valued members of the healthcare team when

they were placed in the CLE. Some also believed that their contribution as a student nurse was undervalued and unappreciated by patients in the CLE. A CoP that does not support nursing students may actually hinder student learning and in turn affect their advancement and retention within the nursing program (Chan, 2002).

For the most part, the SLE is viewed positively by undergraduate nursing students. There has been overwhelmingly support for the SLE among nursing students. In a study completed by Robinson-Smith et al. (2009), 112 junior-level undergraduate nursing students were asked to evaluate the use of an SP approach to clinical learning. One component of the study required the students to complete a Student Satisfaction Survey, which was adapted from the National League of Nursing Student Satisfaction and Self-Confidence in Learning Survey. For the majority of the items on the instrument, students indicated that they either strongly agreed or agreed that they were satisfied with the SP learning experience. Furthermore, the students indicated that the SLE was enjoyable, helpful, and motivating. This current study found similar findings about the SLE. The participants in this particular study, described the SLE has "relaxing," "comfortable," "open," and "accepting." A positive psychosocial learning environment within a CoP has the potential to enhance student learning, influence the development of a professional role concept (Levett-Jones & Lathlean, 2008) and encourage professional progression and retention within nursing education programs (Bowden, 2008).

A supportive learning environment enables students to feel psychologically safe. Edmondson, a Novartis Professor of Leadership and Management at Harvard Business School defines psychological safety as "a shared belief held by members of a team that the team is safe for interpersonal risk taking" (Edmondson, 1999, p. 350). A psychologically safe learning

environment is one that challenges learners but at the same time protects the learner during periods of experimentation from humiliation or intimidation (Rudolph, Raemer, & Simon, 2014).

Psychological safety is not inherent to all learning experiences (Edmondson, 1999). In fact, it is common for nursing students to experience high levels of anxiety during clinical learning experiences (Beck & Srivastava, 1991; Cook, 2005; Elliott, 2002; Hayden-Miles, 2002; Shipton, 2002). Beck and Srivastava (1991) surveyed 94 nursing students who reported that being placed in unfamiliar situations was the most stressful and anxiety-causing component of the undergraduate nursing program.

There seems to be a plethora of factors that contribute to student anxiety in the clinical setting. Some of the more common causes of nursing student anxiety in the clinical setting include unsupportive relationships between students and staff, fear of failure, fear of making harmful mistakes, and difficulty making successful transitions between the classroom and clinical setting (Flynn, 2012). Experiencing a high level of anxiety in the clinical setting has been found to be detrimental to student learning. Students who are immersed in anxiety-causing learning environments may be unwilling to seek help or to ask important questions. There is actually an inverse relationship between student anxiety and student learning: as the anxiety level of a student increases, their learning decreases (Penn, 2008).

Even though psychological safety is not a new phenomenon, there are only a few articles available in the literature which directly link simulation education to psychological safety. In fact, when searching CINAHL and PubMed for English articles with the keywords *psychological safety* and *simulation*, only two articles linking the two concepts could be obtained. The lack of available literature surrounding the impact of simulated learning experiences on the

psychological safety of participants supports the notion that the safety of nursing students in the learning environment has not received the attention it deserves.

The need for enhanced psychological safety among ESL nursing students during learning experiences was not anticipated to emerge as a key perception of this study. It had been erroneously assumed that the students who took part in this study felt safe to learn in the traditional clinical learning environment. However, after analyzing the data collected from the participants, it was evident that the ESL nursing students experienced a tremendous amount of anxiety while learning in the CLE. In contrast, the students felt safe to learn while participating in simulated SP learning experiences. The ESL nursing students felt as though the SPs prepared them to enter the hospital for their first clinical course; they felt that their nursing care was valued by the SPs; and they felt they could make errors without jeopardizing the health and well-being of real patients and families.

Until recently, there has been no doubt that the CLE is the gold standard for clinical nursing education. It was never imagined that there could be a comparable or even better learning environment for undergraduate nursing students. As a result of the groundbreaking NCSBN (2012) study, it is now recognized that up to 50% of clinical time can be effectively replaced with simulation time without jeopardizing student learning. The time has come to begin listening to undergraduate nursing students' perceptions of the CLE. They have been informing nurse educators about their difficulties in the CLE for long enough. Some may argue that the SLE is just that- simulated-and that nursing students will eventually need to be immersed into the nursing culture that may sometimes include hostility or bullying. This is undoubtedly true, but perhaps early immersion in a hostile learning environment is not in the best interest of nursing

students. Perhaps engagement in the SLE and late exposure to the CLE will foster the development of a supportive and caring nursing culture within the healthcare system.

Rich Opportunity for Learning

Since the release of revolutionary reports such as *The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada* and *To Err is Human*, there has been a greater emphasis among nurse educators to improve the quality of undergraduate nursing education. The hazardous training paradigm of *see one, do one, teach one* commonly employed by many instructors needs to be abolished (Rodriguez-Pas, Kennedy, Wu, Sexton, Hunt, & Pronovost, 2009). It has become clear to nurse educators that the informal teaching strategies being utilized throughout the undergraduate nursing curriculum are ineffective and can lead to the occurrence of preventable medical errors.

In an attempt to deliver a more robust nursing education that prioritizes patient safety, nurse educators have begun to integrate strategic teaching-learning strategies such as SPs into the nursing curricula and forego informal teaching strategies. Not only are innovative teaching-learning strategies being integrated into the nursing curricula, they are also being evaluated for effectiveness. Nursing educators are no longer assuming that teaching-learning strategies are working. Instead, they are evaluating the effectiveness of these strategies to determine if they are indeed improving the delivery of education to undergraduate nursing students.

It is essential that teaching-learning strategies being implemented into the classroom are evaluated for effectiveness. I believe that ineffective teaching strategies such as the *see one, do one, teach one* method are leading to an increase in student attrition from undergraduate nursing programs and poor patient outcomes. In this study, the ESL nursing students strongly felt that SP learning experiences were beneficial to their learning and that they enhanced the quality of

nursing care they could deliver to patients and families. The ESL nursing students believed that they had become "better nurses" as a result of participating in simulated SP learning experiences.

When evaluating a teaching-learning strategy for effectiveness, it is important to determine if learning has occurred in the three domains or categories of learning. In any learning activity, the learners will ideally acquire new knowledge, skills, and attitudes. Simulated SP learning experiences provide ESL nursing students with a rich opportunity for learning. As a result of participating in simulated SP learning experiences, the ESL nursing students experienced learning in the cognitive, psychomotor, and affective domains of learning.

Cognitive domain of learning. Learning in the cognitive domain includes the acquisition of new knowledge and the development of intellectual abilities (Anderson et al., 2001). The following six categories are located within the cognitive taxonomy: remember, understand, apply, analyze, evaluate, and create (Anderson et al., 2001). The current evidence surrounding the ability of simulated SP learning experiences to enhance knowledge acquisition is ambiguous at best. The two studies which evaluate the ability of SP learning experiences to improve knowledge acquisition provide conflicting results (Becker et al., 2006; Dearmon et al., 2013). Becker et al. (2006) concluded there was not a significant increase in knowledge of depression management between the group of students who used SPs and those who received traditional education. In contrast, Dearmon et al. (2013) found there was a significant increase in knowledge in basic nursing care among the nursing students who did engage in simulated SP learning experiences.

The ESL nursing students who took part in the current study did not specifically indicate that their knowledge level had increased following the simulated SP learning experiences. However, perhaps knowledge acquisition extends beyond the ability of students to simply recall

facts or information. Knowledge acquisition may also be demonstrated when students have the ability to analyze, evaluate, and create (Anderson et al., 2001). Learners who are able to make judgments based on sound criteria and then integrate those changes to create a new structure have ultimately demonstrated the most challenging component of knowledge acquisition (Anderson et al., 2001).

With such a complex definition of knowledge acquisition, it may be possible that the students who took part in this study did not realize that their knowledge level had improved. However, upon close examination of the comments made by ESL nursing students during the focus group sessions, it can be deduced that the knowledge level of participants likely increased. They described numerous situations where they were able to critique their nursing care during debriefing sessions and then integrate those changes to improve the quality of their nursing care during simulated SP learning experiences. For example, students were able to analyze and evaluate their ability to develop therapeutic relationships and then integrate the necessary changes to improve their relational practice with patients and families.

Psychomotor domain of learning. Learning in the psychomotor domain includes the development of new skills. The existing research surrounding the ability of SPs to significantly enhance the development of nursing skills is unclear (Bornais et al., 2012; Luctkar-Flude et al., 2012). This study adds to our knowledge about the effectiveness of SPs in developing nursing skills by revealing that ESL nursing students believed their relational skills, as well as their ability to perform certain "hands-on" nursing skills, such as vital sign measurement and system specific health assessments, were improved.

Relational nursing skills. A therapeutic nurse-patient relationship is a "planned, time-limited and goal directed connection between a Registered Nurse and a client for the purpose of

meeting a client's health care needs" (Nurses Association of New Brunswick, 2011, p. 5). Many nursing regulatory bodies across Canada have mandated that entry-level Registered Nurses (RNs) possess "theoretical and practical knowledge of relational practice and understand that relational practice is the foundation for all nursing practice" (Association of Registered Nurses of Prince Edward Island, 2011, p. 12; College and Association of Registered Nurses of Alberta, 2013, p. 10).

Even though relational practice is one of the essential competencies of entry-level RNs, it is rarely the focus of clinical learning experiences in medical-surgical settings. There is simply not enough time available to focus on all aspects of nursing care in these settings. As nursing students and faculty struggle to find the time to perfect all the necessary psychomotor nursing skills, there is little time to focus on relational nursing skill development. This does not mean that relational nursing skill development is viewed as unimportant among clinical nurse educators and nursing students, but the practice of 'hands-on' nursing skills are viewed as the main priority. A unique finding of this study was that simulated SP learning experiences helped ESL nursing students gain a new appreciation for developing therapeutic nurse-patient relationships.

The ability of SPs to improve therapeutic communication skills among undergraduate nursing students is well-substantiated in the literature (Doolen et al., 2014; Webster, 2013). The findings of this study provide further support that SPs enhance the ability of undergraduate nursing students to develop therapeutic relationships with patients and families. The ESL nursing students who took part in this study experienced considerable improvement in both their verbal and nonverbal communication. The ESL nursing students also indicated that the SP

learning experiences made them feel more comfortable engaging in therapeutic relationships in the hospital.

'Hands-on' nursing skills. As nursing is a practice-based discipline, psychomotor skill acquisition is an essential component of undergraduate nursing education. In fact, psychomotor skill performance is important enough that nursing students must be able to competently perform clinical skills in real-life situations in order to graduate. Nursing students devote ample time to clinical, hands-on nursing skill development during their nursing program.

With such a strong emphasis on hands-on nursing skill development in the undergraduate nursing program, it was surprising to learn that the impact of simulated SP learning experiences on clinical skill development has not been extensively studied. In fact, there were only two studies that examined the impact of SP learning experiences on psychomotor skill development (Bornais et al., 2012; Luctkar-Flude et al., 2012). Upon review of these studies, it is impossible to conclude that SP learning experiences enhance psychomotor skill performance. If anything, there is ambiguity surrounding the impact of simulated SP learning experiences on psychomotor skill performance.

In the current study, all participants strongly believed that participating in simulated SP learning experiences improved their ability to perform "hands-on" nursing skills. They verbalized marked improvement in their ability to perform vital sign measurements and to complete through and accurate head-to-toe health assessments. While the results of this study support the notion that SP learning experiences improve psychomotor skill development, there is still uncertainty regarding the effectiveness of SPs to improve psychomotor skill development, as this study did not specifically pose research question. Although it may be difficult to ascertain whether SP learning experiences improve psychomotor skill development, it can be concluded

that participants learned about errors in their nursing practice through their simulated SP learning experiences.

Affective domain of learning. Learning in the affective domain involves developing new values, attitudes, and beliefs (Oerman & Gaberson, 2006). This domain of learning focuses on the acquisition of new feelings and emotions. Like the cognitive domain of learning, the affective domain of learning can be divided into a hierarchy. This classification of learning can be arranged from attention to a specific phenomenon to consistently acting in accordance with the new values that the learners internalize (Krathwohl, Bloom, & Masia, 1964).

At the time of conducting the literature review, I could not locate studies that specifically examined the ability of SPs to effect attitudinal change among undergraduate nursing students. However, since that time, a study has been published which examines the ability of simulation to alter nursing students' attitudes towards patients with schizophrenia (Sideras, MacKenzie, Noone, Dieckmann, & Allen, 2015). Sideras et al. (2015) conducted a quasi-experimental study to evaluate the impact of simulation on the attitudes of nursing students towards patients with a diagnosis of schizophrenia. A total of 145 nursing students participated in this study. The control group received classroom education with practicum experiences, and the treatment group received classroom education with practicum experiences and an innovative simulation activity. The simulation activity involved listening to audio players that provided auditory hallucinations and a simulated SP learning experience where the SP portrayed a patient with schizophrenia. The results of the study indicated that the nursing students who took part in the simulation activity experienced a significant decline in negative attitudes towards patients with schizophrenia than those who received traditional education.

The results of this study also suggest that SPs can effect attitudinal change among undergraduate nursing students. In this study, ESL nursing students believed that the simulated SP learning experiences altered some of their longstanding beliefs and attitudes. The ESL nursing students indicated that the SP learning experiences enabled them to develop new practice framework convictions, overcome stereotypical views about patients with mental health illnesses, acquire positive attitudes about older adults, and adapt to new cultural norms regarding gender segregation.

The ability of simulated SP learning experiences to promote the internalization of new attitudes and beliefs was an intriguing finding of this study. This finding may indicate that SP learning experiences are able to alter some of the prevalent attitudes, believes, and values which contribute to negative patient outcomes.

Bridging Language Barriers

English language deficiency is a significant barrier to academic success among ESL nursing students (Olson, 2012). ESL nursing students experience a greater struggle to achieve academic success than their native English speaking counterparts. For instance, the NCLEX-RN pass rate for students whose first language was English ranged from 67.7 percent to 95 percent, while the pass rate for ESL nursing students was only between 33.3 percent and 47 percent (Scheele, Pruitt, Johnson, & Xu, 2008).

English language deficiency is causing ESL nursing students difficulty in both the classroom and the clinical setting. In the classroom, ESL nursing students are finding it challenging to comprehend nursing terminology, ask questions for fear of embarrassment, and understand abstract concepts due to the speed of the lecture (Amaro, Abriam-Yago, & Yoder, 2006; Donnelly, McKiel, & Hwang, 2009; Sanner et al., 2002). In the clinical setting, ESL nursing students find it difficult to communicate with patients and their families. In particular,

they find it problematic to make small talk and to understand the requests made by their assigned patients (San-Miguel, Rogan, Kilstoff, & Brown, 2006). In addition, ESL nursing students are struggling to communicate with staff nurses and other professionals in the healthcare setting. They report great difficulty understanding abbreviations, verbal reports, directions made by staff, and healthcare terminology (Bosher & Smalkoski, 2002; San Miguel et al., 2006).

The Cummins Model of Language Acquisition, a theoretical framework for second language acquisition, describes two types of second language proficiency: Basic interpersonal communication skills (BICS) and cognitive academic language proficiency (CALP) (Cummins, 2003). Cummins (2003) describes BICS as the social language which students utilize to participate in everyday social situations, whereas, CALP is the ability to communicate cognitively challenging information in academic situations. In order to achieve CALP, students must be able to compare, classify, synthesize, evaluate, and infer complex information (Baker, 2006). CALP is usually achieved after reading a variety of academic texts and through repeated exposure to academic terminology. In order for ESL nursing students to be successful during their program of study they need to achieve CALP (Cummins, 2003).

Second language acquisition is a time-consuming and arduous process. For example, it can take an ESL student as long as five to seven years to develop the CALP required to thrive in an academic program of study (Abriam-Yago et al., 1999). This timeline, however, can only be used as a guide, as each individual student will learn at their own pace. It can be difficult to determine an exact timeframe when an ESL student will achieve CALP. In the current study, although 80 % of the students had been learning English for over 10 years, they still struggled to communicate in English. They felt that their low level of English proficiency was hindering their academic success in the nursing program.

Time is not the only factor that leads to the development of CALP. According to the Cummins Model of Language Acquisition (2003), second-language students experience enhanced learning when cognitively demanding concepts such as field-specific terminology or nursing terminology is taught in a contextually rich, rather than a contextually limited, environment (Cummins, 2003). Unlike a contextually limited environment, a contextually rich environment provides learners with facial cues, gestures or concrete objects of reference to enhance learning (Cummins, 2003).

Unfortunately, in most nursing programs, cognitively demanding concepts such as nursing terminology continue to be taught in a contextually limited environment. Teaching nursing terminology in an environment with little contextual support makes it challenging for ESL nursing students to improve their English proficiency (Abriam-Yago et al., 1999). Nurse educators can promote the development of English proficiency among ESL nursing students by encouraging these students to use the language in a contextually rich simulated SP learning experience.

The importance of teaching complex concepts, such as nursing terminology, to ESL nursing students in a contextually rich environment is evident in the opinions of the participants of this study who described a marked improvement in their English when they were learning in a contextually rich environment with SPs rather than a contextually limited environment with part-task trainers. They believed that the interactive nature of the SPs versus the static nature of the part-task trainers played an integral role in helping them communicate with patients and families.

This was the only study found which specifically linked simulated SP learning experiences to improved English proficiency among ESL nursing students. The participants of this study indicated that SP learning experiences helped improve their ability to communicate

verbally with patients and families. For instance, they were able to convey complex healthcare information to patients and families in a way that was understandable to the lay person and they grew familiar with idioms that may have not been present in their own culture such as, "feeling blue." The participants did not indicate that simulated SP learning experiences helped improve their ability to communicate with nurses and other healthcare professionals. This could perhaps be attributed to the objectives of the learning experiences in which the students took part or the students were only required to interact with patients and families during the simulated SP learning experiences, and not healthcare professionals. If the students had been required to communicate with healthcare professionals, they may have also improved their ability to communicate with healthcare professionals.

Debriefing: An Essential Component of Simulation Education

After the completion of a simulated SP learning experience, students are encouraged to participate in a debriefing session. A debriefing session is an interactive follow-up discussion between students and the simulation facilitator. During a debriefing session, the simulation facilitator is able to tailor feedback to students about their performance. The ultimate goal of a debriefing session is to facilitate student improvement (Cantrell, 2008; Rudolph, Raemer, & Simon, 2008). Debriefing is an essential component of simulation education (Decker et al., 2013; Neil & Wanton, 2011). During debriefing sessions, participants are encouraged to reflect upon their performance; they are encouraged to think about it in relation to process, outcomes, and application of knowledge and skills to clinical practice (Neil & Wotton, 2011). The learning that takes place during a debriefing session prevents learners from unknowingly transferring a mistake into their practice or from focusing solely on areas of performance that need improvement (Decker et al., 2013). The debriefing session is the most important component of

simulation education (Decker et al., 2013). Debriefing has been referred to as the "heart and soul" of simulation education (Dieckman & Karge, 2013).

The importance of debriefing cannot be emphasized enough. Debriefing plays a crucial role in ensuring the transfer of learning from the simulated learning experience to the clinical environment (Neil & Wotton, 2011). Debriefing provides participants with the opportunity to clarify and consolidate lessons learned during the simulated learning experience (Neil & Wotton, 2011). The significance of debriefing a simulation has been extensively discussed in the literature among simulation experts. There is an overwhelming consensus among simulation experts that simulated learning experiences which do not provide an opportunity for learners to debrief should not be conducted (Clapper & Kardong-Edgren, 2012; Kriz, 2010; Savoldelli et al., 2006). For example, Kriz (2010) states that to conduct a simulation without a debriefing session is "ineffective and even unethical (p.669)."

The debriefing session that follows an SP simulated learning experience is unique in comparison to the debriefing session that follows other simulation modalities. For instance, during simulations that make use of high fidelity human patient simulators, it is usually only the simulation facilitator and/or the other learners who provide feedback to simulation participants. After a simulated SP learning experience, the SP may also provide additional feedback to the students from the perspective of "the patient." In this study, the ESL nursing students benefited immensely from SP feedback during the debriefing sessions. They found it very helpful to learn the patient's perspective about their performance. While many SPs have been trained to provide objective feedback to learners regarding their interpersonal and clinical skills, it is unknown if SPs are routinely providing learners with feedback during a debriefing session.

It is during the debriefing session that participants are able to glean insight into their nursing practice and become "better nurses." For the majority of the participants who took part in this study, it was during the debriefing session that participants became aware of a significant gap between their nursing practice and best practice. They recognized the need to improve the quality of nursing care they provided to patients. For instance, one student indicated that the simulated SP learning experience helped her recognize the importance of actively listening to clients while providing nursing care. Other participants improved their ability to perform system-specific health assessments so that they no longer needed to duplicate the documentation of other nurses.

In this study, participants were quick to point out that debriefing sessions are in need of improvement. While they seemed to be satisfied with most aspects of the debriefing process, they voiced unanimous concern regarding the timeliness of the feedback that they had received. Some students indicated that they struggled throughout the simulated SP learning experiences to receive feedback in a timely manner. At times, they felt as though there were an insufficient number of simulation facilitators available to watch scenarios unfold and to provide constructive feedback. It is interesting to note that even though participants valued feedback from the SPs, they did not feel this feedback was sufficient. They still needed or wanted the feedback of simulation facilitators before they felt comfortable proceeding with the simulation.

Mastery in Nursing Education

Both nurse educators and nursing students alike have become more comfortable with simulation and have expressed great satisfaction with this teaching-learning modality (Kardong-Edgren, Lungstrom, & Bendel, 2008). However, despite the increasing support for simulation as a teaching-learning strategy, simulation centers are not being utilized to their full capacity. In 2006, a web-based survey conducted by the Canadian Association of Schools of Nursing

(CASN) found that simulation centers in Canada were only being used an average of 25 hours per week (Garrett et al., 2011). The primary reason cited for low simulation use in academic institutions was cost (Garrett et al., 2011).

Unfortunately, to compensate for declining budgets and increasing student enrollments, simulation facilitators are being required to cut corners to ensure that as many students as possible are able to engage in simulation education. Some of the easiest ways for simulation facilitators to increase the number of participants without incurring extra cost is to reduce the time allotted for scenario completion and to eliminate the opportunity to engage in repeat practice after debriefing a simulated learning experience.

In this study, the students did not mention the specific length of time allocated for scenario completion, but they did indicate that the time provided for scenario completion was inadequate. The ESL nursing students who took part in the study were adamant that scenario completion times were too short to accomplish all of the learning objectives of the scenarios in which they had participated. For example, they voiced concern over the time given to the completion of cardiovascular and respiratory assessments. It is not in the best interest of student learning to reduce the amount of time allotted for scenario completion. A short reduction in scenario time can have a significant impact on the ability of participants to achieve the objectives of the simulated learning experience.

Scenario completion time is not the only component of simulation education that may be reduced or eliminated as a result of declining budgets and increasing student enrollments. To further compensate for declining budgets and increasing student enrollments, many simulation facilitators could be required to remove the opportunity for repeat practice following a debriefing session. Repeat practice involves simulation participants practicing a scenario over and over

again until they can demonstrate consistent success or mastery (Clapper & Kardong-Edgren, 2012). In this study, not all participants were able to practice the scenario repeatedly after a debriefing session until they perfected their ability to perform the competencies embedded within the scenario. For example, one student expressed her desire to engage in repeat practice when she emphatically stated that only one opportunity "is not enough!" Due to the inexperience of the focus group moderator, this statement was not expanded upon during the actual focus group session. It was not until the audio recording was transcribed and analyzed that the importance of this participant's comment was realized.

Even though the concept of repeat practice was not mentioned by the other participants who took part in the focus group sessions, it is believed to be a significant finding. According to Krueger and Casey (2009), it is not solely the frequency of an expressed idea which determines if it is worthy of analysis. An idea that is expressed on only one occasion with emotion may be more valuable than a thought expressed on numerous occasions (Krueger & Casey, 2009).

ESL nursing students are more likely to achieve mastery and transfer their learning from the educational setting to the hospital setting when they are provided with ample time for learning and they have been provided with the opportunity to engage in repeat practice until they can demonstrate consistent success. Without adequate time for learning and the opportunity to engage in repeat practice some students will complete a simulated SP learning experience without being able to competently perform the skill(s) embedded within the simulation and some may even leave the simulated SP learning experience with an erroneous assumption that they can perform the skill(s) competently. For reasons such as these, one could potentially argue that simulated SP learning experiences that do not provide sufficient learning time and/or encourage repeat practice are unethical. Students should not be led to falsely assume that because they have

performed a skill correctly during one simulation, they are able to perform the skill competently on patients in the hospital setting. It must be emphasized to students that performing a skill on one occasion in a simulated learning environment does not mean they are experts in a particular skill. ESL nursing students should be required to demonstrate repeated, consistent success before caring for real patients in the hospital setting.

Plan for Dissemination of Findings

It is imperative that all researchers disseminate their research findings. Dissemination of research findings will ensure that others have the opportunity to incorporate new knowledge generated by the study into their field of work. As this study involves ESL nursing students, the results of this study may be of particular interest to ESL nurse educators. However, ESL educators in other disciplines may find the results of this study applicable to their teaching.

The preliminary findings of this study were already presented at a simulation conference in a neighboring country via a poster presentation. The audience at this conference was primarily composed of healthcare educators and healthcare professionals such as nurses and physicians. Conference attendees included local individuals as well as individuals from the international community.

It was hoped that the results of this study could be presented to the ESL nursing students who participated in this study and the simulation educators who facilitate the SP program. This information could be utilized to improve the delivery of the SP program at the academic institution where the study took place. However, due to circumstances beyond my control, the results of this study will not be presented to this audience.

In the near future, I plan to submit my study findings for possible publication in a peer-reviewed nursing education journal. This would enable other ESL nurse educators and

simulation facilitators to learn of the ESL nursing students' perceptions of SPs as a teaching-learning tool and potentially incorporate some of the recommended improvements to the SP program at their academic institution.

Conclusion and Summary of Discussion

It has been challenging to refute the longstanding belief held by many nurse educators that the CLE affords nursing students with the best opportunity for clinical learning. In fact, there are still many nurse educators who are not open to the possibility that the SLE can be just as effective, or perhaps more effective, than the CLE. There are even more nurse educators who would never dream of replacing clinical hours with simulation hours.

But how can we expect ESL nursing students to succeed if the delivery of education does not change? Strongly held notions such as this one that have made it near impossible for ESL nursing students to succeed. Without accepting the possibility that there is a better way to educate ESL nursing students, ESL nursing students will continue to succumb to the rigid educational practices of the nurse educators who hold this belief. Nurse educators need to be open to the possibility that there is a better way to educate all nursing students including those who speak English as a second language.

Simulated SP learning experiences enrich the learning of ESL nursing students. ESL nursing students who engage in simulated SP learning experiences during their program of study will have the opportunity to learn within a supportive community of practice. The opportunity to learn within a supportive learning environment is of paramount importance to ESL nursing students. A supportive learning environment ensures that ESL nursing students are able to overcome many of the barriers to academic success that they experience during their program of study. ESL nursing students who are immersed in simulated SP learning experiences will feel

supported throughout their academic journey and in turn experience an increased likelihood of academic success.

Simulated SP learning experiences provide ESL nursing students with a rich opportunity for learning. Implementation of experiential pedagogy such as SPs into the ESL nursing curricula enhances learning in the cognitive, psychomotor, and affective domains of learning. In turn, ESL nursing students who engage in simulated SP learning experiences will be knowledgeable and skilled practitioners who hold values and beliefs that are consistent with the nursing profession.

As a result of engagement in simulated SP learning experiences, ESL nursing students demonstrated significant improvement in their English proficiency. The opportunity to engage in verbal communication with SPs enhanced the students' ability to relay complex medical information to patients and families in a clear and concise manner. The ESL nursing students also became more familiar with idioms that may be frequently utilized by patients and families in the hospital setting. Simulated SP learning experiences have the ability to help ESL nursing students improve their English proficiency so that they may overcome a significant barrier to academic success.

Debriefing is an essential component of simulated SP learning experiences. Debriefing enables ESL nursing students to gain insight into their nursing practice; they are able to recognize areas of their practice that are in need of improvement and other areas that are in accordance with best practice guidelines. ESL nursing students suggest that because debriefing plays such an instrumental role in student learning, it should take place as soon as the simulated SP learning experience has concluded.

In order for ESL nursing students to achieve mastery during a simulated SP learning experience, they must be provided with adequate time to learn and the opportunity to engage in repeat practice following a debriefing session. Nursing students must be encouraged to strive for mastery during their education. If nursing students are given only one opportunity to participate in a simulated SP learning experience, they may only develop a familiarity of the skill(s) embedded within the simulation. Rather, if ESL nursing students are encouraged to participate in simulated SP learning experience until they are able to demonstrate, repeated, and consistent success, they will achieve mastery of the skill(s) embedded within the learning experience and be more likely to transfer competent nursing care from the educational setting into the clinical setting when caring for patients and families.

Chapter 6: Nursing Recommendations, Areas of Further Research, and Limitations

This study describes ESL nursing students' perceptions of SPs as a teaching-learning tool. In the process of developing a meaningful understanding of ESL nursing students' perceptions of SPs as a teaching-learning tool, I was also able to gain insight into possible recommendations that may guide nurse educators as they strive to integrate standardized patients, a unique educational strategy, into the undergraduate nursing curricula. This chapter is separated into four sections. In the first section of this chapter, I outline recommendations that may enhance the integrations of SPs into nursing curricula. In the second section of this chapter, I suggest an area for further research. In the third section of this chapter, I provide an overview of the limitations of this research study. In the fourth section of this chapter, I provide a conclusion to this research study.

Nursing Recommendations

There is a dearth of research pertaining to ESL nursing students' perceptions of SPs as a teaching-learning tool. Consequently, this study has resulted in a greater understanding of ESL nursing students' perceptions of standardized patients as a teaching-learning tool. During the focus group sessions, ESL nursing students proposed several recommendations that may improve the implementation of SPs into the nursing curricula. These recommendations will be discussed in the remainder of this section.

Recommendation #1: Construct a Psychologically Safe Learning Environment

In this study, ESL nursing students perceived the simulated SP learning environment to be more supportive of student learning than the clinical learning environment. In the clinical learning environment, the students did not feel as though they were valued members of the healthcare team and that their contribution as student nurses was unappreciated by patients.

They also feared that they could jeopardize the well-being of patients and families in the hospital setting. However, in the simulated SP learning environment, the ESL nursing students felt that they were appreciated and supported by the SPs. They did not fear harming patients and families while they were learning; rather, they felt safe to learn. In the simulated SP learning environment, the ESL nursing experienced psychological safety while they were learning.

It is imperative that nurse educators strive to construct a psychologically safe learning environment for nursing students. It is possible to establish a learning environment that challenges learners but does not intimidate or humiliate. Much more emphasis on creating a psychologically safe learning environment for nursing students is needed. Students need to feel safe in the learning environment so that they can engage in learning-orientated behaviors such as asking questions, sharing thoughts, and asking for help.

Immersing nursing students in a threatening learning environment can ultimately derail student learning. Nursing students who feel fear and/or anxiety while learning may question their ability to provide competent nursing care and may even wonder if they are even suited to be nurses. Nurse educators are encouraged to create a psychologically safe learning environment for their students.

Recommendation #2: Strive for a Culture of Mastery

Mastery is a concept more openly and frequently discussed in medical literature than nursing literature. This is peculiar, since both professional groups deliver care that has a tremendous impact on the health and well-being of patients and families. If nursing students are to provide competent patient care in the hospital setting during clinical learning experiences and upon graduation, a culture of mastery within nursing education and simulation education needs to develop.

In this study, ESL nursing students stressed that participating in only one simulated SP learning experience was inadequate. They felt it would be more beneficial to their learning if they were given the opportunity to engage in repeat practice after a debriefing session until they achieved mastery of the skill(s) embedded within a simulation. Ultimately, this would allow them to provide the best nursing care possible to patients and families.

Simulation education is by no means a magical wand. Nursing students will not be magically transformed into expert nurses after participating in one brief, simulated learning experience. If mastery is to be attained, nursing students need to be provided with adequate time to complete simulated learning experiences and must be encouraged to engage in repeat practice after they have participated in a debriefing session. One simulated SP learning experience will not produce competency among undergraduate nursing students. The learning process cannot be rushed. If nursing students are to be competent healthcare practitioners, they need to strive for mastery during their education.

Recommendation #3: Debrief Sooner Rather Than Later

Despite increasing recognition of the importance of debriefing, it was only recently that standards of practice for debriefing were introduced. In 2011, when best practice debriefing guidelines were published by the International Nursing Association for Clinical Simulation and Learning (INASCL), simulation facilitators began to realize that there was a "best way" and a "wrong way" to debrief a simulation. The INASCL identified five criteria that lead to an effective debriefing session. Debriefing session should be: (I) facilitated by a person(s) competent in the debriefing process; (II) conducted in an environment that that supports confidentiality, trust, open communication, self-analysis, and reflection; (III) facilitated by a person(s) who observes the simulated experience; (IV) based on a structured framework for

debriefing; and (V) congruent with the participants' objectives and outcomes of the simulation-based learning experience (Decker et al., 2013).

Prior to the publication of these criteria, too much emphasis was being placed on scenario development and the fidelity of the scenario; there was not enough focus on the debriefing process itself, the component of simulation where learning actually takes place. In the best practice debriefing guidelines published by the INASCL, there is no indication of when debriefing should occur or the optimal duration of a debriefing session. In fact, *Criteria IV: Based on a Structured Framework for Debriefing* only indicates that the time and duration of a debriefing session should be flexible and based on the objectives of the simulation (Decker et al., 2013). It seems as though the timing and/or the duration of a debriefing session are left open to the discretion of the simulation facilitators. There is a lack of clear direction by the INASCL with regards to the timing and duration of debriefing sessions.

In this study, ESL nursing students believed that debriefing is more effective when it occurs as soon as a simulated SP learning experience has ended. A time delay between a simulated learning experience and the debriefing session may lead to forgetfulness about critical performance issues and can cause participants to experience unnecessary anxiety about their performance (Lyons et al., 2015). As the best practice debriefing guidelines published by the INASCL are relatively new, it is reasonable to expect that future revisions will occur. In future revisions of these guidelines, the INASCL may need to consider devising more prescriptive debriefing timelines.

Recommendation #4: Connect the Art and Science of Nursing in Undergraduate Nursing Education

The profession of nursing has long been recognized as both a science and an art (Peplau, 1988). However, in an attempt to produce knowledgeable and competent nurses, many nurse educators have chosen to focus their teaching efforts on enhancing the science of nursing and, less attention on, the art of nursing. The art of nursing is been defined as "the intentional creative use of oneself, based upon skill and expertise, to transmit emotion and meaning to another" (Jenner, 1997, p. 5). The two dimensions of nursing should not be separated in undergraduate nursing education; they should be interconnected so that they may work together harmoniously within nursing practice to improve patient outcomes. It seems that nurse educators have devoted too much attention on what undergraduate nursing students need to know and not enough attention to who they need to become (Valiga, 2014).

The ESL nursing students who took part in this study entered the simulated SP learning experiences with preconceived notions about how nursing care should be delivered, stereotypical views about patients with mental health illnesses, and negative attitudes towards older adults. The longstanding attitudes and beliefs held by these students had the potential to negatively impact the quality of nursing care they provided to patients and families in the clinical setting. Through active participation in simulated SP learning experiences, these students were able to acquire new beliefs and attitudes that were more in line with the core values and thus, the art of nursing.

Nursing is a caring profession. If we want nurses to be knowledgeable, competent, and caring towards patients and families, there will need to be a more concerted effort among nurse educators to connect the art and science of nursing in undergraduate nursing education.

Areas of Further Research

An exciting aspect of completing this study involved discovering areas for future research that will further explore the effectiveness of SPs as a means to achieve academic success among ESL nursing students. Firstly, it is recommended that nurse educators devise a quantitative research study that examines the impact of simulated SP learning experiences on the learning of ESL nursing students. All teaching-learning strategies must be evaluated for effectiveness. The ESL nursing students who took part in this study strongly believed that simulated SP learning experiences enrich learning. However, since this study is of a qualitative nature, it does not provide conclusive evidence to support the notion that simulated SP learning experiences improve the learning of ESL nursing students. There is also ambiguity in the literature regarding the ability of simulated SP learning experiences to enhance knowledge acquisition (Becker et al., 2006; Dearmon et al., 2013). Therefore, a quantitative research study that evaluates the effectiveness of simulated SP learning experiences among ESL nursing students is warranted.

Secondly, it is recommended that nurse educators conduct a future study to determine if simulated SP learning experiences improve ESL nursing students' ability to effectively communicate with other members of the healthcare team. In this study, ESL nursing students' perceived that their ability to convey complex medical information to patients and families in a simplified manner had improved as a result of participation in simulated SP learning experiences. However, improvement in the ability of ESL nursing students to communicate effectively with members of the healthcare team was not a finding of this study. This may be due to the fact that the ESL nursing students in this study had not participated in interprofessional simulated SP learning experiences at the time this study was conducted.

Limitations

Research studies are not flawless. All studies, including those conducted by experienced researchers, will have limitations and challenges. After much consideration, it was determined that two limitations had the potential to impact the quality of the research findings in this study: (1) moderator selection, and (2) choice of methodology.

Moderator selection. Careful consideration must be given when choosing the moderator of focus group sessions. The correct moderator must be selected. To facilitate the timely completion of this study, I appointed myself as the moderator of the focus group sessions. Initially, I was concerned that my position as a nursing instructor at this particular academic institution would make some of the participants feel uncomfortable sharing their perceptions of the SPs as a teaching-learning tool. However, I quickly realized that my professional relationship with the participants would not impede the discussion. In fact, my professional relationship with many of the participants enabled them to trust me and to feel comfortable disclosing sensitive information about their academic journey.

In hindsight, I believe that it would have been beneficial to assemble a moderating team instead of a single moderator. At times during the focus group sessions, it was difficult for me, a native English speaking moderator, to fully comprehend the meaning the ESL nursing students were trying to convey. Since the ESL nursing students often struggled to communicate their ideas and thoughts in English, I would often need to ask the participants to clarify what they were saying. It is quite possible that some of the information communicated from the participants to myself was misinterpreted or entirely missed. It may have been beneficial to have an assistant moderator who was fluent in both English and Arabic attend the focus group sessions. I believe that the assistance of a second moderator who was bilingual would have greatly improved the reliability of the retrieved data.

Choice of methodology. Lastly, the choice of methodology for this research study may be viewed as questionable; some may be skeptical that a qualitative design was the best choice for this study. This question can be addressed by analyzing the purpose of the research study. The purpose of this study was to gain an understanding of ESL nursing students' perceptions of SPs as a teaching-learning tool. I firmly believe that focus group methodology was able to accomplish this objective. A thorough understanding of ESL nursing students' perceptions of standardized patients as a teaching-learning tool was ascertained. There is now a greater understanding of how simulated SP learning experiences can enrich the learning of ESL nursing students. It is now possible to design and develop strategies to enhance the integration of SPs into the ESL nursing curricula.

Conclusion

This qualitative, exploratory research study utilized focus group methodology as guided by Morgan (1995, 1997) and Krueger and Casey (2009) to describe ESL nursing students' perceptions of SPs as a teaching-learning tool. The study also provided insight into possible strategies which may improve the implementation of SPs into the nursing curricula. Until the completion of this research study, there has been a dearth of research completed on the effectiveness of teaching-learning strategies among ESL nursing students. It is through the meaningful disclosure of the 35 ESL nursing students who took part in this study that it has become possible to have a more thorough understanding of ESL nursing students' perceptions of SPs as a teaching-learning tool and possible strategies that may further enhance the effectiveness of this particular teaching-learning modality.

The learning needs of ESL nursing students are unique in comparison to those of their native English speaking peers. ESL nursing students encounter obstacles to success that native English speaking nursing students do not necessarily experience, such as low English

proficiency, inexperience with multiple-choice format examinations, unfamiliar learning models, and trouble adjusting to new cultural norms (Hansen & Beaver, 2012; Olson, 2012; Suliman & Tadros, 2011). The implementation of innovative pedagogy into the ESL nursing curricula may help ESL nursing students overcome the many barriers that are impeding their academic success.

SP simulation creates a supportive community of practice that ensures ESL nursing students experience a sense of psychological safety as they acquire new learning. ESL nursing students who engage in SP learning experiences are not inundated with fear but rather feel supported during their academic journey. During simulated SP learning experiences, ESL nursing students are immersed in a risk-free learning environment where they can make mistakes while integrating theory into practice, without jeopardizing the health and well-being of patients and families.

Optimal learning can take place outside of the traditional clinical learning environment. When engaged in simulated SP learning experiences, ESL nursing students are able to enhance their knowledge, psychomotor skill performance, English proficiency, and acquire new attitudes and beliefs that are consistent with the core values of the nursing profession. Perhaps it is time for nurse educators to reconsider their longstanding belief that the traditional clinical learning environment provides nursing students with the only suitable clinical learning experience.

Debriefing is instrumental to ESL nursing student learning. It is during debriefing sessions that they are able to clarify and consolidate lessons learned during a simulated SP learning experience. In a debriefing session, nursing students are also able to identify areas of their nursing practice that are in need of improvement and areas that are in accordance with best practice guidelines. Learning during a simulated SP experience will be improved if debriefing sessions occur as soon as a simulated SP learning experience concludes. Debriefing in a timely

fashion ensures that students do not develop unnecessary anxiety about their performance during a simulation and that they are able to recall critical issues which occurred during a simulation that need to be discussed. The current INACSL guidelines pertaining to debriefing are somewhat vague. It is recommended that prescriptive timelines for debriefing be devised.

It is challenging for ESL nursing students to acquire the proficiency they require in order to excel in their nursing program after one simulated SP learning experience. One brief, simulated SP learning experience only provides ESL nursing students with the opportunity to become familiar with the skill(s) embedded within a simulation; it does not ensure that students are able to function competently. Learning takes time and cannot be rushed. ESL nursing students should be encouraged to participate in simulated SP learning experiences until they are able to demonstrate, repeated, and consistent success of the skill(s) embedded within a simulation. It is through repeat practice that ESL nursing students will be able to attain mastery and transfer their learning from the educational setting to the clinical setting.

A strategic transformation in the delivery of education to ESL nursing students is necessary. ESL nursing students can achieve positive learning outcomes if they are immersed in a supportive and contextually-rich community of practice that encourages them to strive for mastery. The implementation of innovative, experiential teaching-learning tools, such as SP simulation, into the nursing curricula may enable ESL nursing students to overcome the obstacles that are hindering their learning. ESL nursing students are greatly needed in the Canadian healthcare system. The incorporation of nurses from a variety of cultural backgrounds into the Canadian healthcare system will assist in alleviating the impending nursing shortage and the many healthcare disparities that exist for minority groups within Canada. As the cultural profile of Canadians continues to diversify, there will be an increasing need for competent nurses

who have a thorough understanding of the cultural practices and beliefs of minority groups within Canada and the linguistic competency necessary to provide quality nursing care to all Canadians.

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Appendix A: Consent for Situated Learning Environment Diagram

From: Kenneth Allan Ryba
Sent: February 6, 2014 4:34 AM
To: Krista King
Subject: RE: Situated Learning Theory
Attachments: Situated Cognition Academic Forum Final 120312.docx; Situated- A learning Framework to Support and Guide HFS.pdf

Hi Krista,

I am glad to help out. Attached is my paper and also an article by Paige and Daly. I adapted my diagram from the one they used. Please feel free to use my diagram.

Best wishes from Ken

Appendix B: Recruitment Flyer

English-as-a-Second Language Nursing Students' Perceptions of Standardized Patients as a Teaching-Learning Tool

BE A PART OF A NURSING EDUCATION RESEARCH STUDY!

- Do you speak English as a second language?
- Have you used a standardized patient (patient actor) during your nursing course this semester?

Purpose:

To understand how standardized patients impact the learning of ESL nursing students

Location of Research:

Classrooms at [Name of Academic Institution]

For more information, please contact the primary researcher:

Name: Krista King
Email: [Email Address of Primary Researcher]
Phone #: [Telephone Number]
Office: [Office of Primary Researcher]

This research study has been approved by the Conjoint Health Research Ethics Board (CHREB) and the Health Research Ethics Authority (HREA)

Appendix C: Follow-up Email Message

English-as-a-Second Language Nursing Students' Perceptions of Standardized Patients as a Teaching-Learning Tool

[Date]

[Name of Participant]

Thank-you for accepting my invitation to take part in my Master of Nursing Project to discuss the use of standardized patients (patient actors) in your nursing course. You have valuable information to contribute about this topic and I am very interested in hearing all of your ideas. The group discussion will be held:

[Date/location of focus group session]

It will be a small group, of about 8 people. Your participation in this group discussion is greatly appreciated.

If for some reason you won't be able to attend the discussion, please let me know as soon as possible. If you have any questions about this study, please email me at [Email Addresss of Primary Researcher] so that we can arrange a meeting time.

I am looking forward to speaking with you soon.

Sincerely,

Krista King
Principal Investigator

Appendix D: Reminder Text Message

YOUR FEEDBACK IS IMPORTANT!

Our focus group session will be tomorrow @ [Time] in the [simulation area].

See you there!
Krista

Appendix E: Demographical Questionnaire

Demographic Questionnaire:

Please answer the following questions in the spaces provided.

1. Are you registered in the BNRT program or the PDBN program? ☐ BNRT ☐ PDBN

2. What year of the program are you completing? _____

3. What is your first language? ☐ Arabic ☐ English ☐ Other _____

4. What language do you speak most often when you are at home? ☐ Arabic ☐ English ☐ Other _____

5. How many years has it been since you first learned English? ☐ < 1 Year ☐ 1-2 Years ☐ 2-5 Years ☐ 5-10 Years ☐ > 10 Years

Thank-you for taking the time to complete this questionnaire.

Krista King

Appendix F: Consent Form

CHECKLIST

This checklist is to be completed and submitted with this consent form. It is to be removed from the final version of the consent document.

- ☒ Most recent version of consent template (November 2011) has been used
- ☒ Footer includes consent version, study name, line for patient initials
- ☒ Font size no less than 12 [except for footer]
- ☒ Left justification of text
- ☒ Grade 9 or lower reading level. Assessed reading level is: **9**
- ☒ Accepted definitions for specialized terms used where applicable
- ☒ Plain language principles used for study specific wording – no jargon, no acronyms, short words, short sentences, active voice and, where appropriate, bulleted lists

Standard, required wording (in bold type) has been used in the following sections:

	Yes	**No**
Introduction	☒	☐
Benefits (Q6)	☒	☐
Liability Statement (Q7)	☒	☐
Privacy and confidentiality (Q8)	☒	☐
Questions or problem (Q9)	☒	☐
Signature page	☒	☐
Signature page for minor/assenting participants if applicable	☒	☐

If you have answered No to any of the above, please give the rationale for these changes below:

TCPS2 guidelines provide a list of the information required for informed consent. Please refer to TCPS2, Chapter 3, available at: http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter3-chapitre3/.

The HREB Policy Manual provides detailed information on specific consent issues including: consent to research in emergency health situations; the use of substitute decision makers; assent for children; research involving special populations (children, cognitively impaired); managing consent in situations of difficult power relationships; and community consent to research involving Aboriginal communities. Please refer to the HREB Policy Manual on the HREA website: www.hrea.ca

[Contact information of Primary Researcher]

Consent to Take Part in Research

TI**TLE**: English-as-a-Second language Nursing Students' Perceptions of Standardized Patients as a Teaching-Learning Tool

INVESTIGATOR(S): Krista King, Dr. Alice Gaudine, and Dr. Caroline Porr

SPONSOR: Funding for this study may be obtained from [Name of Academic Institution].

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time. This will not affect your current course or future course grades.

Those students who take part in the study will obtain a letter of participation. All students will also be entered into a draw to win a [$] voucher for a local restaurant.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. Introduction/Background:

English-as-a-Second Language nursing students are having difficulty in the nursing program; they are having a lot of trouble learning new nursing concepts. To help students learn, nursing instructors are using patient actors in the classroom. However, little is known about how English-as-a-Second Language nursing students' think that patient actors are helping their learning.

2. Purpose of study:

To understand how English-as-a-Second Language Nursing Students' think that patient actors are helping their learning.

3. Description of the study procedures:

When you have finished using patient actors in your nursing course, you will take part in one focus group session.

4. Length of time:

The focus group session will last about 75 minutes. It will take place at [Name of Academic Institution].

5. Possible risks and discomforts:

- Breech of personal information (uncommon)
- Loss of time (common)

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However it cannot be guaranteed. Other people taking part in this focus group may know your name and hear your comments. All members of the focus group will be reminded to:

- respect the privacy of each member of the group
- treat all information shared with the group as confidential

When you sign this consent form you give us permission to:

- collect information from you

- share information with the people conducting the study
- share information with the people responsible for protecting your safety

Access to records

The members of the research team will see study records that identify you by name. Other people may need to look at the study records that identify you by name. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information
The research team will collect and use only the information they need for this research study.

This information will include your:

- number/type of spoken languages
- length of time speaking English
- length of time studying nursing in English

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will kept for five years.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored in a locked filling cabinet in my office at the [Name of Academic Institution]. Krista King is the person responsible for keeping it secure.

Your access to records
You may ask the researcher to see the information that has been collected about you.

9. Questions or problems:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is: Krista King.

Principal Investigator's Name and Phone Number: [Contact information of Primary Researcher]

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office
Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

After signing this consent you will be given a copy.

Signature Page

Study title: English-as-a-Second language Nursing Students' Perceptions of Standardized Patients as a Teaching-Learning Tool

Name of principal investigator:

Krista King

To be filled out and signed by the participant:

	Please check as appropriate:
I have read the consent.	Yes { } No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { } No { }
I have received satisfactory answers to all of my questions.	Yes { } No { }
I have received enough information about the study.	Yes { } No { }
I have spoken to Krista King and she has answered my questions	Yes { } No { }
I understand that I am free to withdraw from the study • at any time • without having to give a reason • without affecting my student status	Yes { } No { }
I understand that it is my choice to be in the study and that I may not benefit.	Yes { } No { }
I understand how my privacy is protected and my records kept confidential	Yes { } No { }
I agree to take part in this study.	Yes { } No { }

_____ _____ _____

Signature of participant Name printed Year Month Day

_____ _____ _____

Signature of person authorized as *Name printed* *Year Month Day*

*Substitute decision maker, if applicable*_____

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ -___ _____

Signature of investigator Name printed Year/ Month/ Day

Telephone number: _____