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Using Clinical Narratives in Program and Curriculum Evaluation

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Abstract

Background: Using personal experience stories as teaching tools, clinical narratives are an effective means for sharing the art of nursing practice and provide insight into nurses' critical thinking and clinical proficiency. Using clinical narratives to assess curriculum effectiveness provides important insights into changed practice and learning beyond the classroom. **Aim:** This article provides an example of using clinical narratives in the evaluation of the Department of Veterans Health Affairs Office of Nursing Services (ONS) Evidence Based Practice Curriculum (EBPC). **Methods:** As part of a larger mixed-method evaluation of the EBPC, clinical narrative methods were employed to describe one incident where participants (n=3) applied at least two of three evidence based practice components (best available evidence; clinical expertise; patient preference). **Results:** Examination of clinical narratives demonstrated successful application of key components of evidence based practice and an integration into individual nursing practice beyond data obtained from other evaluation methods. **Conclusions:** Incorporating rich clinical narratives into a rigorous mixed-method program evaluation protocol provides insights beyond information uptake, satisfaction, efficacy, or competency assessment scores.

Keywords: Narratives; Evidence based practice; Program evaluation; Nursing education

Introduction

Program evaluation is an important part of successful program implementation [1]. Often program evaluation uses multiple methods to assess the implementation and uptake of innovation into daily routines [2]. These methods include analysis of administrative data, surveys and interviews among others [2,3]. Elicitation of clinical narratives in for evaluation purposes is not commonly done yet can yield rich, comprehensive data to reflect assimilation of new innovations into the day to day practice within healthcare systems [4]. Clinical narratives are a first-person story written or told by a clinician describing a specific event, which provides context and elements of caring and human relationships, which are often missing from formal guidelines [4]. A clinical narrative allows clinicians to reflect on their practice or specific experiences [5]. They are relatable and can be broadly disseminated to highlight how exposure to the new EBPC can change nursing practice. Benner's work outlined the clinical narrative as an optimal technique for advancing both the art and science of nursing [6].

In 2011 the Veterans Health Administration (VHA) released a directive (2011-039) for the Registered Nurses (RN) Transition-to-Practice (TTP) Program. The TTP Program is a comprehensive, developmental training program Curriculum. The 12-month mentored nurse residency program has both didactic and clinical components designed to give structured around the VA's Evidence Based Practice newly graduated RNs the opportunity to gain confidence while performing roles, such as direct patient caregiver.

The Evidence Based Practice Curriculum (EBPC) contains a project guide, or a tool, to introduce RNs to the concept of EBP (VHA 2011-039, p B1). The EBPC consists of 15 multi-media modules using multiple learning strategies, such as videos, web links, the VHA staff education system, written materials, slide decks, worksheets and discussions. The curriculum does not require RNs to complete a project per se but learning activities (including EBP projects) are expected to facilitate incorporating EBP as a problem-solving approach to clinical decision-making, integrating the best available evidence, clinical expertise, and patient preferences into nursing practice.

In 2017, VA Office of Nursing Services joined with Nursing Innovations Center for Evaluation (NICE) to evaluate the EBPC. The current project was the evaluation of the RNs use of EBPC in their daily practice. This evaluation used qualitative interviews of RNs who completed the new curriculum in their TTP programs to generate clinical narratives. Clinical narratives were used to evaluate the transfer of knowledge from the EBPC trainings into everyday clinical practices of the new RNs. This data collection method was chosen for several reasons. First, clinical narratives are a proven method for sharing nursing knowledge, especially when the purpose of a program being evaluated is to change nursing knowledge [7]. Second, clinical narratives provide concrete and easily digestible examples of changed practice

that can be viewed as an exemplar [8]. Finally, clinical narratives are an important part of nursing culture and a primary way nurses communicate knowledge, experience, and practice [9-11].

Aim

This paper provides a discussion of how clinical narratives may enhance future program evaluations, using results from Phase 3 of the EBPC evaluation as an example.

Subjects and Methods

This project was approved as a quality improvement project by the James A. Haley Veterans' Hospital Research and Development Committee. Qualitative over the phone interviews were used to elicit specific clinical examples of applying the EBP clinical framework at the bedside.

Sample

Program evaluation team members identified a purposive sample of graduate nurses based on their responses to the EBPC evaluation survey. Program evaluation team members reviewed the postgraduate RN responses to three specific questions: 1) How did the EBP class(es) affect your understanding of EBP as a framework for practice? 2) How did the EBP classes affect your understanding of EBP as a process for conducting projects? and 3) Do you plan to incorporate your understanding of EBP into your nursing practice? The responses were evaluated by evaluation team members with both qualitative and clinical expertise for quality and richness. Nurses with high quality answers were invited to complete an interview. Of the 30 participants surveyed, 17 responders were identified as potential clinical narrative participants. Nine of the 17 were coded "rich", while the remaining were identified as responders that provided decent responses and could be interviewed to ensure the appropriate sample size is met (12). Of those nine, three agreed to participate.

Instruments

The program evaluation team had developed a Clinical Narrative Guide as a qualitative interview script for phone interviews. However, the team quickly recognized our Clinical Narrative Guide was too narrowly focused and not effective in eliciting rich narratives from phone interviews. The program evaluation team subsequently reached out to the five greatest likelihood of integrating EPB as a framework for practice and interviewed them using the newly revised Clinical Narrative Guide. Some respondents were unable to provide clear clinical narratives that were easy to follow.

Three of those five clinical narratives are described in this paper.

The EBPC Clinical Narrative Guide included three open-ended questions and was developed based on Benner's work. The first question asked for the EBPC graduates to share a story about a clinical situation where at least two components of EBP were applied to make a difference for a patient and/or his or her family. The next two questions asked about the influence others had on the situation and the nurse's feelings and concerns about the situation.

Data collection procedures

Graduate nurses were invited to participate in a 30-45-minute interview. An experienced qualitative researcher reviewed data collection procedures and confidentiality with each participant. The facilitator used an interview protocol to elicit the clinical narrative and used probing questions as needed to prompt a rich and complete narrative. Unlike an evaluation interview with focused, programmatic questions, facilitators prompted participants to describe context in detail and the thoughts and emotions they experienced at the time.

Analysis

Two evaluation team members edited each clinical narrative to yield a clear and concise story, e.g., removing false starts, hedging phrases. All efforts were made to keep the content of the narratives intact.

Results

Three narratives illustrated different ways that nurses incorporated EBP into practice. The narratives are summarized from the interview notes and are essentially their stories in their own words.

Narrative 1: Clinical Expertise in the Emergency Department

> I was working in a busy emergency department during the day shift when an ambulance arrived. It was carrying an elderly, frail gentleman. I met the first responders at the ambulance bay, and they provided a quick report: My patient, Mr. Jones (not his real name), had dementia, lived in a nursing home, and was found in his bed. He was weak, had a history of diabetes, and no complaints of pain, although he fell on transfer. All his vital signs were within normal limits. The first responders had given Mr. Jones IV fluids flowing at 300 cc per hour (a very high rate) and oxygen per nasal cannula at 2 liters/minute.
>
> Immediately performing a thorough assessment, I looked for physical injuries from the fall and listened to his lungs, heart, and abdomen. I assessed his skin turgor and integrity. It was evident that Mr. Jones was well hydrated. Using my clinical expertise, I recognized the potential danger for fluid overload with the high rate of IV fluid because of his advanced age, frailty, and history of diabetes, which can impact renal function. I was scared to disagree with first responders. How could I change his fluid rate without conferring with a superior? I took a deep breath and made my decision based on my assessment. I decreased fluids to 30 cc per hour and was immediately met with resistance from the first responders. Fluid rate of 300 cc per hour was their protocol for anyone transferred from a nursing home. I insisted they had to consider his physical status before overloading him with fluids. As voices became more

heated, my mentor joined the conversation. My mentor supported my decision to decrease fluids. She gave additional rationale for the change and offered to speak to responsible leadership to change first responder protocol.

I felt empowered during that shift. My mentor supported my clinical decision. My voice was strong enough to stand up to those with more years of experience. My informed decision-making and improved confidence helped to save an elderly gentleman from unnecessary hospital complications.

In this first narrative, the nurse reported feeling empowered by the EBP Curriculum. She used her nursing assessment skills (clinical expertise) to do what was best (best available evidence) for a Veteran when other providers ignored a critical aspect of the Veteran's condition. She was confident in her assessment of his need for a lower rate of fluid. This confidence, and the subsequent support of her mentor, helped her to prevent a potential adverse event, fluid overload.

Narrative 2: Clinical Expertise in the Cardiology Unit

While working the evening shift on the cardiology unit, I received a call for another admission. This was the third admit to the unit during this shift. Everyone was tired. The emergency department (ED) called with report on my new patient, Mr. Thomas (not his real name), a middle-aged man with uncontrollable hypertension (HTN). He was brought to the ED by family who felt he needed assessment. Mr. Thomas felt fine, so he was very unhappy to be admitted. The ED nurse reported that his pressure was improved after medication to what might be expected for his age.

I received Mr. Thomas from the ED and started his admission paperwork. He denied headache, pain, or feeling ill. I educated him on the need to lower his blood pressure. My initial assessment was thorough, including vital signs, even though the ED nurse reported recent vital signs were within normal. The blood pressure machine did not read his pressure in his right arm, so I moved to his left arm. Again, the machine was showing an error message. I went down the hall and found a new machine—the same error occurred. Next, I found a manual cuff, took his pressure, and it was critically high. I contacted the attending physician for medication.

The physician declined my request stating the blood pressure was fine in the ED. I urged the physician to please reconsider her decision for additional medication and was given an order for a small dose. I administered a stat dose and continued to assess Mr. Thomas frequently. After 30 minutes, his blood pressure was rising again. I advocated for Mr. Thomas and insisted the physician evaluate him in person. The physician soon arrived and performed her own assessment. An additional health crisis was confirmed, which prompted the physician to transfer Mr. Thomas to the Intensive Care Unit (ICU), where he stayed for several days. When he returned to the cardiology unit, he was very appreciative of the attention to detail and communication I provided.

In this second narrative, the nurse felt that the incident was a turning point in her professional development—she recognized that her evidence based assessment could save a life. She respected the family's concern for their loved one's medical condition and helped meet their expectation of thorough assessment (patient/family preference). She did not settle for blood pressure readings that someone else reported. She persisted when machines failed to provide the data needed. It was her clinical expertise that identified his life-threatening situation. She used best available evidence and her clinical expertise to advocate for necessary medication with proper dosing. She reported that, with this solid foundation of clinical expertise and best available evidence, she was confident when advocating for her patient in communications with the health care team.

Narrative 3: Patient Preference and Clinical Expertise in the ED

It was a Friday evening at the end of the month. Our ED was slammed with Veterans. Many needed medication refills and could not wait. Many were frustrated with the slow process and even slower response to their needs. Our techs were bringing Veterans back for triage. I was a new RN and charged with triaging that night. This entailed asking Veterans what their needs were and deciding who would be fast tracked and who could wait. Those who needed immediate attention were taken to rooms to wait for the doctor. One such patient was Mr. Smith (not his real name).

Mr. Smith was an older gentleman, with gray hair and facial stubble. His clothes were tattered and dirty. He came in for a refill of his pain medication. Years of marching with a pack had damaged his knees, and he was in constant pain. The ED resident was rushed. He had many people to assess and treat, and he had little time to stop and truly listen to his patients. I was quick to notice Mr. Smith's disheveled appearance and his angry affect. Even though I was busy, I decided to ask questions about his life and home environment. He told me he had been homeless for a few weeks and had been struggling to get food and shelter each night. We continued to talk and bonded over a fondness for dogs. After a few minutes, I left to tend to my other patients, finish my triage rotation, and take my lunch break.

After my break the charge nurse assigned me to care for Mr. Smith. I took report and reviewed his chart. The doctor had ordered pain medication and anti-anxiety medication. I had a faint twitch in my memory —what was it Mr. Smith had said? He was recovering from an addiction—I went to Mr. Smith's room and clarified. Yes, he was recently discharged from a rehabilitation program and was struggling to avoid a variety of prescription medications he had abused, including the same antianxiety medication just now prescribed by the doctor. I explained the Veteran's preference to the doctor. By listening to my patient and taking his preferences into account, I was able to get Mr. Smith's order changed and make a referral to social work to assist with housing.

In this third narrative, the nurse again relayed confidence in her decision making based on her use of EBP as a clinical decision-making framework. In this example, the nurse used all three components of EBP. Much of her success was rooted in her clinical expertise. Not only was she observant but based on her observations from time spent talking with the Veteran (and learning his preferences), she was able to assure his needs were met. Her caring attitude elicited open responses from an angry man, helped diffuse his anger and helped earn his trust. Her conversation elicited vital information about her patient's preferences, important for altering the treatment plan. Best available evidence was to avoid certain medications after rehabilitation. Clinical expertise guided this nurse to use her observations to further her assessment of the patient's current situation. The patient's preferences to be respected, listened to, and avoid certain medications were honored. All three components of EBP led to a referral for social work to help with housing.

Discussion

These clinical narratives were provided by new TTP graduate RNs, when asked to describe how the ONS EBPC had affected their clinical practice. In practice, when urgent matters arise in seconds, rarely do nurses stop to look up current clinical guidelines. Professional nurses keep up to date on clinical guidelines relevant to their practice through ongoing education. For the purposes of analysis, we operationalized 'best available evidence' as evidence known through ongoing education such as review of clinical guidelines, reading of nursing literature, and guidance from reliable online sources (e.g., CDC.gov). These narratives illustrate the thought processes in applying principles of evidence based practice in clinical care.

Each of the new TTP graduate RNs demonstrated an assimilation of EBPC teachings and practices into their bedside practice. Of interest is that when initially asked to describe how the EBPC affected their clinical practice, each nurse struggled to put to words how their practice had changed. Through the Clinical Narrative Guide, each nurse described a memorable clinical event and identified components of EBP applied to the event. Each expressed satisfaction with the newfound clarity provided by the experience of developing a clinical narrative through the Clinical Narrative Guide. Each reported that until developing a clinical narrative they had not yet recognized their instinctual use of EPB as a framework for practice as a result of the EBPC.

Implications

RNs who participated in the 12-month Transition to Practice Residency with the revised ONS EBPC reported feeling empowered and confident in their clinical decision making at the completion of the program. The clinical narratives illustrate how nurses incorporate key components of EBP into patient care. Evidence based practice is not a one-time project; it is a learned mindset to help guide clinical decisions for patient care. This effective EBP mindset is continuously informed by the best available scientific evidence (clinical guidelines, research, pathophysiology), clinical expertise (professional experience and training), and influenced significantly by the patient's (and patient's family) preferences. In all three reported narratives, nurses demonstrate the value of EBP in meeting patient needs. Additionally, the use of clinical narratives was shown to be a useful tool to evaluate the effectiveness of the VHA EBP curriculum and elicit rich feedback from program participants. Furthermore, all participants who provided clinical narratives seemed to enjoy telling their stories and reported the process of providing a clinical narrative helped the event become more meaningful and reinforced the EBP process for them. In conclusion, empowering nurses by providing a strong and consistent framework (such as EBP) to approach every clinical care situation, increases the nurses' potential to improve clinical care and save lives.

Evaluation of nursing practice is best done via narratives as they describe the practice within a context [13]. Curriculum evaluation is critical to the educator's ability to measure and understand the effectiveness of an educational endeavor. While a myriad of tools are available for this task, this evaluation is notable for its illustration of assessing curriculum effectiveness via the clinical narrative. Additionally, the clinical narrative can provide a deeper evaluation and understanding of curriculum effectiveness as it is able to demonstrate not only the acquisition of knowledge, but the nurse's ability to comprehend, apply and analyze practice [14]. This ability to reflect and apply is critical in advancing the nurse from novice to expert.

Post graduate RNs participating in a 12-month Transition to Practice Residency were learners associated with the use of this curriculum. In clinical narratives, these nurses reported feeling empowered and confident in their clinical decision making because of program participation. Clinical narratives illustrated how the nurses were able to incorporate key elements of EBP into patient care, demonstrating not only knowledge acquisition but the ability to apply this knowledge and reflect and analyze on their exemplar. Even more importantly, this narrative demonstrated the curriculum's effectiveness in conveying the important concept of EBP as a continuous practice and mindset that is critical to informing patient care and clinical decision making versus a process for project work. In all three clinical narratives, the nurses articulated the importance and the value of having an evidence based practice, demonstrating the ability of the EBP curriculum to move nurses to informed action.

Conclusion

Evidence based practice is not a one-time project, it is a learned mindset to help guide clinical decisions for patient care. In all three reported narratives, these nurses demonstrate the value of EBP in meeting patient needs. Empowering nurses by providing a strong and consistent framework (such as EBP) to approach every clinical care situation, increases the nurses' potential to improve clinical care and save lives. Additionally, the use of clinical narratives was shown to be a useful tool to evaluate the effectiveness of the VA EBP curriculum, and elicit rich feedback from program participants. All participants who provided clinical narratives enjoyed telling their stories and reported the process of providing a clinical narrative helped the event become more

meaningful to them and reinforced the EBP process for them. Clinical narratives are useful not only as program evaluation tools, but also as course evaluation tools, to cement in the learner's mind the impact of course (program) teachings. Based on this and other evaluations [7], the authors encourage program evaluators to consider adding clinical narratives to their tool kit of evaluation tools.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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