

THE MEANINGFUL EXPERIENCES OF BEING AN RN BUDDY

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ABSTRACT

This paper describes the previously unexplored Buddy RN experience. Critical interpretive theory underpinned this exploratory study set in a large metropolitan teaching hospital in South East Queensland. Participants were five RNs who had been buddies to undergraduate nursing student(s) in the previous twelve months. They were interviewed using semi-structured techniques and their transcribed interviews summarised to identify relevant verbatim data for participant checking. Common themes were generated via critical interpretive analysis and points of tension extrapolated. Four main points of tension were uncovered: *Acknowledgement*, *Experience*, *Balance* and *Interruption*. These revealed a number of paradoxes: the Buddy RN role is not professionally recognised by bodies that manage nursing; nursing is still influenced by essentialist discourses which perpetuate out-dated practices and attitudes to the detriment of the buddy RN; RNs are compelled to follow direction without question or dissent even though they are mandated by nursing's regulating body to be independent and accountable critical thinkers. A clear articulation of the Buddy RN role in the form of policy is required from nursing's regulating bodies. From this, health service management and universities can initiate the process of creating a framework for preparing, supporting, assessing and educating the Buddy RN.

INTRODUCTION

Tertiary Schools of Nursing (SONs) in Australia currently utilise a system of clinical education where undergraduate students receive practical experience in a variety of health settings. This system is constrained by various issues and these have become more acute over the last five years. Current issues faced by those involved include a lack of resources for clinical education (National Nursing & Nursing Education Taskforce [N₃ET], 2005, p. 19); a shortage of suitable clinical placements (Queensland Health, 2005a); an increase in undergraduate enrolments for nursing degree programs in an attempt to curtail the nursing shortage (Queensland Health, 2005b); competition between SONs to acquire quality clinical placements (Queensland Health, 2005a); confusion in the health industry about the variety of curriculum goals of competing SONs (Department of Education, Science and Training & Department of Health and Aging [DEST & DHA] 2002a; 2002b; Queensland Health, 2005a); inflexible university semester timetables resulting in SONs seeking large numbers of clinical places at around the same time (Queensland Health, 2005a); and uncertain relationships between SONs and their significant health agency stakeholders (Clare, Edwards, Brown & White, 2003; DEST & DHA, 2002a; Queensland Health, 2005a).

Working within this system of undergraduate clinical nursing education is the RN Buddy. The RN Buddy is a registered nurse, often previously unknown to students, assigned by nurse managers or shift coordinators to work with a student for a shift at a time. Registered Nurses are usually chosen randomly from the staff working on the required shift, indicating that an RN Buddy can have a different student for each shift worked. The RN Buddy role is mandated by the Australian Nursing and Midwifery Council (ANMC, 2005) and although informal, carries important responsibilities and challenges. Unlike the role of the 'Mentor' in the UK context (or 'Preceptor' in the Republic of Ireland) and 'Preceptor' in the US context, the RN Buddy is not formally prepared or qualified to directly assess the student (Leners, Sitzman, & Hessler, 2006; Mallik & McGowan, 2007). Both preceptor and mentor roles exist in Queensland, as well as that of the 'Clinical Facilitator' who works with and assesses 6-8 students in a block placement (of one to four weeks). The Clinical Facilitator will often seek summative feedback from the RN Buddy; that is a succinct yet meaningful interpretation of the student's performance during the shift. Unfortunately the response from the RN Buddy is often incomplete, emotive and /or inarticulate which points to a lack of preparation for and understanding of the role.

Although the RN Buddy role in the Queensland context is not readily defined or discussed in academic texts and journals, anecdotal evidence suggests it is characterised by its poor preparation, short-term interaction and lack of recognition as a contributor in undergraduate nursing education. Feedback from health agencies and students suggests that RNs are student fatigued; having to carry unrealistically heavy clinical loads as well as work with and informally educate undergraduate nursing students (Edmond, 2001). As a result many RNs overtly resent having to teach students when they are already heavily burdened by a system profoundly impacted on by economic

constraints (Jackson, Clare & Mannix, 2002; Senate Community Affairs References Committee [SCARC], 2002; Turner, 2001). The outcome of this reliance on an already burdened RN population to work with undergraduate nursing students results in a stressful education system which, due to its inflexibility, is only able to react to its many inherent troublesome variables, making it frequently ineffective (DEST & DHA, 2002a; 2002b; 2002c).

BACKGROUND / LITERATURE

A review of nursing and education literature reveals confusion about the various nursing education roles (Andrews & Chilton, 2000; Atkins & Williams, 1995; Cahill, 1996; Ehrich, Tennent & Hansford, 2002; Neary, 2000; Phillips, Davies & Neary, 1996), and little formal recognition or mention of the RN Buddy. The ANMC's National Competency Standards (2005, p. 4) direct RNs to contribute to the learning experiences and professional development of health care students, however this mandate could be criticised by Registered Nurses for being vague. Adding to this confusion of role is the evidence of poor preparation and support of RNs involved in undergraduate nursing clinical education (Andrews & Roberts, 2003; Andrews & Chilton, 2000; Corlett, 2000; Spouse, 2001, Watson, 2000), from tertiary providers (Atkins & Williams, 1995; Neary, 2000; Rummel, 2004), hospital management and clinical staff (Cahill, 1996; Phillips et al, 1996; Spouse, 2001; Watson, 2000).

There are calls for change, most notably from the [Australian] National Review of Nursing and Nursing Education (DEST & DHA, 2002a) which highlighted clinical education as an integral and essential component of teaching nursing and suggested that successful clinical education could only occur where there were effective working partnerships between educational institutions and practice settings (DEST & DHA, 2002a). This examination of nursing and nursing education has been more recently reviewed and discussed within the Queensland context (Queensland Health, 2005a; 2005b). These local reviews suggested that collaboration between educational and health stakeholders would have positive impact on the recruitment and retention of RNs (Henderson, Winch & Heel, 2006; Hutchings, Williamson & Humphreys, 2005; Queensland Health, 2005a), as well as enabling approaches in nursing, nursing education and research which value democracy, community building, empowerment, caring and holism in health care management and delivery (McAllister et al, 2006; Diekelmann, 2001; Hooks, 2003).

METHODS

This study links critical (social) theory and interpretive epistemology to form a critical interpretive methodology. Critical theory challenges the reason and rationalism of the assumed status quo and seeks to explore and acknowledge the multitude of subjective or hidden influences that impact on the human experience at any time. Interpretive research is focused upon creating theory that translates experience into something meaningful thus, the combined

critical interpretive methodology aims to deconstruct and theorise the experience of the RN Buddy. This is accomplished through immersion in the context of interest to possibly uncover invisible or silenced experiences and in doing so reveal the links between personal experience and dominant ideologies. Critical interpretive methodology therefore acknowledges theory as potentially emancipatory if it utilises the knowledge gained from immersion within a context to promote social change (Kincheloe & McLaren, 2000; Pease, Allan & Briskman, 2003).

A convenience sample of five RN Buddies was invited to participate in response to a flyer advertisement and introduction by a key informant at a health agency used in the clinical education of students at Griffith University. The criterion for inclusion in the study was that participants had to have been an RN Buddy to an undergraduate nursing student(s) in the previous twelve months in the chosen health agency. Ethical approval was gained from both the hospital and university ethics committees before the recruitment process commenced. Those RN Buddies expressing an interest in participating in the study were provided with an information sheet which outlined the inclusion criteria, what they were being asked to do, possible risks, the maintenance of their confidentiality and the voluntary nature of their participation.

The interview questions were directed using techniques based on Patricia Benner's clinical incident technique (1984). The overarching research question asked: Can you recall any stories from your experience as a RN Buddy? This broad question was broken down into sub-questions which explored the policies and practices of the RN Buddy role including the ANMC National Competency Standards (2005), to reveal the ways in which they did and did not influence the work of the RN Buddy. The transcribed texts of the recorded semi-structured interviews were analysed using a critical interpretive lens. This approach was used because it had the potential to give meaning to this previously unexplored perception of the role and to possibly expose a slice of social, cultural, political, and historical construction within a contemporary nursing context (Kohler Riessman, 2002; McAllister, 2001).

The goal of data analysis was to explore the total experience of participant RN Buddies within the encompassing perspective of critical interpretive theory. This meant an uninhibited rather than a strictly structured linear approach was necessary to capture the multitude of influences on the role. Three levels of engagement with the data (*Description, Analysis between participants and Critical cultural analysis*) were established based upon Janice Morse's four cognitive and sequential processes *comprehending, synthesizing, theorising and recontextualizing* (Morse, 1994, pp. 23-43). The three levels of engagement guided the process of analysis for the neophyte researcher and enabled verbatim interview material to be summarised into core information, common themes to be generated and points of tension to be extrapolated. It also allowed standard and divergent meanings that were illuminated to be explored within broader cultural, historical and political influences.

DATA / RESULTS

The findings uncovered four 'points of tension'. *Acknowledgement, Experience, Balance and Interruption*. These were deconstructed and interpreted using standard and divergent lenses and revealed the following meanings of the RN Buddy experience (pseudonyms were allocated to maintain the anonymity of the participants).

Acknowledgement:

The term *Acknowledgement* refers to the way RN Buddies perceive the level of recognition in their role (Walker, 2006, p.57).

RN Buddies indicated that they felt respected, supported and recognised by facilitators and undergraduate nursing students.

Yes I think I am [a popular Buddy]...last week, I got a gift; I got a gift just for being the Buddy RN. (Cath)

It was a positive experience because as much as she (the student) was helping me, I helped her [which] made her relaxed and [gave] her more ...esteem. (Cath)

However the RN Buddies interviewed also identified that they were not acknowledged sufficiently by the regulating bureaucracies of nursing, health and tertiary education whose respect they sought. It was this lack of professional recognition of the role that was perhaps the main source of all the identified points of tension associated with the experience of being a RN Buddy.

There was no...[preparation] to be a Buddy RN. I'm probably not [aware of any kind of policy relating to supervising nursing students] unfortunately. Do you think I should? (Beth)

Apart from the preceptorship programs, not formal [preparation] ...we've talked about it amongst ourselves, like our CNC (Clinical Nurse Consultant) has said like you're going to get some [students]...but as for going to an actual lecture on how you whatever, no, not really. (Dana)

Experience:

The term *Experience*, refers to the relevance of personal knowledge and practice, age and related generational influences that impact upon the overall acceptance and perception of the RN Buddy role (Walker, 2006, p. 67).

Personal knowledge and practice, age and related generational influences impacted upon the overall acceptance and perception of the RN Buddy role and suggested essentialism remains a dominant influence in nursing; that is the irrelevant practices and dogmatic attitudes which perpetuate to the detriment of the nursing profession. This generation gap is fuelled by outdated rituals and traditions of nursing and is manifested in some tense relationships between RN Buddies and undergraduate nursing students as well as between

older and younger RNs. The following excerpts from the RN Buddy participants exemplify this:

[Sometimes]...you work with people [who] obviously have to do it because they're told to do it and it's awful. Yeah [some of those people exist on my ward]. I think it's because they feel threatened because they get asked questions all the time. [They're] older normally. (Ruth)

At the beginning, when I had just started [as an RN Buddy], I was excited about having them because it was like: 'Oh well now it's my turn to teach'. Now it's a bit like: 'Oh, a student... really bad'. (Beth)

I find most of them (students) very lazy. ...I think all teenagers, like young people are damn lazy anyway. I mean like a girl said to me the other day, she's just turned 22 and she said "you'd be really proud of me Dana, I've just done my first load of washing at home". Well that pretty floored me because I thought my God, no wonder you're useless here because you can't even do your own washing. (Dana)

It was also revealed that undergraduate nursing students tend to question the authority and experience of their RN Buddy if the Buddy hasn't been registered for long:

The first day that I was facilitating one of my second year students said to me: 'How long have you been nursing for?' I [replied]: 'Two years, about that', and [he said]: 'Don't you have to be a nurse for five years before you're a facilitator?' I [said]: 'Well if that was the case, I wouldn't be here.' That was the first thing that he said to me and it put me...[on]... guard for the rest of the time that he was with me. (Beth)

An association emerged that suggested the experience as an undergraduate nursing student informed the perception and practice of the RN Buddy role.

... [in] all of my third year pracs [as a student] I ...worked with some wonderful people who allowed me to really push the boundaries of what I knew and what I was capable of and so that when I came out into nursing, I was probably a lot more confident than a lot of the other people that I graduated with. (Alan)

Yeah I love [being a Buddy RN]... I just remember when I was a student and it was...good when you worked with someone that really enjoy[ed] doing it... you'd have a really good day. (Ruth)

Balance

The term *Balance* refers to the tension RN Buddies face when trying to maintain an even consideration towards the demands of teaching undergraduate nursing students and direct patient care (Walker, 2006, p. 72).

The complexity which results from balancing the supervision and teaching of undergraduate nursing students with the provision of quality patient care,

created tensions for the RN Buddies. For some of them, a sense of shame emerged from not being able to effectively meet the demands of both roles which may have resulted from the unreal expectations of contemporary nursing.

...they (the patient) were hideously sick with pulmonary oedema and then I remember...it not being a very good experience for the student because [she was] just ... pushed out the way and everything sort of happened... [A]fterwards [I] tried to talk with her [about] what happened. ... (Ruth)

The lack of consultation associated with the preparation for and allocation to the RN Buddy role was identified as another ritual that reinforces a disempowered position for nurses.

No-one told you anything. They wouldn't even say you're getting students today. There'd just be a name next to yours, and then [the student's] would say; 'Who's Cath?' I'm Cath and you are such and such? Right okay, alrighty and then I have to go through, ask them: "Where are you at? Right, what do you know?" I mean I forget too then I think are you up to IVs yet? I forget so you find all that out in the first ten minutes. (Cath)

This situation represents an important site of resistance – by requesting consultation, by working through feelings of guilt, RN Buddies have the potential to change nursing practice and ritual, and advance and improve clinical educational practices.

Interruption

The term *Interruption* refers to the confidence of RN Buddies to interrupt student nursing practice when it was perceived to be unhelpful or negative (Walker, 2006, p. 75).

Finally, it is important to note another site of resistance - some RN Buddies were effective in interrupting and challenging what they perceived to be ineffective nursing practices and in turn allowed their own set beliefs and practices to be interrupted and challenged.

... I've sat down with facilitators and students and just said: 'Look you know, you've become a little bit too close here or you've stepped over the mark by doing this you know, do you recognise [that]?'; and go through the points of professional conduct and then you know hopefully they've used it as a learning experience. (Alan)

I don't think you're doing your job as a Buddy RN if you let [students] get away with fumbling and excuses because they obviously don't know and that's what I see my role as being, [as] someone that's trying to help them know that ...it doesn't matter if you don't know. I think that some people might see ...me [as] being a bit short with them. (Ruth)

...I'm asking them more questions and sort of challenging them more. I know I would have hated that as a student, I really would have. (Beth)

DISCUSSION

The four main 'points of tension' uncovered (*Acknowledgement*, *Experience*, *Balance* and *Interruption*) revealed a number of paradoxes. For example, a paradox exists within the tension *Acknowledgement*. This contradiction suggests that although RN Buddies play an important role in clinical education, they remain devalued within the overall context of undergraduate nursing clinical education. The relationship between undergraduate nursing student and RN Buddy has the potential to transform learning for students and the RN however, it remains invisible because of its lack of formal acknowledgement and articulation by the bureaucracies that regulate and manage nursing.

An important related issue requiring mention is that the RN Buddy role is unique to nursing training. Roles and responsibilities for the RN Buddy within the Queensland context are different to those of the Clinical Facilitator, Preceptor and Mentor, in that the RN Buddy must be dynamic and adaptable to quickly develop an effective relationship with a different student each shift and meet both their educational/supervisory and patient-care responsibilities. There is also little consultation with, preparation of, or support for RN Buddies who work with undergraduate nursing students. Even though the role is mandated (ANMC, 2005), and there is a recognised oral culture devoted to the responsibility, there is little evidence of formal preparation, support or evaluation of the RN Buddy role.

Another paradox exists within the tension *Experience*. That is, length of time served as an RN continues to be valued over other manifestations of knowledge and understanding. Hooks argues (1994) that experience ('time in the job') continues to have authority in a dominant paradigm, whilst naivety, enthusiasm and energy that may come from being new were devalued. Although the ranks of nursing are filled with new graduates and frequently occupied by growing numbers of undergraduate nursing students, the 'authority of experience' seems to continue to dictate who has value and what knowledge is valued in nursing (Hooks, 1994).

The study identified that students perpetuated the 'authority of experience' by valuing RN Buddies who had 'experience' in the traditional sense – that is those who have worked for a number of years (Hooks, 1994). Conversely, they devalued RN Buddies who lacked that 'experience' even if they were skilled, supportive and otherwise excellent in their Buddy role. Similarly, RN Buddies themselves devalued excellence in favour of experience.

With greater recognition and understanding of the RN Buddy role within undergraduate tertiary and health care settings, the new nursing graduates who inevitably become RN Buddies should be able to understand the

restraints of outdated beliefs and practices. Becoming informed might enable RNs to feel less vulnerable to the criticisms associated with the 'authority of experience' (Hooks, 1994), and encourage them to learn skills to identify and reject the pressure to conform to outmoded ways of thinking and the resulting cycle of self-diminishment.

The tension of *Interruption* offers possibilities for the future of RN Buddies, one that is not constrained by the negative cultural traits common to the nursing profession. If undergraduate nursing students were taught about the problematic nature of experience and invited to value other things such as optimism and enthusiasm, then when they themselves became an RN Buddy, these negative traits could be interrupted. In this way memories of experience exposed during undergraduate training might not always necessarily perpetuate the current status quo. Indeed it was encouraging to find that the interruption of negative practices and attitudes by RN Buddies suggested transformation within nursing is already beginning to occur. Some of the participant RN Buddies were open about their desire to learn from others including undergraduate nursing students. Moreover, a few RN Buddies indicated that they thought an important aspect of their role was to interrupt and challenge out-dated ritualised nursing behaviours mimicked by undergraduate nursing students.

The tension *Balance* reveals another paradox. Registered Nurses in contemporary health settings are professionally mandated to be independent and accountable critical thinkers; however there is also an expectation that they will follow direction without question (Roberts, 1994). This contradiction once again points to the lack of preparation, support and recognition for the RN Buddy role and also to the maintenance of outdated views of nursing and nurses which continue to demoralise and oppress all nurses, including undergraduate nursing students.

The study also revealed that the experience of *Balance* may be impossible for RN Buddies to achieve. The nature of the contemporary nursing role requires attendance to both patients and students; however patients must always come first. As a consequence RN Buddies frequently experience a degree of guilt and shame when they are unable to sustain their responsibilities to undergraduate nursing students whilst providing for holistic patient care (Hooks, 2003; McIntosh, 2005).

There are obvious links that influence this tension. The complexity of the RN Buddy role requires a delicate balancing of competing needs which is often unrecognised by bureaucracy and students. This lack of recognition for those skills and knowledge may lead RN Buddies to feel isolated, insecure and devalued. It should also be acknowledged that as modern health settings become increasingly complicated and demanding there is an even greater need for these nonlinear, dynamic approaches to being an RN that identify more with ethical care than task-achievement. RN Buddies should therefore not feel guilty about having to focus their attention on patient care at the occasional expense of a learning experience for an undergraduate nursing

student. This reality should be a formally accepted aspect of the RN Buddy role and one which has authority based on principles of humanism.

CONCLUSION

The objective of the research was to uncover the complexities of the RN Buddy experience, thus positivist-based criterion to judge the rigor of research conclusions were considered inappropriate. The true goal of this exploratory snapshot was to capture the reader's attention and allow them to determine what is real, useful and meaningful. The recommendations that emerged from this study have implications for policy, education, management and future research. Primarily a clear articulation of the RN Buddy role in the form of policy is required from nursing's regulating professional bodies, working in concert with management of health-care services. From this, health service management in collaboration with universities can initiate the process of creating a framework for preparing, supporting, and assessing the RN Buddy role. Undergraduate and postgraduate nursing programs can include discussions about the complexity of the RN Buddy role so that students have some preparation for their future role as clinical teachers. Specific innovations include testing the Learning Circle innovation developed by early childhood academics (Nobel, Macfarlane, Kilderry & Nolan, 2005), and on-line assistance in the form of advice and discussion similar to the on-line learning community for clinical educators devised by McAlister & Moyle (2006). Activities which engage, acknowledgement, support and value the RN Buddy role may in turn improve the processes and outcomes of clinical education for nurses, students and health-care consumers.

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